

HIV COUNSELOR PERSPECTIVES

Volume 15 Number 1 January 2006

MOTIVATING BEHAVIOR CHANGE

Reducing risk for HIV infection and transmission is difficult, in part because it usually involves changing behaviors that are deeply ingrained and often highly pleasurable. Counselors seek to help clients find the reasons, desire, and energy to make these changes—that is, to increase their motivation for change. This issue of PERSPECTIVES defines key concepts related to the motivation of behavior change, reviews three models that build upon these concepts and discusses the application of motivation to HIV test counseling.

Research Update

The challenge of facilitating behavior change is at the heart of HIV prevention counseling. But what is the process by which people create behavior change? In the early years of the pandemic, the slogans “Fight the fear with the facts,” and “Knowledge is power” illustrated the belief that if the public had the right information, individuals would be able to take the appropriate steps to protect themselves and others. This approach, part of the “health education model,” focused on getting the word out about behavioral risks and how people could reduce these risks. It assumed that, armed with this information, people would then change their sexual and injection behaviors accordingly.

But while accurate information about risk and its reduction has always been critical to successful HIV prevention efforts, over time, it has become clear that knowledge alone is not enough to produce behavior change—especially lasting behavior change.^{1,2} Rather, a set of factors must cause a person to want to

make a change and to believe he or she can do so. When grouped together, these factors and are for research

What is

Motivation is a concept. Research has defined the term “motivation” to broadly describe a range of motivation’s features. For example, the word “motivation” may describe both the desire a person has to change a behavior and how important it is to the person to make the change.³ But what makes a change seem desirable or important? Whether or not people are motivated to try to prevent HIV transmission is related to personal attitudes toward prevention activities such as condom use or using clean injection needles, as well as the attitudes of their communities and their sexual partners. In addition, motivation is fluid and can change as these interceding factors change.⁴

The Health Belief Model states that whether or not a person makes a change

depends on several factors.⁵ These factors include how vulnerable a person feels to the problem, how severe the person feels the problem is, which strategies are used to activate readiness, and how confident a person is in his or her ability to take action (called self-efficacy).⁶

To make a change, a person must also believe that there is some cost involved in not changing,¹ and that the benefits (pros) of making a change outweigh the costs (cons).⁷ People sometimes feel both the positives and the negatives very acutely, for example, they understand their risks for contracting HIV but they feel afraid to ask their partners to use condoms. This ambivalence often stands in the way of making change.⁴

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This Research Update reviews three intervention models designed to help resolve ambivalence and facilitate motivation for HIV-related behavior change. They are the Transtheoretical Model; Motivational Interviewing and its adaptations; and the Information-Motivation-Behavior model.

The Stages of Change

The Transtheoretical Model, which includes the stages of change, has been used since the early 1980s to help people change addictive behaviors, beginning with smoking. Clinicians have since applied it in a variety of arenas, including HIV prevention and test counseling.

Rather than labeling a client as “motivated” or “not motivated” to change, this model proposes five stages of motivational readiness that a person passes through as he or she attempts to adopt a new behavior or eliminate an old one.^{8,9} These stages are: *precontemplation*, (change is not yet intended); *contemplation*, (thinking about change within the next six months); *preparation* (or *ready for action*), (seriously planning change); *action*, (starting to make change); and *maintenance* (consistently behaving in the new way for at least six months). The theory also proposes that relapse to prior stages is a natural, expected, and often temporary outcome rather than a failure to change.⁹

When people are in one of the first two stages (precontemplation or contemplation), their ability to move forward to the next stage depends mainly on cognitive and emotional factors, that is, deciding that the change is important and that they want to do it. Progress in the later stages depends more on behavioral processes, for example, learning about, practicing, and getting support for the new behavior.⁸

As people move forward to another stage, their “decisional balance” changes, and their ambivalence decreases. That is,

the reasons for making a change grow stronger, while those against making a change lose power. In the precontemplation stage, people are likely to feel that the losses that come with changing a behavior overshadow the benefits. The benefits of change grow stronger in the contemplation phase and outweigh the costs by the action stage.⁷ For example, someone in the precontemplation stage around condom use might not be ready to learn how to use a condom because that change has not yet become important to her or him. Instead, that person might be more open to an informational discussion about HIV risk.

