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SafeTalk, a Multicomponent, Motivational Interviewing-Based, Safer Sex Counseling Program for People Living with HIV/AIDS: A Qualitative Assessment of Patients' Views

Carol E. Golin, M.D.,[1–4] Rebecca A. Davis, M.P.H.,[2] Sarahmona M. Przybyla, Ph.D.,[2] Beth Fowler, M.S.I.S.,[6] Sharon Parker, M.S.W., M.S.,[7] Jo Anne Earp, Sc.D.,[2] E. Byrd Quinlivan, M.D.,[1,4,5] Seth C. Kalichman, Ph.D.,[8] Shilpa N. Patel, M.P.H.,[3] and Catherine A. Grodensky, M.P.H.[3]

Abstract

With the continued transmission of HIV each year, novel approaches to HIV prevention are needed. Since 2003, the U.S. HIV prevention focus has shifted from primarily targeting HIV-negative at-risk persons to including safer sex programs for people already infected with HIV. At least 20–30% of people infected with HIV engage in risky sexual practices. Based on these data, policymakers have recommended that interventionists develop strategies to help HIV-infected people reduce their risky sexual behaviors. In the past, the few safer sex interventions that targeted HIV-infected people met with limited success because they basically adapted strategies previously used with HIV-uninfected individuals. In addition, often these adaptations did not address issues of serostatus disclosure, HIV stigma, or motivation to protect others from HIV. We had previously tested, in a demonstration project named the Start Talking About Risks (STAR) Program, a monthly three-session motivational interviewing (MI)-based intervention to help people living with HIV practice safer sex. In this study, we refined that program by enhancing its frequency and intensity and adding written and audio components to support the counseling. We theorized that an intervention such as MI, which is tailored to each individual's circumstances more than standardized prevention messages, would be more successful when supplemented with other components. We qualitatively assessed participants' perceptions, reactions, and preferences to the refined prevention with positives counseling program we called SafeTalk and learned that participants found the SafeTalk MI counseling and educational materials appealing, understandable, and relevant to their lives.

Introduction

Each year from 2003–2006 approximately 55,400 Americans became infected with HIV with increases in incidence being proportionally greater in the southeastern United States.[1–3] With the continued transmission of HIV, novel approaches to HIV prevention are needed. While most people living with HIV practice safer sex or abstinence, at least 20–30% continue to engage in risky sexual practices and this proportion appears to be increasing.[4–16] Based on these data, policymakers have recommended that interventionists develop strategies to reduce risky sexual behaviors of HIV-infected people.[17–24] In the past, the few safer sex interventions that targeted HIV-infected people met with limited success because they often did not address issues of serostatus disclosure, HIV stigma, or motivation to protect others from HIV.[15,25–29] Recent meta-analyses found that "prevention with positives" programs can be successful and those more likely to be so were based on behavioral theories of change, targeted HIV transmission risk behaviors, included skills-building, were delivered by counselors or medical providers, were intensive, and lasted more than 3 months.[23,24]

[1]Department of Medicine, UNC School of Medicine, [2]Department of Health Behavior and Health Education, UNC School of Public Health, [3]UNC Cecil G. Sheps Center for Health Services Research, [4]UNC Center for AIDS Research, [5]UNC Center for Infectious Diseases, [6]UNC CHAI Core, [7]UNC School of Social Work, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.
[8]University of Connecticut, Storrs, Connecticut.

Furthermore, meta-analyses of behavior change programs have shown that multicomponent programs are more likely to change behavior than single-component programs.[23] Few safer sex programs for people living with HIV meet all these criteria.[23,24] Furthermore, few studies have assessed qualitatively the opinions of people living with HIV regarding specific components of a "prevention with positives" program. Few studies have measured clients' reactions to or input on specific aspects of motivational interviewing or other safer sex counseling programs. Nor have researchers assessed the preferences of people living with HIV for what components they believe would be most useful in safer sex programs.

