

## Technical Guidance on HIV Counseling

### Summary

*Human immunodeficiency virus counseling and testing services (HIV-CTS) have been recommended by CDC since 1985, when serologic tests became available to detect antibodies to HIV (1,2). In August 1987, CDC published the Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS (3). These guidelines remain in effect today.*

*In December 1991, CDC convened a meeting of expert consultants to address the need for additional technical guidance on the subject of HIV counseling. As a result of that meeting, this document was developed to supplement the existing guidelines and distributed to state and local health departments in February 1992. This document updates the original guidelines to address: relevance of prevention messages; opportunities to provide and reinforce HIV-prevention messages; messages tailored to behaviors, circumstances, and special needs of clients; development of individualized, negotiated HIV risk-reduction plans; barriers to return for post-test counseling; and appropriate, ongoing counselor training.*

## INTRODUCTION

In 1991, more than 2 million serologic tests to detect antibodies for human immunodeficiency virus (HIV) were performed at publicly funded HIV counseling and testing sites (4). In addition to the provision of HIV counseling and testing services (HIV-CTS) at publicly funded sites, many private providers, including physicians, offer HIV-CTS (5).

CDC identifies the following as major functions of HIV-CTS: a) provide a convenient opportunity for persons to learn their current HIV serostatus; b) allow such persons to receive prevention counseling to help initiate behavior change to avoid infection, or, if already infected, to prevent transmission to others; c) help persons obtain referrals to receive additional prevention, medical-care, and other needed services; d) provide prevention services and referrals for sex and needle-sharing partners of HIV-infected persons (6).

To achieve the functions stated above and to address the specific HIV-prevention needs of each client, HIV counseling must do more than provide factual information in a didactic manner. This form of counseling — as the following recommendations define — should be “client-centered” and based on consultation with expert HIV counselors, program managers, and other specialists.

## RECOMMENDATIONS

### HIV Prevention Messages

*Counselors in programs that offer HIV-CTS should take advantage of all available opportunities to provide clients with HIV-prevention messages.*

Clients manifest varying degrees of acceptance of HIV CTS. Some clients are highly motivated to learn their HIV serostatus, while others may be wary or suspicious of suggestions that they learn their HIV serostatus. Still others may not perceive themselves to be at risk for HIV infection and consider the test unnecessary. Changing high-risk behavior is not an "all-or-nothing" process. Even after availing themselves of HIV-CTS, seronegative clients may continue to engage in behaviors that place them at risk for HIV infection.

Therefore, counselors should view all clinical encounters with clients as potential opportunities to provide and reinforce HIV-prevention messages. These messages should be clear and straight forward (e.g., "If you are not infected with HIV, you should take steps to make sure you stay that way, and, if you are already infected, early treatment can preserve your health by delaying the onset of illness.")

### Client-Centered Counseling

*HIV counseling must be "client-centered."*

To fulfill its public health functions, HIV counseling must be client-centered; i.e., tailored to the behaviors, circumstances, and special needs of the person being served. Risk-reduction messages must be personalized and realistic. Counseling should be:

- Culturally competent (i.e., program services provided in a style and format sensitive to cultural norms, values, and traditions that are endorsed by cultural leaders and accepted by the target population);
- Sensitive to issues of sexual identity;
- Developmentally appropriate (i.e., information and services provided at a level of comprehension that is consistent with the age and the learning skills of the person being served);
- Linguistically specific (i.e., information is presented in dialect and terminology consistent with the client's language and style of communication).

HIV counseling is not a lecture. An important aspect of HIV counseling is the counselor's ability to *listen* to the client in order to provide assistance and to determine specific prevention needs.

Although HIV counseling should adhere to minimal standards in terms of providing basic information, it should not become so routine that it is inflexible or unresponsive to particular client needs. Counselors should avoid providing information that is irrelevant to their clients and should avoid structuring counseling sessions on the basis of a data-collection instrument or form.

### Client-Risk Assessment

*HIV pretest counseling must include a personalized client-risk assessment.*

A focused and tailored risk assessment is the foundation of HIV pretest counseling. Risk assessment is a process whereby the counselor helps the client to assess and take "ownership" of his/her risk for HIV infection. Client acceptance of risk is a critical component of this assessment. Risk assessment is not a counselor's passive appraisal of the client's behavior, such as checking off risks from a written list, but an interactive

process between counselor and client. Risk assessment should be conducted in an empathic manner with special attention given to the ongoing behaviors and circumstances (e.g., sexual history, sexually transmitted disease [STD] history, drug use) that may continue to place the client at risk for HIV infection/transmission. For example, clients who are being counseled in STD clinics, where they have come for the treatment of a symptomatic STD (other than HIV), should be advised that their current infection demonstrates that they are at increased risk for HIV.

