

MANAGEMENT OF PERSONS LIVING WITH HIV/AIDS AND OTHER SEXUALLY TRANSMITTED DISEASES

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Counselling as primary prevention for Sexually Transmitted Diseases

Definition

Counselling should be regarded as a technical approach which allows decision making and a way to solve problems. In the context of primary prevention, counselling is a psychological approach which is adapted to the needs of a client or those of a group of clients. It is a very adaptable tool which requires marginal medical competence and can be practiced by all categories of educators.

Aims

In general terms, the tasks of counselling for primary prevention should include the following:

- To promote changes in individual behaviors.
- To ensure support to each of the different phases of the decision process leading to behavioural changes.
- To propose actions which may realistically adapt to the specific client's situation.
- To help clients in translating into actions their own knowledge on disease and risk. When applied to the prevention of STD/HIV, counselling has the following scopes:
- To explain to the client, in a way which is easily understandable and appropriate for the culture, the need to modify sexual behaviours and practices in order to decrease the chances to both acquire and transmit an STD.
- To encourage people living with HIV infection or AIDS to stop practices and behaviours which may lead to transmit the infection to others.
- In the context of tertiary prevention (management of persons who have already acquired the infection), to reach the best possible psychological and social equilibrium for the clients themselves and those who care for them.

Schematically, four components of counselling can be identified:

- Active listening
- Help
- Support
- Education

Active listening

Counselling is based on classical communication steps:

- Being physically present.
- Reformulate any message into a verbal structure.
- Reformulate any feelings into a verbal structure.
- Personalize problems, feelings, and matters.
- Make matters concrete.
- Define each step you are going through (Robert R. Carchuff).

Two points deserve special remarks:

- Individual's schemes should always be respected, avoiding any attempt of interpretation.
- Never try to justify current behaviours with situations occurred in the past, better try to help the individual using just the current context (Gestalt-therapy).

Help

Individuals being counselled need help to solve problems. However, it is important that the counsellor maintain a balance between steering and supporting attitudes. The two situations which need to be avoided are those of victim/persecutor/ saver, and parents/ children.

Educators should be confident in behavioural changes which are personalized to the individual's needs. The awareness of the availability of positive behavioural alternatives is important to make counselling effective (Transactional Analysis).

Support

Support originates from sharing experiences in the material, psychological, and affective domains. A supportive atmosphere allows for the manifestation of specific feelings like frustration, anger, or gratitude, which are often disproportionate and amplified. By definition, the support component of counselling has precise limits in terms of time. The aim of this phase is to allow counselling recipients to understand and accept the defensive mechanisms which are normally elicited by the offer of new and alternative behaviours; such mechanisms develop into well codified stages and require specific support, including counselling in a crisis situation, a problem-solving counselling, and a decision-making counselling.

Education

Education needs to be based on the understanding of the beliefs and values of the person being counselled, because it is essential to elicit the personal interest of the individual. The educational process requires a continuous balance of the client's needs and counsellor's plan of education. It is necessary to stress the existence of hopes in order to avoid a sense of condemnation. In the case of HIV infection, at present, available treatment does not allow a cure, but may still be regarded as an important support for affected people. The use of transactional analysis may be effective in the implementation of such an educational approach.

Ethical limitations

The health domain, specifically in the field of prevention, is interested by a number of conflicts of interest: between the single individual and the population as a whole, between what is ideal and what is real, between knowledge and practice.

To implement a preventive intervention, or to accept to be the object of a preventive intervention, requires having a positive perspective of prevention. But is prevention really a positive action? Prevention is implicitly linked to positive values. However, it is interesting to examine what are the tools necessary to put preventive interventions into practice. The principles of prevention are based on medical and scientific knowledge. Prevention, targeted to both individuals or populations, is managed by either professional or voluntary staff. Although the aim of prevention is definitely positive, the tools used to apply it strongly interfere with the intimate part of the individual, with its way to relate with him/herself, the others, and his/her cultural background.