The purpose of this article is to describe a multicomponent, motivational interviewing (MI)-based safer sex program for people living with HIV called SafeTalk, and report reactions of people living with HIV who were exposed to a description of the counseling programs and shown and listened to its audiovisual materials in focus groups. These focus groups were conducted to use participant input to refine the materials to best meet client needs. The SafeTalk program was developed based on social cognitive theory that informs motivational interviewing. MI is a client-centered yet directive counseling style and has been shown to improve health behaviors successfully, including risky sexual practices, by enhancing self-efficacy and motivation.[23,30–34] Negotiation around risk dynamics and decisions about when and how to practice safer sex are complex, particularly for people living with HIV. As a result, a comprehensive intervention, such as MI, that can be tailored to each individual's circumstances, may be more likely to be effective at reducing risky behaviors among people living with HIV than are more standardized prevention messages that are sometimes seen as confrontational.[31–34]

To learn more about the mechanisms through which the intervention might operate, we qualitatively assessed the perceptions, reactions and preferences of people living with HIV to the enhanced program. In addition to describing the SafeTalk program, this article presents results from focus groups we conducted among more than 50 people living with HIV. Although all of the components of the intervention were developed prior to the qualitative study reported in this article, the results obtained from focus groups were used to refine the materials and counseling protocol to meet the needs of clients better. Below, throughout the results, we describe ways in which the information garnered in this qualitative study has been used to refine the program. In addition, we describe the views of people living with HIV regarding "prevention with positives" safer sex programs.

Methods

Overview of the SafeTalk program and materials

SafeTalk is a theory-based, multicomponent MI safer sex program for HIV-infected persons. Based on social cognitive theory and Rogerian psychology, the SafeTalk program consists of four structured monthly MI sessions, a series of four booklet/CD pairs such that each pair helps prepare patients for each MI session, a fifth booklet/CD pair providing tailored safer sex information, and four booster letters each linked to the content of its preceding MI session. The scripted CD/booklet series uses conversations between patient and counselor characters in an entertaining manner to demonstrate empathy and model mastery over behavior change. These program materials stress individual stories; realistic characters discuss topics related to HIV transmission. We included sound bites, sometimes known as witnessing,[35] from five people living with HIV discussing their experiences with disclosing that they were HIV positive, being intimate, and practicing safer sex or abstinence.

In addition to providing opportunities to hear how others have experienced and addressed sexual and romantic relationships while living with HIV, the sessions and booklet/CD pairs also contained: (1) choices of safer sex topics; (2) assessment of personal relationships, sexual activities, motivation and self-efficacy for chosen behaviors; (3) values clarification; (4) consideration of pros and cons for behavioral topics selected; (5) strategy brainstorming; and (6) goal-setting. The fifth informational booklet/CD pair, which was intended to be given before the first session, provided tailored safer sex information and skills-building exercises. The informational booklet/CD allowed participants to select CD tracks and corresponding booklet pages that met their individual informational and sexual needs (e.g., anal sex versus vaginal sex, female condom use versus male condom use versus dental dams), and included information about communicating with partners (e.g., sexual negotiation, safer sex comebacks, disclosure to partners) that could be reviewed if needed. The use of audio CDs with the booklets served not only to introduce clients to SafeTalk and prepare them for the counseling, but also to reinforce efficacy for behavior change, maintain patients' engagement between sessions, and address low literacy issues.

The MI counseling style is based on the idea that the client–counselor relationship is a partnership[36–38] and that avoiding confrontation increases a client's intrinsic motivation and confidence to change behavior.[37,38] MI is based on the supposition that clients feel ambivalent about unhealthy behaviors,[36–38] and the MI counselor guides the client toward positive behavior changes following five principles that help clients resolve their ambivalence: (1) expressing empathy; (2) avoiding argument; (3) rolling with resistance; (4) developing discrepancy; and (5) supporting self-efficacy.[38]

In SafeTalk, consistent with MI principles, and parallel to the SafeTalk materials, the SafeTalk counseling sessions involve a thirteen step protocol which emphasizes the client's autonomy (Table 1). The protocol begins with building rapport and risk assessment and then invites clients to choose, from a menu of options, a safer sex topic that is salient to them.[36–38] Finally, the SafeTalk MI protocol includes specific steps to build clients' self-efficacy, or confidence, to make the change selected, such as helping them identify strategies to overcome barriers, conducting skills-building exercises, or enhancing facilitators (for example, using a buddy for support) to change.[38] The program emphasizes setting small realistic goals focused on harm reduction.[30] The 13-step protocol is summarized in Table 1.

