UNIT 4  COUNSELLING FOR HIV / AIDS

Structure

4.0  Introduction
4.1  Objectives
4.2  Nature and Definition of HIV Counselling
   4.2.1  Epidemiology
   4.2.2  HIV in India
   4.2.3  Who Should Be Offered Test?
   4.2.4  How Often to Test
   4.2.5  Antenatal Care
   4.2.6  Which Test to Use
   4.2.7  Routine Tests within 24 Hours
   4.2.8  Body Fluids That Spread HIV
4.3  Goals of HIV Counselling
   4.3.1  Aims of Counselling in HIV Infection
4.4  HIV Counselling Programmes and Services
4.5  HIV Counselling Process
   4.5.1  Conditions Necessary for HIV Counselling
   4.5.2  Pre-test Discussion
   4.5.3  Post-test Counselling
   4.5.4  Causes of Uncertainty
4.6  Counselling during Combination Antiretroviral Therapy
   4.6.1  Coping Strategies
4.7  Psychological Responses to an HIV Positive Result
   4.7.1  Psychological Issues in HIV/AIDS Counselling
4.8  Counselling Patients and Partners Together
   4.8.1  Worried Well
   4.8.2  Characteristics of Worried Well
   4.8.3  Coping Strategies
4.9  Let Us Sum Up
4.10  Unit End Questions
4.11  Glossary
4.12  Suggested Readings

4.0  INTRODUCTION

In this unit we will be dealing with counselling for HIV / AIDS. We start the unit with Nature and Definition of HIV Counselling in which we discuss the epidemiology of HIV both abroad and India. We also discuss who all to be offered the test and how often and which tests. An emphasis is placed on antenatal test which can prevent HIV being passed on to the progeny. Then we discuss the routine test results and the bodily fluids which spread HIV. This is followed by goals of HIV counselling and the emphasis is on the aims of such counselling and what should be the focus etc. This is followed by HIV Counselling
programmes and services and the counselling process. Then we delineate the conditions necessary for HIV counselling and have a discussion on pretest for HIV as to its nature and context. Then we discuss the HIV counselling programmes and services and the intricacies involved in counselling process. The next section deals with counselling during combination antiretroviral therapy and the coping strategies. Then we take up the psychological issues related to HIV AIDS counselling especially when the test results are positive. In the counselling process we discuss how counselling patients and partners together has to be undertaken in which we discuss the worried well, and their characteristics and coping strategies.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define the nature of HIV counselling;
- Delineate the epidemiology of HIV AIDS both abroad and in India;
- Elucidate the aspects related to HIV Testing;
- Describe goals of HIV counselling;
- Explain the various programmes and services for HIV counselling;
- Describe the Nature and goals of HIV counselling;
- Delineate the Conditions necessary for HIV counselling;
- Analyse the Psychological Issues in HIV counselling; and
- Present the techniques for Counselling Patients and Partners together.

4.2 NATURE AND DEFINITION OF HIV COUNSELLING

There have been significant developments in the treatment of HIV in recent years. This progress and up to date knowledge about HIV and the epidemiology of HIV infection has informed new guidelines on counselling and testing for HIV.

New guidance is prefaced by a number of important assertions:

It is possible with the advent of new and improved treatment for the majority of those living with HIV to remain fit and well on treatment.

A significant number of people in the United Kingdom are unaware of their HIV infection and thereby put at risk their own health and the health of others by transmitting infection unknowingly.

Late diagnosis is the most important factor associated with HIV-related morbidity and mortality in the UK. For example in the UK 24% of deaths in HIV-positive patients in 2006 were directly attributable to late diagnosis of HIV.

Patients should therefore be offered and encouraged to accept HIV testing in a wider range of settings than is currently the case.
Application of Counselling in Different Settings

Patients with specific indicator conditions should be routinely recommended to have an HIV test.

The consensus is that doctors, nurses and midwives should be able to obtain informed consent for an HIV test in the same way that they currently do for any other medical investigation.

4.2.1 Epidemiology

Some of the following points may be of value to the patient:

Men having sex with men (MSM) remain the group in the UK at highest risk of acquiring HIV with evidence that transmission is continuing at a substantial rate.

The estimated number of people infected through heterosexual contact within the UK has increased from 540 new diagnoses in 2003 to 960 in 2007, and has doubled, from 11% to 23%, as a proportion of all heterosexual diagnoses during this period.

