

# Risk STD/HIV Reduction

A Quick Reference Guide  
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# RISK REDUCTION COUNSELING \_\_\_\_\_

Risk reduction is the selective application of appropriate techniques and management principles to reduce the likelihood of a risky event and/or the negative consequences of such an event. The goal of risk reduction counseling is to decrease the number of new cases of sexual and blood-borne infections by decreasing the risks related to substance use (including alcohol) and sexual behavior.

## **Risk reduction counseling techniques include:**

- A comprehensive and effective risk assessment.
- Risk-reducing prevention methods for people who are at risk of infection or already infected.
- Motivational interviewing techniques to engage and motivate patients to change personal risk behaviors.

Information in this guide focuses on the last two bullets. Risk assessment is covered in the *HIV/STD Risk Assessment Quick Reference Guide* (attached to this guide).

# METHODS TO REDUCE RISK \_\_\_\_\_

## **Substance use risks may be decreased by:**

- Using drugs and/or drinking less frequently.
- Changing the route of delivery (e.g., smoking rather than injecting a drug).
- Not injecting *any* substance; injecting is the most risky way to use substances.
- Appropriately bleaching and cleaning drug-using equipment.
- Not sharing injection equipment or other drug paraphernalia.
- Accessing substance use treatment, which remains the most effective form of risk reduction for substance users.
- Not using drugs or alcohol.

## Sexual risks may be decreased by:

- Not having sexual relations while intoxicated, high, or otherwise impaired.
- Not having sex with unknown/anonymous partners.
- Limiting the number of sexual partners.
- Using condoms, optimally with every sexual encounter.
- Avoiding high risk sexual behaviors (unprotected anal or vaginal intercourse).
- Engaging only in sexual activities that do not involve insertive vaginal, anal or oral sex.
- Having sex only in a mutually monogamous relationship.
- Abstaining from sexual activity.

**Remember:** for many people, sex and drugs are inextricably linked. Alcohol and stimulants are particularly risky.

- Stimulants make sex more exciting, so that users report sex to be “boring” in the absence of cocaine or amphetamines. Stimulants also increase sex drive, pleasure, and risky sexual behaviors.
- Alcohol is commonly associated with all forms of substance use and high-risk sex behaviors. It is often used to make sex less frightening or painful for those who have been sexually hurt or abused.

## MOTIVATIONAL INTERVIEWING\_\_\_\_\_

*Motivation is the probability that a person will enter into, continue, and maintain a specific behavior change strategy. The provider's responsibility is not simply to dispense advice but to motivate the patient toward change. Discussing prevention strategies in light of the following principles has been shown to be an effective way to motivate a patient to change.*

- The patient is the expert in his/her own life.
- The patient is responsible for personal change.
- The patient must function within a unique social context that influences the personal choices for change methods and the ability to change.

- Patient interaction and buy-in are essential for change.
- The provider possesses knowledge and skills related to prevention, risk reduction, and counseling.
- The provider is supportive and persuasive in encouraging change.
- The provider helps the patient overcome ambivalence.

Use motivational interviewing techniques to identify perceptions of personal risk; support initial changes; focus on small, achievable steps; and encourage incremental changes that can lead to bigger, long-term changes in risk reduction behaviors.

### **General guidelines for motivational interviewing:**

- **Express empathy.** Use active, reflective listening. True empathy requires “meeting the person where s/he is,” warmth, genuineness, and non-identification with the patient.
- **Create a discrepancy.** Help the patient see a difference between current behavior and broader goals. Make use of the patient’s ambivalence to help clarify goals, and support reasons for change.
- **Avoid arguing.** Arguing evokes resistance. The more you tell someone “You can’t,” the more they internally respond “I can” or “I will.”
- **Roll with resistance.** Remember that resistance is a signal for the provider to change tactics. Offer information but do not impose goals. Turn problems and questions back to the patient; s/he must actively participate in problem-solving.
- **Support self-efficacy.** Demonstrate your belief in the patient’s ability to change. Offer the patient a “menu of options.” The patient is responsible for choosing and carrying out necessary actions.
- **Explore extremes.** In the examination of patient goals, it is often helpful to confront fears:
  - What’s the best/worst thing that might happen if you continue as you are?
  - What is the best/worst thing that might happen if you make the change?
  - What concerns you the most?

