



Interamerican Journal of Psychology

ISSN: 0034-9690

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Sociedad Interamericana de Psicología
Organismo Internacional

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Interamerican Journal of Psychology, vol. 35, núm. 2, 2001, pp. 41-58

Sociedad Interamericana de Psicología
Austin, Organismo Internacional

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When Briefer Can Be Better: Single Session Approaches to HIV Risk Reduction Interventions

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Abstract

Interventions have been demonstrated effective in reducing behavioral risks for HIV infection. Unfortunately, the most effective and most studied HIV prevention intervention models have been delivered in multiple small group session formats that are difficult to implement in clinical and community practice settings. This paper examines the potential for delivering intensive and highly interactive HIV risk reduction interventions based on the same principles of behavior change and consisting of the same intervention components but delivered in single session formats. We describe studies that have tested single session small group workshop-type interventions and single session one-on-one counseling interventions. We conclude by presenting the content of a theory-based HIV risk reduction counseling intervention designed for delivery in a single session.

Compendio

Se ha demostrado que las intervenciones pueden ser efectivas en la reducción de riesgos comportamentales para la infección con el VIH. Desafortunadamente los modelos de inter

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vención para la prevención de VIH más efectivos y más estudiados se han desarrollado en formatos de múltiples sesiones de grupos pequeños que son difíciles de implementar en escenarios clínicos y comunitarios. Este artículo examina el potencial para desarrollar intervenciones intensas y altamente interactivas para la prevención del contagio con VIH basadas en los mismos principios de cambio comportamental y con los mismos contenidos pero desarrolladas en formatos de una sola sesión. Describimos estudios que han ensayado intervenciones de taller de grupo pequeño de una sesión e intervenciones de consejería de persona a persona en una sola sesión. Concluimos presentando el contenido de una intervención con base teórica para la consejería de reducción de riesgo para infección por el VIH, que puede constataarse en una sola sesión.

Palabras claves: Intervenciones cortas; Sesión única; Única reducción de riesgo con base teórica.

Key words: Short interventions; Single session; Theory-based risk reduction

Since 1985 several theory-based behavioral interventions for HIV risk reduction have been developed and tested in clinical studies. Comprehensive literature reviews conducted by governmental panels (e.g., NIH Consensus Panel, 1997; Office of Technology Assessment, 1995), as well as reviews published in peer refereed journals, (e.g., Kalichman, Carey, & Johnson, 1996; DiClemente & Wingood, 1995) have consistently shown that behavioral risk reduction interventions that are grounded in behavior change theories demonstrate meaningful reductions in unprotected sexual acts and increased use of condoms. These interventions usually require individuals to attend multiple small group sessions usually delivered independent of, although potentially integrated with, other clinical or community services. Although multi-session group intervention models are clearly promising, they have proven difficult to transfer to community and public health services. For example, studies that have investigated HIV prevention services suggest that HIV prevention interventions demonstrated effective in research are rarely adopted by service providers (Goldstein, Wrubel, Faigles, & DeCarlos, 1996; Kalichman, Belcher, Chery, & Williams, 1997). Although a gap between prevention science and prevention practice is not unique to HIV/AIDS (Beutler, Williams, Wakefield, & Entwistle, 1995), HIV prevention technology transfer is clearly impeded by behavioral interventions that are not usually feasible for integration with routine public health services.

Among the most significant limitations facing many HIV risk reduction interventions are challenges to recruiting clients into multiple group sessions and high intervention dropout rates. Research suggests that persons at highest risk for HIV infection are the least likely to attend intensive community-based prevention programs (Hoff, Kegeless, Acree, Stall, Paul, Ekstrand, & Coates, 1997). HIV prevention intervention studies with inner-city women have experienced significant

rates of client dropout, ranging 38% (Kalichman, Carey, & Johnson, 1996) to 50% (Kelly et al., 1994). These high rates of attrition have occurred even in studies that provide clients with transportation, childcare, and cash incentives for attendance. Problems that result from client reluctance to attend groups and attrition from group interventions may be exacerbated by having to schedule several people to attend a given group session at a specified time when they have competing and understandably more pressing needs. In addition, many individuals are uncomfortable discussing their sexual behavior in groups of people they have only recently met. For example, a study of 349 low-income inner-city men showed that 31% indicated that they would not feel comfortable attending a group intervention and discussing sexual relationships with other men in a group. In addition, 44% of the men surveyed stated that they would prefer to attend an individual counseling intervention rather than a small group intervention (Kalichman, Belcher et al., 1997). Another potential source of attrition from multiple group sessions may be the reluctance of some persons to take part in potentially stigmatizing discussions of sexual behavior and drug use, particularly within the context of a peer group.

