



Citation for published version:

Byrne, A, Watson, R, Butler, CA & Accoroni, A 2006, 'Increasing the confidence of nursing staff to address the sexual health needs of people living with HIV: The use of Motivational Interviewing', *Aids Care-Psychological and Socio-Medical Aspects of Aids/Hiv*, vol. 18, no. 5, pp. 501-504. <https://doi.org/10.1080/09540120500358985>

DOI:

[10.1080/09540120500358985](https://doi.org/10.1080/09540120500358985)

Publication date:

2006

Document Version

Peer reviewed version

[Link to publication](#)

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Abstract

The need to promote safer sexual behaviour has taken on new urgency in the UK because of large increases in the number of sexually transmitted infections (STIs). The sexual health needs of people living with HIV and AIDS (PLHA) also require attention as part of health promotion efforts. Many sexual health clinics are however struggling with high demand and limited resources. Within this context, this paper describes an innovative attempt at STI prevention with PLHA. Specifically, nursing staff were trained in the use of motivational interviewing to address sexual health issues and safer sexual behaviour in PLHA. We describe the training package and the impact upon participants. We conclude that by providing a positive training experience, front-line health staff that see the highest volume of PLHA with repeat STIs, can be assisted in developing their skills and confidence in prevention work with clients.

Introduction

The Stages of Change Model (Prochaska & DiClemente, 1982) is one of the most influential theories of behaviour change and is recognized as effective in HIV prevention (e.g. Baker & Dixon, 1991). This model is central to Motivational Interviewing (MI), a client-centred brief psychological intervention, developed by Miller and Rollnick (1991, 2002). MI is a counselling technique aimed at addressing, in a non-confrontational manner, sensitive and potentially difficult issues about personal health-related behaviours. In the context of the continued increase in the rate of new sexually transmitted infections (STIs) in the UK (Health Protection Agency, 2003), there is also a parallel increase in STIs for people living with HIV and AIDS (PLHA) (Health Protection Agency, 2003). Amongst the acknowledged goals of Behaviour Change Communication (BCC) for HIV/AIDS are 'increasing the adoption and continued use of safer sex practices' and 'promoting visits to clinics treating STIs...' (Family Health International, 2001). Health professionals have therefore a central role in facilitating this process and enabling sexual behaviour change. However, the authors have encountered many health professionals expressing concern about their relative lack of confidence and skills in addressing sexual health issues with PLHA. This may partly reflect fears that health promotion efforts may inadvertently

increase stigma and blame in an already stigmatized group.

Increasing health professionals' confidence and skills in trying to achieve the BCC goals discussed above requires targeted training in this area. MI has already demonstrated efficacy in other settings, such as drug and alcohol services (e.g. Bien et al., 1993; Saunders et al., 1995). However, there have been few published studies on the use of MI in sexual health settings, although Harding et al. (2001) demonstrated the utility of training volunteers in MI as part of a risk-reduction intervention in commercial and public sex settings. One of the advantages offered by MI compared to other counselling techniques is that its theory and techniques are expressly formulated so that they can be easily taught to health workers with no prior specific training in psychology or counselling (Rollnik & Bell, 1991). The current project came about in the context of a service strategy to address the sexual health needs of PLHA (that also included the establishment of a nurse consultant-led clinic), when nursing staff of an inner-London HIV clinic approached the authors to request training.

The authors are clinical psychologists working within central London HIV/sexual health services. In common with other clinics, services are over-subscribed in both the HIV-positive and negative populations. A significant proportion of people attend clinics with repeat STIs. While individual

clinical psychology sessions are available to address STI prevention, there is limited capacity and a high number of people referred for psychological interventions aimed at health behaviour change do not attend. It is the 'front line' health staff therefore who see the highest proportion of PLHA attending with STIs. In discussions with nursing staff in the HIV clinic they identified a general lack of confidence as a barrier to raising sensitive sexual health issues with PLHA. In particular, they cited concerns that raising sensitive issues with clients about their sexual behaviour might lead to confrontation or superficial acquiescence.

This paper describes the process of training front line nursing staff in MI and examines the usefulness and some of the challenges of this training.

Procedure

Participants

The participants were ten nursing staff of the HIV clinic of different grades and levels of experience in working with PLHA. The gender split within the staff team was 50:50 male to female.

The training

There were three phases to the training: an initial consultation; the training package itself; and a follow-up. The authors met with nursing staff to identify specific training needs, and (just as importantly) identify existing areas of strength that could be reinforced. The training package developed as a result of this consultation. The workshop included Models of Behaviour Change (Prochaska & DiClemente, 1982), MI, and basic counselling skills. Teaching methods comprised didactic teaching, group work and role play. The latter focused on clinical situations that staff identified as both common and challenging (e.g. a client who is well informed about risk but repeatedly attends with STIs). The initial training package was delivered in one morning on a day when the clinic was routinely closed for staff meetings. Six months later there was a follow-up session, to consider challenges, successes and troubleshooting.

