

HIV COUNSELOR PERSPECTIVES

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CONTROVERSIAL RISK REDUCTION ISSUES

As the AIDS epidemic has progressed, information, attitudes, beliefs, and behavior have constantly evolved. Sometimes this evolution has led to clarity and agreement; sometimes it has led to uncertainty, debate, and controversy. This issue of HIV Counselor PERSPECTIVES looks at five key prevention-related topics that remain unsettled, with the goal of defining the current state of the science and the reasons each topic remains controversial. It also discusses how HIV counselors can talk about unsettled issues in a client-centered way.

Research Update

HIV test counseling always involves the interaction of knowledge and behavior. As a way of exploring this interaction, this Research Update describes and reviews the literature on five controversial topics related to HIV transmission: strategic positioning, oral sex, viral load calculation, serosorting, and superinfection. Some of these topics, such as superinfection, oral sex, and strategic positioning, involve unanswered questions. Others, such as viral load calculation and serosorting, are controversial because, while the science behind them is sound, they are difficult to apply in real-life situations. For example, while it appears that higher viral load increases the likelihood of transmitting HIV, a number of other factors make this knowledge difficult to put to use as a risk reduction strategy.

A key change in HIV prevention over the past few years is the movement away from the strict adherence to the “condom code”—the idea that condoms are the only acceptable prevention method. It is

useful to remember that some counselors and clients will embrace new ideas early on, and some will embrace them only when they have been scientifically confirmed. Similarly, in any question of public or personal health, there are people who prioritize safety above all other goals, and others who prioritize values such as intimacy and pleasure above safety.

While the goal of HIV test counseling is to promote safety, important questions remain. Is absolute safety, for example, 100 percent condom use, sustainable over the long-term? Can clients use harm reduction strategies such as serosorting, oral sex, strategic positioning, and viral load calculation to reduce their risk more successfully over time?

The research in this section offers insights into current science about these topics. It is important to note that this science will likely continue to change. The greatest challenge for counselors remains navigating uncertainty and helping clients understand their feelings, beliefs, and values well enough to make

informed, achievable, and sustainable decisions about their behaviors.

Strategic Positioning

Strategic positioning, also called seropositioning, refers to the practice of an HIV-negative partner in a mixed HIV-status male couple adopting the insertive or “top” role during unprotected anal intercourse and the HIV-positive partner adopting the receptive or “bottom” position. This strategy allows mixed-status couples who wish to have unprotected sex to take advantage of the fact that HIV is more easily transmitted from the insertive partner to the receptive partner than from the receptive partner to the insertive partner.^{1,2}

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A key study that followed 2,189 gay and bisexual men in San Francisco, Denver, and Chicago for 18 months between 1992 and 1994 supported the effectiveness of strategic positioning to reduce risk. All the study subjects were initially HIV-negative, and 60 became HIV-positive during the course of the study. In reporting on subjects' sexual activity with HIV-positive or unknown status partners, researchers found that having insertive anal sex without a condom was even less likely to result in HIV acquisition than having protected receptive anal sex.³ Strategic positioning remains controversial, however, since it may still lead to transmission and because individuals may not know, or accurately disclose, their HIV status.¹

Oral Sex

Oral sex is far less likely to lead to HIV transmission than anal or vaginal sex. This insight offers another option for strategic positioning for both gay male and heterosexual partners,¹ and many people use unprotected oral sex as a safer alternative to unprotected anal or vaginal sex. Despite this the technique is controversial because some studies suggest that oral sex can still transmit the virus.^{3,4}

Most studies have focused on the risk of HIV infection for people who have receptive oral sex with male partners, also called “performing fellatio,” since this activity seems to present the greatest possibility of transmission. In the three-city study of 2,189 gay and bisexual men noted above, researchers found a low risk of HIV transmission to receptive partners during unprotected receptive oral sex.³

The risk of HIV transmission may increase, however, in the presence of a sexually transmitted disease or cuts or sores for either partner.⁵ Dry mouth, which can result from certain medications, may also increase risk, since saliva

apparently has a protective effect against HIV. Allergies in the receptive partner, as well as other conditions that affect the immune system, may also play a role in increasing risk.⁶