The gap between the research knowledge base showing the effectiveness of cognitive behavioral interventions and the state of prevention practice can be bridged by structuring effective intervention components into a format that can feasibly be implemented in service delivery settings. In addition, delivering interventions in single session formats increases the intensity of the interaction between counselors and client, potentially reducing the amount of contact time required to deliver comparable intervention components. Delays between client recruitment and convening groups may also reduce the effectiveness of small group interventions, whereas brief individual counseling interventions are delivered immediately and potentially at "teachable moments".

HIV prevention interventions will obviously only be effective when populations at greatest risk are exposed to the intervention content. Despite the urgent need for brief HIV prevention interventions, there have been few studies that have tested brief intervention models. One likely reason for the lack of research on brief interventions is the skepticism that brief "one-shot" intervention approaches could yield meaningful HIV preventive behavior changes. However, the tendency to compare brief interventions with strategies that require multiple sessions creates a false impression that a single type of prevention intervention is needed to stem the HIV epidemic, rather than recognizing the roles of multiple intervention strategies implemented at multiple levels (Heather, 1998). Skepticism about brief HIV risk reduction interventions has also been fueled by

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the ineffectiveness of standard practices in HIV antibody testing and counseling in reducing risk behaviors (Doll & Kennedy, 1994; Higgins et al., 1991) and the moderate effects observed in even the most intensive multi-session interventions (Kalichman et al., 1997). It is important to recognize, however, that brief, intensive, and well-timed single-session interventions have been effective in assisting people change difficult health compromising behaviors (Miller & Heather, 1998).

In the current article, we examine selected studies that have tested brief HIV risk reduction interventions. For our current purposes, we first define the parameters of a "brief" prevention intervention. We overview the promise of brief interventions tested in other areas of health promotion research. Next, we present a summary of studies that have tested HIV risk reduction interventions in single session small group workshops and in single session individual counseling sessions. Finally, we provide an example of how theoretical models of HIV risk reduction can be translated into the components of a brief HIV prevention intervention.

DEFINING BRIEF INTERVENTIONS

There is no consensus regarding what defines the duration of a "brief" intervention. In the field of HIV prevention, risk reduction interventions have ranged in duration from several seconds, such as public service announcements, to numerous hours of group sessions. Among the lengthiest HIV risk reductions have been those that have integrated HIV prevention into a broader social context and service delivery program to meet multiple social needs. For example, Rotheram-Borus, Koopman, & Haignere (1991) tested a 20-session HIV prevention intervention that was melded with multiple components to address the social and emotional needs of runaway and homeless youth. Integrating HIV prevention with other social services assumes that individuals must have their basic needs met before they can effectively focus on reducing their risk for disease. For the most part, HIV risk reduction interventions have been delivered in four or five 90-120 minute small group sessions. Briefer interventions carry fewer burdens for participation as well as agency implementation. In many settings, health service providers are under increasing pressure to deliver the briefest possible services, with primary care contacts limited to as little as 10 minutes. However, interventions that do not afford intensive interactions between clients and prevention counselors demonstrate limited effects. The challenge is therefore to balance intervention time with their highest-risk clients, such as sexually transmitted disease (STD) clinics, if an effective intervention model were avail-

able. Thus, for our current purposes, we are defining a brief HIV risk reduction intervention as a single contact session within which intensive and interactive risk reduction counseling occurs.

Brief Counseling Interventions for Health-Behavior Problems

Brief counseling interventions based at least in part on cognitive behavioral skills building approaches have been effective in smoking cessation, cardiovascular risk reduction, and weight loss. These models include many of the same problem solving, behavioral self-management, and social skills building components that form the core of the most effective HIV risk reduction interventions (NIH Consensus Panel, 1997; NIMH Multisite Study Group, 1998). Perhaps most impressive is evidence for the effectiveness of brief alcohol and drug treatment strategies (Bien, Miller, & Tonigan, 1993; Zweben & Rose, 1998). Miller and Sánchez (1993) described six active ingredients of relatively brief interventions that induce change in problem drinkers, including: feedback of personal risk or impairment; emphasis on personal responsibility for change; clear advice to change; a menu of alternative change options; therapist empathy; and facilitation of client self-efficacy. Interventions that deliver these elements in a motivational interviewing style have been demonstrated effective in initiating treatment and in reducing long-term alcohol use, alcohol-related problems, and health consequences of drinking (Anderson & Scott, 1992), as well as success in other areas of health behavior change such as cardiovascular rehabilitation, diabetes management, and adherence to mental health and substance abuse treatments (Miller & Rollnick, 1991).