Focus group evaluation of intervention materials and program

Focus group overview and study participants. To inform and test the SafeTalk materials and program features for usability and acceptability, we conducted six focus groups with a total of 51 people living with HIV from in North Carolina.

Table 1. Thirteen-Step Protocol

Step	*Description*	*Sample wording*
1	INTRODUCTION (corresponds to CD Tracks 1–3) (corresponds to booklet pg. 4–7)	These sessions are part of a program to help people living with HIV deal with issues that have to do with sex or intimate relationships. This is a time for you to explore any concerns that you have related to safe sex or intimate relationships. The four sessions that we will have together are a time for us to talk about how what you heard on the CD and saw in the booklet relates to your life. So the purpose of the booklet and CD were just to get you thinking about what kinds of things are on your mind related to safe sex.
2	WHAT MAKES ME TICK? (corresponds to CD Track 4) (corresponds to booklet pg. 8)	Do you remember that list of things in your booklet that describes different things that matter to people? Discussing these important things will help me know you and understand your life better. It will also help me to know what you think about when making decisions. Of these choices, what are things you think about when you are making important decisions?
3	EXPLORATION OF VALUES (corresponds to CD Track 4) (corresponds to booklet pg. 9)	So you mentioned that _____, _____and ____ are things that come to mind when making a big decision. I would like to know more about how that works for you. Tell me about _____.
4	RISK ASSESSMENT (corresponds to CD Track 5) (corresponds to booklet pg. 10–11)	Now I feel that I have an idea of what matters to you and how that affects the decisions you make. I would next like to ask about what is going on in your life right now in terms of sexual relationships.
5	TOPIC SELECTION (corresponds to CD Track 6) (corresponds to booklet pg. 12)	If it is OK with you, what I would like to do now is have a discussion about the list of different safer sex topics that were listed in your booklet. What if any topics on the list did you find to be important for you?
6	ASSESS AND REFLECT (corresponds to CD Track 6) (corresponds to booklet pg. 12)	"So it sounds like _____ is something that you would really like to talk about today. I would like to understand a little more what _____ means to you and why it is an important issue for you. Please tell me more about that."
7	RATE IMPORTANCE (corresponds to CD Track 7) (corresponds to booklet pg. 13)	How important is it to you personally to change AT THIS POINT? If "0" was "not at all important" and "10" was "very important," what number would you give to the importance you put RIGHT NOW on [changing this behavior]? Question Down: "Why an 8 and not a 1?"
8	RATE CONFIDENCE (corresponds to CD Track 7) (corresponds to booklet pg. 13)	Ok, let me switch gears for a minute if that's OK with you. Say that today you decided that you were going to [START/CONTINUE/MAINTAIN] _____, how easy or hard would this be? How confident are you using that same scale where 0 is no confidence and 10 is very confident that you could make this change happen?
9	EXPLORE GOAL SETTING (corresponds to CD Track 8) (corresponds to booklet pg. 14–15)	From what I hear you saying today you think topic _____ is important. this (topic) has some things that work for you, for example _____ You are not comfortable with some things for example, you mentioned_____. Tell me more. It sounds like you may be ready to think about trying to take some / a small step(s) toward [*changing this behavior*] at this time. Is that right?
10	DECISIONAL MATRIX (corresponds to CD Track 8) (corresponds to booklet pg. 14–15)	Sometimes when people are thinking about changing the way they do things it can be helpful to look at the behavior you are thinking about changing in different ways. If you would like, we could do that together. First, can you tell me what you like about your [*current behavior*]? Second, can you tell me what you don't like about/some of the not so good things about your [*current behavior*], if anything?
11	SUMMARIZING (CD Track 8; corresponds to booklet pg. 14–15)	PROVIDE DOUBLE SIDED REFLECTION/SUMMARY

Table 1. (Continued)

Step	Description	Sample wording
12	MAKING PLANS (CD Track 9; corresponds to booklet pg. 16)	You have talked about thinking about changing X and you have talked about some of the things that make X easy, some that make it hard, some of the good things about changing and some of reasons why changing X may not be something you want. You have named a number of ways that you might do X, what specific things do you feel ready to try between now and when we meet again?
13	CLOSURE	Review session. Did I miss anything? Is there anything you would like to add? Do you have any questions? Make appointment for next visit. Give CD/Booklet for next visit.