Unfortunately, the risks associated with oral sex are difficult to research. For example, unprotected oral sex is often performed along with other sexual behaviors such as vaginal or anal intercourse, which are more likely to allow infection. So, therefore, if seroconversion occurs, experts have a difficult time pinpointing which behavior transmitted HIV.³

The lack of ideal research environments also creates uncertainty about oral sex risk. For example, the studies to date documenting this harm reduction strategy—as well as other strategies such as serosorting, viral load calculation, and strategic positioning—are observational, rather than controlled, experiments. They depend on individuals to accurately report their sexual behaviors and rely on their memory, as well as their honesty and comfort, in disclosing HIV risk-related details.^{1,4,7-8} This is complicated by the fact that people may be more likely to over report oral sex as a risk behavior and underreport other behaviors, such as unprotected anal sex, because of the stigma associated with not using condoms for “high risk” behaviors.⁴

A more recent study overcame some of these research challenges. Between 1999 and 2001, researchers followed 239 gay men who said their only sexual activity was unprotected oral sex, including fellatio, on at least one male partner. This very specific sample isolated oral sex from other sexual behaviors. Researchers found no cases of HIV transmission from oral sex and concluded that this method of sexual activity presents an “extremely low risk” for HIV transmission.⁴ The modest sample size of this study, the fact that less than one-

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third of the sample had sex with known HIV-positive partners, and that only 35 percent of subjects performed fellatio to ejaculation makes it difficult to generalize the results.

Experts continue to disagree about the significance of HIV risk from oral sex, particularly oral sex on a male partner with ejaculation, with some maintaining that this activity poses a “low risk” and others an “extremely low risk.” There seems to be consensus, however, that fellatio in which the insertive partner does not ejaculate poses “an exceedingly low risk.”⁶

While receptive fellatio entails a low risk of HIV infection, other forms of oral sex are believed to pose even less risk. Insertive oral sex in which the mouth of an HIV-positive person is on the genitals of an HIV-negative person could theoretically pose some risk. This could occur if the receptive partner had blood in their mouth which entered the lining of the urethra or vagina (or skin, through cuts or sores).^{9,10} Since this risk is so minimal, some couples may choose to have the HIV-positive partner in a mixed-status pair take the receptive role during oral sex.

Little research has been done on the risk of cunnilingus, or oral sex on women, in transmitting HIV. It is believed, however, that sexually transmitted diseases, the presence of menstrual blood, and the presence of cuts or sores in the mouth could increase the risk of what is presumed to be a very low-risk activity.

Compared with other sexual activities, oral sex presents a relatively low risk of HIV infection. It is important to remember, however, that other STDs can easily be transmitted through oral sex.

Viral Load Calculation

Some people living with HIV limit unprotected sex to the times when their viral load (the amount of HIV in their blood) is below the level of detection. Current research supports the theory that greater concentrations of HIV increase the likelihood of transmission, so that HIV-positive people with higher viral loads are more infectious than people with lower viral loads.^{11,12,13}

A Ugandan study that tracked seroconversion rates in 415 serodiscordant heterosexual couples identified viral load as the “chief predictor of the risk of heterosexual transmission of HIV.”¹³ During the course of the study, 90 of the 415 initially HIV-negative partners seroconverted. These 90 individuals had HIV-positive partners whose viral loads were significantly higher than were the viral loads of the 325 HIV-positive study participants whose partners did not become infected. Moreover, the researchers found that the risk of HIV transmission was very low when viral load levels were less than 1,500.

While there is some scientific evidence to support the theory that reduced viral load lessens HIV transmission risk, other variables can make this a difficult strategy to put into practice. An individual’s viral load may vary¹⁴ by time of day, type of test done, and whether a person has an STD. In addition, viral load tests measure concentrations of virus in the blood, which may be different from levels in other body fluids such as semen.¹⁵

Serosorting

While not a new strategy, researchers have found that increasing numbers of gay men use serosorting, the practice of

having unprotected sex only with partners of the same serostatus, in order to reduce the risk that an HIV-positive person will transmit HIV to an uninfected person.¹⁶ Many HIV-positive people of all sexual orientations seek out HIV-positive partners through HIV-positive social groups, and personal ads in print and on the internet.

