

Rochester STD/HIV Behavioral Counseling (RoSHBeC)

CASE EXAMPLES

Identifying target behaviors, assessing client readiness, and
using counseling strategies that match

**RoSHBeC is a method of Stage-based Behavioral Counseling developed by the
STD/HIV Program and the CHBT in Rochester, New York –
a collaboration of the:**

University of Rochester:

- **Infectious Diseases Unit, Department of Medicine**
- **Department of Community and Preventive Medicine**
- **Behavioral and Psychosocial Medicine Unit, Department of
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Direct inquiries to: Patricia Coury-Doniger, FNPC, Infectious Diseases Unit, Department of Medicine, University of Rochester
Medical Center, 601 Elmwood Avenue, Rochester, New York 14642; (716) 464-5928, Fax (716) 464-6510.

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INTRODUCTION

In the first 15 years of the HIV epidemic, client education alone has not resulted in sustained sexual and substance use behavior change needed for primary prevention. More recently, interventions grounded in behavioral science have demonstrated efficacy in the primary prevention of HIV and other sexually transmitted diseases (STDs). Many barriers exist, however, in the implementation of research-proven behavioral interventions in “real world” settings. This paper describes an adaptation of the Stage of Change/Transtheoretical Model (SOC/TTM) to develop a stage-based method of counseling that is currently being used to promote sexual and substance use behavior change for reducing the risk of acquiring STDs and HIV. This behavioral counseling intervention, named Rochester STD/HIV Behavioral Counseling (RoSHBeC) was developed for front-line providers who deliver STD/HIV prevention interventions to at-risk individuals in both clinical and community based settings. A systematic method for assessing the client’s SOC, previously described in Coury-Doniger, Levenkron, Knox, Cowell, & Urban (1999), provides the basis for the selection of practical counseling strategies adapted from the processes of change described in the TTM. The present paper traces our efforts to develop these counseling strategies specific to sexual behaviors and illustrates their use in 12 common clinical cases (STD/HIV-prevention counseling sessions). The RoSHBeC behavioral counseling intervention can also be used to influence other health-related behaviors at the individual and group levels. The steps of RoSHBeC provide a structured psychological intervention that is grounded in behavioral science (SOC/TTM) and is practical enough to be delivered by a wide variety of providers with limited formal training in counseling and behavioral treatment methods.

Utilizing Counseling Strategies matched to Stage of Change:

This booklet describes each of the five stages of readiness for change and discusses the Transtheoretical Model’s processes of change that were used to develop the stage-based RoSHBeC counseling strategies. The RoSHBeC counseling strategies were assigned easy to remember names. The more formal processes of change are included in parentheses after each strategy (and are summarized in Table 1). The case examples are offered to illustrate how a counselor can use each counseling strategy for a specific SOC. The case examples came from real client scenarios.

A. PRECONTEMPLATIVE STAGE – PC

Considered the earliest stage of change, precontemplation is marked by either a lack of recognition of the need to change or an attitudinal rejection of the change. As opposed to being merely reluctant to change, individuals in precontemplation may lack sufficient information to recognize that change is needed, or they may possess strong, fixed emotional resistance that obstructs any desire to or appreciation of the benefits of change. Consequently, interventions are typically aimed at redressing the lack of knowledge or awareness of the problem, or addressing the underlying emotional obstacles to change. The following counseling strategies can be used to help the client see the need for change and introduce ambivalence.

1. PC Counseling Strategy: Information Giving (consciousness raising)

Much information can be shared with clients about STD and HIV that allows them to begin to consider change in sexual risk behavior. A list of eight specific information-giving strategies appears in Table 2. These are most useful or appropriate when the client does not recognize that change is needed because of a lack of specific knowledge or awareness of STD/HIV risk. Based on the likely target for behavior change and the personal circumstances of the client, the counselor can present one or more of the most relevant strategies. The information given should be short, culturally and linguistically appropriate, and followed by active listening to allow the client to process and react to the information by relating it to his/her personal circumstances.