Because the risk-assessment process serves as the basis for assisting the client in formulating a plan to reduce risk, it is an essential component of all pretest counseling.

### **HIV Risk-Reduction Plan**

*HIV counseling should result in a personalized plan for the client to reduce the risk of HIV infection/transmission.*

HIV counseling is more than providing routine information. Such counseling should also include the development of a personalized, negotiated HIV risk-reduction plan. This plan should be based on the client's skills, needs, and circumstances, and it must be consistent with the client's expressed or implied intentions to change behaviors. HIV counseling should not consist of the counselor "telling" the client what he/she needs to do to prevent HIV infection/transmission, but instead should outline a variety of specific options available to the client for reducing his/her own risk of HIV infection/transmission. The counselor should confirm with the client that the risk-reduction plan is realistic and feasible — otherwise, it is likely to fail.

When negotiating a personalized risk-reduction plan, counselors should be especially attentive to information provided by the client — especially information about past attempts at preventive behaviors that were unsuccessful (e.g., intentions to use condoms but failure to do so) and those which were successful. Identifying and discussing previous prevention failures help to ensure that the risk-reduction plan is realistic, attentive to the clients' prevention needs, and focused on actual barriers to safer behaviors. Identifying previous prevention successes (e.g., successful negotiation of condom use with a new sexual partner) offers the counselor the opportunity to reinforce and support positive prevention choices.

An interactive risk assessment and a personalized risk-reduction plan developed during pretest counseling ensure that clients receive adequate prevention information, even before they learn the results of their tests. Counselors can use the client's expectation of test results to facilitate the development of a personalized risk-reduction plan (e.g., "What do you expect your test results to be? Why? What will you do if you are HIV seropositive? Is there anything different you will do if you are HIV seronegative?").

### **Post-test Counseling**

*Programs should take active steps to address the problem of failure to return for post-test counseling.*

Not all clients who receive pretest HIV counseling and testing return for post-test counseling and test results. In 1991, 31 state and local health departments recorded HIV counseling and testing data in such a way that analysis of individual post-test

counseling return rates was possible. These project areas reported an average 63% return rate for post-test counseling. However, this rate ranged from 41% to 86% and varied by age, sex, race/ethnicity, self-reported risk behavior, service-delivery site, and HIV serostatus. Analyses indicate that adolescents, blacks\*, and clients served in family-planning clinics and STD clinics, have lower return rates for HIV post-test counseling (7).

HIV-CTS programs should be active in addressing the problem of failure to return for HIV post-test counseling. Program managers should determine if specific operational barriers exist that prevent clients from returning for HIV post-test counseling (e.g., excessive waiting time). Counselors should stress the importance of receiving post-test counseling and should identify it as a specific component of the personalized risk-reduction plan. HIV-CTS programs should give priority to contacting seropositive and high-risk seronegative clients who have not returned to learn their test results and have failed to receive post-test counseling.

As part of a comprehensive quality-assurance program, publicly funded counseling and testing programs must monitor: a) blinded seroprevalence rates to assess the extent of client access and acceptance of recommended counseling, testing, referral, and partner-notification services (CTRPN); and b) the rates at which clients return to receive HIV-antibody test results and post-test counseling.

When <50% of high-risk clients are receiving counseling and testing, or when low return rates (e.g., <80% for seropositives and <60% for high-risk seronegatives) are identified, documented "action steps" must be initiated to determine the reasons for such low rates and to resolve barriers to clients in accessing services, learning their test results, and obtaining counseling and referral services (6).

*Counselors should routinely assess whether clients require additional post-test counseling sessions.*

Many HIV counselors have reported that some clients may require more than a single post-test counseling session. Seropositive clients are often disturbed by the realization that they have a life-threatening disease and often require additional counseling and support. Seronegative clients who are at increased risk for HIV infection or transmission may also require additional counseling to develop the skills needed to practice safer behaviors.

