HIV Prevention and the Changing Role of the HIV Counselor

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HIV prevention has always been the most important part of the work of HIV counselors. In an effort to refine this process, counselor training is focusing even more than it has on building risk assessment and prevention intervention skills.

Client-centered counseling is at the crux of an effective prevention approach, while obstacles like lack of time and a counselor’s discomfort discussing sexuality are at odds with it. This article will explore client-centered prevention counseling and will suggest how counselors can examine personal limitations that may interfere with this work. It will also present questions for further thought and discussion.

Prevention and HIV Counseling

Information dissemination focusing on how HIV is transmitted has been the most common prevention approach used by mass media campaigns, teaching curricula, and outreach efforts to the general public. For most people, however, particularly for those at highest risk for infection, information alone is not enough to change HIV-related risk behavior.

Prevention efforts must help people integrate HIV-related risk information, understand their own motivations for changing risky behaviors, and take action to prevent HIV transmission. This is where HIV counselors, through one-on-one counseling, can have an especially significant influence. Prevention counseling requires that counselors: listen actively; explore both the behaviors that pose a direct risk for HIV infection and the contextual factors that surround and support a person in taking risks; assess where clients are on the continuum of behavior change; explore steps that clients can take in the behavior change process; and support clients in making or sustaining change.

To obtain the information needed for assessment and intervention, counselors must be willing to ask personal questions about their clients’ lives. It is necessary to discuss topics such as sex, drug use and addiction, illness, death, poverty, physical abuse, rage, and grief in order to assess risk behaviors and contextual factors that may prevent them from making behavior changes.

Research shows that counselors can promote behavior change by identifying the ways in which clients put themselves at risk and the personal factors related to these behaviors, followed by presenting appropriate interventions. Mismatched interventions can inhibit change. Research on behavior change has also found that people who have help in progressing from one stage of behavior change to the next—for instance, from the stage of contemplating change to preparing for it—are twice as likely to make successful changes on their own in the future.

Client-Centered Counseling

To reflect a heightened emphasis on HIV prevention, counselor training in California has changed dramatically in the past year. The Enhanced Risk Assessment (ERA) training, which was revised this year, is now a requirement for all counselors. The two-day ERA (called the “Basic II training”) stresses a “client-centered” counseling approach. Client-centered counseling emphasizes counselor neutrality and individualized sessions organized to assess the HIV-related and contextual risk factors of each client.

Contextual issues include cultural, economic, social, psychological, or other health-related concerns that could lead to risk behaviors. For example, a client may present with HIV-related risk apparently directly related to unsafe sex, but the counselor may discover on further exploration that contextual issues such as alcohol use and survivor guilt contribute to this risk. The counselor in this scenario may determine that while the client has the information necessary to engage in safer sex, he or she may benefit from an intervention that helps make the connection between alcohol use and HIV-related risk behaviors.

Counselors must prioritize clients’ concerns, address the one or two that are most critical, and then intervene. Counselors must then determine the appropriate referrals and link clients to them. In the example above, the counselor may determine that the client would benefit from being linked to a support group, individual counseling, or alcohol-specific counseling or treatment. Throughout the session, counselors can measure clients’ willingness to address behavior changes and explore where clients are in the process of making changes. For instance, counselors can determine whether clients are even thinking about change: actively contemplating it; considering it but not ready to act; ready for action; or in an ongoing period of maintaining changed behavior.

Obstacles to Prevention Counseling

Counselors face several obstacles to performing effective prevention counseling. These include time, personal resistance on the part of counselors, and the inability or unwillingness of clients to view counseling sessions as having a role in HIV prevention. In responding to these obstacles, it is useful for counselors to set realistic expectations for their work, to view change as an incremental process, and to see the counseling role as one of facilitating change.

Time appears to be a fundamental obstacle. Standards of practice developed by the state’s Office of AIDS and included in its contractual language with test sites require that counselors take at least 20 minutes for each risk assessment session, at least 15 minutes for disclosing a negative result, and at least 30 minutes for disclosing a positive result. One study, however, found that some sessions last no more than three minutes.

In addition, time is often perceived as money, especially when HIV-related funding is limited. In particular, some programs are dependent upon volume to survive, and some program administrators feel that the financial pressures they ascribe to current “per-test/per-session” reimbursement methods leave them no alternative but to take shortcuts, often by abbreviating counseling.
FOCUS On HIV Antibody Test Counseling

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FOCUS On HIV Antibody Test Counseling is a quarterly supplement to FOCUS: A Guide to AIDS Research and Counseling, both published by the AIDS Health Project, which is affiliated with the University of California, San Francisco.