Participants were recruited from two sites serving patients infected with HIV, one located at a tertiary care center and the other at a local AIDS Service Organization. Participants were eligible if they were HIV-infected, spoke English and had been sexually active in the last 12 months. Participants from the tertiary care center had participated previously in a demonstration project used to develop and assess the feasibility of a draft of the safer sex motivational interviewing protocol and had given us permission to contact them by phone or mail to invite them to be part of future studies. Study staff contacted interested participants either by phone, in clinic or at the AIDS service organization to inform them of the research, screen them for eligibility and assess their interest by stating "I'm talking with you to see if you are interested in being in a focus group. This is a group of about 8 people, like yourself, who will give us their opinions on some booklets and a cassette we have put together. These booklets and cassette have been developed for a new prevention program we will be implementing in the clinic called SafeTalk. Your reactions and thoughts about the booklets and cassette will help us know what changes we need to make them better." Staff scheduled eligible, interested persons to come on one of six times to a local off-campus office building.

Participants were recruited from the AIDS service organization on food pantry days when clients stopped by for services. Interested clients were referred to study staff for screening and consent on another day. Verbal informed assent was obtained from all participants. The study procedures were reviewed and approved by the Institutional Review Board of the University of North Carolina at Chapel Hill.

We enrolled a total of 51 participants, all of whom were people living with HIV. Twenty six (50.5%) participants were male, 83% were African American and 17% white. Their mean age was 43 years.

Focus group guides. We developed two standardized focus group guides that walked participants through different aspects of the SafeTalk program and exposed them to the materials and then assessed their reactions to each of these aspects and the materials to which they were exposed. The first guide was used during two focus groups from each site (four in total) and assessed participants' reactions to the overall SafeTalk MI counseling program and the introductory and follow-up booklet/CD pairs; we also solicited input on the project logo, color scheme and graphics. In addition, we asked participants their opinions about program content, specifically their understanding of the MI concept, the language and graphic presentation of the values clarification and "weighing it out" sections, what information seemed relevant, most useful or new to them, anything they thought was missing, and their preferences for frequency of sessions and having some sessions take place over the phone. The second standardized guide assessed reactions to the informational "Did you know . . ." booklet/CD pair. Questions were designed to use simple language probes as needed. We tested the focus group guides in a mock focus group with our Community Advisory Board to ensure understandability and meaningfulness of the questions.

Focus group data collection procedures. Each 90-minute focus group was run by two moderators and two note-takers. The groups were audio-recorded and transcribed verbatim to ensure accuracy of information collected. In addition, note-takers made additional notes of nonverbal communication. To conduct the groups, all participants were given: a copy of the booklet and CD being tested and a CD player and headphones to listen privately to the CD. The focus groups drew participants' attention to specific tracks and corresponding booklet pages and had them listen to these sections of the CDs while looking at the booklets. After all participants had reviewed the relevant section of the materials, the moderator asked questions about their reactions to specific aspects of the materials and facilitated a group discussion around that topic. Once that section of the booklet/CD had been reviewed sufficiently, the moderator provided instructions to move on to the next section. After each focus group, research staff conducted an audio-recorded debriefing of participants' observations and impressions of the session. All participants were provided with $30, a meal, and travel reimbursement if needed for their participation. They completed a brief, anonymous demographic survey that assessed their gender, race, education level, and age.

Focus group analyses

Initially, one team member transcribed each focus group recording and prepared a brief statement describing the general feedback from the groups about the SafeTalk coun-

seling session and materials. This feedback was used to make changes and additions. Next, six study group members, including the PI, were each assigned three of the focus group transcripts to review and generate potential codes for data analysis. The PI then combined these codes into a master list that was distributed to the team for evaluation and feedback. Next, three team members conducted a more detailed analysis of the focus group data. They independently coded each focus group session, using Atlas-ti qualitative analysis software.[39] They then met to discuss findings, resolve coding discrepancies, revise data codes as needed, and assess emerging themes.