A counselor discovers a client’s stage by reflective listening; the counselor encourages the client to talk about his or her feelings and summarizes these feelings in the counselor’s own words. A counselor applying the stages of change does not try to aggressively push a client past his or her current stage, but meets the client where he or she is. Counselors are able to target interventions to the specific needs of the individual client, rather than using limited counseling time to work on issues the client is not ready to explore or has already mastered.⁸

In 2004, researchers studied two types of Transtheoretical Model interventions to conduct HIV prevention with women in five cities. The community-based intervention assessed almost 1,000 participants for their stage of change and then created interventions to target the concerns of each stage. These interventions included: written materials, personal outreach strategies such as role-model stories and reinforcement strategies. Women who received the stages of change interventions were 37 percent more likely than those in comparison groups to have attempted to convince their main partners to use condoms.⁸ Women in the comparison groups were more likely than those in the intervention group to say that they had never discussed condoms with their

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partners and that they had never used condoms.

Similar interventions reaching about 1,600 women based in clinics, drug treatment centers, and homeless shelters found that HIV-positive women in the treatment group were more than twice as likely as those in the comparison group to have progressed one or more stages toward consistent condom use with their main partners, and less likely to have regressed one or more stages. Women receiving the intervention who were HIV-negative and whose behaviors were most likely to expose them to HIV were similarly less likely to relapse and more likely to be at a more advanced stage of change for condom use than their comparison group counterparts.⁸

Motivational Interviewing

Motivational interviewing is based on the idea that clients talk themselves into or out of behavior change and that the role of the counselor is to gently elicit “change talk” from the client.¹⁰ Like the Transtheoretical Model, motivational interviewing works with a client’s current degree of readiness to change, with the goal of helping the client move as far forward as he or she feels able to.

Motivational interviewing is based on the belief that people have mixed feelings about change, and that this ambivalence is normal but can stand in the way of their progress. It suggests that in order to help resolve ambivalence, counselors should

work in partnership with clients, using the clients' own best arguments for change. There are four key principles for motivational interviewing.³ The first is to express empathy, accepting of the client as he or she is. Counselors can do this through reflective listening, which involves paraphrasing the client to confirm that the counselor has correctly understood the client. Next, counselors develop discrepancy, that is, they listen for and highlight ways that the client's current behaviors are not aligned with the client's stated goals and values.

Third, throughout the session, counselors roll with resistance, accepting that clients may be opposed to a change, rather than trying to argue for or convince a client of the "right" choice. Finally, counselors support self-efficacy, enhancing the client's confidence in his or her own ability to succeed in changing.³

An analysis of motivational interviewing suggests that it has two phases: increasing motivation for change and consolidating commitment.¹⁰ In the first phase, the counselor uses the four principles described above to help the client discover arguments for behavior change.¹⁰ The second phase appears crucial because the strength of client language about commitment in this phase was found in studies to be most predictive of whether change would take place. Tests of motivational interviewing have demonstrated its effectiveness, especially in substance abuse settings.¹¹

Several reviews of studies of the motivational interviewing technique for health behavior change have been published since 2001. Most studies look at what authors term "adaptations of motivational interviewing"³ or "motivational enhancement therapy."¹² These adaptations use the basic concepts of motivational interviewing but add components such as personalized feedback from assessment tools to help counselors and clients discover discrepancy and motivation.

A meta-analysis of adaptations of

Motivational Interviewing Strategies by Stage of Change

Adapted from Miller WR. Treatment Improvement Protocol (TIP): Enhancing Motivation for Change in Substance Use Treatment. Rockville, Md.: U.S. Department of Health and Human Services, 1999.

PRECONTEMPLATION	ACTION
<ul style="list-style-type: none"> • Establish rapport, ask permission, and build trust • Raise doubts or concerns in the client about current behavior patterns • Express concern and keep the door open 	<ul style="list-style-type: none"> • Support a realistic change through small steps • Note difficulties of early stages • Help identify high-risk situations and develop appropriate coping strategies • Help client in finding new reinforcers
CONTEMPLATION	MAINTENANCE
<ul style="list-style-type: none"> • Normalize ambivalence • Help the client "tip the decisional balance scales" toward change • Elicit client self-motivational talk 	<ul style="list-style-type: none"> • Support lifestyle changes • Help the client practice new coping strategies • Review long-term goals with the client
PREPARATION	RELAPSE
<ul style="list-style-type: none"> • Clarify client's own goals/strategies for change and offer change options • Negotiate a change contract • Elicit past change successes from client • Help client negotiate potential barriers 	<ul style="list-style-type: none"> • Commend any willingness to reconsider positive change • Explore recurrence as a learning opportunity • Help client find alternative coping strategies

motivational interviewing showed this technique is successful for substance dependency interventions. Across seven studies, 51 percent of clients in groups receiving adaptations of motivational interviewing reduced their substance use after the intervention compared to 38 percent who improved after no treatment.³ Looking only at abstinence from substance use, 38 percent of clients receiving adaptations of motivational interviewing abstained compared to only 18 percent of those not receiving treatment.