Prevention means taking actions before, and to avoid the occurrence of specific situations. It requires dealing with a complex context in order to make an individual have an easier choice. Starting from a stated information, the individual is supported to develop his/her own thoughts of the nature and magnitude of risks, and is put in a position to take decisions which are nested in his/her specific context. The major ethical limitations of prevention are in fact represented by this process of interference with the freedom and autonomy of the individual.

During the seventies lawyers and philosophers had an ethical debate on the rights of self-determination of the individual based on four principles: the autonomy of a person, justice, the

good-aiming of actions, and the avoidance of bad-aiming of actions. Being aware of the existence of these principles and the ethical limitations of prevention is important in order to avoid the risk that good wishes turn into bad actions.

The autonomy of a person may best be respected by answering to the following questions:

- Are the knowledge at the basis of specific preventive actions really sound ? What is the cost-benefit profile of the action ? What level of satisfaction the action may generate in the target individual?
- Have different perceptions been linked to specific cultural contexts and different educational background appropriately been considered in the intervention?
- What are the effects of the action in terms of the individual perception of health, disease, and risk?

The freedom of an individual may be endangered as a consequence of the following issues:

- The message we pass: should it be complete or partial, and how to pass it? The facts which are implicitly carried on by the message and the arguments the message can induce in the individual need to be considered.
- The power we have while passing a message, which is a function of the place we hold, and the right we have to use it to modify behaviours
- The right to propose "normal" models of practices and to pretend that individuals comply to the model
- The effect of messages on a public which is forced anyhow to respect rules made by others: such as children at school, workers in a firm, prisoners in a prison etc.
- Group actions which raise questions of the limits between the freedom of the individual and that of the community
- The possibility to create feelings of guilt in persons who are not willing or not able to adhere to behaviours presented as the ideal model.

In the context of prevention we can identify the person giving the message, the message itself, and the recipient of the message. The person giving the message needs to tailor his/her educational tools on the knowledge and comprehension capacities of the recipient. The very aim of health promotion is to develop in the recipient a sense of responsibility towards the well-being of the individual as well as that of the community, and to improve the capacities to control the determinants of such well-being.

To make counselling effective, messages which may lead to social control in a coercive way should be avoided.

A balanced intervention consists of supporting the client's efforts to become aware of his/her own values and to take decisions in order to maintain personal and communal well-being. Autonomy can be supported by different means: by satisfying essential needs; by maintaining social links; by recognizing his/her own social role; by increasing the self-esteem; by obtaining educational degrees etc. Reaching an acceptable level of autonomy is essential to make a person acknowledge and accept his/her own responsibilities towards the community.

Ensuring freedom means:

- To operate within the limits of the position covered respecting the boundaries between public and private space.
- To maintain the awareness of the power of the role.
- To not forget the essentials of the role of someone giving a message, in particular the need to comply with the characteristics and the needs of the recipient.

Counselling as secondary prevention for Sexually Transmitted Diseases

A. Definition

Secondary prevention is centred on screening activities, which provide the opportunity of early diagnosis and treatment, as well as appropriate follow-up. Screening may be passive, carried out on selected subjects, identified for example during a medical consultation for genital symptoms. Screening may also be active, as is the case of blood donors: in this context screening is systematic, and all donors are aware that they will undergo HIV testing as a consequence of their decision to donate blood.

