INTRODUCTION

It is clear that when people learn that they are HIV positive, this knowledge can have profound effects in all areas of their lives and that how one reacts to an HIV diagnosis is affected by many factors. The purpose of this chapter is to review available research on the effects that an HIV diagnosis has on the sexual risk behaviors that may have led to infection. Although many cross-sectional and longitudinal studies have demonstrated that a substantial proportion of HIV infected individuals engage in high-risk sexual practices with HIV-negative or unknown serostatus partners (e.g., Crepaz and Marks, 2002; Kalichman, 2000), relatively little information is available on how notification of an HIV diagnosis affects sexual risk behavior or the extent to which these behaviors are prevalent among those newly infected with HIV.

In 1999, a meta-analysis of the effects of HIV testing and counseling on sexual risk behavior found that persons who tested HIV-negative did not change their risk behavior compared to persons who were not tested (Weinhardt et al., 1999). This result was at odds with two hypotheses being discussed at the time: (a) A negative test result leads to increased risk behavior because it reinforces previous risky behavior; and (b) participating in HIV-counseling and testing, even with a negative test result, results in decreased risk behavior in response to the risk reduction counseling or other characteristics of the testing experience. In contrast, we found that people who tested HIV-positive, either alone or with a partner, significantly reduced their sexual risk behavior compared to HIV-negative and untested individuals. These results implied that HIV counseling and testing was not
a particularly effective primary prevention strategy, but that an HIV positive diagnosis, at least when coupled with test counseling, does lead to reductions in sexual risk behavior. However, there have been several significant developments since the publication of this meta-analysis, which included only studies published between 1985 and 1997.

First, a major study of the effects of HIV test counseling (Kamb et al., 1998) demonstrated that brief, theory-based test pre and post-test counseling can have a meaningful impact on sexual risk behavior and associated sexually transmitted infections. Project RESPECT (Kamb et al.) enrolled HIV negative participants only and compared HIV risk reduction counseling models of different length. This study indicated that a brief two-session pre and post test counseling model was as effective as a four session intervention. If the Project RESPECT/CDC model of HIV test counseling were disseminated and adopted by service providers, it is likely that many people testing HIV-negative who received this counseling would likely reduce risk behaviors. Second, in 1996, effective treatments for HIV infection were introduced for the first time. The development of highly active antiretroviral treatment (HAART) fundamentally changed the nature of what it means to be HIV positive (at least in communities with access to effective treatments). As people with HIV began to live longer and healthier lives, many people aware of their HIV diagnosis regained their health and resumed sexual activity, of course whether or not this sexual activity constitutes an HIV transmission risk depends on whether condoms are used, the HIV status of the sex partner, etc. Thus, data from studies conducted before HAART and before Project RESPECT may not be generalizable to people who test HIV positive or negative today.

Another relevant development is the recent change in HIV testing procedures. Rapid tests, which provide initial results in 20 minutes, have been in wide use in many countries for years and are now becoming standard in the US. An even more convenient test that provides rapid results from a saliva sample received FDA approval in March 2004. The shift to a rapid test model necessitates an adapted counseling strategy, and the CDC has responded with a model that de-emphasizes pre-test counseling and risk reduction counseling with people who test negative in order to reduce barriers to providing testing to large numbers of people in routine care.

Counseling resources are instead shifted toward working with those who test positive, which is presumably a more cost-effective and direct way to prevent further infections. Even a short term reduction in HIV transmission risk behavior following HIV infection may have large effects on the course of the epidemic. If risk behaviors with uninfected individuals are high at a time when viral load is high, a substantial proportion of new infections could result. Reduction of risk behavior during this period of