Results

Overall reactions to SafeTalk safer sex MI counseling

Participants' reported negative experiences in the past with counseling in general. They also voiced an unmet need for counseling programs to discuss safer sex topics. Several participants expressed optimism that they would find MI highly acceptable and useful if it were truly non-judgmental and centered on the client's perspective. However, many participants discussed fears, based on past negative experiences, that MI counselors might be judgmental and rigid. The following quotes provide examples of participants' reactions to the proposed MI safer sex counseling sessions:

> I've never had anyone sit down and talk to me about sex—I mean, you know, since I've been sick. And I've never felt comfortable talking to anyone about it. And if there was someone that, you know, that's what I was there for and that's what they did, I would like to learn something. I would like to learn more about HIV. (Focus Group #2).
>
> I like the way that they tell you that it's not about "you got to do this, you got to do that." It's about choices. It's—you have these options that you can work with and you are in control of what choice that you want to make. It's not about your preaching to them and you've got to do this and you've got to do that or you're gonna, you know, suffer these particular consequences. It's about choices. (Focus Group #5).
>
> . . . in motivational interviewing I think I'd be more willing and open to talk to them because that way I know that they know where I'm coming from and can really relate, you know. (Focus Group #4).

While participants presented at different stages of readiness for safer sex counseling, almost all focus group members expressed that they would be willing to meet with a SafeTalk counselor. This was true even for participants who noted they were not yet ready to talk with someone about sex.

Reactions to questions related to gender of counselors, mode of session delivery (in person or via telephone), and time between sessions was mixed among the participants. Counselor gender did not seem to be an issue for most participants, though focus group members stating a preference noted they would want a counselor of the same sex as themselves. In general, participants preferred face to face counseling but also felt phone counseling would be acceptable. A few even felt the anonymity of phone counseling might help facilitate more honest conversations. Several people mentioned barriers to both modes of counseling, such as lack of phones or transportation. Although the amount of time people reported they would prefer to have between counseling sessions varied from twice a week to once every 3 months, the general consensus was that once a month was acceptable. A suggestion was made for follow-up phone calls between the monthly sessions for a quick check in on progress towards goals.

Reactions to SafeTalk educational materials

Tailoring materials to diversity rather than risk groups. Participants overwhelmingly recommended that program material design emphasize diversity by including topics important to gay and heterosexual men and women, rather than separate booklets and CDs tailored by gender or sexual orientation. Participants consistently expressed the belief that general education about safer sex was very important for people living with HIV and they welcomed receiving such information, even when it related to risk behaviors they traditionally associated with a risk group to which they did not belong. The suggestions for diversity went beyond including a broad range of people in the photographs to including safer sex information that appeals to and is salient for a group of people who were diverse regarding their sexual orientation, relationship status, and racial as well as ethnic background. Several people expressed the idea that having materials that appeal to people from many different backgrounds would communicate the idea that HIV can affect anyone. As one participant expressed it, "In other words, the disease doesn't discriminate." The belief that the experiences of living with HIV were universal was expressed by some participants as an important concept to help guide our intervention material development that would also make them less stigmatizing.

Reactions to specific physical aspects of materials. Booklet covers, logos, and introductions piqued their interest. Participants recommended showing close-ups of entire faces of men and women on the booklet cover rather than more distant or partial views of faces. They specifically suggested that we use figures that appeared to be proud and self-confident rather than embarrassed or ashamed. The participants related well to vignettes, characters and narratives presented on the CDs and in the booklets. The candid discussions by the characters and on the sound bytes by people living with HIV/AIDS about risk behaviors elicited positive reactions and motivated participants to continue in the program. As one participant noted, "You can tell there are different personalities talking. And, you know, you can usually identify with somebody.." (Focus Group #6).

Many participants also praised the materials for being explicit about safer sex techniques, particularly the visual depictions of how to use barrier methods during sex and including slang, or "street," terminology for safer sex discussions. Participants said these approaches made the information seem more relevant to their lives and could potentially make it easier to talk with the counselor. A small subset of participants, however, stated preferences for less graphic materials.

Reactions to specific educational content of materials

Reactions to topics. Many participants liked the coaching offered in sections on "Other ways to be intimate . . ." and "talking to partners," including about ways to "negotiate safer

sex" and to "disclose one's serostaus." The appreciation of these topics demonstrated a desire to discuss challenging relationship issues that play a role in keeping oneself and partners healthy.