In 2005, 70% of diagnoses were in people aged 15 to 39 and 73% of heterosexual cases were in people of African origin or were acquired there.

The Health Protection Agency estimates that 77,400 people were living with HIV in the UK at the end of 2007, of whom over a quarter (28%) were unaware of their infection.

In 2005, 34% of newly diagnosed patients were diagnosed late with serious immunosuppression and 11% had progressed to AIDS. The figure for late diagnosis was 31% in 2008.

4.2.2 HIV in India

At the beginning of 1986, despite over 20,000 reported AIDS cases worldwide, India had no reported cases of HIV. There was recognition, though, that this would not be the case for long, and concerns were raised about how India would cope once HIV and AIDS cases started to emerge.

Later in the year, India’s first cases of HIV were diagnosed among sex workers in Chennai, Tamil Nadu. It was noted that contact with foreign visitors had played a role in initial infections among sex workers, and as HIV screening centres were set up across the country there were calls for visitors to be screened for HIV. Gradually, these calls subsided as more attention was paid to ensuring that HIV screening was carried out in blood banks.

In 1987 a National AIDS Control Programme was launched to co-ordinate national responses. Its activities covered surveillance, blood screening, and health education. By the end of 1987, out of 52,907 who had been tested, around 135 people were found to be HIV positive and 14 had AIDS. Most of these initial cases had occurred through heterosexual sex, but at the end of the 1980s a rapid spread of HIV was observed among Injecting Drug Users (IDUs) in Manipur, Mizoram and Nagaland – three north-eastern states of India bordering Myanmar (Burma).
At the beginning of the 1990s, as infection rates continued to rise, responses were strengthened. In 1992 the government set up NACO (the National AIDS Control Organisation), to oversee the formulation of policies, prevention work and control programmes relating to HIV and AIDS. In the same year, the government launched a Strategic Plan, the National AIDS Control Programme (NACP) for HIV prevention. This plan established the administrative and technical basis for programme management and also set up State AIDS Control Societies (SACS) in 25 states and 7 union territories. It was able to make a number of important improvements in HIV prevention such as improving blood safety.

By this stage, cases of HIV infection had been reported in every state of the country. Throughout the 1990s, it was clear that although individual states and cities had separate epidemics, HIV had spread to the general population. Increasingly, cases of infection were observed among people that had previously been seen as ‘low-risk’, such as housewives and richer members of society.

In 1999, the second phase of the National AIDS Control Programme (NACP II) came into effect with the stated aim of reducing the spread of HIV through promoting behaviour change. During this time, the prevention of mother-to-child transmission (PMTCT) programme and the provision of free antiretroviral treatment were implemented for the first time. In 2001, the government adopted the National AIDS Prevention and Control Policy and former Prime Minister Atal Behari Vajpayee referred to HIV/AIDS as one of the most serious health challenges facing the country when he addressed parliament. Vajpayee also met the chief ministers of the six high-prevalence states to plan the implementation of strategies for HIV/AIDS prevention.

The third phase (NACP III) began in 2007, with the highest priority placed on reaching 80 percent of high-risk groups including sex workers, men who have sex with men, and injecting drug users with targeted interventions. Targeted interventions are generally carried out by civil society or community organisations in partnership with the State AIDS Control Societies. They include outreach programmes focused on behaviour change through peer education, distribution of condoms and other risk reduction materials, treatment of sexually transmitted diseases, linkages to health services, as well as advocacy and training of local groups. The NACP III also seeks to decentralise the HIV effort to the most local level, i.e. districts, and engage more non-governmental organisations in providing welfare services to those living with HIV/AIDS.

As for current estimates, in 2006 UNAIDS estimated that there were 5.6 million people living with HIV in India, which indicated that there were more people with HIV in India than in any other country in the world. In 2007, following the first survey of HIV among the general population, UNAIDS and NACO agreed on a new estimate – between 2 million and 3.1 million people living with HIV. In 2008 the figure was estimated to be 2.31 million. In 2009 it was estimated that 2.4 million people were living with HIV in India, which equates to a prevalence of 0.3%. While this may seem low, because India’s population is so large, it is third in the world in terms of greatest number of people living with HIV. With a population of around a billion, a mere 0.1% increase in HIV prevalence would increase the estimated number of people living with HIV by over half a million.
4.2.3   **Who Should be Offered a Test?**

Universal HIV testing (where all individuals are offered and recommended an HIV test routinely but can refuse testing) is recommended in all the following:

1) Sexual health clinics  
2) Antenatal services  
3) Termination of pregnancy services  
4) Drug dependency programmes  
5) Healthcare services for those diagnosed with tuberculosis, hepatitis B, hepatitis C and lymphoma.  
6) HIV testing should be routinely offered and recommended to the following patients:
   7) All patients presenting for healthcare where HIV, including primary HIV infection, enters the differential diagnosis (see article on primary HIV infection)  
   8) All patients diagnosed with a sexually transmitted infection  
   9) All sexual partners of men and women known to be HIV positive  
   10) All men who have disclosed sexual contact with other men  
   11) All female sexual contacts of men who have sex with men  
   12) All patients reporting a history of injecting drug use  
   13) All men and women known to be from a country of high HIV prevalence (>1%*)  
   14) All men and women who report sexual contact abroad or in the UK with individuals from countries of high HIV prevalence (see up to date UN AIDS list in Internet and Further REading section below)  
   15) HIV testing should also be routinely performed in the following groups in accordance with existing Department of Health guidance:  
   16) Blood donors  
   17) Dialysis patients  
   18) Organ transplant donors and recipients.

An HIV test should be considered more widely when there is a particularly high HIV prevalence in the local population. Local PCT data should be consulted. If the HIV prevalence exceeds 2 in 1000 population then testing should be offered to all registered patients. The introduction of universal HIV testing should be considered in such circumstances.

4.2.4   **How Often to Test?**

Repeat testing should be provided for the following:

All individuals who have tested HIV negative but where a possible exposure has occurred within the window period (the time between infection and a positive test result).
Men who have sex with men (MSM) – annually (more frequently if clinically suspect seroconversion or ongoing high risk exposure).

Injecting drug users – annually (more frequently if clinically suspect seroconversion).

4.2.5 Antenatal Care
If HIV test at booking is refused a further offer of testing should be made.

If they decline again a third offer of a test should be made at 36 weeks.

Women presenting to services for the first time in labour should be offered a Point Of Care Test (POCT).

A POCT test may also be considered for the infant of a woman who refuses testing antenatally.

In areas of higher seroprevalence, or where there are other risk factors, women who are HIV negative at booking may be offered a routine second test at 34–36 weeks’ gestation.

4.2.6 Which Test to Use?
Testing including confirmation should follow the standards laid out by the Health Protection Agency. All acute healthcare settings should expect to have access to:

Urgent HIV screening assay result within eight hours (definitely within 24 hours), to provide the best support for exposure incidents.

4.2.7 Routine Results within 72 hours
There are two methods in routine practice for testing for HIV involving either venepuncture and a screening assay where blood is sent to a laboratory for testing or a rapid Point Of Care Test (POCT).

Blood tests
The recommended first-line assays:
Fourth generation assay tests for HIV antibody and p24 antigen simultaneously and have the advantage of reducing the time between infection and testing HIV positive to one month.

Third generation assay detects antibody only and has the disadvantage of giving a positive result after a longer (6 to 7 week) interval.

The better fourth generation tests are not offered by all primary screening laboratories.

HIV RNA quantitative assays (viral load tests):
These are not recommended as screening assays because of the possibility of false positive results. They offer only marginal advantage over fourth generation assays for detecting primary infection.
HIV (human immunodeficiency virus) is the virus that causes AIDS. This virus is passed from one person to another through blood to blood and sexual contact. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breast-feeding. People with HIV have what is called HIV infection. Most of these people will develop AIDS as a result of their HIV infection.

4.2.8 Body Fluids that Spread HIV

The body fluids that have been proven to spread HIV are given below:

- Blood
- Semen
- Vaginal fluid
- Breast milk
- Other body fluids containing blood
- These are additional body fluids that may transmit the virus that health care workers may come into contact with:
  - Cerebrospinal fluid surrounding the brain and the spinal cord
  - Synovial fluid surrounding bone joints
  - Amniotic fluid surrounding a fetus.

The HIV and AIDS pandemic in many low-and middle-income countries is growing, and it is estimated that fewer than 20 per cent of people living with HIV and AIDS know their status. Most people have a test too late, often only finding out their positive status when they already have an AIDS-related illness. People who do not know their positive status may not be able to take sufficiently early action to mitigate the effects of the disease. They will also not be aware of the need to alter their behaviour to avoid the risk of infecting others or reinfecting themselves.