Only a few of the studies in these reviews were focused on HIV outcomes. The earliest review, published in 2001, examined 29 studies, four of which focused on HIV-related risk behaviors.¹³ Two of these studies, whose subjects were predominantly low-income, African American women, reported that motivational interviewing and its adaptations had significant, positive effects, resulting in a heightened perception of risk, lower rates of unprotected vaginal sex,

decreased use of alcohol before sex, and increased frequency of condom use. The models researched in these studies also had skills-training components, much like the Information-Motivation-Behavior Model described below.

The other two studies reviewed in 2001, however, found that for injection drug users, motivational interviewing was not effective in reducing HIV-related injection or sex practices. The reviewers did not offer a theory as to why motivational interviewing was less effective in this case.¹³

A study published in 2001 showed that motivational enhancement therapy was effective for men who have sex with men.¹⁴ The phone-based study of 89 men found that men who had received the motivational enhancement intervention showed significantly less ambivalence about change.

The intervention was especially effective for African American, Asian American, and Latino men, who were

more likely to reduce their frequency of unprotected anal intercourse if they received the motivational enhancement therapy than if they only received assessment and feedback. White male study participants were as likely to reduce their risk in either condition. Researchers speculated that this racial disparity in results could have been due to counselors' greater success in eliciting self-motivational statements from participants of color. They noted that "counselors were more likely to discuss the negative consequences of unsafe sex behavior, and the benefits and losses of safer sex practices" with minority participants.¹⁴

Another meta-analysis of motivational interviewing, published in 2005, covered 72 studies, five of which addressed HIV risk.¹⁰ The analysis found that behavior change was significant at the time of intervention delivery but diminished over time. Researchers suggested that "booster" sessions might counter the loss of motivation. The data suggest, however, that motivational interviewing used as a prelude to other treatment is effective and maintains its effects over time.^{10,13}

From Knowledge to Action

A 1992 review of 48 studies of HIV-related interventions identified several characteristics that facilitated behavioral change.¹ The most successful interventions were based on theory; tailored to the target group; and not only contained informational and motivational components, but also provided opportunities for clients to develop HIV-risk-reduction behavioral skills. This research review led the authors to create the Information-Motivation-Behavioral Skills (IMB) Model.

Like the Transtheoretical Model and motivational interviewing, this model also uses open-ended questions to identify the techniques that would be most effective for clients from specific groups.¹⁵

The Information-Motivation-Behavioral Skills Model uses motivational interviewing techniques to alter individuals' attitudes towards HIV prevention as well as the prevention attitudes and practices of his or her community. Finally, it seeks to increase client efficacy and create behavior change by teaching relevant skills, including, as appropriate, the abilities to accept one's sexuality; negotiate HIV prevention behavior and exit a situation in which safer sex is not possible; engage in public prevention behaviors such as condom purchase; and reinforce safer sex behaviors in self and others.¹

In 1996, researchers applied information-motivation-behavior techniques in a three-session intervention for 134 Connecticut college students.¹⁵ A workshop conveyed general information about HIV as well as specific resources near campus for condoms and HIV testing. Small- and large-group discussions explored attitudes and social norms regarding preventative behaviors, with the goal of shifting negative thoughts and beliefs about using condoms and communicating with partners. Behavioral skills training focused on communication about safer sex, condom use, and identifying and overcoming obstacles to prevention behavior. Participants reported an increase in behaviors such as buying condoms and keeping them accessible, using condoms during intercourse, and discussing condom use with sexual partners. Two months after the intervention, participants had sustained increases in buying and keeping condoms and using them during intercourse.¹⁵

A second study, in 2005, randomized 612 men and women into four intervention groups at a Milwaukee clinic offering services for sexually transmitted infections.¹⁶ Each group received a 90-minute intervention. One group received information only, including facts about HIV transmission, risk behaviors, and HIV testing. The second

received information plus motivational enhancement, incorporating many motivational interviewing techniques. The third group received information plus behavioral skills, including identifying triggers for high-risk behaviors and strategies for communicating with sexual partners. The final group received all three interventions: information, motivational enhancement and behavioral skills.