In addition, participants strongly encouraged the researchers to place greater emphasis on drug abuse and addiction as issues related to safer sex in the next set of materials. Many participants recognized substance use as a barrier to practicing safer sex and desired an opportunity to discuss the impact of this topic with a knowledgeable MI counselor.

Reactions to exercises

While exercises to rate the importance and list the "pros and cons" of chosen topics were reported to be "easy to understand," participants found it more difficult to rate their self-efficacy or to use a chart to assess pros and cons of changing behaviors. Based on feedback, the order of the sections was changed, and the way that the information was presented in the tables and rating scales was reformatted to improve comprehension.

Participants responded positively to the section that provided a list of values and asked them to think about and check those that were important to them. Participants identified a wide range of values, including being healthy, having independence, and being happy. The two values most commonly cited as important were "being close to God" and "being there for my family."

Relevance and impact of SafeTalk materials

Many participants relayed appreciation for gaining new knowledge by reviewing the audiovisual materials. This response demonstrates the need for, acceptance of, and desire to obtain accurate safer sex information by HIV positive people. Participants mentioned learning new safer sex techniques as well as correction of inaccurate safer sex beliefs during the discussions. As an example, one participant noted:

> I didn't know about the double bagging either. I didn't know that if you wore two [condoms], then it would make them rub up against each other and cause them to tear. That's something that I just learned today. (Focus Group #6).
> You have information here that tells you what's most risky and what's least risky and where in the book you can find the information to be safer when you participate in those particular activities. (Focus Group #5).

Several participants mentioned the materials provided a positive opportunity to hear things they already knew in a different way. The SafeTalk materials also reinforced accurate knowledge and thus were relevant for a wide range of participants at various stages of understanding safer sex practices.

Concerns and suggestions

Some participants worried about whether SafeTalk counselors would actually administer MI as described, that is, in a nonjudgmental manner. While they expressed a desire for such counseling, a few wondered whether a counselor could really be this way. Second, participants also stressed that it would be important for the SafeTalk counselor to know and understand HIV well, including public health laws and regulations related to practicing safer sex for people living with HIV. Third, participants described concerns about confidentiality related to having booklets and CDs at home or seen in public. We addressed this in the final materials by providing black 5×7 envelopes with each CD/booklet pair to help ensure privacy and offered other participants use of the CD/booklet pairs in clinic before counseling sessions if they preferred not to bring them home for fear of disclosure to family members.

Participants requested that MI counseling sessions include opportunities for active learning with different barrier methods, especially with female condoms and dental dams. Therefore, condoms and dental dams will be available for practical skills-building exercises with anatomical models during counseling sessions.

Discussion

Increasingly clinicians and researchers recognize the need to help people with HIV practice safer sex and factors that are associated with their conducting risky sexual practices and reducing their risky behavior.[8,40–45] To address this, we have developed SafeTalk, a safer sex program for people living with HIV, as four motivational interviewing sessions combined with innovative audio and visual materials that support and enhance counseling. Overall, participants found the proposed SafeTalk MI counseling and educational materials appealing, understandable, and relevant to their lives. Favorable focus group responses were mainly related to: (a) the nonjudgmental nature of MI; (b) the chance to discuss sex with a knowledgeable person; (c) the opportunity to clarify one's values; (d) the range of safer sex topics offered; and (e) the direct, candid and relevant nature of the educational information provided. These findings highlight the desire of people living with HIV to be able to talk with health professionals about sex and to obtain as much information as possible about safer sex practices. Fears of being judged, shamed, or criticized did emerge as potential barriers that needed to be attended to and overcome in prevention with positives programs. These findings suggest that the client-centered nature of MI, which emphasizes that counselors use techniques to ensure that clients do not feel judged, may be a particularly effective approach for safer sex counseling among people living with HIV. Many participants reported unfavorable previous counseling experiences, albeit not safer sex counseling, which made them less trustful of mental health professionals. This possibility must be kept in mind in rapport-building with such clients in future counseling sessions.