Motivational enhancement counseling, for example, is a brief, structured treatment approach that was developed as an approach to treating problem drinking. A large national clinical trial (Project MATCH) tested a motivational enhancement brief treatment as a stand-alone outpatient and aftercare approach. A total of 1,726 clients were randomly assigned to receive motivational counseling or to one of two 12-session treatments: Twelve-Step Facilitation or Cognitive-Behavioral Therapy. Outpatients in all three treatments demonstrated substantial improvements in drinking outcomes. Prior to treatment, clients abstained on an average 20% of the days each month. However, during the one-year follow-up, outpatients abstained a mean of approximately 85% of the days per month. Thus, brief motivational counseling has been shown effective in reducing alcohol and other drug use in large-scale as well as smaller scale intervention trials (Miller & Heather, 1998).

Elements of motivational counseling have been applied to reducing HIV risk

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behaviors. For example, Baker, Kochan, Dixon, Wodak, & Heather (1994) showed that motivational counseling reduced HIV risk injection practices among injection drug users, but there were no effects on sexual transmission risk behaviors. Importantly, Baker et al. focused the goals of their intervention in reducing risks associated with injection practices to a greater extent than sexual transmission risks. Similar findings were reported in another study that tested a brief counseling intervention for injection drug users (Gibson, Lovelle-Drache, Young, & Hudes, 1999). Three studies, however, have shown significant effects on sexual risk behaviors from integrating motivational counseling within cognitive behavioral HIV risk behavior skills building interventions.

Carey, Maisto, Kalichman, Forsyth, Wright, & Johnson (1997) used behavioral feedback and therapeutic process techniques borrowed from motivational interviewing to bolster the motivational components in a 4-session small group intervention for women. Similarly, Kalichman, Cherry, & Brown (1999) integrated motivational interviewing techniques with cognitive behavioral skills building components in a 2-session small group intervention for men. Belcher et al. (1998) included feedback and motivational processes within a single session one-on-one cognitive behavioral skills building counseling intervention. This study is described in greater detail below. In all three studies, the integrated motivation interventions demonstrated significant reductions in high-risk sexual practices and increased use of condoms. However, these previous study designs did not allow for the analysis of the independent effects of the motivational interviewing techniques assumed to enhance risk reduction outcomes. In addition, given the success of brief motivational enhancement therapy for substance abusers, it is feasible that a brief motivational counseling intervention that focuses on HIV and other STD transmission risks could demonstrate positive outcomes without inclusion of intensive skills building components.

Brief Interventions I: Single Session Small Group Intervention Formats

To address issues of limited feasibility of multi-session interventions, programs based on motivation and skills training principles have been delivered in more concentrated formats. For example, in a study of gay men, Valdiserri, Lyter, Leviton, Callahan, Kingsley, & Rinaldo (1989) randomly assigned clients to either a single session group HIV education intervention or a single session skills training intervention that emphasized negotiation of safer sex and rehearsal of risk reducing behaviors. Results of this study showed that men exposed to the brief skills training intervention significantly increased their use of condoms during insertive anal intercourse over a 12-month follow-up period. In a similar

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study, Jemmott, Jemmott, & Fong (1992) demonstrated that a single session, workshop-like program, focusing on cognitive-behavioral skills training produced risk behavior changes among African-American male adolescents, including significant increases in HIV-related knowledge, reductions in risk promoting beliefs, and lower frequencies of high-risk sexual behaviors at 3-month follow-up.

There have also been tests of single session small group workshops designed for heterosexually identified men and women at risk for HIV and other STDs incorporating all aspects of the motivational skills building HIV risk reduction models. Investigators have tested a brief intervention to reduce HIV risk behavior and increase female condom use among inner-city African-American women (Kalichman, Rompa & Coley, 1996). Women in Atlanta, Georgia (USA) were randomized to attend either a (a) single 3-hour group session focused on HIV and STD risk education, enhancement of readiness to change, and cognitive-behavioral HIV risk reduction skills building or (b) a single 3-hour group session focused on general women's health issues. The study found that women in the HIV risk reduction intervention demonstrated increased use of both male and female condoms at the 1-month follow-up assessment, with differences between groups dissipating at the 3-month follow-up. Another study tested a single group session HIV risk reduction intervention for inner-city men (Kalichman, Cherry et al., 1999). This study randomized African-American men to one of 3 conditions: (a) 3-hour HIV education session without any motivational enhancement or behavioral skills building components; (b) 3-hour information, motivational enhancement, behavioral skills building session focused on increasing use of latex condoms; or (3) the same 3-hour motivational and skills intervention used in condition (b) described above, but focusing on use of male polyurethane condoms. Kalichman, et al. (1999) found that both of the motivational skill building interventions increased condom use over a 1-month period, with effects diminishing over 3-months.