Case 1: Information Giving – Mucosal Immunity

Client: A 27-year-old single mother denies any risk of HIV but has recently been treated for gonorrhea. The client and partner are not intravenous drug users (IDUs) and do not use other substances. She is sexually involved only with this one partner and knows that her partner has other partners. Condoms are not used because the client says “I’m monogamous.”

SOC and target behavior: The provider assesses client to be precontemplative (doesn’t see the need) for sexual risk reduction via condom use, believing that her own monogamous sexual behavior is low risk.

Counseling Strategy: The provider then chooses the information-giving strategy, specifically discussing mucosal immunity, which explains how the presence of STDs increases biological susceptibility to HIV infection. The client is surprised to learn of her enhanced vulnerability to HIV as a result of her recent gonorrhea infection. The provider then suggests that monogamy is only protective if both partners are having sex only with each other. The client then revises her perception of risk when she realizes that her partner’s risk of STD/HIV (and therefore her own) is relatively high.

Case 2: Information Giving – Factors Determining Risk of Acquiring STD/HIV

Client: A 42-year-old salesman who intermittently has sex with multiple partners and reports not using condoms because “I’m careful” in selecting sexual partners. He often travels to and selects partners in geographic areas where there is relatively high STD and HIV disease prevalence.

SOC and target behavior: The provider assesses this client to be precontemplative for sexual risk reduction via condom use, believing that he can adequately select safe partners.

Counseling strategy: The counselor chooses to give the client information about the prevalence of STDs and HIV in some of the cities visited by the salesman and explains how his personal risk of acquiring an STD or HIV is increased by the community disease prevalence. The client reports that he had “never thought about that.” He had always assumed that his risk depended solely on the total number of sexual partners and whether or not they were “respectable” people. He then reports feeling ambivalent about the idea of routine condom use.

2. PC Counseling Strategy: Storytelling (dramatic relief)

In comparison to the fact-delivering approach of giving information, the storytelling strategy attempts to indirectly address emotional resistance to STD/HIV sexual behavior change. Some precontemplative clients are openly rebellious, appearing hostile, defensive, and overtly rejecting any possibility of their need to alter risk behavior. Others offer many rationalizations, constructing an argument for why the behavior is not a problem for them (Miller & Rollnick, 1991). In both cases, storytelling can indirectly alter perception of risk through a role identification process that is critical in dramatic relief.

The provider engages the client by recounting a story of his or her professional experience with a similar client and how it affected both the counselor and the client in the story. The counselor tells the client about another client with similar attitudes and behaviors and the unexpected negative consequences so that the client becomes emotionally engaged in the story. The provider then explores the emotional reactions that the story elicits and invites the client to imagine his/her own feelings if these consequences were personally experienced. The goal of dramatic relief is to engage the client emotionally in a way that circumvents direct conflict with either rebellious or rationalizing resistance. The effect of storytelling is to help the client identify that a problem related to the target behavior exists. As a result, the client now sees a need to change and thus has progressed to the contemplative stage (the counseling goal with a precontemplative client).

Case 3: Storytelling

Client: A 19-year-old male who has been treated for gonorrhea and chlamydia in the past 6 months gives a history of four partners in the previous 3 months, but argues angrily with a counselor who attempts to identify HIV risk. The client emphatically states, “I don’t want to hear about that; I’m not gay and I don’t do drugs, now just give me my medicine; I want to get out of here!”

SOC and target behavior: The provider assesses the client to be precontemplative for condom use because of misperceptions of who is at risk.

Counseling Strategy: The provider shares the following story:

“Tony, I hear you. You’re not worried about HIV, but I have to tell you that I am. I know you think that getting STD infections is no big deal and that you’re not at risk for HIV, but try to imagine my position. Last week I saw a client just like you – a smart, energetic guy, planning to make his life better. He felt fine, but his girlfriend had just been treated for an infection at her doctor’s office and they said he needed some medication as well. He had never thought about HIV since he said it was only a problem for “gays” and “druggies”. He decided to take the test anyway. It came back positive and I had to tell him he had HIV. He was only 22 years old. Worse yet, his girlfriend was pregnant and there was a chance that he had infected his girlfriend and his baby without even knowing it. It was one of the hardest things I had to do.”