Provider Initiated Testing and Counselling (PITC) has been suggested as a possibility for dramatically scaling up testing. This is opt out, rather than opt in testing. For example, everyone attending a GP’s surgery could be tested unless they requested otherwise (opted out) if it were part of a full package of HIV and AIDS services. PITC would mean a much higher percentage of people living with HIV and AIDS would be aware of their status and would therefore be able to access treatment, care, support and prevention information and services.

It refers to a process where in support and strength is provided to individuals, couples, families or groups by competent persons to help them cope with the knowledge that they are infected or affected by HIV. It is an ongoing process that allows the individuals to develop a sense of responsibility in meeting challenges posed by their infection. Counselling should also be given to HIV negative individuals to promote behaviour change and condom use.

One of the core elements in a holistic model of health care is counselling in HIV and AIDS. In counselling HIV and AIDS, psychological issues are recognised as integral to patient management. HIV and AIDS counselling has two general aims: (1) the prevention of HIV transmission and (2) the support of those affected directly and indirectly by HIV.
HIV counselling should have these dual aims because the spread of HIV can be prevented by changes in behaviour. One to one prevention counselling has a particular contribution in that it enables frank discussion of sensitive aspects of a patient’s life. Such discussion may be hampered in other settings by the patient’s concern for confidentiality or anxiety about a judgmental response. Also, when patients know that they have HIV infection or disease, they may suffer great psychosocial and psychological stresses through a fear of rejection, social stigma, disease progression, and the uncertainties associated with future management of HIV.

Good clinical management requires that such issues be managed with consistency and professionalism, and counselling can both minimise morbidity and reduce its occurrence. All counsellors in this field should have formal counselling training and receive regular clinical supervision as part of adherence to good standards of clinical practice.

### 4.3 GOALS OF HIV COUNSELLING

The goals of HIV counselling are mainly on prevention of the disease and to provide support to those affected with disease. An overview of the goals of HIV counselling can be understood from the following.

#### 4.3.1 Aims of Counselling in HIV Infection

**Prevention**

- Determining whether the lifestyle of an individual places him or her at risk
- Working with an individual so that he or she understands the risks
- Helping to identify the meanings of high risk behaviour
- Helping to define the true potential for behaviour change
- Working with the individual to achieve and sustain behaviour change

**Support**

- Individual, relationship, and family counselling to prevent and reduce psychological morbidity associated with HIV infection and disease

### 4.4 HIV COUNSELLING PROGRAMMES AND SERVICES

The different HIV counselling programmes and services that are organised for the target group can be seen in the following:

- Counselling before the test is done
- Counselling after the test for those who are HIV positive and HIV negative
- Risk reduction assessment to help and prevent transmission
- Counselling after a diagnosis of HIV disease has been made
- Family and relationship counselling
- Bereavement counselling
- Telephone “hotline” counselling
Application of Counselling in Different Settings

- Outreach counselling
- Crisis intervention
- Structured psychological support for those affected by HIV
- Support groups

**Self Assessment Questions**

1) Define HIV counselling.

   1. 
   2. 
   3. 
   4. 
   5. 

2) Explain the goals of HIV counselling.

   1. 
   2. 
   3. 
   4. 
   5. 

4.5 HIV COUNSELLING PROCESS

The individual suspected of having HIV infection should be referred to the appropriate level for counselling depending on the availability of the HIV test result. If it is available then counselling can be given at level A, if not then referral to a testing facility at level B is recommended. This can be understood from the following figure.
4.5.1 Conditions Necessary for HIV Counselling

a) An individual attending a health center with a confirmed HIV positive result will require information on the HIV result and its implications.

b) The attending clinician may wish to follow up the individual or may delegate this responsibility to a trained counsellor. The patient needs to be involved in this decision so that issues of confidentiality are dealt with. Follow up of the patient may be in the out patient clinic or in the ward. During the initial meeting an assessment to determine the circumstances that lead to an HIV test being performed should be done. Based on the outcome of this the individual can then be provided supportive or problem solving counselling or a combination of both.

c) If there is an underlying medical condition that requires treatment, this should be attended to first before HIV counselling is offered.

d) Whether admitted or reviewed in the clinic, the counsellor should take the opportunity to plan with the patient how follow up counselling will be provided. With the patients consent relatives may be involved in the counselling process. Based on the patients needs, plans for referral to other health and social services can be made. Home-based care as a complement to hospital care should be considered if it is available.

