How do single-session counseling and standard counseling differ?

A. Standard counseling and testing is a two-step process; rapid testing is a one-step process, a single session. The first session of standard counseling is a risk assessment. If the client decides to be tested, the counselor confirms informed consent and a sample of blood is collected and sent to a lab for testing. One to two weeks later, the client can return for the results.

In single-session counseling, counselors verify the client’s desire to test, confirm informed consent, and collect a sample. The test develops during the risk assessment, which lasts at least 20 minutes. When the result is ready, the counselor retrieves it and returns to the client for disclosure counseling.

Note that the counseling that accompanies rapid testing is called single-session counseling to emphasize that rapid testing does not mean “rapid counseling.” Many counselors and clients report that single-session counseling encourages longer sessions and creates a greater intimacy between counselor and client. The urgency of the impending result enhances the connection between counselor and client.

The advent of single-session counseling has enhanced standard counseling and testing in two ways. First, counselors focus on the client’s most recent, compelling risk incident, the event that motivated the client to test. Counselors explore the context of the event in detail, allowing the client to tell his or her story. This story forms the foundation of the risk assessment, enabling clients to enhance their perception of risk by recalling exactly what motivated their behavior. The counselor can then explore behavior change informed by the client’s realistic recollection of the context of the HIV risk.

Second, as is apparent from California’s new Counselor Information Form (CIF), goals and long-term plans have been replaced with incremental, realistic steps. This change—now used in both single-session and standard counseling—encourages counselors and clients to limit their exploration to a single, realistic, and manageable step the client is motivated to take.

How do clients feel about single-session counseling and testing?

A. Single-session counseling has been well-received in California. The Office of AIDS surveyed clients at selected HIV test sites throughout California during the pilot phase of the single-session counseling program. Of the 1,089 clients who were offered rapid HIV testing, 1,048 (96 percent) accepted.

Of those who received a rapid test, 95 percent said they would prefer a rapid test the next time they tested, and 99.5 percent said they would recommend rapid testing to a friend. Less than 1 percent said they preferred coming back a different day for results.

For clients who had experienced both standard and rapid testing, only 5 percent reported feeling more anxious during rapid testing than during standard testing. During single-session counseling, the majority of clients felt more connected to their counselors (65 percent) and more focused while talking about HIV risk (55 percent) than they had during standard counseling.

Of the 41 clients who declined to take a rapid test, 11 (1 percent of the whole sample of 1,089) did not want same-day results; two (0.2 percent) did not want a finger stick; five (0.5 percent) had concerns about accuracy; 12 (1 percent) did not have enough time; and 11 (1 percent) reported some other reason.
3. How do counselors feel about single-session counseling and testing?

A. A small survey of 15 counselors from the initial group of California agencies performing single-session counseling found that while counselors had some concerns, they generally felt positive about the process and what it offered clients. Counselors reported that single-session counseling increased clients’ perceptions of HIV risk; that counselors were able to establish better rapport with clients because sessions were more focused; and that the time counselors were able to spend on risk assessment was actually longer than it had been. (There had been fears that single-session counseling might lead to shorter, and therefore less effective, risk assessments.)

Being able to follow the session through to disclosure gave some counselors a greater sense of closure. This especially pleased counselors working with populations such as homeless youth who are less likely than others to return for standard test results.

Chief among the few concerns counselors had about single-session counseling was giving preliminary positive results, particularly when these results were unexpected by both counselor and client. In such cases, counselors reported a great deal of stress. In standard counseling, counselors generally have time to prepare themselves to disclose and to provide referrals for an HIV-positive result. In single-session counseling, the counselor delivers a preliminary positive result shortly after he or she learns the result. (As described in the answer to Question 5, since all HIV-positive antibody tests need to be confirmed by a different test, a “reactive” result on a rapid test is considered “preliminary” until it can be confirmed through laboratory testing.)

In addition, a few counselors described clients who came to single-session counseling with anxiety levels so high it was difficult for these clients to focus on the session. Counselors also reported that for clients with low levels of HIV risk, it could be difficult to sustain the session for a full 20 minutes. In such cases, the key goal of the session—assessing and responding to risk—may seem to be completed before the test result is ready.