Several problems may be considered:

- the subject's choice of the health care provider, based on reliability and confidence criteria
- the development of the consultation
- the consignment of test results
- the search for sexual contacts if required

B. Reliability

The patient in the health care provider's perspective: This perspective is influenced by personal and professional experience about -

- sexuality
- a "noble" concept of medicine and the social impact of diseases (theory of justice in the world)
- what is normal/abnormal
- prejudices
- doubts (from reasonable doubts to incredulity)

The health care provider in the patient's perspective: This perspective is also influenced by personal experience and its interactions with knowledge -

- confidence in his/her own intimacy
- feeling of fears and blame
- lack of knowledge and heterogeneity of information
- importance of the doctor's figure and professional secrecy

C. Confidence during medical interview

Confidence during medical interview is influenced by the capacity of the counsellor:

- to agree that sexual manifestations are a normal component of any human being
- to be aware of his/her own prejudices
- to dedicate enough time to the consultation
- to express in verbal terms his/her own malaise
- to be simple and sincere
- to give the chance to express questions
- to explain and reassure

D. Individualized dialogue

1. Anamnesis
2. Antecedents

3. Questions related to risky behaviours:

3.1 Objective: to improve comprehension, facilitate diagnosis

Question: single or multiple sexual partnership

3.2 Objective: to have a quantitative measure of risk

Question: mean number of sexual partners

3.3 Objective: to evaluate the likelihood of specific diseases

Question: sex with usual or occasional partner(s)

3.4 Objective: to define the context of sexual activity

Question: usual or occasional partner

3.5 Objective: to better investigate anatomical sites

Question: type of exposed anatomical sites, by active or passive way; genital, oral, anal, exchange of objects.

3.6 Objective: to investigate adoption of preventive measures

Question: type of preventive measures used; regular or occasional use.

4. Questions in the context of HIV screening

Depending on the risk degree, we can propose a pre-counselling questionnaire for restricted or general screening, as well as specific screening for HIV infection:

4.1 Objective: to evaluate the client's awareness of risk factors

Question: would you think you are at risk for acquiring AIDS?

4.2 Objective: to evaluate the knowledge on HIV transmission modalities

Question: how could you have got AIDS?

4.3 Objective: to evaluate the correct understanding of the timing in the chain of events

Question: when you last had a risky sexual relation?

4.4 Objective: to explore the client's feelings about AIDS

Question: express a feeling and make the client reformulate it

4.5 Objective: to explore the expectations for the future of an HIV infected individual

Question: let's imagine that one week ago you made the test and today I give back to you a positive result

4.6 Objective: to verify the attitude towards HIV prevention

Question: what would you do in case of a negative result?

5. Questions concerning factors which may limit the client's capacity to adopt safe sexual behaviours

5.1 Objective: to evaluate the risk related to the partner(s)

Question: did he/she make an HIV test?

If he/she did it and the result is positive, remember that the periods at increased risk of transmission are both the early and late stages of the natural history of HIV infection.

If he/she did the test and the result is negative, we need to consider the time lag since the test, the existence of a conversion window, and the type of sexual exposure.

If he/she did not perform an HIV test and the client does not use condom, the offer of the test should be based on the knowledge of HIV prevalence in the reference population, the history of extra-couple relationships, fidelity, etc.

5.2 Objective: to investigate the type of exposure

Question: vaginal or anal intercourse?

Answers will show the attitude of the clients with respect to type of sexual contacts (vaginal, anal, oral - active or passive exposure), existence of cofactors of HIV transmission (genital ulcerations, other STDs, sex during menses, violence during sex)

Question: do you use condom?

This will address the issue of self estimate, the capacity to negotiate with himself/herself and the others, condom acceptability and accessibility, appropriate use (quality of condom, correct use of lubricants, etc.)

E. Genital examination

Genital examination is intended to explore:

- skin and mucous membranes
- inguinal lymph nodes
- abdominal (pelvic) organs
- genito-anal region in females
- genito-anal region in males

F. Consignment of the HIV test

The consignment of the test aims at orienting the patient according to the positive/negative result and at providing counselling (tertiary prevention) for those with a positive test.

G. Partner tracing

Requires the full cooperation of the HIV infected person, which often may be obtained only after some time. Allowing the patient to understand the basics and aims of partner(s) tracing will make it possible to identify contacts before and after the supposed time of contamination.