This can be seen in the following figure -

![Flowchart](image_url)
The above figure reflects the following process -

a) An individual with suspected HIV infection is admitted to the hospital with a medical condition requiring treatment. The medical condition should be attended to without discrimination before HIV testing is done. Appropriate treatment is given according to the presenting condition.

b) The patient is offered pre-test counselling by the attending clinician, or a trained counsellor. This involves the giving of information on the technical aspects of HIV testing and possible personal, medical, social, psychological and legal implications of being found either HIV positive or HIV negative. The information is given in a manner that the individual understands and feels he/she can make an informed decision about taking the HIV test. The issue of confidentiality surrounding test results and subsequent counselling and follow up is also covered.

c) If the outcome of pretest counselling is favourable the individual is then tested using the approved testing procedure.

d) Post-test counselling is given by the clinician or a trained counsellor. This involves discussing the interpretation of an HIV result and whether it was expected or not. The focus of the discussion will depend on whether the result is positive, negative or equivocal.

e) Whether admitted or reviewed in the clinic, the counsellor should take the opportunity to plan with the patient how follow-up counselling will be provided. With the patients consent, relatives may be involved in the counselling process. Based on the patients needs, plans for referral to other health and social services can be made. Home-based care as a complement to hospital care should be considered if it is available.
4.5.2 Pre-test Discussion

A discussion of the implications of HIV antibody testing should accompany any offer of the test itself. This is to ensure the principle of informed consent is understood and to assist patients to develop a realistic assessment of the risk of testing HIV antibody positive. This process should include accurate and up to date information about transmission and prevention of HIV and other sexually transmitted infections.

Patients should be made aware of the “window period” for the HIV test that a period of 12 weeks since the last possible exposure to HIV should have elapsed by the time of the test.

Given below is the discussion checklist of a pre test of HIV and the factors that necessitate counselling the patients:

1) Pre-test discussion checklist
2) Indications for further counselling and referral to counsellor
3) People who have been sexually active in areas of high HIV prevalence
4) Men who have sex with men
5) Current or previous sexual partners HIV positive
6) Client presenting with clinical symptoms of HIV infection
7) High risk sexual behaviour
8) High risk injecting drug practices
9) Learning or language difficulties
10) Points for counsellor and/or physician to cover
11) What is the HIV antibody test (including seroconversion)
12) The difference between HIV and AIDS
13) The window period for HIV testing
14) Medical advantages of knowing HIV status and treatment options
15) Transmission of HIV
16) Safer sex and risk reduction
17) Safer injecting drug use
18) If the client were positive how would the client cope: personal resources, support network of friends/partner/family
19) Who to tell about the test and the result
20) Partner notification issues
21) HIV status of regular partner: is partner aware of patient testing?
22) Confidentiality
23) Does client need more time to consider?
24) Is further counselling indicated?
25) How the results of the test are obtained (in person from the physician or counsellor)?
Patients may present for testing for any number of reasons, ranging from a generalised anxiety about health to the presence of HIV related physical symptoms. For patients at minimal risk of HIV infection, pre-test discussion provides a valuable opportunity for health education and for safer sex messages to be made relevant to the individual. For patients who are at risk of HIV infection, pre-test discussion is an essential part of post-test management. These patients may be particularly appropriate to refer for specialist counselling expertise. In genitourinary medicine clinics where HIV antibody testing is routinely offered as a part of sexual health screening, health advisers provide counselling to patients who have been identified as high risk for testing HIV positive.

The importance of undertaking a sensitive and accurate sexual and or injecting drug risk history of both the patient and their sexual partners cannot be overstated. If patients feel they cannot share this information with the physician or counsellor then the risk assessment becomes meaningless; patients may be inappropriately reassured, for example, and be unable to disclose the real reason for testing.

Counselling skills are clearly an essential part of establishing an early picture of the patient and his/her history and of how much intervention is needed to prepare him or her for a positive result, and to further reinforce prevention messages. It is at this stage that potential partners at risk are identified which will become an important part of the patient’s management if HIV positive.

### 4.5.3 Post-test Counselling

HIV results should be given simply, and in person. For HIV negative patients this may be a time where the information about risk reduction can be “heard” and further reinforced. With some patients it may be appropriate to consider referral for further work on personal strategies to reduce risks for example one to one or group interventions. The window period of 12 weeks should be checked again and the decision taken about whether further tests for other sexually transmitted infections are appropriate.