The provider asks a series of questions to facilitate the client’s reactions. “Could you imagine what that was like?” “What do you think he felt like?” “How do you think you would react if something like that happened to you?”

3. PC Counseling Strategy: Discuss Impact of Behavior on Others (environmental reevaluation)

Many clients express perceived risk of acquiring STD/HIV but, because of fatalistic attitudes, lack any perceived benefit of behavior change. These clients have attitudes of low outcome expectancy (Bandura, 1997), and so behavior change to avoid HIV infection will not make a positive difference in their lives. These clients express an overt lack of caring about acquiring HIV even though they may have known someone affected by HIV. This counseling strategy invites clients to assess the impact of their behavior on others about whom they may care deeply: their children, other family members, sexual partners, friends and neighbors. Additionally, clients can be invited to describe how the HIV/AIDS epidemic has impacted their neighborhoods or community. Using this intervention, the counselor attempts to get the client to see the need for change in order to avoid undesirable consequences for significant others and/or their community as a whole.

Case 4: Discuss Impact of Behavior on Others

Client: A 19-year-old male with multiple sexual partners who belongs to a street gang states in response to the counselor's assessment of his STD/HIV risk, "I don't care if I do get it, I'll probably not live to be 25 anyway".

SOC and target behavior: The provider assesses the client to be precontemplative for condom use because he sees no need to protect himself against HIV when he faces more immediate threats of violence and possibly early death.

Counseling strategy: The provider, choosing to discuss the impact of the client's behavior on others, learns that the client lives with his 60-year-old grandmother, to whom he feels close and provides help. The counselor facilitates a discussion of how the client acquiring HIV would impact his grandmother asking, "How she would feel if something happened to you? If you got HIV, how would it affect *her* life?" The client states he had never considered that, but that he thought she would be very sad and helpless because "when I was little she took care of me and now I take care of her." The counselor helps the client to see how his using a condom is actually protecting his grandmother.

B. CONTEMPLATION STAGE – C

At the contemplation stage, the client acknowledges the problem but is not able to initiate or even plan to take action in pursuit of change because of ambivalence. Risk reduction efforts may proceed only after the client resolves this ambivalence and conflict aroused by the possibility of change. The client must weigh personal needs and choices that create tension and allow current behaviors to be maintained. The strategies for contemplation can build upon those employed with precontemplative clients – giving information, storytelling, or discussing impact of behavior on others – all in an effort to illuminate one side of the conflict over the other. However, the process of self-reevaluation offers several additional counseling strategies appropriate to this stage.

4. C Counseling Strategy: Explore Ambivalence and Offer Substitutes (self-reevaluation)

Clients in the contemplation stage can usually identify reasons why change in the direction of reducing risk would be health promoting for them, but are often in conflict with a number of potential costs or negative consequences for themselves or their relationships. This commonplace counseling technique invites clients to acknowledge both the pros and cons of initiating change in sexual behavior. Clients might perceive that the consequences of initiating change in a sexual behavior includes loss of a relationship, financial support, or trust of the partner, and may even result in personal harm. The reasons for ambivalence must be articulated by the client if some resolution to this conflict is to be achieved. Resolution of ambivalence results in a client moving from the contemplation stage to the ready-for-action stage.

Contemplation can often be resolved when clients identify or recognize substitutes for the risk behavior. Like other behaviors, sexual behaviors occur in response to emotional and physical needs. Altering risk behaviors is often perceived as giving up something that is familiar, automatic, pleasurable, and is meeting specific needs. Many clients in the contemplation stage

cannot easily recognize or identify substitutes for the risk behaviors that have been part of an establish pattern. It is important to determine the pros related to the behavior that contribute to ambivalence and help the client identify which substitutes might meet some of the same needs. Adopting these substitutes often serves as a harm reduction strategy (MacCoun, 1998; Marlett, 1998).

Case 5: Explore Ambivalence and Offer Substitutes

Client: A 17-year-old unmarried student who has had sex with only one partner feels “safe” because she “doesn’t sleep around”. She reports that they are not using condoms, as she is very sure that she and her partner are mutually monogamous. She is willing to take an HIV test and sees the need for her partner to be tested, but is reluctant to discuss it with her partner because she doesn’t want to “get in his business,” stating that this behavior on her part has elicited a negative reaction from him in the past.