H. Answers to common questions

1. What is an HIV test?

It is a laboratory test which detects the presence of antibodies to the HIV virus in the body of the person being tested. The simple collection of a blood sample is required. The laboratory performs HIV testing only upon specific request from the health care provider. This test is not performed during regular check-ups. In case of first positive result the test needs to be confirmed by additional laboratory investigations.

2. What is the most common method to make a diagnosis of HIV infection?

The most common method to detect HIV infection is the detection of specific antibodies in the blood. There are three major techniques to verify HIV antibodies in the blood: an ELISA test, a Western Blot, and an immunofluorescence test. A person carrying the antibodies is currently infected by the virus and can contaminate others. Such a person is usually referred to as a "seropositive" individual; such a condition will last life-long. Being seropositive is not the same as being affected by AIDS. A reactive serological test may often be detected several years before a person develops AIDS-defining diseases. Antibodies to the HIV are not produced immediately after viral infection: it usually takes 4 to 6 weeks after the contamination for the HIV test to become positive. Hence, a person can be infected by the HIV and can transmit the HIV even if seronegative, if the test has been performed at a too early stage.

3. What are other available methods to detect the HIV?

a) an antigen detection test, which aims at identifying a part (antigen) of the virus in the blood. A positive HIV antigenemia usually develops early (usually 15 days) after infection, well before the antibodies are detectable. Thereafter the antigen usually disappears from the blood for several years, to reappear at a later stage to indicate the reactivation of viral replication. The presence of a positive antigenemia immediately after infection does not always last until the appearance of the antibodies in the blood: therefore there is always the possibility that soon after infection neither the antibody nor the antigen detection test are positive, though the person is actually infected.

b) A PCR (Polymerase Chain Reaction) test. This test identifies the presence of the HIV genome within the cells of an individual. It is a recently developed technique, which, for a variety of reasons, is not yet applied to screening programs. This test would be positive in the "window" period soon after infection, when both antibody and antigen detection tests may be negative: however, this property is currently exploited only in the context of research, rather than routine

diagnosis. The PCR test is useful for the diagnosis of HIV infection in babies born to HIV infected mothers, as the presence of antibodies is not a reliable tool in this context: maternal antibodies may persist in the newborn blood for several months, even if the newborn did not in fact acquire the infection.

c) Viral load. This technique allows to measure the quantity of the HIV virus in the blood of an infected person. The viral load provides important information for the management of a person with HIV infection:

CD4 > 500 / mm³ and viral load > 104 copies /ml = monitoring, and discuss indication to treatment

CD4 < 500 / mm³ and viral load < 104 copies /ml = monitoring

CD4 < 500 / mm³ and viral load > 104 copies /ml = indication to treatment

4) What is an anonymous test? How much does it cost? Where can we do it?

When a blood sample is collected a coded number is put on the label to replace the name of the person, who, therefore, remains unknown. Such a test is called anonymous.

Some persons are afraid that the result of the test, especially should it be positive, be divulged generating stigma, social discrimination and, in some case, loss of the job. It is important to make it very clear that all possible precautions are taken to maintain the privacy. A test can always be kept anonymous if the patient requires it.

The costs of an anonymous test in France and Reunion Island is approximately 80 French francs (sometimes more than this, if a confirmatory test is automatically performed after a positive ELISA test). In many countries, however, at least one or a few offices are available where the HIV test is performed without any charge.

5) Why should a person know if he/she is seropositive?

Possible advantages of knowing someone's seropositivity state are:

a) to get access to health care at an early stage

b) to get access to appropriate treatment at an early stage

c) to take precautions during sexual intercourse not to pass the infection to the partner(s)

d) to evaluate carefully the risk of a pregnancy (risk of vertical transmission to the newborn)

6) Should regular testing be performed to be sure about one's serological state?

The ELISA test is sensitive, provided that it is performed not less than 6 weeks after exposure to a possible source of contamination. The test should thereafter be repeated only in case of eventual exposures. That is why it is so important to discuss about risks and prevention at the moment of the request or the offer of an HIV test.