### 4.5.4 Causes of Uncertainty

Following are the causes of uncertainty:

- The cause of illness
- Progression of disease
- Management of dying
- Prognosis
- Reactions of others (loved ones, employers, social networks)
- Effects of treatment
- Long term impact of antiretroviral therapy
- Impact of disclosure and how this will be managed

HIV positive patients should be allowed time to adjust to their diagnosis. Coping procedures rehearsed at the pre-test discussion stage will need to be reviewed in the context of the here and now; what plans does the patient have for today, who can they be with this evening? Direct questions should be answered but the focus is on plans for the immediate few days, when further review by the counsellor
should then take place. Practical arrangements including medical follow up should be written down. Overloading the patient with information about HIV should be avoided at this stage. Sometimes this may happen because of the health professional’s own anxiety rather than the patient’s needs. Counselling support should be available to the patient in the weeks and months following the positive test results.

### Self Assessment Questions

1) Explain pre test and post test counselling.

2) What are the points to be covered by physician or a counsellor during the discussion with HIV patient?

---

### 4.6 COUNSELLING DURING COMBINATION ANTIRETROVIRAL THERAPY

Significant developments in combination antiretroviral therapy have led to a surge of optimism about long term medical management of HIV infection, and people are now living much longer with HIV. Patient adherence is an important factor in the efficacy of drug regimens. However, taking a complicated drug regimen often taking large numbers of tablets several times a day is a constant reminder of HIV infection. The presence of side effects can often make patients feel more unwell than did the HIV and some may be unable to cope with the side effects. Counselling may be an important tool in determining a realistic assessment of individual adherence and in supporting the complex adjustment to a daily routine of medication.

#### 4.6.1 Coping Strategies

- Using counselling
- Problem solving
- Participation in discussions about treatment
- Using social and family networks
- Use of alternative therapies, for example relaxation techniques, massage
Application of Counselling in Different Settings

- Exploring individual potential for control over manageable issues
- Disclosure of HIV status and using support options.

### 4.7 Psychological Responses to HIV Positive Result

Many reactions to an HIV positive diagnosis are part of the normal and expected range of responses to news of a chronic, potentially life threatening medical condition. Many patients adjust extremely well with minimal intervention. Some will exhibit prolonged periods of distress, hostility, or other behaviours which are difficult to manage in a clinical setting. It should be noted that serious psychological maladjustment may indicate pre-existing morbidity and will require psychological/psychiatric assessment and treatment. Depressed patients should always be assessed for suicidal ideation.

Effective management requires allowing time for the shock of the news to sink in; there may be a period of emotional “ventilation”, including overt distress. The counsellor should provide an assurance of strict confidentiality and rehearse, over time, the solutions to practical problems such as who to tell, what needs to be said, discussion around safer sex practices and adherence to drug therapies. Clear information about medical and counselling follow up should be given. Counselling may be of help for the patient’s partner and other family members.

#### 4.7.1 Psychological Issues in HIV/AIDS Counselling

1) Shock of diagnosis
2) Recognition of mortality
3) Of loss of hope for the future
4) Fear and anxiety
5) Uncertain prognosis
6) Effects of medication and treatment/treatment failure
7) Of isolation and abandonment and social/sexual rejection
8) Of infecting others and being infected by them
9) Of partner’s reaction
10) Depression due to adjustment to living with a chronic viral condition
11) Depression over absence of a cure
12) Depression over limits imposed by possible ill health
13) Possible social, occupational, and sexual rejection if treatment fails
14) Anger and frustration over becoming infected
15) Anger and frustration over new and involuntary health/lifestyle restrictions
16) Anger and frustration in over incorporating demanding drug regimens, and possible side effects, into daily life
17) Guilt interpreting HIV as a punishment; for example, for being gay or using drugs
18) Guilt at anxiety caused to partner/family
4.8 COUNSELLING PATIENTS AND PARTNERS TOGETHER

This should only take place with the patient’s explicit consent, but it may be important for the following reasons:

Adjustments to sexual behaviour and other lifestyle issues can be discussed and explained clearly to both.

If the patient’s partner is HIV negative (i.e. a serodiscordant couple) particular care and attention must be paid to emotional and sexual consequences in the relationship.

Misconceptions about HIV transmission can be addressed and information on safer sex given.