In 2004, San Francisco researchers concluded that men who have sex with men could have high levels of unprotected sex without a rise in new HIV infections, as long as these men were accurately serosorting.¹⁶ Researchers in New York interviewed 115 attendees of 10 different POZ Parties, gatherings intended to facilitate sexual activity among HIV-positive men who have sex with men. They found attendees liked the parties because they appreciated being able to have uninhibited sex, not having to worry about infecting someone else, and not having to worry about disclosing HIV status.¹⁷

Some HIV-negative people also use serosorting to determine their choice of partners. Again, if accurate—that is, if both partners are truly uninfected at the time of a sexual encounter—this strategy obviously prevents HIV infection. However, according to recent research, many people misperceive their HIV status.¹⁸ Researchers analyzing seroconversion rates among men who have sex with men found that between 15 percent and 30 percent of new cases of HIV are among men who report sex only with HIV-negative partners.¹⁸

This strategy’s success also depends on partners’ ability to switch to protected sex or refrain from sex if disclosure reveals that the partners are of differing serostatus. Some male couples use a variant of this serosorting strategy called “negotiated safety:” two HIV-negative primary partners do not use condoms to have sex with each other, but use condoms when either partner has sex outside the relationship.

Another difficulty with serosorting for HIV-negative individuals is that a newly-infected person in “the window period” may test negative, but, in fact, may be in one of the most infectious stages of the disease.¹⁹ London researchers suggest that the first three months after infection is the time when viral load is the highest, and, therefore, most likely to lead to HIV transmission.¹¹

Serosorting demands a high level of knowledge, honesty, communication, and commitment.¹⁷ Like the other risk reduction techniques discussed here, it is a strategy that allows some sexual freedom while reducing the odds of spreading the virus.^{7,17} However, even when partners share the same HIV status, serosorting entails a risk of STD infection.^{7,17} Further, when both partners are HIV-positive, serosorting may lead to HIV superinfection.¹⁷

Superinfection

Superinfection is not infection with a “super” virus in the sense of a particularly strong or dangerous form of HIV. Instead, it occurs when an HIV-positive person is infected with an additional, different strain of HIV “on top of” or “superimposed upon” his or her existing virus. Sometimes, this phenomenon is referred to as “reinfection,” but this is technically incorrect, since reinfection means that a person has eliminated the initial HIV infection from his or her body before becoming infected again.²⁰

Potential biological consequences of superinfection include more rapid disease progression, increased viral load levels, and decreased CD4+ cell counts, all of which reflect diminishing health.^{20,21,22} Superinfection may also lead to HIV antiviral drug resistance and possible treatment failure if an individual is superinfected with a drug-resistant strain.²⁰

The primary reason superinfection is controversial is its apparent rarity. According to the Gladstone Institute of Virology at UCSF, only 16 cases have been reported in the scientific literature, and “transmission has not been fully documented to confirm these cases.”¹⁹ Some researchers believe the incidence of superinfection is between 2 percent and 5 percent during the first two years of HIV infection, and perhaps even as high as 8 percent in the first year after initial infection.^{23,24} There are researchers who believe that these figures suggest a significant risk, warranting concern regarding unprotected sex and needle sharing between HIV-positive people and undermining the practice of serosorting.²⁵ At the same time, other researchers report no cases of superinfection in individuals with long-term infection.^{22,26,27} These researchers believe that superinfection among those with long-term infection is rare and are reluctant to warn against its dangers without more evidence.²⁶

All of this suggests that there may be a period of susceptibility to HIV superinfection. According to Robert Grant, a leading researcher in the field, this period of superinfection susceptibility seems to be the first two to three years after initial infection, the time before the body develops full immunity.^{23,28,29,30}

Since it began in 2000, Grant’s ongoing San Francisco-based Positive Partners study has followed more than 140 HIV-positive gay male and heterosexual couples for approximately one year each.

Researchers have found no evidence of superinfection in these couples, although they engage in unprotected anal and vaginal intercourse.²² Study participants have all been HIV-positive for an average of more than eight years, supporting the idea that long-term HIV infection may provide immunity to superinfection.²⁶

In contrast, Grant’s team has found what they believe are at least four cases of possible superinfection among participants in their ongoing Options study of 104 HIV-positive participants, all of whom were infected less than six months at their time of entry into the study. Researchers could not identify the partners who transmitted HIV to these subjects, therefore they cannot determine whether these cases truly represent superinfection or whether they might be related to another phenomenon known as coinfection.²³