SOC and target behavior: The counselor assesses the client to be contemplative about getting her partner tested for STD/HIV because she sees the need to know her partner’s HIV status, but considers this action to be risky to her relationship.

Counseling strategy: The counselor explores the client’s ambivalence by inviting the client to compare the positive results of getting her partner tested (knowing that she was not at risk for acquiring an STD/HIV) with the potential negative consequences (her partner getting angry at her because of her questioning his sexual/substance use past history). The counselor then offers a substitute by suggesting that the client can tell her partner that the provider is recommending STD/HIV testing to all clients and their partners. The client can then suggest the partner be tested as part of a routine medical recommendation, without the need to elicit or disclose personal past history. The client agrees to try this approach.

5. C Counseling Strategy: Explore Self-image in Relation to Behavior (self-reevaluation)

The second strategy for self-reevaluation focuses on exploring the client's self-image. Sexual behaviors often occur in secrecy because of anticipated shame and social disapproval. A client may live two lives: a social role accepted by and responsible to others and a sexual role that goes against societal taboos and is potentially harmful to self or others. A client's sexual behaviors that cause risk for STD/HIV may or may not relate to self-image. Discussing a client's sexual behaviors in relation to how they see themselves in their social roles can be a strategy for self-reevaluation.

Case 6: Explore Self-image in Relation to Behavior

Client: A 45-year-old married man is engaging in anonymous, unprotected sex with men in adult bookstores. He is not using condoms because these encounters are unplanned; he doesn't carry condoms with him because he is married and doesn't use them with his wife. He doesn't want anyone to know about the encounters because it would be devastating to his wife and children.

SOC and target behavior: The provider assesses this client to be contemplative for condom use because he knows that his behavior is high risk for acquiring STD/HIV, but feels the presence of condoms would be disclosing.

Counseling strategy: The provider explores the client's ambivalence about having anonymous sexual encounters and not disclosing to his wife his feelings of sexual attraction to men. The client refuses to consider individual or marriage counseling. The provider then asks the client to describe his self-image in relation to his family and his job. The client states that he is intelligent and highly competent at work and is the protector and provider for his wife and children. The provider then asks the client to describe how he feels about himself after having unprotected anonymous sex in a bookstore. The provider then helps the client to see how having and using condoms consistently during these encounters would be intelligent, competent behavior that would protect his wife and family from the devastation of infection with STD/HIV. The provider compiles a listing of counseling resources in case the client reconsiders his willingness to address the larger sexual identity and relationships issues.

C. READY-FOR-ACTION STAGE – RFA

The RoSHBeC intervention substitutes the name *ready for action* for the preparation stage described in SOC theory. At the ready-for-action stage, the client has acknowledged the need to change and has worked through his or her ambivalence about the consequences of making the change. At this stage, the client views the consequences as more positive than negative, and will often ask *how* to make the change. However, the client now needs to make an explicit commitment that change will be initiated. The steps for change need to be operationalized. The client needs to affirm his or her confidence for learning the skills needed to accomplish the change. The perceived capacity for change becomes especially important. The main counseling strategy at this stage is to help the client develop skills and enhance self-efficacy in relation to a negotiated and specific plan of action.

6. RFA Counseling Strategy: Develop a Plan (self-liberation)

As the name implies, clients who are ready for action must prepare to initiate specific steps that lead to behavior change. Although Prochaska et al. (1992) characterize the change process of self-liberation as an internal commitment built upon optimism and belief about the way to establish a new behavior, this stage can be mastered only by carrying out specific behavioral steps. The interventions that reflect self-liberation involve a collection of steps to develop a plan for change. A key objective in developing a plan is to heighten self-efficacy. Both outcome expectancies and efficacy expectancies can strengthen a client's confidence in adopting new behaviors. Building confidence can be achieved by encouraging clients to express their needs for change to others who are significant in their life. Sharing the perceived need for change creates commitment, builds confidence, and is a first step in the development of any personal plan. Counseling a client who is ready for action often can move directly into practicing skills.