The studies discussed above demonstrate the feasibility of delivering information, motivation, and behavioral skills building intervention components in a relatively brief group session. However, these studies also show that a single group session does not provide an adequate format for addressing the individual needs, contexts, and personal patterns of risk presented by persons at-risk for HIV. Single group session interventions may be useful for delivering circumscribed public health messages - such as HIV antibody test promotion - or for exposing populations to new HIV prevention technologies and products - such as female condoms, microbicides, and polyurethane male condoms. However, a single

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small group session does not afford the opportunity to personalize intervention components and place risk reduction in the context of an individual's life. Most limited in the group setting is the ability to enhance motivation to change, identify individual patterns of risk, and develop an individual risk reduction plan.

Brief Interventions II: One-on-one HIV Risk Reduction Counseling

Recent research has demonstrated promising outcomes for brief individual counseling sessions for HIV risk reduction in high-risk populations. For example, Project RESPECT, sponsored by the Centers for Disease Control and Prevention recently showed that two 20-minute HIV risk reduction counseling sessions conducted in conjunction with HIV antibody testing demonstrated the same efficacy in reducing HIV risk behavior and recurrent STD treatment as did a 4 session enhanced counseling intervention (Kamb, et al., 1998). The Project RESPECT counseling intervention focused on providing risk education and conducting a personal risk assessment that formed the basis for an individualized risk reduction plan. Counseling in Project RESPECT also relied heavily on the relationship established between the counselor and client within the context of STD clinic services. Results showed that participants in the two-session risk reduction counseling intervention evidenced a 30% reduction in new STDs over 6-months follow-up and a 20% reduction over 12-months follow-up compared to participants receiving didactic information messages. Thus, two brief counseling sessions conducted in conjunction with HIV testing demonstrated meaningful reductions in recurrent STDs.

In another randomized clinical study of a brief counseling intervention discussed above, Belcher et al. (1998) showed that a single 2-hour risk reduction counseling intervention effectively reduced high-risk sexual practices among women at risk for HIV and other STDs. The 2-hour HIV risk reduction counseling intervention achieved a magnitude of change (Cohen's $d = .42$) greater than that observed in HIV prevention interventions of more than 4 times the duration (Cohen's $d = .25$, Kalichman et al., 1997). Figure 1 displays the relative effect sizes of selected multiple small group intervention studies and the effect size from the Belcher et al study.

In the Belcher et al. (1998) study women recruited from an inner-city neighborhood in Atlanta, Georgia (USA) were screened for high-risk behavior. Women were then randomly assigned to 1 of 2 conditions: (a) 2-hour HIV risk reduction counseling based on the Information, Motivation, and Behavioral Skills (IMB) model, or (b) 2-hour matched contact HIV information education session. The HIV risk reduction counseling was based on Fisher and Fisher's

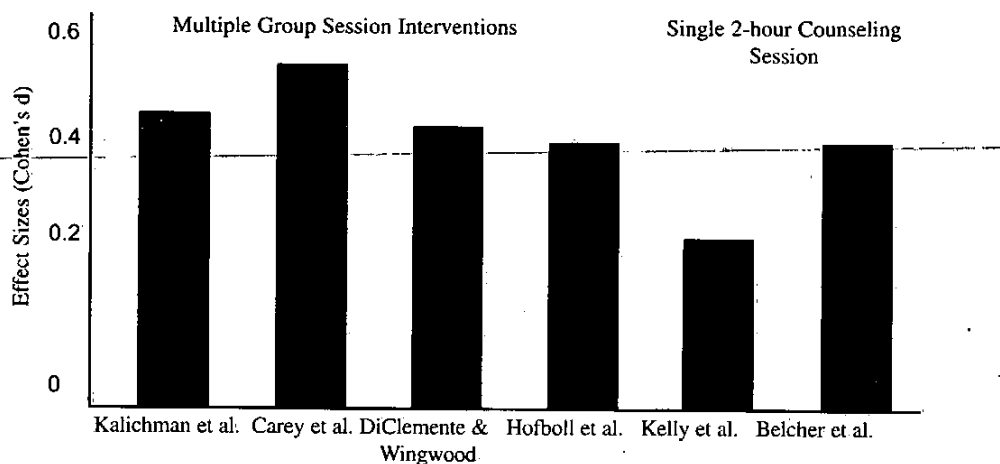
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(1992) IMB Model providing clients with: (a) personalized risk behavior feedback; (b) individualized counseling around the personalized feedback; (c) HIV risk and risk reduction information; (d) counseling to place personal risk behavior feedback in the context of risk information; (e) communication skills training and behavioral feedback in the context of risk information; (f) communication skills training and behavioral rehearsal for negotiating safer sex and condoms use with male partners and problem solving situations in which partners are resistant to use condoms; (g) managing risk situations including risk for violence and other negative repercussions of initiating condom use; and (h) instruction in the correct use of male and female condoms with rehearsal for correct condom application using anatomically correct models. Women randomized to the comparison intervention were exposed to information about HIV and STDs without the motivational and skills building counseling components. To control for counselor effects, the same team of counselors conducted both interventions. The interviewer conducting the assessments also remained blind to study condition assignments. Belcher et al. (1998) found that women in the HIV risk reduction counseling intervention condition demonstrated significantly less unprotected vaginal intercourse (Cohen's $d = .33$) and significantly greater condom use (Cohen's $d = .42$) than women in the comparison condition. Condom use increased from 22% of vaginal intercourse occasions protected at baseline to 66% at the 3-month follow-up for women in the HIV counseling condition compared to an increase of 27% to 43% for women in the control condition. Belcher et al. therefore demonstrated significant effects of a 2-hour single session HIV risk reduction counseling intervention. Using Cohen's d (1998) as a standardized index of effect size, the study found that the 2-hour counseling intervention demonstrated effects comparable to those found in interventions of much greater duration, client and resource burden, and expense (See Figure 1).