A coinfection occurs when an individual is infected with two different strains of HIV, either simultaneously or during the first month of initial infection, before the body has produced HIV antibodies.²⁰ When coinfection occurs, one of the HIV strains may be inactive for a period of time, and, when this second infection later presents, it may appear to be a case of superinfection. This makes research into HIV superinfection very difficult.¹⁹

The Positive Partners study seeks to avoid this coinfection confusion. To be accepted into the study, partners must have begun having sex with each other

after testing HIV-positive and must have genetically different strains of the virus. This makes it more likely that if a study participant presents with his or her partner’s strain, this truly represents a case of superinfection.²⁶

In summary, it appears that superinfection does exist, but it is rare. Further, it may be most likely to occur during the first three years of HIV infection, making it less of a threat to people with longer-standing infection.²⁹

Conclusion

Some HIV-risk related issues, such as superinfection and oral sex, remain controversial in part because they are so difficult to study. Others, like serosorting, strategic positioning, and viral load calculation, involve strategies that science suggests are effective but may be difficult to put into practice. The most controversial aspect of each of these strategies is that they are often used as alternatives to condom-protected sex, which remains the most reliably effective method of HIV prevention.

It is important to remember that the same behavior may carry different risks at different times and under different conditions, so an individual’s risk during a specific sexual encounter may be very different from the average risk of a group in a research study. To the extent that controversy and inquiry drive further research on these topics, they will encourage the development of more effective HIV-risk reduction strategies.

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Implications for Counseling

Controversial risk questions challenge HIV test counselors, who must help clients manage several complex issues. These include: helping clients make decisions about risk behaviors in the context of limited, sometimes conflicting information; helping clients weigh HIV transmission concerns against other values and needs; helping clients think through the implementation of their strategies; and increasing their own capacity to discuss non-condom-based risk reduction strategies with clients.

Managing Limited Information

Clients rely on counselors for accurate, current information about HIV risk. Even with ongoing education, however, counselors cannot know everything about this topic, and cannot give clients absolute answers to questions that may never be completely resolved. It is best to state what is known about the relative risk of the activity, while acknowledging that individual circumstances and behaviors can change this risk.

At times, a counselor may feel inadequate because he or she cannot give a client an exact answer. However, decisions about behavior are always made in the context of limited information. Test counseling helps clients use available information to weigh costs and

benefits and make realistic plans about behavior.

Exploring Client Comfort with Risk

Through reflective listening, counselors can help clients move from a general discussion of controversial risk issues to a specific exploration of the risks they are comfortable taking. Acknowledge that the goal of the counseling session is not risk elimination, but risk reduction. In developing risk reduction strategies, clients weigh competing values, including safety and health, against the potential benefits of unprotected sex, such as pleasure and intimacy. Exploring the meaning of unprotected sex and harm reduction for the client is a good place to begin.

Once the counselor understands the competing values at work for the client, he or she can articulate the concern. For example, a counselor might say, “It sounds like you don’t use condoms when you top because the risk of infection seems small, and the pleasure is greater without a condom. On the other hand, you’ve tested three times this year, and you’re concerned that this strategy might not protect you from infection. I can tell you that the risk of infection from topping without a condom is much lower than bottoming without a condom, but not as safe as using a condom when you top. How comfortable are you with that risk?”

Some clients may be anxious about risks that are relatively small, such as unprotected insertive oral sex, and may not be persuaded by the counselor’s explanation of relative risk. Some clients who focus concern on low-risk behaviors may prioritize safety over all other concerns. Others may be more comfortable, consciously or unconsciously, discussing lower-risk activi-

ties rather than ones that put them at greater risk for HIV infection.

During this exploration, counselors confront their own feelings about risk and comfort with strategies that are more complex than “use a condom every time.” To be effective, counselors must be willing to help people make distinctions among behaviors that entail more or less risk, and be comfortable with the fact that clients’ choices about risk behaviors may be different than their own.

Thinking Strategies Through

Risk strategies such as serosorting, oral sex, strategic positioning, and viral load calculation, while controversial, can be effective in reducing risk. For each of these strategies, however, certain conditions must be met for the strategy to be effective. Counselors can help clients explore their ability to meet these conditions, noting any potential barriers to success.

Some strategies can be difficult to use because they require strong communication skills and confidence in a partner’s reported HIV status. For example, limiting sexual activity to partners with the same HIV status is 100 percent effective at preventing new seroconversions, but this approach works only if both partners know and honestly disclose their HIV status.