Skill-building techniques including coaching, role-play to rehearse communication skills of the client, and encouraging practice of these skills with friends or other significant relationships can provide the client with specific skills used to negotiate new sexual behaviors. Other skills to be practiced tend to rely on communication but can also involve specific motor acts such as rehearsing the use of a condom (either male or female), preparing a standard verbal statement to be used in communicating with partners, or even developing nonverbal cues or signals. Clients who are ready for action often need to articulate a step-by-step plan of how they might implement their specific STD/HIV risk reduction. This helps the client to clarify the actual steps to take, foster further commitment for change, and adjust the steps based upon feedback from the counselor. The counselor can prompt the client to specify this plan and identify a first step, as in the following example.

Case 7: Develop a Plan

Client: A 27-year-old female is coming for STD/HIV screening because she has recently become engaged, and she and her fiancé are planning to start a family soon after marriage. She just wants to make sure that she “didn’t get anything” from her previous sexual partners. She indicates that she also wants her partner to be tested. She has not yet discussed it with him. She knows he hates “going to the doctor” and is afraid of needles.

SOC and target behavior: The provider assesses the client to be ready for action for getting her partner tested.

Counseling strategy: The provider applies a strategy to develop a plan by addressing both the logistics of getting the partner tested and the client’s self-efficacy to accomplish this. The provider asks how the client currently motivates her partner to do something when he is not enthusiastic, and builds the client’s self-efficacy based on her previous successes. The provider offers a list of potential HIV testing sites including one that uses an oral specimen for testing and does not require a venipuncture procedure involving needles. The provider then role-plays the discussion the client plans to have with her partner, portraying the potential responses of the client’s partner and coaching the client’s responses. The client agrees to speak with partner that evening as the first step.

D. ACTION/MAINTENANCE STAGES – A/M

The action stage occurs when the clients actively perform new or modified behaviors for less than 6 months. The counseling challenge of the action stage involve the need to help clients refine, adjust, and more firmly establish the new behaviors, particularly as disruptive life events occur. Less time is devoted to helping clients adopt positive attitudes about change or learn new information; more time is devoted to preparing clients to solve actual or anticipated problems, sustain successes, and control the immediate factors that influence performance of the target behavior. Clients enter the maintenance stage after 6 months of consistent change. Even though clients in these stages have been successful in changing their behaviors, relapse may occur at any time and so interventions are still needed. The processes of change that operate during action and maintenance are similar and overlapping and include reinforcement management, maximizing helping relationships, counterconditioning techniques, stimulus control, and social liberation. Specific counseling strategies should reflect these underlying change processes.

7. A/M Counseling Strategy: Identify Rewards (reinforcement management)

Behavior change is often sustained if a client receives the positive reinforcement of being rewarded for having been successful in making a change. For some clients, identifying specific rewards, even for small but recognizable changes, allows the client to gradually shape a new behavior pattern. Rewards can be extrinsic or intrinsic. The provider can help reinforce the change by helping a client identify how to create meaningful self-rewards, thus increasing the likelihood that the newly acquired behavior will be maintained.

Case 8: Identify Rewards

Client: A 32-year-old female client with a history of multiple STDs for the previous 5 years presents for STD/HIV screening was found to be uninfected, and had not experienced a new infection for the previous 8 months. The client told the provider that she had been successful using the female condom.

SOC and target behavior: The client was assessed to be in maintenance for consistent condom use.

Counseling strategy: The provider recognizes and praises the client's hard work and suggests that she think of a way to reward herself for her efforts. The client returns an hour later to proudly show the provider her newly purchased pair of sterling silver earrings, stating, "I decided that every time I wear them, it will remind me that I am a strong woman who can make changes in her life and I'm proud of myself."

8. A/M Counseling Strategy: Identify Supports (helping relationships)

Social supports who are invested in helping a client sustain a behavior change are essential for many clients. The supports can be informal friends, family members, or sexual partners or they can be more formal support groups that are available in variety of community settings. Facilitating a client's recognition of the importance of and ongoing need for social support is an important strategy counseling for clients in the action/maintenance phase.