7) Why some persons are scared by the offer of an HIV test?

Someone believes he/she can have a better life with the doubt of being seropositive than with its certainty. They need time to acquaint to the possibility of being seropositive. Trying to force them to make the test may cause the disruption of the trustful climate with the counsellor. Should they be forced to make the test, they would be likely not to come back to collect the result, or would not anyway accept a positive result.

At present, effective antiretroviral therapy does exist for subjects with symptomatic HIV infection or with low immune levels; hence, whenever antiretroviral therapy is actually available, we have a strong argument for the offer of an HIV test. In addition, case management and medical follow-up may be offered to those being positive to the HIV test.

8) What method is currently available to detect HIV infection in the newborn?

During the first 15 months of life, the seropositive state of the infant may be the result of the passage of maternal antibodies through the placenta during the gestational period; hence, the

detection of antibodies is not a suitable test for HIV infection in a newborn from an HIV infected mother. Alternative diagnostic tests include:

- the presence of clinical signs of AIDS
- the persistence of HIV antibodies after 15 months of age
- a positive HIV culture from peripheral lymphocytes (or a positive PCR test)

9) Why is it so important never to perform a screening test to a person without his/her knowing about it?

The scope of a screening test is to help decreasing the diffusion of the HIV in the population and to allow for an early care of HIV infected persons. Hence, when informing a person that he/she is seropositive you wish him/her:

- to avoid risky behaviours which may cause the passage of the infection to others
- to seek care at an early and still asymptomatic stage

When a person is informed about the HIV test he/she is going to have, it is reasonable to expect this person to have an attitude of confidence with the health care provider proposing the test. The favourable climate may therefore increase the capacity to accept a positive result of the HIV test and to take care of him/herself and the others. The offer of the test gives an important chance for discussion, which may greatly help initiating a process of behavioural changes if the test will result to be negative.

10) When to propose the HIV test?

The test should be offered to all persons having, or having had, risky behaviours: frequent change of partner, presenting with an STD, having commercial sex, being an intravenous drug user (IVDU), having an IVDU sexual partner, or having a partner from a country at high endemicity for HIV. It is not always easy to recognize all these conditions, and the health care provider needs to plan for appropriate time to discuss these issues with the client. Clients are often prevented from requesting a test by the fear of being judged.

Health care providers should think about offering the test while facing clinical conditions which may suggest a state of immune deficiency: pneumonia not responding to standard treatment in persons with a history of risky behaviours, tuberculosis, a herpes zoster infection, severe oral infections, etc.

11) What is a false positive result?

The HIV test is remarkably sensitive (it detects all infected persons if appropriate timing is respected). However, it may happen that a positive test is not later confirmed by a second test (confirmatory test). The person is not infected. This is a toll we have to pay to the great sensitivity of the screening tests.

Counselling as tertiary prevention for Sexually Transmitted Diseases

A. Definition

This type of counselling aims at preventing the psycho-social and affective consequences of HIV on infected persons and their relatives. The scope is to provide support throughout the sequential stages of the disease. It also aims at producing changes in the community towards the AIDS problem, in order to limit social exclusion and the relevant consequences.

B. Postulates

- Help the patient to exploit his/her own resources
- Respect the patients' schemes and timing to go through the different phases

- Never make judgements
- Establish an empathic climate
- Be flexible
- Help "here and now"

C. Relational skills

They include communication skills useful to interact with the patient:

- Physical listening
- Reformulation of messages and feelings
- Personalisation of objectives
- Peer dialogue, avoiding both "parent/child" and "saver/saved" types of relations
- Avoidance of a questioning approach
- Preparation of a positive and constructive atmosphere for both protagonists

D. The different stages

1. The initial crisis

The reactions face to the information that a person has HIV or AIDS are well defined and reproducible in a wide variety of cultural contexts, and are similar to those described by E. Kubler Ross for persons in the final stages of other incurable diseases.