Experience with the 2-hour intervention tested by Belcher, et al. (1998) suggested that HIV risk reduction counseling that incorporates all elements of the IMB Model can be achieved in a 120-minute session, or perhaps even in less time when the counseling is implemented in a clinical setting where clients are receiving HIV and STD diagnostic and treatment services. STD clinic patients are sensitized to their risk for HIV infection (Kalichman, Adair, Rompa, Multhaupt, Johnson, & Kelly, 1994), and are therefore amenable to risk reduction interventions (e.g., Kamb et al., 1998; NIMH Multisite Trial Group, 1997). The potential for brief interventions to have a significant impact on complex behaviors increases when individuals are at a heightened state of readiness to change (Miller & Heather, 1998). Receiving diagnostic and treatment services from an

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Figure 1

Comparison of Effectiveness of Multiple Group and Single Counseling Sessions

STD clinic may therefore create teachable moments that offer unique opportunities for brief interventions and STD clinics are a natural environment for delivering HIV risk reduction counseling.

Information-Motivation-Behavioral Skills (IMB) Model Applied to Single Session HIV risk Reduction Counseling

Fisher and Fisher (1992) proposed a three-factor conceptualization of AIDS-preventive behavior: information, motivation, and behavioral skills (IMB). In the IMB model HIV transmission and prevention information is a necessary precursor to risk reduction. Motivation to change, however, also directly affects whether one acts on information about risk and risk reduction. Finally, the authors hold that behavioral skills related to preventive actions are a final common pathway for information and motivation to result in AIDS preventive behavior change (See Figure 2). IBM model proponents assume that information and motivation activate behavioral skills to ultimately enact risk reduction behavior. They also show that information or motivation alone can have direct effects on some preventive behaviors, such as when information about HIV transmission prompts purchasing condoms, or when meeting someone with HIV infection motivates a person to seek HIV antibody testing. However, behavioral skills become increasingly important when preventive actions require complex skills, such as refusing unprotected intercourse and initiating condom use. Thus, risk behavior skills are theorized to have a direct effect on risk reduction behaviors,

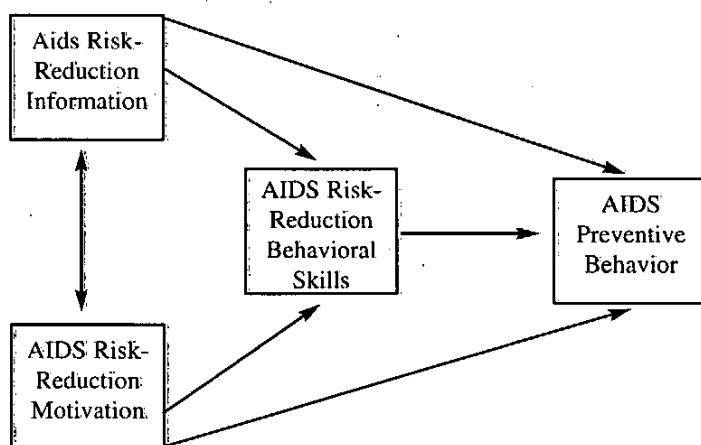
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and information and motivational enhancement may have direct effects on risk reduction skills and indirect effects on risk reduction behaviors.

The IMB model was constructed from elements found in most effective HIV risk reduction interventions. The independent elements of the IMB model may also synergize with each other to effect risk reduction outcomes. The IMB model therefore provides a compelling heuristic for developing briefer HIV risk reduction interventions because all of the essential elements, namely information (knowledge), motivation (behavior change readiness and intentions), and behavioral skills building (condom use and communication skills), can be packaged for one-on-one counseling. In the following sections, we provide a brief description of a single session HIV risk reduction counseling intervention that integrates all of the components of the IMB model into a 90-minute session that could be delivered in community and clinical service settings.