Case 9: Identify Supports

Client: A 15-year-old female client is brought into the clinic by her older sister for a pap smear and STD/HIV screening. The 15-year-old had been involved in her first sexual relationship with a 28-year-old male who had been abusive and had broken up with her 4 months ago. She has not had another sexual relationship since. Her sister recently found out and was worried that she "had gotten something".

SOC and target behavior: This client was in action for sexual inactivity (she had not had sex in the previous 4 months).

Counseling strategy: The provider explored the client's feelings about her first sexual relationship with an older male partner. The client recognized that it started out well, but became coercive and abusive due to the excessive jealousy and control needs of the partner. At the end of the relationship, the partner became physically abusive and threatened the client and her family during the breakup. When asked about her intentions to begin a new sexual relationship, the client states, "I've decided to cool it and not get involved again for a while; that guy really scared me." The provider recognizes the concern displayed by the older sister and asks the client if she could continue to seek support from her. The client agrees to talk with older sister prior to becoming involved in another sexual relationship.

9. A/M Counseling Strategy: Find Substitutes (counterconditioning)

Sexual behaviors occur in response to emotional and physical needs. As such, sexual behaviors cannot be “taken away” without identifying another behavior that can substitute by meeting the same needs, although in a different and safer way. Providers can facilitate this process by helping clients identify the physical and emotional needs being met by their risk behaviors and to explore alternatives.

Case 10: Find Substitutes

Client: A 45-year-old single male who has been arrested twice in the past for soliciting a sex trade worker has not done so for the past 3 months. When asked how the change is working, he expresses concern that he is increasingly tempted as he “is not very good with having a relationship with a woman” and this is a way for him to “get a release without owing the woman anything.”

SOC and target behavior: The client is in action for being sexually inactive but is at risk for relapse relative to having sex with a sex trade worker.

Counseling strategy: The provider acknowledges the client’s expressed need for sexual release. The client states he usually feels the need “every couple of weeks on a Friday night, after working hard all week.” The provider asks the client if he ever considered having this need gratified differently, and then offers an alternative: getting a good takeout meal and a home video with explicit sexual content. The provider suggests that the client could fantasize while watching video and achieve a sexual release. The provider also suggests an option of phone sex if client feels a need for a more personal interaction. The provider reinforces the client’s understanding of the goal to experience sexual gratification, albeit in a less risky manner.

10. A/M Counseling Strategy: Avoid Cues (stimulus control)

Behavior becomes patterned by environmental, psychological, or emotional mood state cues that act as a stimulus for the behavior. This change process has been well documented in the area of substance use, but can often be identified in relation to a client’s sexual behaviors. Many clients describe patterns of sexual behaviors that result from specific mood states or social environments. Facilitating a client’s recognition of their risky sexual behavior cues helps them to avoid or to find alternatives to these antecedents of risk behaviors and is an important strategy to keep clients in action/maintenance stages.

Case 11: Avoid Cues

Client: A 24-year-old male has been using condoms consistently for the past 4 years, but occasionally experiences “slip-ups”. Recently he had unprotected sex with a female partner whom he did not know. The provider asks the client to share the specific circumstances surrounding the behavioral slip. The client states that he went out after work on a Friday night, had too much to drink, and had sex with a girl he met. He had had a stressful work week and had just gone out to “help him let down for the weekend.” The provider asks about previous slips and learns that they all occurred in under similar circumstances at the same bar.

SOC and target behavior: The client was in maintenance for condom use but was experiencing slips due to excessive alcohol use and unplanned sexual encounters with strangers, about which he felt guilty the next day.

Counseling strategy: The provider discussed the need for client to carry condoms even if he wasn’t planning to have sex, emphasizing that the riskiest time to acquire STD/HIV is when one is not planning to have sex. If sex occurs under these circumstances, it is likely to be with a stranger whose STD/HIV status is unknown. The provider then facilitated the client’s awareness that the slips were related to excessive alcohol use in a pick-up setting, and the client recognized these factors, combined with his stress feelings acted as cues for his unsafe sex. He decided that he could invite friends to his house for a Friday night of drinking and avoid unplanned, unsafe sex, or that he needed to always carry a condom if he did go to the bar.

