Integration of the Interaction Model of Client Health Behavior and Transactional Model of Stress and Coping as a Tool for Understanding Retention in HIV Care Across the Lifespan

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Retaining people living with HIV (PLWH) in care over the lifespan is critical to quality and longevity of life. Individual health behavior decisions that affect care retention are complicated and multifactorial. Current health behavior theories are inadequate in isolation to guide retention in care research. Two existing models, Cox's Interaction Model of Client Health Behavior, and Lazarus and Folkman's Transactional Model of Stress and Coping have both guided research with PLWH, although not related to retention in care. Integration of these models may more comprehensively inform care retention research and practice across the lifespan as it incorporates not only intra- and inter-personal characteristics and relationships but also the stress and coping experiences inevitable when living with a chronic illness such as HIV.

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As people living with HIV (PLWH) live longer, retention in health care over time becomes critical to the quality and longevity of life. A recent study found that patients who missed medical visits had a more than two-fold increase in mortality compared with patients who kept appointments (n = 543; Mugavero et al., 2009), but most PLWH are not retained in care. When the continuum of HIV care was analyzed for the entire population of PLWH in the United States (N = 1,106,400), only 39% maintained regular medical care; just 19% of PLWH achieved viral suppression (Gardner, McLees, Steiner, del Rio, & Burman, 2011). This has implications for general public health, as patients on HIV medications are much less likely to transmit their virus (Cohen et al., 2011). Because of this, the National HIV/AIDS Strategy has made care retention to improve health outcomes for PLWH a national priority (White House Office of National AIDS Policy, 2010).

Nursing's metaparadigm, the overarching discipline-specific focus on the relationships between and among person, health, nurse, and environment (Fawcett, 1984), supports nurses as instrumental to the team of professionals intervening to retain PLWH in care. Even before interventions can be tried and tested, however, more needs to be known about the characteristics and circumstances of PLWH and their relationships with others that keep them in care. Individual health behavior

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decisions that affect health outcomes are complicated and multifactorial. As a result, theories to guide this work must not only focus on the complexity of each individual, but also on processes and other relationships, including the patient–provider relationships, that affect these decisions over the lifespan. Few health behavior theories incorporate the patient–provider interaction, and limited literature exists on successful interventions to improve retention in care, particularly related to care providers' roles in fostering better retention (Higa, Marks, Crepaz, Liau, & Lyles, 2012).

Additionally, being diagnosed with HIV is a life-changing event that requires daily medication, regular interaction with health care, and all the associated skills required to manage a chronic illness. Ironically, the stress of managing this diagnosis may promote the progression of HIV in a disease that already attacks the immune system (Leserman, 2008). As such, incorporation of theoretical constructs into research that focuses on stress and coping is essential. However, no one model has comprehensively described the complexity of individual and patient–provider characteristics in the context of stress and coping on health behavior and outcomes. Fortunately, two separate models, the Interaction Model of Client Health Behavior (IMCHB; Cox, 1982) and the Transactional Model of Stress and Coping (TMSC; Lazarus & Folkman, 1984, as cited in Glanz & Schwartz, 2008), in synthesis provide a comprehensive framework to guide retention in HIV care over the lifespan. Linking theories across disciplinary lines supports an interdisciplinary approach to care retention. It also combines redundant constructs, addressing the problem of different disciplines, using dissimilar words to express similar ideas (Larsen, Voronovich, Cook, & Pedro, 2013).

The Interaction Model of Client Health Behavior

The IMCHB is a nursing model designed to explain the multifaceted interactions of individual health promoting or suppressing characteristics. These characteristics, when coupled with provider interactions, affect health outcomes (Cox, 1982). Cox's model was heavily influenced by health behavior theories originating from the fields of sociology and cognitive psychology. Nurse scientists support the use of the IMCHB as a "broad framework for complex behaviors to investigate how various antecedents predict behavioral outcomes" (Carter & Kulbok, 1995, p. 68).

The three main concepts—client singularity, client–professional interaction, and health outcomes—are distinctly defined and consistently used across a variety of studies spanning nearly 30 years (Ackerson, 2011; Cox, 1982; 2003; Cox, Miller, & Mull, 1987; Cox et al., 2009; Cox & Roghmann, 1984; Robinson & Thomas, 2004). However, there are no published studies using the IMCHB to guide research on retention in HIV care and health outcomes. The only IMCHB study related to HIV focused narrowly on condom use and sexual risk behavior (Abel & Chambers, 2004).

Client singularity is the assemblage of generally static background variables and more modifiable dynamic variables. Background variables include demographic characteristics, social influences, previous health experiences, and environmental resources (financial, informational, or geographical influences on health behavior). Dynamic variables include a client's emotional reaction to a health situation (cognitive affect), motivation, and attitudes, knowledge, or beliefs about health (cognitive appraisal; Cox, 2003). An essential view of this model is the undeniable uniqueness and complexity of every person.

The essence of the client–professional interaction is the extent to which a provider attends and listens to each client or patient as a unique individual. Cox (1982) believed this relationship was essential in influencing health outcomes. Nurses, in particular, were the professionals or providers to whom Cox referred, but the model is applicable to other health care professionals. Cox described the client–professional interaction as nonrecursive, with the dynamic components of client singularity, meaning there is a reciprocal relationship between the elements of the client–professional interaction and the dynamic components of client singularity. Four sub-concepts define the client–professional interaction: affective support, provision of health information, decisional control, and professional or technical competence

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