Men in the information plus behavior skills group and the full information-motivation-behavior group showed significant improvement in their HIV prevention skills.¹⁶ These men were more likely at the three-month follow-up to report reminding themselves to practice safer sex, and at the six-month follow-up to report discussing using condoms with their partners, and refusing unsafe sex. Men in the information-motivation-behavior group also reported less unprotected sex than men in the other groups at the six-month follow-up. Results differed by gender, with the information-motivation-behavior intervention less effective for women. The researchers reported this finding as "perplexing" and noted that women were underrepresented in the sample.

Conclusion

While motivation is critical to behavior change, what motivates a particular client may be elusive, and may vary depending on a range of factors, including his or her gender, sexual orientation, and community affiliation. The reviews and meta-analyses mentioned here also note that there is an absence of studies that follow scientific experimental guidelines.^{14,17} More research is needed to identify the interventions that most help clients to adopt and maintain safer sexual and injection practices. In the meantime, these studies suggest a variety of tools that can help counselors determine a client's stage of readiness, build motivation, and encourage change.

Implications for Counseling

Counselors use a variety of tools to help clients reduce HIV-related risk. Among the most important tools are those that focus on increasing or solidifying a client's motivation for change.

Starting Where the Client Is

HIV test counseling starts with the client-counselor relationship, and the client's sense that the counselor is caring, understanding, and "real." Counselors communicate these qualities by treating the client as an individual, with unique needs and abilities, and by being willing to work within the client's level of knowledge about HIV risk and of motivation for change. It is also important that the counselor hold a generally positive expectation for the session and for the client: the belief that this person can and will make the changes he or she is ready to make.

Since there is usually some shame associated with behaviors people want to change, a nonjudgmental attitude and the use of open-ended questions can help create a setting where clients feel comfortable talking about these issues. Counselors can also use open-ended questions

to help assess a client's stage of change, for example, "What do you think you would like to do about your speed use?" "What brings you in to test today?" or "In what ways are you concerned about not using condoms?"

A client may be primarily concerned about "other people's" concerns for him or her (which might indicate precontemplation), or conflicted about whether or not he or she will really be able to follow through on their plan to stay safer (which could be preparation). The counselor can then choose an intervention appropriate to the person's stage of change.

Ambivalence: The Heart of Change

For most people, changing is not simple and straightforward. Often, this is because people are ambivalent. That is, they have both positive and negative feelings about the changes they are thinking of making. One of the greatest challenges for counselors is remembering that ambivalence can help change along, not just stand in its way, because ambivalence is where most change starts. Counselors will be most effective if they help clients explore the pleasurable and functional aspects of their risk behaviors as well as those that do not serve the client.

Whether they are conscious of it or not, when most people are thinking of making a change, they go through a process of "decisional balance." It is as if they were making a mental list—a balance sheet—with reasons to make a change on one side and reasons not to make a change on the other. When people become convinced that the reasons on the side of change are numerous and strong enough, they usually try to find a way to make the change. Counselors can help clients by making what is often an unconscious process conscious.

One of the ways to do this is through

a special kind of reflective listening called "double-sided listening." A counselor helps a client talk about the pros and cons of an issue, then reflects back the ambivalence in the client's statements. For example, a counselor might say to a female client, "It sounds like you have thought about talking with your partners about HIV, but you haven't tried it yet. What's getting in the way for you?" If the client says, "Guys get angry when you bring up that stuff, they don't think you trust them, or they think you must be with a lot of guys," the counselor might respond "On the one hand, you'd like to talk with your partners about HIV, but you're concerned about the possibility that they might get angry or think you don't trust them. Is that right?"

Building Intention and Commitment

In counseling, clients can talk about why they want to change, how important change is to them, and what changes they might be willing to make in the near future. Engaging clients in this discussion is called "eliciting change talk." This is based on the idea that when people give their own reasons for change, it increases their motivation and builds their commitment, which will help them produce and maintain change.

There are several ways to draw out change talk with clients. For example, a counselor might say, "What are some of the ways having unprotected sex has been a problem for you?" or "What worries you about sharing needles?" or "The fact that you've come in today means that at least part of you thinks it's time to do something different. What makes you think it's time for a change?"