Figure 2

Information, Motivation and Behavioral Skills Models¹



Brief IV Risk Reduction Counseling for STD Clinic Patients

The following IMB counseling intervention elements are formatted for a single 90-minute session. Each of the three IMB components are structured for delivery in 30 minutes. Each element, however, could feasibly be delivered in 20 minute segments, yielding a 60 minute session. Alternatively, it is possible to

¹ Fisher and Fisher, 1992.

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abbreviate the information component to 10 minutes and extend the duration of the motivational and behavioral skills building components. Research, however, is needed to test the limits of minimally necessary and sufficient contact time for delivering specific IMB components to various populations with optimal effects.

Information: HIV Risk Education

In this component of the intervention counselors will review information about HIV transmission, risk behaviors, and disease processes; discuss the prevalence of HIV and AIDS; clarify misconceptions; dispel myths about AIDS; and describe HIV antibody testing. The education is delivered using a didactic style, flip charts, and visual materials to illustrate key concepts, interactive activities to dispute HIV myths and misinformation, and education about HIV testing options. The risk education component also briefly relates HIV to other STDs and provides information about HIV prevention programs and resources available in the community.

Motivation: Motivational Enhancement

Adapting procedures described by Miller, Zwebi, DiClement, & Rychtarik (1992), clients are provided with direct feedback on their personal risk history as a means of sensitizing participants to their potential risks for HIV infection to increase their intentions to change risk behaviors and reduce negative attitudes toward condoms. Motivational enhancement counseling is a systematic approach for evoking change based on principles of motivational psychology and designed to produce rapid, internally motivated change. This treatment approach does not attempt to train the client, step by step, but instead employs motivational strategies to mobilize the client's own change resources. Motivational counseling is divided into two major phases: building motivation for change and strengthening commitment to change (Miller & Rollnick, 1991). Our adaptation of motivational counseling uses the same techniques outlined by Miller and Sánchez (1993), including: feedback of personal risk or impairment, emphasis on personal responsibility, clear advice to change, a menu of alternative change options, therapist empathy, and facilitation of optimism to change. Motivational enhancement focuses on (a) providing structured feedback from the initial assessment regarding HIV risk and its personal context and (b) building client motivation to initiate and continue change.

Counselors in this model begin the motivational elements by telling clients that they will receive feedback from the assessment instruments they completed earlier (such as a pre-counseling or baseline assessment), but that they first want to understand better how the client views the situation. The counselor pro-

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ceeds to use strategies to elicit self-motivational statements - such as being open to input about HIV-STD risk, acknowledging real or potential problems related to risk behavior, or expressing a need, desire, or willingness to change. This is accomplished using strategies such as open-ended questions, gentle paradox, and reflective listening. When the major themes of concern have been elicited from the client, counselors offer a summary statement. When the feedback process is completed the client is asked for his/her overall response. Counselors give clients their Personal Feedback Report to take home (See Appendix A). The counselor then uses cues from the client to begin eliciting thoughts, ideas, and plans for what might be done to address the risk. The counselor elicits from the client what they perceive as the possible benefits of action and the likely negative consequences of inaction. These perceptions are written down in the form of a balance sheet (reasons to continue as before versus reasons to change) and given to the client as part of the Personal Feedback Report. The counselor proceeds toward the confirmation of a plan for change, and will seek to obtain a formal commitment to change from the client.

Behavioral skills: Behavioral self-management and sexual communication skills

The behavioral skills building component is adapted from cognitive behavioral skills building interventions for HIV risk reduction. The counselor in behavioral self-management skills and sexual communication skills related to HIV risk reduction instructs clients. The counselor engages the client in a functional analysis of their risk behavior by having the clients discuss personal risk behaviors and personal cues related to sexual risk situations. Counselors instruct clients in identifying environmental and cognitive-affective cues that serve as "triggers" for high-risk situations including mood states, substance use, settings, and sexual partner characteristics that have served as risk-related factors in the client's past. Clients are asked to think of ways to manage factors that may contribute to their personal risk and are instructed in methods of rearranging their environment and strategies to reduce their risk by performing specific acts; redirecting sexual activities toward safer sex alternatives, carrying condoms, and avoiding sex after drinking. There is also a focus on identifying barriers to risk reduction efforts. Proper male and female condom use are instructed, modeling condom use on anatomical models and allowing clients to practice condom application with corrective feedback from the counselor.

The behavioral skills intervention component also focuses on the role of sexual negotiation, assertiveness and refusal skills to reduce risk for HIV infection. Increasing skills for resisting partner coercion to engage in sexual inter-

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course without condoms, and increasing comfort discussing safer sex with partners in advance of sexual activity are accomplished through instruction, modeling, and practice in communicating sexual decisions and discussing individual limits to behavior change. Clients are assisted by counselors in identifying past situations of sexual risk and are assisted in generating and verbalizing statements that would have led to lower risk in that situation. Emphasis is placed on learning techniques of effective communication of feelings and sexual behavior limits prior to entering sexual situations. Practice is conducted in role-plays to increase communication skills, self-efficacy, and comfort in discussing sexual alternatives with partners. Basic skills in: (a) interpersonal assertiveness, (b) refusal to engage in risk-related sexual behaviors, and (c) negotiating safer sex activities with partners are first modeled by the counselor and then practiced by clients with feedback on performance. Practice, review, and feedback of sexual assertiveness negotiation, and refusal skills in risk-related situations are the heart of the skills building component and are conducted for individually tailored risk scenarios.