When exploring the strategy of serosorting with an HIV-negative client, the counselor might ask how the client determines that his or her partners are also HIV-negative. How comfortable does the client feel talking about his or her own HIV status, and when is the discussion held? Does the setting in which the client meets partners promote honest discussion of HIV status? What happens when the client is attracted to someone of a different HIV status? Some clients may describe more “informal” serosorting—for example,

A Counselor’s Perspective

I can’t give clients exact “odds” on the risks of their behaviors. But I can help them decide which risks they’re comfortable with.

a client may say “He didn’t look like he had HIV,” or “He didn’t bring it up, so he must be negative.” Counselors can question these assumptions, encouraging clients to engage in a more conscious process.

Likewise, when an HIV-negative client shares that he or she uses viral load calculation to minimize risk, the counselor can ask how the client implements this strategy. How does the client monitor his or her partner’s viral load, and how frequently does the partner get a viral load test? How does the client feel about the fact that several factors can cause viral load to vary?

For men who have sex with men, strategic positioning is another technique that can greatly reduce risk of HIV transmission. A client must be certain of his HIV status at the time of the sexual encounter

and be willing to be the insertive partner in anal sex if he is HIV-negative and the receptive partner if he is HIV-positive.

It may be difficult for counselors to discuss strategies involving unprotected sex between partners of mixed or unknown status, because HIV prevention typically advocates condom use in these situations. Counselors can emphasize that while non-condom-based harm reduction strategies can reduce risk, HIV transmission is still possible.

Finally, if a client tests HIV-positive and asks about the safety of unprotected sex with other HIV-positive partners, the counselor can acknowledge that serosorting is a strategy some HIV-positive people use to enjoy unprotected sex and minimize new HIV infections. The counselor can also raise issues regarding the potential implications of such

an approach. For example, the counselor can outline the potential risks of STDs, superinfection, and hepatitis C transmission. Counselors can also help clients think about how and when they would disclose to sex partners, and provide referrals clients might use to find other HIV-positive partners and connect with support.

Managing the Counselor’s Feelings

Discussing controversial risk issues can bring up uncomfortable feelings for counselors. Perhaps the most common of these feelings is anxiety about uncertainty, risk, and responsibility.

Counselors may feel anxious or uncomfortable when clients seek absolute answers about a risk behavior—especially if research has not yet provided a conclusive answer. When clients

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Case Study

Matt is a single 26-year-old gay man who has tested for HIV six times. Each time his result was negative. He reports frequent unprotected sex “usually oral, unless I know the guy, and I know he’s okay.” He says he is testing again now because he “had a slip” about eight months ago, and had unprotected receptive anal sex with a guy he wasn’t so sure about. Matt also wonders “Should I be more concerned about oral sex? None of my friends use condoms if it’s just a blow job.”

Affirm that Matt is using various strategies to take care of himself—that is, usually engaging in lower risk activities, knowing his HIV status, and examining whether he is comfortable with the level of risk oral sex involves. Also explore Matt’s experience with condoms, and find out when he is able to use them before assessing barriers to their use for him. If he says he cannot imagine life without any unprotected sex, affirm that this could be an overwhelming idea. Encourage him to think about each sexual encounter as a separate opportunity not only for pleasure and connection, but also to find ways to reduce risk—which may or may not mean condoms every time.

Respond to Matt’s question about oral sex by talking about relative risk. Acknowledge that almost all sexual activity carries some risk of HIV transmission and that, while oral sex poses a much smaller HIV threat than, for example, unprotected receptive anal sex, a small risk of HIV transmission remains. Since Matt reports having unprotected oral sex with a large number of partners, explore whether he has been tested for STDs.

Discuss ways that Matt can reduce this risk. For example, suggest to him that not brushing or flossing before having oral sex (to avoid opening cuts in his mouth), being tested for and treating STDs, and not having his partner ejaculate in his mouth are ways to further reduce risk. How comfortable is he with his risk for STDs? Is it possible that he might be comfortable with a different level of risk than his friends who do not use condoms for oral sex? Another option Matt could consider is being the insertive partner in oral sex, which

would greatly reduce any risk.