## Techniques include:

- **Define goals clearly.** Help the patient verbalize specific goals that can be used to measure progress at future meetings.  
**EX:** “I will have sex only with my primary partner.”
- **Be interactive.** Format discussions that actively engage the patient in the conversation.
- **Focus on open-ended questions.** These are questions that cannot be answered with a simple yes or no. “What,” “how,” and “tell me about ...” questions gather the most information and allow the patient to do most of the talking.  
**EX:** “What are some other things you could do when you have the urge to use drugs?”
- **Use reflective listening techniques.** Reflect what the patient has said back to him/her to see if what you heard is what the patient meant.  
**EX:** “So your family is concerned about your drinking, but you do not think it is a problem. Is that correct?”
- **Don’t interrupt.** Interrupting can kill a conversation. Allowing the patient sufficient time to finish his/her thoughts and sentences serves to gather more information, avoid misunderstanding, and enhance the provider-patient relationship.
- **Be comfortable with silence.** Patients often need time to think about a question in order to formulate a response. Allow at least 10 seconds before offering prompts or explanations. Try silently counting to 10 to decrease your discomfort.
- **Respond to patient questions.** This provides the patient with helpful information for overcoming ambivalence and making behavior changes. It also lets the patient know you are actively listening.  
**EX:** “You wonder if stimulants increase the amount of HIV in your body. Here is some information about that...”
- **Communicate at the patient’s level of understanding.** This may involve using non-medical terms, and some of the same terms for drugs or sex behaviors that the patient uses.  
**EX:** “How does it feel when you are tweaking?”

- **Use affirming statements.** Statements of appreciation and understanding help support the patient during the counseling process.  
**EX:** “I know how hard it is to stop using drugs, and I admire the effort you are making. I believe you can achieve your goal.”
- **Elicit self-motivating statements.** Ask questions and reflect answers in a way that motivates the patient to make the arguments for behavior change.  
**EX:** “What do you think would improve in your life if you decided to change?” or “What strategies have worked for you in the past?”
- **Clarify the discrepancy between the patient’s goals and behaviors.** Create and strengthen the inconsistency between the patient’s current behavior and long term objectives.  
**EX:** “How does your current substance use impact your long-term relationship goals?” or “I understand you are afraid your sex partners will think you are promiscuous if you carry condoms with you (affirming), but how does not using condoms impact your goal of not giving HIV to your partners?”
- **Reframe defeatist statements.** This approach acknowledges the validity of the patient’s statements, but offers a new meaning or interpretation.  
**EX:** If the patient says, “I’ve tried to quit using drugs in the past, and I always relapse. I’m hopeless,” consider responding with, “I think all those past efforts show how much you want to change. I admire you for that, and each of those attempts was practice for the day you make the change permanent. Don’t give up now.”
- **Emphasize personal choice.** This reminds the patient about alternatives and control, and helps the patient generate options to the current behavior.  
**EX:** “You’re the one who will decide what to do, but I can tell you about some strategies that have worked for other people. Would you like to hear them?”

- **Summarize the patient’s statements.** This reviews the information and provides clarification. It also helps create a transition for inviting more information.

**EX:** “It sounds like you are torn in two ways. Stimulants make sex more exciting, but they can raise your viral load. This is difficult for you. What else?”