Answers can help both client and counselor understand the client's motivations for change. The counselor then reflects back this motivation, which helps the change process move forward. For example, "It sounds like last week, when you found out one of your former

A Counselor's Perspective

"It's tempting at times to impose my own reasons why clients should change a risk behavior. When I stay focused on the client's concerns, it throws open the door to the client's motivations for change."

partners was positive, you panicked, because you thought you might be, too. But you're not sure you're ready to carry condoms. What is something that you could do both to protect yourself next time, and to not feel so panicky?"

The HIV test counseling practice of identifying a "small, manageable step" fits in well with all of the models of change and motivation presented above. It is individualized, seeks to identify something the client feels motivated to change, and does not push the client past his or her stage of readiness. Think about (and ask the client) what he or she needs to do to get to the next step. Remember that in the beginning stages of change, the client may especially need to get information and to create intention and commitment, while later he or she will need to work out how to put the new behavior into practice, and get support.

Once a step is identified, counselors can support the client's confidence in his or her ability to change. A variety

of techniques can support this feeling of self-efficacy, including affirming and reinforcing client strengths. For example, a counselor may ask "What are the things that make you feel confident about making a change?" or "How do you think that some of the other successful changes you've made can help you with this one?" Counselors may offer to role-play difficult scenarios such as a disclosure or safer sex negotiation, help with skill-building such as proper condom usage or safe injection practices, and refer to community resources for additional skills and support.

Countertransference Issues

Many feelings can come up when counselors work with clients around motivation. Because it is part of the counselor's job to help clients create change, it can be frustrating (and may even feel like a failure) when it seems that a client is not ready to change or relapses. It can be difficult to understand how clients can have information about

their risk for HIV infection, yet still not change or maintain a change in their behavior. This can be especially true if the counselor feels he or she would make a change in a similar situation. In response, counselors may feel a strong temptation to push clients past their stage of readiness, so it is important to remember that change can be slow and incremental. One of the advantages of the models discussed in this issue is that they offer counselors a place to start, even with clients who may not seem highly motivated.

Even with all of these tools it is challenging to motivate change. Clients often present with more than one HIV risk-related issue. It is important for counselors to remember that a client may be in a different stage of change, and have a different level of motivation for each of these issues. For example, a person may be contemplative about how to tell their primary partner that they are having sex outside the relationship, and precontemplative about how their meth-

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Case Study

Scott, a test site coordinator, asks Mike, a test counselor, about the prior night's shift. Mike describes his frustration counseling Rick, a 48-year-old man, who has tested before, including with Mike.

"It turned out fine—he was negative—again. But as smart as this guy is, he's still going out and meeting guys in the park and every once in a while, he doesn't use a condom. And he's a bottom! I just can't understand how he can keep doing that, knowing the risks, and going through the anxiety he has about testing afterwards. It's usually so good to help people make a risk reduction plan, but with him I feel like there's almost no point."

Scott sighs and smiles: "I don't know about you, but I always feel a little frustrated when people show up again and again with the same risk." Mike nods. "Sometimes, it's easy for me to take on whether or not someone has made a change, to feel like it's a failure for me as a counselor if there's something he just can't get a handle on."

"Yeah," Mike replies, "Clearly, he is not ready to change. I've given him all the information, and we've even planned out lots of the steps he needs to go through to be safer—where he could buy condoms near the park, not drinking too much before he goes out so he can remember to use them, even being the insertive partner. But he's just not following through."

"What do you think could be some of the reasons you're not seeing as much change in his risk behavior as you'd hope?" Scott asks. Mike pauses: "I know change is hard, and the truth is, he has made some changes—for about six months he was using a condom all but twice. He says he's just really tired of condoms, that they make sex really boring. Inside, I was thinking, 'I'd rather be bored than take that risk.'"

Scott smiles again: "Sometimes it's hard not to think about how you'd make a different choice. It sounds like he was able to take in some of what you talked about together in the last session. Even though he didn't use a condom every single time, he did make some changes which helped him stay negative. I also really like how you've offered him alternatives for reducing risk. Even if he hasn't been ready to take all those steps, you may have planted a seed he can use in the future. I wonder if

really getting into his ambivalence with him would help make it clearer what the next step is?"

Mike reflects on this, then responds "I guess I don't want to focus on the part of him that's still stuck. We have so little time together, it's my one chance to be the voice advocating for change." "Yes," Scott replies. "Your time together *is* short, and it can feel really strange to make a space for the part of the client that's not ready to change. And you want to give Rick something he can use in the moment when both of those feelings come up—wanting to change, and not wanting to.