Evaluation

A brief self-administered questionnaire was completed immediately before and after the training session. This contained four items that participants were required to rate as to their level of agreement, using a six point scale where 1 = 'do not agree at all' and 6 = 'completely agree'. Items related to knowledge and confidence in using MI, as well as knowledge and confidence in addressing sexual

health issues generally. Qualitative feedback was also collected immediately after the training session. A follow-up meeting took place six months post training; the self-administered questionnaire was repeated, and further qualitative feedback collected.

Results

Table I gives mean ratings pre-, post- and at six-month follow-up. The greatest impact of the training was in increasing participants' knowledge of, and confidence applying, MI. These increases were largely unchanged at six-month follow-up. Training appeared to reinforce the nurses' sense of self-efficacy in working with PLHA about their sexual risk behaviour, which was one of the aims of the intervention. This was apparent in that there was only a modest increase in numbers in this already positive trend.

Qualitative feedback about what staff found useful suggested a shift in the way they viewed the process of behaviour change. One participant said, 'I learnt that change comes from the person and is not just about throwing information at people'. Another remarked that it was useful to 'know that people may decide not to change'. Other feedback suggested that participants had learnt new ways of having conversations about behaviour change with clients. One participant said they had: 'Learnt how to get people to think about their behaviour by weighing up the pros and cons of behaviour change'. This is one of the major tenets of MI, and is seen by Miller and Rollnick (1991, 2002) as one of the main pre-requisites for health behaviour change.

Reports from both the nurse team leader and nurse consultant at the six-month follow-up meeting indicated gains made from the training day continued to accrue. Nursing staff were observed to be more comfortable discussing issues of sexual risk with clients and there was also increased documentation of these discussions in the medical notes. They had also independently organized their own training sessions and had begun using video tapes,

Table I.

| Item | Pre | Post | Follow-up |
|---|-----|------|-----------|
| I am confident in my ability to work with PLHA on issues of sexual risk behaviour | 4.1 | 4.5 | 4.8 |
| I possess the skills to work with PLHA on issues of sexual risk behaviour | 4.2 | 4.6 | 5 |
| I possess knowledge of MI | 3.3 | 4.5 | 4.2 |
| I am confident in using MI techniques in my work | 3.2 | 4.4 | 4.6 |

taken during their consultations, to focus on their interviewing style with patients. The authors joined the nursing team in viewing some of these tapes and providing feedback to staff.

Discussion

Front-line health staff working in HIV/sexual health clinics see high numbers of patients. Many of these will have engaged in recent sexual risk behaviour. In MI terms, a successful intervention should raise levels of cognitive dissonance (i.e. an individual's appraisal of the pros and cons of change) in attendees within a relatively narrow window of opportunity, without entrenching people's position in respect of the target behaviour. Our study highlights the benefits of integrating optimal sexual health care with MI, a well-established counselling technique, aimed at changing (sexual) health behaviours. This can be achieved by offering training, feedback and supervision within the framework of MI as well as basic counselling skills. These skills in addressing sexual behaviour change – we argue – are easily transferable across the often present divide between Genito-Urinary Medicine (often focusing exclusively on HIV negative populations affected by STIs) and HIV clinics focusing primarily on PLHA.

The relationship between increased staff confidence and patients' sexual behaviour change was not investigated in this study. Therefore, a positive correlation cannot be assumed, considering the manifold factors at play in any behavioural change, and sexual behaviour change in particular (e.g. use of drugs and alcohol, assertiveness skills, relative power of the participants in a sexual interaction, etc.). However, a number of positive outcomes were identified.

The nursing staff who participated in this study experienced MI as a useful and constructive approach in discussing sexual health issues and risk behaviour with PLHA. Participants reported increased knowledge and confidence in addressing these issues with their clients, and being able to recognize their more successful interventions and ways of discussing these topics with patients. As a significant result of this increased awareness, there was increased documentation of conversations about sexual health issues and sexual risk behaviour with PLHA in medical notes. The training led nurses to be more aware of the dynamics in individuals' health behaviour change, and facilitated viewing this, and sexual risk behaviour, as resulting from PLHA active individual and interpersonal negotiations, rather than a lack of information, or negative constructions, such as irresponsible or careless conduct.

The training led to further requests for training on sexual health issues using MI, and increased uptake

of such training. These outcomes suggest that front-line health staff, who are most likely to come into contact with people at risk of sexually transmitted infections (STIs), can be trained in a short space of time to engage in discussions with their patients regarding STI prevention using MI.

The positive emphasis of the training in highlighting sexual health staff's areas of effective communication and the non-threatening, co-operative stance adopted by the authors, appeared to have been particularly successful. Staff approached the authors for further training on MI and discussed openly the difficulties they experienced in their work. This shows the importance of providing a positive training experience so that training is regarded as valuable, rather than threatening, a dynamic that can be present when one set of professionals 'trains' another allied profession. The present authors found it essential to discover, acknowledge, and positively connote what medical/health staff were already doing well in terms of their communication and negotiating skills with PLHA regarding STIs, and increase their awareness of their competence and effectiveness. However, further investigations are needed to elucidate the impact of this type of training on the quality of conversations frontline nursing staff have with PLHA.

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