1.1 The phase of the shock

It is the phase of awareness of having an incurable disease which affects the most intimate part of an individual. It is a shock because the problem involves the entire society with no racial or social limitations; because it affects persons in the reproductive age and the infants of infected mothers; because it obliges a person to think about oneself, own personal and social relations; because it revives the fear of death associated to that of sex.

The objective of counselling is to facilitate persons to regain self-confidence, despite emotional derangement and paralysis caused by the magnitude of the problem. The type and extent of the crisis may be defined by the person experiencing it only. The counsellor need to start from where the patient is at that moment and explore the crisis, without minimising it and without trivialising the feelings of those who play a role of a victim. The first priority of active listening will be not to deny, to respect the feelings, and to help rebuilding self-esteem and self-control. This implies that the counsellor should have thoughts about these problems in order to share considerations, and should be able to inform in a clear way to contribute to the re-elaboration process of the patient.

1.2. The phase of the denial

It is an unavoidable passage, "it is not me, it is somebody else !" Such a reaction is necessary to rebuild oneself. It is advisable to make the individual express his/her feelings, as the most these feelings are verbalised, the less negative actions will be taken. Often, during the phase of the denial, a person shows his/her feelings with an aggressive attitude.

The objective of counselling is to help the individual to explore the very intimate parts of oneself here and now, and to guide him/her in verbalising feelings and messages. The aim is to reach the third phase.

1.3. The phase of the response or the retreat

The individual is depressed and he/she talks of sadness and despair. The counsellor will need, once again, to help the individual expressing his/her feelings, to observe and confirm

the loss of control. The counsellor will then need to explore and assess the client's physical and psychological capacities to analyse his/her own situation.

1.4. The phase of the revolt

Anger is the characteristic reaction. The counsellor will allow the complete expression of such anger: "you are angry with the society.... with myself.....we both need to know what is going on..... what is threatening us". By reformulating and personalising the feeling of anger, the counsellor will help to take initiatives, which represents the next phase.

1.5. The phase of acceptance

The existence of the problem is admitted and accepted: now it is possible to start managing it. This represents the end of the phases of shock, denial and response. From now onwards it is possible to start counselling to take decisions and drive actions.

2. Solving problems

The objective is to understand the consequences of the HIV/AIDS on the real life of the individual, to establish and strengthen the capacity to face the problems associated to the risk of further transmission, and to facilitate behaviours intended to protect oneself.

The counsellor will have to demonstrate a real interest and never minimise any sort of problem raised by the counselled person. He/she will have to help examining the different aspects of problems, to talk openly of the fear of further transmission of the infection, and to explore any possible action personalised to the needs of the counselled person. The client is reassured that any reaction is normal and start building a programme of actions.

3. Taking decisions

The objectives are to:

- Help the individual to think about issues which are usually difficult and disturbing, and to help him/her in exploring changes in behaviours which may be required by the new situation.
- Recognize resource persons who may help in putting such changes into practice and establish a dialogue with persons who may have similar problems. Help the client communicating within the family and work environment, after having assessed whether this is feasible.
- Explore the consequences on usual and unusual sexual behaviour

4. Difficulties in behavioural changes

One of the scopes of counselling is to identify the difficulties of behavioural changes. The counsellor will often need to underline, repeatedly and in different ways, the factors preventing behavioural changes. Knowing something does not imply that relevant changes will be put into practice. Some individual may think that a fact is not relevant for his/her own situation, or may think against proposed changes (for example, proposing condom use may destroy the confidence in him/herself or the partner). Changes may sometimes be in contrast with cultural or religious beliefs. Behaviours are usually modified only if a real gain is perceived by the person who need to apply them.