Scott continues "Sometimes it's as simple as saying 'You've really improved your consistency with using condoms, and you feel anxious when you think you might be positive, but you're also feeling stuck because using condoms for sex feels boring. What's something that you could do now to keep going in the direction of protecting your health?' He may decide that even though they're boring, condoms are the way to go—even if he never manages to use them every time. Or he may come up with something that has nothing to do with condoms—maybe even go back to one of the ideas you've discussed in the past."

Mike agrees; "But at least, then, he'd own it; it probably feels different than when I'm coming up with the ideas." "Yeah," Scott nods, "and it's always a good reminder for me that the client is the one who has to make the change happen. I'm just there to do my best to facilitate the process. The other thing is that when I feel frustrated, it's hard to affirm the changes the client *has* made, because I wish they'd gone further. In a case like Rick's I have to keep reminding myself that people's motivation to make a change or stay safe goes up and down, and that relapse is often part of change. Don't forget, too, that there's a new group at the Community Center for men over forty eroticizing safer sex—something like that might help Rick boost his motivation between test counseling sessions."

amphetamine use before sex may alter their decision making.

A counselor's assessment skills are critical not only in determining the client's key risks, but also the client's

knowledge, interest in, and capacity for change. Supervision plays a critical role in helping counselors hone these assessment skills, keep to their client-centered focus, and make the most of their limited

role. It is the counselor's responsibility to provide information, elicit change talk, and facilitate commitment, but it is ultimately the client's responsibility to make change.

Test Yourself

Review Questions

1. True or False: Arming clients with the facts about HIV prevention will motivate them to change their risk behaviors.
2. “Decisional Balance” refers to: a) the space between two stages in the stages of change; b) the way counselors present arguments for and against a change; c) the process by which people weigh the pros and cons of making a behavior change; d) the outcome of the behavior change process.
3. True or False: When a counselor sees that a client is not ready to make a specific behavior change, the counselor should end the session because counseling will not be effective.
4. Motivational interviewing uses all but the following techniques: a) expressing empathy; b) repeating requests to change behavior; c) rolling with resistance; d) developing discrepancy.
5. True or False: Motivational interviewing suggests that instead of advocating for change or arguing against a client’s resistance, a counselor uses reflective listening

and guiding questions to elicit change talk from the client.

6. According to the Transtheoretical model, by the time a person is in the “Action” stage, his or her ambivalence is very strong.
7. The Information-Motivation-Behavior Model adds to the other models: a) a chart documenting daily behavioral goals; b) a clear line between “good” and “bad” behavior; c) behavioral modification techniques; d) behavioral skills training.

Discussion Questions

1. Have you encountered resistance from clients when you suggested behavioral change? How did you handle it?
2. How might you use the stages of change and motivational techniques with a client who says she has been thinking about stopping her drug injection habit? With someone who says he can not imagine not using substances before sex? With someone who’s had one or two successes negotiating condom use? With someone who says he is safe every time he has sex?
3. What are some ways you might explore discrepancies between a client’s values

and behaviors? Are there ways you have done this before that have worked particularly well?

4. In your experience, does learning new risk reduction skills enhance your clients’ motivation for behavior change?
5. What are some ways that you can keep yourself from arguing with a client when she or he rejects your change suggestions?

Answers to Review Questions

1. *False. Even when people are aware of HIV risks, they may not change their behaviors.*
2. *c.*
3. *False. Working with a client’s readiness level, a counselor can help a client increase his or her motivation for change.*
4. *b.*
5. *True.*
6. *False. Although ambivalence may not have resolved completely, it decreases between the precontemplation and action stages.*
7. *d.*

Using PERSPECTIVES

PERSPECTIVES is an educational resource for HIV test counselors and other health professionals.

Each issue explores a single topic. A **Research Update** reviews recent research related to the topic. **Implications for Counseling** applies the research to the counseling session. Also included are a **Case Study** and two sets of questions for review and discussion.

HIV Counselor PERSPECTIVES

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PERSPECTIVES depends on input from HIV test counselors and other health professionals. For this issue, PERSPECTIVES acknowledges the contributions of Kama Brockmann, PhD, LCSW.

PERSPECTIVES is funded in part through a grant from the California Department of Health Services, Office of AIDS. PERSPECTIVES is published four times a year and is distributed to HIV counseling and testing sites in California. PERSPECTIVES is also available by subscription.

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Volume 15 Number 1 January 2006



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