Follow up on Matt’s comment that he usually has oral sex unless he “knows the guy, and knows he’s okay.” Does this mean that when Matt feels more certain that his partner is HIV-negative, they have unprotected anal sex? If so, how does he know his partner’s status?

During Matt’s recent “slip,” what was different about himself, his partner, and the situation? Help Matt troubleshoot future “slips” by understanding this experience. Explore Matt’s comfort in discussing HIV status and risk with partners, as well as negotiating sexual activities and condoms. If Matt thought his partner was “okay” because he reported that his viral load was undetectable, help him understand that a low or undetectable viral load may minimize, but does not eliminate, transmission risk, since viral load can change rapidly, and vary between semen and blood.

Express to Matt that of the activities he engages in, unprotected receptive anal sex with partners of unknown status is the one most likely to transmit HIV. If he were able to use condoms at least when he “bottoms,” he would greatly reduce his likelihood of contracting HIV.

If Matt typically chooses unprotected oral sex over unprotected receptive anal sex with partners of unknown HIV status there is no question that he is reducing his chances of contracting HIV. The counselor should affirm his efforts at risk reduction. After revisiting the idea of relative risk, Matt may decide, for example, that he wants to add regular STD testing and condom use for receptive anal sex to his tools for protecting himself.

seem anxious or as if they would like the counselor to make decisions for them, counselors may find themselves “taking on” this anxiety. Other clients may seem to “have all the answers,” or want to debate with the counselor about a given question. All these scenarios can trigger counselors’ feelings of inadequacy and irritation, hindering effective interaction.

Supervisors and peers can help counselors recognize and resolve these feelings and remember their limited role. Ultimately, it is the client’s responsibility to choose the risks he or she is comfortable taking. Referrals to other educational, medical, or support resources may also be appropriate for clients who have further questions.

Controversial risk issues challenge

counselors not only to examine emerging information but also to re-examine their own comfort with discussions about sexuality and levels of risk. Willingness to talk with clients about a range of prevention strategies, including those which do not include condom use, allows for more collaborative, realistic, and potentially successful risk reduction planning.

Test Yourself

Review Questions

1. It is difficult to study the risk unprotected oral sex presents for HIV infection because: a) so many people have oral sex; b) so many people use condoms when they have oral sex; c) so few people have oral sex as their only risk for HIV infection; d) people underreport unprotected oral sex.
2. True or False: Between mixed-status male partners, unprotected anal sex is just as risky for the “top” as for the “bottom.”
3. Which of the following is a problem in researching many controversial or unsettled risk-related issues? a) subjects in studies may not accurately recall their behavior; b) people may feel uncomfortable reporting their behaviors honestly; c) study conditions are different than real-life conditions; d) all of the above.
4. True or False: Current research suggests that a higher viral load makes an individual more infectious.
5. True or False: Serosorting is one way that HIV-positive people can enjoy unpro-

tected sex without a risk of infecting someone who is HIV-negative.

6. For serosorting to work, both partners must: a) know their own HIV status; b) know each other’s HIV status; c) not ejaculate; d) Both a and b.
7. Which of the following is true for people during the first few months of their HIV infection? a) they usually know their HIV status; b) they often have a high viral load and may be quite infectious to others; c) they are at the lowest risk for superinfection; d) a and c.
8. True or False: Current research suggests that superinfection is a significant risk for all HIV-positive people.

Discussion Questions

1. Do you feel more comfortable discussing some of the controversial risk reduction strategies discussed in this issue more than others and why?
2. When a client asks a difficult question about an unsettled risk-related topic, how do you respond? How does your response change if the client is anxious or confrontational?

3. How do you help clients explore the risks they feel comfortable taking? How do you respond when a client’s tolerance for risk is very different from your own?
4. In the past, prevention guidelines suggested that people use the microbicide nonoxonyl-9 to reduce HIV transmission risk. Now it is no longer recommended because it can irritate sensitive tissues and increase the risk of infection. Can you think of any other examples of how HIV prevention recommendations have changed over time? How do you help clients adjust to changing prevention guidelines?

Answers to Review Questions

1. c
2. False. HIV is much more easily transmitted from the insertive partner (“top”) to the receptive partner (“bottom”) than from the “bottom” to the “top.”
3. d
4. True
5. True
6. d
7. b
8. False. It appears that people in the first three years of HIV infection, and possibly with end-stage disease, may be most at risk for superinfection.

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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