5. Psychological support to patients receiving treatment

Providing support to patients receiving antiretroviral therapy is intended to improve adherence. Effective support requires regular updates in the field of available drug regimens (multi-drug regimens, early indication to treatment, adverse events of new compounds), their increasing efficacy (decrease in the number of notified AIDS cases, reduction in hospital admissions), and the

advances of behavioural science. Adherence is a more appropriate terminology than compliance, as it implies a direct involvement of the patient.

Adherence will depend on three factors:

The attitude of the health care provider: this is influenced by the availability of drugs, his/her specific knowledge, personal experience, communication skills (from the offer of HIV test to post test counselling and to the dialogue established with those being infected), costs, framework of treatment (clinical trials, research protocols, etc.), capacity to link with the patient and his/her general practitioner, capacity to appreciate and manage adverse events of therapy.

The drug: frequency and type of adverse events, number of pills, knowledge on the mode of action, length of therapy, costs, drug-drug interactions, specific contraindications (pregnant women and children, etc.)

The patient: age, gender, ethnicity, social status, medical history, time since knowing to be seropositive, clinical stage, comprehension of side effects, personal motivation or difficulties, perception of the importance of missing pills, insurance problems, existence of a supportive network, comprehension of the mode of action of drugs and the length of therapy, the desire and expectations to be cured and to maintain a "status quo-ante".

The three most important factors influencing adherence seem to be the length of therapy (the shorter the best); an optimistic attitude of the patient towards treatment (the patient feels to play an active role in his/her cure); adverse events (the deeper the initial explanation on the nature and frequency of adverse events, the best the adherence).

All the above factors will need to be taken into account at the time of each consultation: it is therefore easy to appreciate that consultations require time, and that availability of time is indeed the most important factor to allow the patient to participate actively in this process.

E. Answers to common questions

1. I am seropositive, I could never tell it to my wife (husband)

The burden of being seropositive is increased by the lack of communication and discussion with the partner, relatives and friends. By inviting the individual to express his/her feelings (fear, remorse, blame, etc.) the counsellor may facilitate the process of focusing on major problems and implications of the new situation on the day-to-day life. The confrontation with the partner is part of this process.

2. I am seropositive, I fell in love with somebody, do I have to talk about my condition?

It is easy to imagine how difficult it is to tell some body you love that you are infected by the HIV.

Will the person decide to stop seeing you?

Nevertheless, how continuing the relation with such a secret burden to carry?

How long will it take to the person to know the truth?

What is the future of such a couple?

The counsellor cannot as well ignore the risk that the client will infect the partner.

The most important thing in this difficult issue is that the client will feel that we share his/her problems. The attention and confidence the client may obtain from the counsellor will later facilitate his/her decision to take care of the well-being of the partner.

3. I am seropositive, but I don't use preventive measures with my partners

This person demonstrate a need to talk to somebody of his practices and, maybe, to test the reactions of the others. Solitude, tension and despair are the most common determinants and consequences of these practices.

The normal reaction of the counsellor is that of shock; often, the client has an aggressive attitude while presenting the problem, which may be interpreted as a complete lack of remorse.

However, if we start immediately talking about preserving the well-being of the partner(s) who may be contaminated, the client will have the impression that we don't care enough about his/her own well-being. We may risk that the client will continue his/her risky practices out of spite. The scope of counselling in this instance is to make the client aware of the suffering that surely motivate his/her behaviours.

4. Now that I know that I am seropositive, shall I tell to my sexual partners?

This issue is particularly problematic, especially if the counsellor do not know the partners. The partner may not only terminate the relation, but may also divulgate the information, worsening the isolation of the seropositive person. It is our responsibility to discuss this with the client, keeping in mind that our first task is to avoid him/her further suffering and isolation. If the client will decide not to tell the partner(s), the counsellor will need to encourage him/her to take all necessary precautions not to transmit the infection to others.

5. I have done the HIV test thrice, always with a negative result, but still I don't feel safe and I believe I have symptoms of AIDS.

The counsellor need to assess the magnitude of the HIV risk of the client's behaviours. Sometimes the risk is high, and the client may be referred to specialised services to repeat the screening.