Although the two sites where the study took place had provider-delivered "prevention with positives" programs in place, participants perceived a large unmet need for opportunities for people living with HIV to discuss issues related to sex openly with a health professional. The predominant desire for candid, graphic discussions about sex with a trusted health professional stood out in all of the focus groups. Clients also responded positively to exercises and narratives, which provided opportunities to build specific practical skills for practicing safer sex, including use of barrier methods and communication skills. These findings are consistent with components emphasized in many other "prevention with positives" programs[23–25,30] but suggest that

expansion of existing programs is desired by people living with HIV.

The focus group participants thought that the values clarification exercises in the materials and sessions was useful because they invited them to think about how safer sex fit into larger, more salient issues in their lives. Implied in participants' combined comments was that having the values clarification exercises early in the materials and sessions (before risk reduction) would add meaning to the safer sex discussions.

The preference for materials that emphasized diversity by including together topics important to gay and heterosexual men and women, rather than tailored by gender or sexual orientation, was interesting and surprising. Historically, many HIV prevention programs have been tailored specifically to women or men who have sex with men, sometimes tailoring programs to specific ethnic groups as well, with the assumption that differences in gender, ethnicity, lifestyle, and sexual orientation warrant culturally tailored approaches to HIV prevention. However, our participants spontaneously expressed the opinion that the issues faced by people living with HIV were more universal than gender or cultural differences but, also, they expressed an interest in gaining knowledge of all aspects of HIV prevention, not only for those behaviors or issues specifically applicable to them. In addition, from a practical perspective, men in particular, including both MSM and heterosexual men, seemed to feel that materials that were more universal in nature would be less stigmatizing. These qualitative findings suggest that we need to understand better whether factors that influence risky sexual behavior differ for men, women or men who have sex with men to inform whether aspects of HIV prevention programs require tailoring or not. The individualized nature of MI allows the counseling sessions to address a range of issues most relevant to each individual, regardless of his or her gender, race, or sexual orientation.

This formative study also highlights that the reactions and concerns of participants can provide concrete suggestions that can be taken into account in refining program materials for further testing in a larger trials. While increasing information about factors associated with reducing risky behavior among people living with HIV, such as depression, greater exposure to health programs, having multiple casual partners, stage of HIV infection, alcohol use during sex, and among men who have sex with men, willingness to disclose one's sexual orientation.[8,40–46] While such factors identified in quantitative observational studies are critical to inform the development of "prevention with positives" programs, suggestions from focus group participants informed specific changes we made to the focus, appearance, and content of many aspects of our prevention program materials.

Limitations must be kept in mind in interpreting our findings. First, these findings were conducted at two sites in the southeastern United States with existing medical-provider–delivered prevention with positives programs. While we found the need for additional safer sex programs to be great among this sample, such need may be even greater in areas without existing prevention with positives programs or different in regions with different programs. Furthermore, while the demographic characteristics of our sample are consistent with clients at the two sites and most people approached agreed to participate in the focus groups, ours was a convenience sample and it is possible that those choosing to participate in the focus groups have a greater interest in safer sex programs than those who did not choose to participate. In particular, during recruitment, we informed potential participants that we wanted their opinions regarding safer sex materials. Persons who felt less confident about expressing their opinions for programming or who would have trouble coming in the evenings or selected times, perhaps even those most in need of safer sex counseling, may have been underrepresented. Finally, we were testing reactions only to SafeTalk, a specific "prevention with positives" safer sex program. While we believe participants' discussions reflect preferences and beliefs that can inform other "prevention with positives" programs as well, specific feedback was limited to reactions to motivational interviewing programs and we do not know how participants might react to other approaches.

Keeping these limitations in mind, our findings highlight clients' views on the development of health promotion programs and the abilities of people living with HIV to provide insightful input into such programs. The optimistic and interested nature of participants' responses was encouraging. People living with HIV seem to be highly open to and desirous of opportunities to gain knowledge and skills in safer sex practices and appreciated a chance to talk openly about their experiences with a supportive, trustworthy and knowledgeable individual, despite, in some cases, previous negative experiences with counseling. These findings reinforce the rationale for developing and implementing prevention with positives programs.

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Address correspondence to:
Carol E. Golin, M.D.
UNC Sheps Center for Health Services Research
725 MLK Jr. Boulevard
Campus Box 7590
Chapel Hill, NC 27599-7590

E-mail: Carol_Golin@unc.edu