CONCLUSION

Over the past three decades there has been great progress in developing and testing HIV risk reduction interventions for populations most vulnerable to HIV infection. We now know that HIV prevention interventions grounded in sound principles of behavior change can reduce rates of HIV risk behaviors. The challenge now lies in formulating effective HIV prevention models into procedures that can be assimilated into the routine services offered by community and clinical service providers. In some instances, briefer interventions will be easily adopted into services. However, the effectiveness of briefer interventions with various populations at risk for HIV-AIDS must be determined. A research agenda that focuses on identifying the optimal effects of brief HIV risk reduction interventions should therefore remain a public health priority.

References

- Anderson, P., & Scott, E. (1992). The effect of general practitioners' advice to heavy drinking men. *British Journal of Addiction*, 87, 891-900.
- Baker, A., Kochan, N., Dixon, J., Wodak, A., & Heather, N. (1994). HIV risk-taking behavior among injection drug users not currently in treatment. *Drug and Alcohol Dependence*, 34, 155-160.
- Belcher, L., Kalichman, S.C., Topping, M., Smith, S., Emshoff, J., Norris, F., & Nurss, J. A. (1998). Randomized trial of a brief HIV risk reduction counseling intervention for women. *Journal of Consulting and Clinical Psychology*, 66, 856-861.

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- Beutler, L., Williams, R., Wakefield, P., & Entwistle, S. (1995). Bridging scientist and practitioner perspectives in clinical psychology. *American Psychologist*, 50, 984-994.
- Bien, T.H., Miller, W.R., & Tonigan, J.S. (1993). Brief interventions for alcohol problems: A review. *Addiction*, 83, 315-336.
- Carey, M.P., Maisto, S.A., Kalichman, S.C., Forsyth, A., Wright, I., & Johnson, B.T. (1997). Enhancing motivation to reduce risk for HIV infection for economically disadvantaged urban women. *Journal of Consulting and Clinical Psychology*, 65, 531-541.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd Ed.). Hillsdale, NJ: Erlbaum.
- DiClemente, R., & Wingood, G. (1995). A randomized controlled trial of an HIV sexual risk-reduction intervention for young African-American women. *Journal of the American Medical Association*, 274, 1271-1276.
- Doll, L.S., & Kennedy, M.B. (1994). HIV counseling and testing: What is it and how well does it work? In G. Schochetman & J.R. George. *AIDS testing: A comprehensive guide to technical, medical, social, legal and management issues*. (2nd edition). (pp. 302-319) New York, NY: Springer-Verlag.
- Fisher, J.D., & Fisher, W.A. (1992). Changing AIDS-risk behavior. *Psychological Bulletin*, 111, 455-474.
- Gibson, D.R., Lovelle-Drache, J., Young, M., & Hudes, E. (1999). Effectiveness of brief counseling in reducing HIV risk behavior in injection drug users: Final results of randomized trials of counseling with and without HIV testing. *AIDS & Behavior*, 3, 3-12.
- Goldstein, E., Wrubel, J., Faigles, B., & DeCarlos, P. (1996, July). *Do researchers reach non-governmental organizations in the United States?* XI International Conference on AIDS, Vancouver, BC.
- Heather, N. (1998). Using brief opportunities for change in medical settings. In W. Miller & N. Heather (Eds.). *Treating addictive behaviors* (2nd Ed.), (pp. 133-148) New York, NY: Plenum Press.
- Higgins, D.L., Galavotti, C., O'Reilly, K.R., Schnell, D.J., Moore, M., Rugg, D.L., & Johnson, R. (1991). Evidence for the effects of HIV antibody counseling and testing on risk behavior. *Journal of the American Medical Association*, 266, 2419-2429.
- Hoff, C.C., Kegeles, S., Acree, M., Stall, R., Paul, J., Ekstrand, M. & Coates, T. (1997). Looking for men in all the wrong places: HIV prevention small group programs do not reach high risk gay men. *AIDS*, 11, 829-831.
- Jemmott, J.B., Jemmott, L.S., & Fong, G.T. (1992). Reductions in HIV risk-associated sexual behaviors among Black male adolescents: Effects of an AIDS prevention intervention. *American Journal of Public Health*, 82, 372-377.