Most of the times, however, the risk is minimum. The common situation is that of a person blaming him/herself for the behaviours which led to taking the HIV risk, usually an extramarital relation. The person is not able to forgive him/herself and awaits for the punishment, possibly under the form of HIV infection. The task of counselling is to make the person discuss about infidelity, the cause of his/her feeling of blame, in order to take consciousness that the HIV risk is unreal.

6. I fear dying

When a person fear dying, sometimes it is easier to discuss it with persons who are not so close and directly touched by the event, as a counsellor can be. It is surely difficult to listen to somebody talking about his/her death because it reminds us of our incapacity to help (there is nothing else to do that listening), but this is still an important contribution. It is certainly important to differentiate between a situation in which death is really unavoidable and that in which it is just feared of.

Seropositive persons have many years of healthy life to spend and the prognosis is constantly improving. Despite this, infected persons are right to think that this time is short. In addition, somebody will experience the infection as a death sentence as they will have to give up to many projects: marriage, children, career. Usually, with appropriate time, these persons will reconsider their projects and will adapt them to their new condition. It is important to offer the chance to cancel previous projects and start rebuilding new ones.

On the contrary, persons who are really in the proximity of their death, should not be deceived about the length of the remaining life. These persons often take advantage by having somebody to listen to them: life summary, regret for what they may have missed, fear of dying, life beyond death, etc.

7. I am seropositive, but I would like to have a baby

We need to consider that the risk of vertical transmission from an infected mother is around 20%, and can be reduced to less than 10% by the use of appropriate treatment in the mother and the

newborn. However, whether an individual newborn is actually infected or not may presently be assessed not earlier than the age of 15 months. Pregnancy may worsen the course of HIV infection, hence reducing the chances that the mother will be able to care for the infant and grow him up. Despite the lack of optimism of this picture, we can understand the desire of pregnancy of young women with HIV infection. It is important that these women can discuss their desire without feeling of being judged.

8. I had risky behaviours but I do not want to know whether I got the HIV infection

The expectation of being seropositive is unbearable to some persons: fear of being rejected, remorse, fear of the disease, of death, not to be loved any more, etc. These persons may feel incapable of standing a possible positive result of the HIV test.

However, some circumstances may stimulate these persons to solve the doubt (a new stable partner, for instance). Knowing about the HIV status would have the advantage of giving access to treatment and other health care standards at an earlier stage of infection.

9. I need to go to the hospital but I am afraid I will not get out of it

It is important to establish the basis of this fear. Why the person is being admitted to the hospital? Is it the first time he/she has the fear of dying while getting into the hospital? What are the physical conditions? What is the opinion of the doctors? Is the person confident of the medical team? Does he/she receive psychological support from the medical team? Does she/he feel like having less resources to fight the disease?

By posing some or all the above questions the person may be helped in identifying the real causes of his/her fear and increase the confidence of his/her own resources.

10. I am seropositive, I am going to commit suicide

By listening to these persons we may allow them to be aware of the specific reasons for which they believe that being seropositive is an unbearable condition. Is it discrimination? The fear not to be loved? The physical decline? The shame? The feeling of dependence? The feeling of injustice? The fear of dying?

It will be important to assess what the person did to avoid getting the infection and how he/she assessed he/she was actually infected. Sometimes, by a paradox effect, persons are attracted by what they fear most.

11. I am seropositive but I do not want to be cared for

It is somehow understandable that some person prefer to live a shorter but normal life rather than trying to live longer by behaving as a sick person for many years. It is important to advice this persons to consult a doctor at least once, to be explained in details what does the follow-up of an HIV positive person consist of. These persons will therefore be able to take an informed decision. We can also offer, in addition or as an alternative to medical follow-up, a psychological follow-up which may not be centred on the problem of HIV infection. We should always work to leave an open door to persons who initially decide they do not want to be cared for.