Although CDC does not require its funded programs to routinely provide repeated post-test counseling sessions, counselors and program managers should be aware that certain clients may require additional support and further counseling opportunities. If deemed appropriate, additional counseling should be provided on-site or through referral. In considering options for additional post-test counseling, program managers should work with local community-based organizations that might offer such services.

*Programs should ensure that HIV CTS clients receive appropriate referrals.*

Seronegative clients at continuing risk for HIV infection and HIV-infected clients often require additional primary and secondary HIV-prevention services that may not

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\* CDC's National Center for Prevention Services recognizes that a variety of terms are used and preferred by different groups to describe race and ethnicity. Racial and ethnic terms used in this document reflect the way data are collected and reported by official health agencies.

be available on-site. For example, clients, whose drug use continues to place them at risk for HIV infection should be referred for appropriate drug treatment. HIV-infected clients should be provided (on-site or through referral) with immune system monitoring and a medical evaluation to determine the need for anti-retroviral therapy and prophylaxis for *Pneumocystis pneumonia*. Facilitating referrals for these services, as well as for tuberculosis (TB) and STD care as needed, are important aspects of HIV post-test counseling.

Identifying appropriate referral sites (i.e., sites where appropriate services which meet acceptable standards of quality are offered in a timely manner) should not be the sole responsibility of the person performing HIV counseling. Program managers should take the lead in identifying referral sites and developing programmatic relations (e.g., contracts and memoranda of understanding) with those sites to facilitate needed client referrals.

### **Training and Counselor Feedback**

*Programs should provide training and counselor feedback to ensure the quality of HIV-CTS.*

Counselors, as well as their supervisors, require adequate training in HIV-CTS. In addition to training on the scientific/public health aspects of HIV-CTS, training should address other relevant issues such as substance abuse, human sexuality, the process of behavior change, and the cultural perspectives of the clients being served.

Training for HIV counseling is not a one-time event — it should be an ongoing process. An important component of ongoing quality assurance and training for HIV counselors is routine, periodic observation during counseling sessions and subsequent feedback. When a trained supervisor is not available to perform this important function, routine observation should be done by trained peer counselors. Performance standards that define expectations for the content and delivery quality of counseling should be developed. (Note: observational supervision requires the consent of the client being counseled.)

### **CONCLUSION**

Publicly funded HIV-CTS are a major component of the national HIV-prevention program (4). Further, national health promotion and disease prevention objectives for the year 2000 target increases in the proportion of HIV-infected persons who have been tested for HIV infection and the number of health-care facilities (e.g., family-planning clinics, TB clinics, drug-treatment centers, primary-care clinics) where counseling and testing is provided (8).

These recommendations, which supplement existing guidelines (3), focus on the counseling portion of the HIV counseling and testing process — a cooperative endeavor that includes giving information and assisting the client in identifying his/her HIV-prevention needs, and in developing a strategy to address those needs (9). These guidelines stress the importance of ensuring that HIV counseling is empathic, a quality known to be important in other clinical encounters (10).

By ensuring that counseling is empathic and “client-centered,” counselors will be able to develop a realistic appraisal of the client’s level of risk and assess at which

stage the client has reached in the behavior change process (11,12). Assessing the client's state of behavior change is important since intentions to reduce/modify risky behavior or initiate/ increase healthy behavior will vary among clients. The "Stages of Behavior Change" model recognizes that persons usually pass through a series of steps before achieving consistently safe behavior—whether in terms of sexual or drug-use behavior (13,14). These stages are: precontemplation (no intention to change one's behavior); contemplation (long-range intentions to change); ready for action (short-term intentions to change); action (attempts to change); maintenance (long-term consistent behavior change); and relapse (which can end the new behavior or restart the process) (11,12,14).

Assessing the client's stage of behavior change is necessary to ensure that prevention messages are individually relevant—a crucial consideration if HIV counseling is to effect behavior change. For instance, counseling messages that increase clients' intentions to reduce risky behaviors are different from those required to maintain safer behaviors and prevent relapse (15).

Cost-benefit analysis of HIV-CTPRN indicates that, even under conservative assumptions, CDC's expenditure on HIV-CTS results in a substantial net economic benefit to society (16). Program managers and staff must have realistic expectations about HIV counseling and testing programs. Although it is unlikely that a single episode of HIV counseling will result in the immediate and permanent adoption of safer behaviors (17), client-centered HIV counseling and attendant prevention services (i.e., referral and partner notification) do contribute to the initiation and maintenance of safer behaviors.

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