The partner’s and the patient’s psychological responses to the diagnoses or result, such as anxiety or depression, can be explained and placed in a manageable perspective

There may be particular issues for couples who have children or who are hoping to have children or where the woman is pregnant.

Partners and family members sometimes have greater difficulty in coming to terms with the knowledge of HIV infection than the patients do themselves. Individual counselling support is often required to manage this, particularly role changes within the relationship, and other adjustment issues that may lead to difficulties. This is part of a holistic approach to the patient’s overall health care.

In many cases the need for follow up counselling may be episodic and this seems appropriate given the long term nature of HIV infection and the different challenges a patient may be faced with. The number of counselling sessions required during any of these periods largely depends on the individual presentation of the patient and the clinical judgment of the counsellor.

4.8.1 Worried Well

Patients known as the “worried well” present with multiple physical complaints which they interpret as sure evidence of their HIV infection. Typically, fears of infection reach obsessive proportions and frank obsessive and hypochondriacal states are often seen. This group shows a variety of characteristic features, and they are rarely reassured for more than a brief period after clinical or laboratory confirmation of the absence of HIV infection. A further referral for behavioural psychotherapy or psychiatric intervention may be indicated, rather than frequent repetition of HIV testing.

4.8.2 Characteristics of the Worried Well

1) Repeated negative HIV tests
2) Low risk sexual history, including covert and guilt inducing sexual activity
3) Poor post adolescence sexual adjustment
4) Social isolation
5) Dependence in close relationships (if any)

6) Multiple misinterpreted somatic features usually associated with undiagnosed viral or post viral states (not HIV) or anxiety or depression

7) Psychiatric history and repeated consultation with general practitioners or physicians

8) High levels of anxiety, depression, and obsessive disturbance

9) Increased potential for suicidal gestures

4.8.3 Coping Strategies

The importance of encouraging and working towards coping strategies involving active participation (to the extent the patient can manage) in planning of care and in seeking appropriate social support has been demonstrated clinically and empirically. Such an approach includes encouraging problem solving, participation in decisions about their treatment and care, and emphasising self worth and the potential for personal control over manageable issues in life.

Many patients diagnosed with HIV some years ago are now feeling well enough to return to work and to study and are, paradoxically, learning to readjust to living, as they had formally adjusted to the possibility of dying. Patients also have to deal with the uncertainty which remains about the long term efficacy of current medical treatment, and there are some who will fail on combination therapy. Even with the significant medical advances in patient management, counselling remains an integral part of the management of patients with HIV, and their partners and family.

Self Assessment Questions

1) What are the psychological responses to an HIV positive result?

...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................

2) What are the characteristics of worried well?

...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................
HIV/AIDS counseling is confidential communication between a client and a care provider aimed at enabling the client to cope with stress and take personal decision relating to HIV/AIDS. The counseling process includes the evaluation of personal risk transmission, the facilitation of preventive behaviours and evaluation of coping mechanisms when the client is confronted with a positive result.

The aims of counseling are to help each individual to take charge of his life by developing the ability to make wise and realistic decisions, altering own behaviour to produce desirable consequences providing information.

Counselling micro skills are essential for effective communication and the development of a supportive client counselor relationship. These skills facilitate pre-test and post-test counseling effectively.

4.10 UNIT END QUESTIONS

1) Explain the concept of HIV counselling and discuss the goals of HIV Counselling.
2) Explain the pre-test discussion checklist during HIV counselling.
3) Discuss the coping strategies suggested during HIV counselling.
4) What are the psychological responses to an HIV positive result?
5) What are the characteristics of worried well?

4.11 GLOSSARY

HIV: HIV (Human Immunodeficiency Virus) is the virus that causes AIDS. This virus is passed from one person to another through blood-to-blood and sexual contact.

Coping strategies: coping refers to a process of using some techniques to manage taxing circumstances, expending effort to solve personal and interpersonal problems, and seeking to master, minimise, reduce or tolerate stress or conflict.

Worried well: Patients known as the “worried well” present with multiple physical complaints which they interpret as sure evidence of their HIV infection. Typically, fears of infection reach obsessive proportions and frank obsessive and hypochondriacal states are often seen.

Window period: The “window period” is the time it takes for a person who has been infected with HIV to react to the virus by creating HIV antibodies. This is called seroconversion. During the window period,
people infected with HIV have no antibodies in their blood that can be detected by an HIV test, even though the person may already have high levels of HIV in their blood, sexual fluids, or breast milk.

4.12 SUGGESTED READINGS