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Kalichman, S.C., Adair, V., Rompa, D., Multhau, K., Johnson, J., & Kelly, J. (1994). Sexual sensation-seeking: Scale development and predicting AIDS-risk behavior among homosexually active men. *Journal of Personality Assessment*, 62, 385-397.

Kalichman, S.C., Belcher, L., Cherry, C., & Williams, E. (1997). Primary prevention of sexually transmitted HIV infections: Transferring behavioral research to community programs. *Journal of Primary Prevention*, 18, 149-172.

---Kalichman, S.C., Carey, M.P., & Johnson, B.T. (1996). Prevention of sexually transmitted HIV infection: Meta-analytic review and critique of the theory-based intervention outcome literature. *Annals of Behavioral Medicine*, 18, 6-15.

Kalichman, S.C., Cherry, C., & Brown, F. (1999). Effectiveness of a video-based motivational skills-building HIV risk reduction intervention for inner city African-American men. *Journal of Consulting and Clinical Psychology*, 67, 959-966.

Kalichman, S.C., Rompa, D., & Coley, B. (1996). Experimental component analysis of a behavioral HIV-AIDS prevention for inner-city women. *Journal of Consulting and Clinical Psychology*, 64, 687-693.

Kamb, M., Fishbein, M., Douglas, J., Rhodes, F., Rogers, J., Bolan, G., & Zenilman, J. (1998). Efficacy of risk-reduction counseling to prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases. *Journal of the American Medical Association*, 280, 1161-1167.

Kelly, J.A., Murphy, D.A., Washington, C.D., Wilson, T.S., Koob, J.J., Davis, D.R., Ledezma, G., & Davantes, B. (1994). The effects of HIV/AIDS intervention groups for high-risk women in urban clinics. *American Journal of Public Health*, 84, 1918-1922.

Miller, W., & Heather, N. (1998). *Treating addictive behaviors (2nd Ed.)*. New York, NY: Plenum.

Miller, W.R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, NY: Guilford.

Miller, W.R., & Sánchez, V.C. (1993). Motivating young adults for treatment and lifestyle change. In G. Howard (Ed.), *Issues in alcohol use and misuse by young adults* (pp. 55-82). South Bend, IN: University of Notre Dame Press.

Miller, W.R., Zweben, A., DiClemente, C., & Rychtarik, R. (1992). *Motivational enhancement therapy manual* (DHHS Publication No. ADM 92-1894). Washington, DC: U.S. Government Printing Office.

NIH Consensus Panel. (1997). *National Institutes of Health consensus development statement on interventions to prevent HIV risk behaviors*. Bethesda, MD: NIH Office of Medical Applications Research.

NIMH Multisite Study Group. (1998). The NIMH multisite HIV prevention trial:

HIV PREVENTION INTERVENTION

Reducing HIV sexual risk behavior. *Science*, 280, 1889-1894.

Office of Technology Assessment (1995). *The effectiveness of AIDS prevention efforts*. Washington, DC: American Psychological Association Office on AIDS.

Rotheram-Borus, M.J., Koopman, C., & Haignere, C. (1991). Reducing HIV sexual risk behaviors among runaway adolescents. *Journal of the American Medical Association*, 266, 1237-1241.

Valdiserri, R.O., Lyter, D., Leviton, L., Callahan, C.N., Kingsley, L.A., & Rinaldo, C.R. (1989). AIDS prevention in homosexual and bisexual men: Results of a randomized trial evaluating two risk reduction interventions. *AIDS*, 3, 21-26.

Zweben, A., & Rose, S.J. (1998). Innovation in treating alcohol problems. In D. Biegel & A. Blum (Eds.), *Innovations in practice and service delivery with vulnerable populations*. (197-227) New York, NY: Oxford University Press.

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APPENDIX A
Sample Personal Feedback Report

The In The Know Survey asked a lots of questions. Below is your summary...

- 1- Had sex with 5 partners in the past 6-months.
- 2- In the past 6-months, you often drank or used drugs before having sex
- 3- Almost never use condoms.
- 4- Below are specific things that may put you at risk for HIV and other STD's

Traded sex for money or a place to stay

Had an STD

Sex with a partner who may have shot-up drugs

Sex with someone who had other partners

A sex partner who may have had an STD

Sex with a person who may have had HIV

The following best described you...

Thought about protecting myself, but not trying

How important is it to you to reduce your risk for HIV/STD's?

Not at all Important		Fairly Important		Very Important		Extremely Important			
1	2	3	4	5	6	7	8	9	10

How confident are you that you can reduce your risk for HIV?

Not at all Important		Fairly Important		Very Important		Extremely Important			
1	2	3	4	5	6	7	8	9	10

Concerns/Reasons to change

Barriers/Things in the way of change

Your Risk Reduction Goal

GOAL _____

Step 1 _____

Step 2 _____

Step 3 _____

Step 4 _____