The Supplement is published under a grant from the California Department of Health Services, Office of AIDS, and is distributed to HIV antibody test sites. Permission to reprint any part of the Supplement is granted, provided acknowledgement of FOCUS and the California Department of Health Services is included. FOCUS itself is copyrighted by the UC Regents, which reserves all rights.

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A sense of scarcity regarding both time and money can lend support to the notion that counseling sessions are merely data collection pre-test interviews, rather than powerful tools for assessing risk and preventing infection. It is important for counselors to recognize the potentially missed opportunities of abbreviated sessions and to identify what causes them to end sessions prematurely. It is especially important to realize that despite this sense of scarcity, when the counseling session is used most efficiently, it is possible to cover a great deal of ground in a short period of time.

Counselors may resist prevention counseling for several reasons: personal discomfort with what they see as a change in their role away from a focus on HIV screening; lack of skill or perceived lack of skill to implement a client-centered approach; or biases that make counselors afraid of learning personal information about clients. Some HIV counselors remain skeptical that sessions can be critical to positive change. While they may feel able to identify clients’ primary HIV infection risks, counselors may feel ill-equipped or uncomfortable assessing secondary or contextual risk factors. By recognizing their resistance, counselors will be better able to respond to it in counseling sessions and assess the personal basis of their concerns.

For example, while counselors may legitimately fear that probing for personal information may seem intrusive to some clients, they can anticipate this and appropriately frame discussions in ways that minimize the sense that there has been an invasion of privacy. The counselors could begin a session by stating that in order to best assist the client in assessing risks and making necessary changes, he or she will need to answer personal questions. If, in the process of discussing sexual behavior, the counselor senses that the client is uncomfortable with the specificity of questions, it might also be useful to validate and explore the client’s feelings about answering such personal questions.

Counselors may feel uncomfortable or believe they are making judgments or accusations when asking specific questions about partners or behaviors. This might happen when counselors ask clients: “Do you have sex with men, women or both?” or when they ask male and female clients, regardless of sexual orientation: “Do you engage in anal sex?” A situation is not judgmental if a counselor asks a question from a neutral stance to better help the client in the behavior change process. Personal questions about behavior merely acknowledge possibilities and provide room for clients to answer.

When counselors feel uncomfortable asking a question, it is important for them to look at their own beliefs. Any reason a counselor may have for not asking a question should relate to a client’s presentation and disclosures, not to a counselor’s reluctance. Counselors should explore their own values in supervision or consultation in order to eliminate obstacles to talking about sensitive topics.

Counselors may be challenged in prevention counseling efforts by clients’ perceptions about the process. These perceptions may be shaped by misinformation or previous experience with counseling and testing. Counselors must clarify the purpose of the counseling session. This is best accomplished at the time when clients first inquire about testing. Staff involved in setting appointments for clients can explain by telephone or in person that clients should expect to spend about 20 minutes with a counselor discussing HIV-related risks and other pertinent topics. Counselors must be able to communicate to clients that this program is, in fact, a counseling and testing program.

Next Steps

Changes that reflect a heightened emphasis on HIV prevention raise a variety of questions about ensuring the effectiveness and quality of counseling and testing programs. As planners evaluate publicly funded programs, it is important to ask in what ways the activities of a particular testing site are consistent with the public health mandate. If the California model for HIV counseling—with an emphasis on prevention—assists HIV counselors in meeting that mandate, how will sites be evaluated for future support if they fail to fully implement this approach?

As counselors become more skilled at conducting client-centered sessions, it is important that they be supported in their work at their counseling and testing sites. Who will ensure that this occurs? Given programmatic constraints and, in some instances, administrative conflict, is this prevention counseling model a good idea that has no practical application? For counseling to be most effective, should there be minimum qualifications for or certification of HIV counselors as there are for some other health care practitioners? Should there be required college-level counseling courses or other training beyond the state-sponsored Basic I and II trainings?

As these questions arise, it is important to acknowledge that the potential effectiveness of prevention counseling is not clear. Different studies suggest different outcomes. Those who would eliminate counseling suggest that studies have not proven the efficacy of antibody counseling and testing in leading to prevention, while proponents argue that the testing venue is an ideal place for prevention interventions.

In order to assess this, HIV counselors in California’s counseling and testing programs must recommit themselves; those already doing client-centered behavior change counseling must continue to do so and make the most of what is a brief opportunity with each client. Those not yet convinced of its benefits must attain the experience and skill that will demonstrate to them that their work can and will make a difference.

References


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