*While routine testing for HIV is recommended for all patients between the ages of 13 and 64, patients at increased risk should be tested as needed, and at least annually. Testing for sexually transmitted and blood borne diseases should occur as needed based on symptoms and/or risk assessment.*

**For updates to this guide and other MPAETC materials,  
visit the MPAETC Web site at [www.mpaetc.org](http://www.mpaetc.org)**

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# ADDITIONAL RESOURCES

## **The Mountain Plains AIDS Education and Training Center**

<http://www.mpaetc.org>

## **Seattle STD/HIV Prevention Training Center**

<http://depts.washington.edu/seaptc/index.shtml>

## **AIDS Education and Training Centers National Resource Center**

<http://www.aidsetc.org>

## **The National Network of STD/HIV Prevention Training Centers**

<http://depts.washington.edu/nnptc/index.html>

## **The AIDS Infonet**

<http://www.aidsinfonet.org>

## **CDC HIV Website**

<http://www.cdc.gov/hiv>

## **HIV InSite**

<http://hivinsite.ucsf.edu/InSite>

## **National HIV Testing Resources**

<http://hivtest.org>

## **Assess all patients for signs or symptoms consistent with an STD, including:**

- Genital ulcers, warts, blisters, or other lesions
- Pain or burning with urination
- New or unusual skin rash
- Oral lesions
- Anal lesions or bleeding

### **For women:**

- Bloody or foul-smelling vaginal discharge
- Vulvar itching
- Bleeding between periods or after intercourse

### **For men:**

- Urethral discharge
- Testicular or groin pain

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## **Ask for an explanation.**

- “When you say you had sex, what exactly do you mean?”
- “Tell me what you mean when you say you are always ‘the top’.”
- “How do you protect yourself from sexually transmitted diseases?”
- “What did you mean when you said you had ‘the drip’?”

## **Direct and non-judgmental questions are best.**

- “Do you have oral sex? vaginal sex? anal sex?”
- “What do you know about your partner(s)’ past sexual activities?”
- “When was the last time you had unprotected sex?”
- “Tell me about how and when you use condoms.”
- “Have you ever had sex with someone you didn’t know or just met?”
- “Have you noticed any STD-type symptoms in your partner(s)?”

# **CLINICAL RISK ASSESSMENT**

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In addition to obtaining the history of risk factors, a basic medical history to identify symptoms of early HIV infection and other STDs is appropriate.

## **Include HIV and STDs in your differential diagnosis.**

### **Assess the patient for the following, which may be associated with acute and chronic HIV infection:**

- Headaches
- Fever, chills, night sweats
- Diarrhea
- Skin lesions/rash
- Fatigue
- Weight loss
- Shingles
- Oral Thrush
- History of STD, hepatitis, or TB
- Generalized lymphadenopathy
- History of opportunistic infection

## **Look for other clues in the history and physical:**

- Antisocial behavior
- Anxiety, depression, insomnia
- Recurrent legal problems
- Needle tracks or other physical evidence of drug use
- Family reports of use

## **If there is a positive history of drug use, get more information:**

- “How do you use drugs (inject, snort, smoke, etc.)?”
- “Have you ever injected any kind of drug?”
- “What drugs do/did you inject?”
- “Do/Did you share any drug-using equipment?”
- “Is/Was the equipment you use(d) clean? How do/did you know it is/was clean?”
- “Tell me about the last time you had sex when you were high.”

# **SEXUAL RISK ASSESSMENT**

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## **Use specific terms and neutral language.**

- Use “men who have sex with men” or “women who have sex with women” instead of gay or lesbian.
- Avoid words like “faithful/unfaithful,” “promiscuous,” “prostitution,” and other value-laden terms.

## **Do not assume anything.**

- Marriage does not always mean an individual is monogamous or heterosexual.
- People who identify as homosexual may also have heterosexual sex and vice versa.

## **Important questions to ask in a sexual history.**

- “How old were you when you started having sex?”
- “Have you ever had an STD? If so, when? How was it treated?”
- “Have you ever been afraid in a sexual interaction?”
- “Have you ever been tested for HIV?”