11. A/M Counseling Strategy: Become a Role Model (social liberation)

Clients can change their social roles and find their newly discovered social support helpful in maintaining their behavior change. Their social role changes can also help them avoid cues by creating an environment of new people, places, and things, illustrating the overlapping of processes of change during action/maintenance stages. This is a common intervention used in HIV prevention where persons infected through intravenous drug-related needle sharing, for example, can be employed by HIV prevention programs as peer educators. Their new social roles – helping others avoid their drug addiction experiences – can help them maintain a drug-free existence.

Case 12: Become a Role Model

Client: A 42-year-old female intravenous drug user, who had been attending a needle exchange program for 2 years, agreed to enter a drug treatment program because she “got tired of being on the streets” and decided that she was “too old to put up with all of the hassles”. She completed treatment and has not used for 6 months. She met a male partner in the treatment program who also is still drug free. Both have been tested negative for STD/HIV and are maintaining a mutually monogamous sexual relationship.

SOC and target behavior: The client is in maintenance for mutual monogamy with an uninfected partner.

Counseling strategy: The provider provides praise and recognition for the difficult behavior changes the client and her partner have accomplished. The provider asks if they would join a speaker’s list for presentations about HIV prevention sponsored by a local community based organization (CBO). The couple agrees and ultimately is hired by the CBO as HIV-prevention outreach workers. They are especially motivated to talk to adolescents about the less-than-glamorous consequences of drug use. They become well-known and respected members of their community and are successfully maintaining their own sexual and substance use behavior changes.

Table 1. Stage of Change Matched to RoSHBeC Counseling Interventions For The Ten Processes of Change

Precontemplation	Contemplation	Ready For Action	Action	Maintenance
<i>Consciousness Raising</i>				
Information Giving				
<i>Dramatic Relief</i>				
Story-telling				
<i>Environmental Reevaluation</i>				
Impact of Behavior on Others				
<i>Self-reevaluation</i>				
		Explore Ambivalence Explore behavior/self-image		
<i>Self-liberation</i>				
			Develop A Plan	
<i>Reinforcement Management</i>				
		Identify Rewards		
<i>Helping Relationships</i>				
		Identify Supports		
<i>Counter Conditioning</i>				
		Find Substitutes		
<i>Stimulus Control</i>				
		Avoid Cues		
<i>Social Liberation</i>				
		Become a Role Model		

Table 2. Counseling Strategy: Information Giving

Examples of Giving Information	
Client's risk assessment	Have client discuss their perception of his/her STD/HIV risk and compare that with the factors known to influence one's risk of acquiring an infection – review risk of infection formula.
STD/HIV cocaine connection	Explain connection between cocaine and HIV; for syphilis clients, explain the connection between syphilis and HIV, and sex for drugs behavior.
Mucosal immunity	Explain synergistic relationship between STDs and HIV and describe how STDs increase both susceptibility and communicability of HIV. Describe the mucous membrane surfaces of the vagina, urethra, rectum, and mouth and how it is affected by STD infections.
Local STD core population	Review rates of gonorrhea and syphilis to define local STD core population. If a client is a resident of a STD core population, discuss how the risk of transmission is affected.
Seroprevalence of HIV in your community	Discuss what is known about local HIV/AIDS prevalence – percent of gay men, commercial sex workers, women, etc., living with HIV/AIDS in local area.
Future fertility	Discuss the risks of ectopic pregnancy and infertility related to STD complications of pelvic inflammatory disease and epididymitis; discuss client's desire for future pregnancies, relationships between STDs/HIV and poor pregnancy outcomes, neo-natal infection, etc.
Use stick figures	Use stick figure diagrams of the client's actual sex partner situation to illustrate how their partner's partners' behaviors can impact their own STD/HIV risk.
Rate your relationship (rate scale)	On a scale of 1-10, ask client to assess their risk of HIV and then their partner(s) risk. Discuss their perception if the risk ratings are different. This will help the client to evaluate their risk of STD/HIV based on their partner's behavior.