# SUBSTANCE USE RISK ASSESSMENT

## **It is important to be non-judgmental.**

- Many patients are reluctant to disclose illicit drug use unless a safe environment is established.
- Avoid words like junkie, crack head, addict, alcoholic, and other pejorative terms.

## **Start with less threatening questions.**

- “What over-the-counter or prescription medications are you taking?”
- “How often do you use alcohol? tobacco?”
- “Have you ever used drugs from a non-medical source?”

## **Do not assume anything.**

- Drug use occurs in all socioeconomic strata.
- If a patient says s/he uses/has used drugs, ask about specific drugs (e.g., heroin, methamphetamine, marijuana, etc.).
- Don't forget that people also inject insulin, steroids, and hormones.

## **There is no completely safe form of drug use.**

- Alcohol use is highly correlated with unsafe sexual activities and the spread of HIV and STDs.
- Nasal straws and pipes also carry some risk for transmitting blood borne diseases.
- Any drug (including alcohol) that alters decision-making capabilities can lead to sexual risk behaviors.
- Any sharing of injection equipment, even one time, can result in exposure to HIV, hepatitis B, or hepatitis C.

- Questions about blood exposure (occupational, transfusions, etc.) should be asked before questions about drug use. Questions about sex are generally better left until later in the assessment.

## **Use a variety of questioning methods to gather information. Different people respond to different styles.**

- **Close-ended questions.** These are questions that can be answered in a few words. The answers don't give a lot of information, but they can help set a topic for discussion. In general, close-ended questions should be used less often than open-ended questions.  
**EX:** "Do you have sex with men or women or both?" or "Do you use drugs?"
- **Open-ended questions.** These questions invite more expansive answers and can provide a lot of information on a topic.  
**EX:** "Tell me about your alcohol use." or "How do you get your sexual needs met?"
- **Direct questions about specific behaviors.** Ask questions that are clearly focused.  
**EX:** "Who do you share your injection equipment with?" or "When would you be comfortable using a condom?"
- **Exploratory questions.** When patients are reticent to share information with you, it may be helpful to find out what is happening in their social environments. This can be especially true for adolescents.  
**EX:** "What do your friends think about using condoms?" or "How easy is it to get drugs?"
- **Presumptive questions.** Asking a question as if you assume that the patient has sex or uses drugs will sometimes get a positive response. If the patient doesn't have sex or use drugs, s/he can correct you.  
**EX:** "How often do you use meth?" or "When was the last time you had sex with someone you just met?"
- **Normalizing questions.** These questions let the client know that you understand that the behavior in question is not unusual or "weird."  
**EX:** "Sometimes people have anal intercourse. Have you ever had anal intercourse?" or "Some of my patients tell me they share their crack pipes. Have you ever shared a pipe?"

# RISK ASSESSMENT

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Risk assessment specific to sexually transmitted and blood borne diseases is critical in the era of HIV infection.

- Sexual and drug use risks should be determined during routine history taking with every new patient, and updated regularly during periodic health care.
- Risk assessment helps to identify individuals at risk, determine risk reduction education strategies, and support recommendations for HIV, STD, and hepatitis screening.
- The risk assessment process can reduce the rates of infection through targeted prevention efforts.
- Risk assessment can help people who are already infected access treatment and learn how to avoid spreading infections to others.

Information in this guide, individualized to the patient, can help care providers determine a patient's risk for sexually transmitted and blood borne diseases. Conducting a risk assessment is only one part of risk reduction counseling. Information on other risk reduction counseling techniques is covered in the *HIV/STD Risk Reduction Counseling Quick Reference Guide* (attached to this guide).

## KEY POINTS

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**Begin by assuring confidentiality and explaining why these questions are important.**

**EX:** “I am going to ask you some personal questions. I ask them of all of my patients to help provide the best possible care. All of your responses will remain confidential. Do you have any questions?”

**Start with less threatening topics.**

- General health and safety questions that are typically asked during a history should be raised first.

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