4. How do I counsel clients with little or no HIV risk?

A. While it serves public health goals to target clients at highest risk, a counselor need not keep a low- or no-risk client from testing. Yet, low- and no-risk clients pose two challenges to counselors: sustaining the risk assessment for 20 minutes and determining the goals for this type of session. The time challenge seems the most pressing, but its resolution actually follows the setting of goals. There are three goals in these sessions. First, it is important to confirm that a client actually has minimal risks. Remember that clients may hesitate to disclose their true concerns about HIV infection and risk-related behaviors.

Once it is clear that a client has minimal risks, it is important to understand why the client has come in. Ask the client what he or she knows about HIV transmission and provide basic information if necessary. Correct misinformation, whether it be about HIV transmission, itself, or about the need for frequent HIV counseling and testing. For example, it is useful for counselors to inform clients that if they have little to no risk for HIV infection, they do not need to return for periodic testing.

Finally, it is important to communicate to clients with minimal risk that they need not come in for testing unless they engage in a behavior that can transmit HIV. For example:

Counselor: From what you’ve shared with me, I don’t see a way that HIV could get into your body. At the same time, I can see you’ve been very concerned.

Client: Well, I’ve always been told I should come in every six months, just to be sure.

Counselor: That makes a lot of sense. You’ve been trying to take care of yourself by following that recommendation.

Client: Well, yeah.

Counselor: I want you to know something. You don’t have to test unless you receive someone else’s fluids into your body. You know better than anyone if that’s something that could have happened.

Client: Yes. I can still get my result today, right?

Counselor: Yes, of course. We still have a few minutes until it’s ready. While we wait, if you’re interested, I’m really curious what it’s been like for you to feel like you have to come in every six months.

In this scenario, the counselor acknowledged that the client seems not to have an HIV risk, sought clarity about the client’s motivation for coming to test, and conveyed that the client does not have to test unless there is an HIV risk. The counselor then opened the discussion to explore broader contextual issues that might affect this client’s HIV-related concerns.

Be aware that a client with minimal risk may be coming in for testing for reasons other HIV risk. Such clients may benefit from referrals to other services, for example, for mental health or substance use treatment.

5. I’m confused: what is a “preliminary positive” result?

A. The OraQuick Rapid HIV Test screens a drop of blood for the presence of HIV antibodies. As with other screening tests (like the enzyme-linked immunosorbent assay [ELISA]), a “nonreactive” (HIV-negative) result does not require confirmation. However, a “reactive” result needs to be confirmed with a supplemental test (most often the Western Blot). In standard counseling and testing, a reactive ELISA screening test is always confirmed with a supplemental test before the lab returns an HIV-positive result to a test site and before a counselor discloses that result to the client.

In single session counseling, a reactive rapid test result is disclosed to the client as a “preliminary positive.” The OraQuick test is at least as accurate as the standard ELISA. In other words,
a client who receives a preliminary positive result is highly likely to be infected with HIV. However, it is not possible to confirm the result and state that it is definitely HIV-positive without collecting a second sample and sending it to a lab for a confirmatory test. Almost all clients in the state who have been tested using the rapid test and who received a preliminary positive result consented to a second sample and returned for confirmatory results.

In 2003, more than 600 clients tested HIV-positive at Office of AIDS test sites but did not return for results. This new technology gives such clients, who otherwise would not learn they are HIV-positive, easy access to crucial results. Knowledge of HIV status can lead to earlier access to appropriate treatment and support, improved care for people with HIV, and increased likelihood that both HIV-positive and HIV-negative people reduce transmission risk.

**As a counselor, how can I manage the complexity of disclosing a preliminary positive result?**

A. Seek ways to prepare both yourself and your clients for any test result. Discuss the possibility of both preliminary positive and HIV-negative results with every client. Keep in mind that even an HIV-negative result can be surprising to a client and challenging to disclose. When a test result is a preliminary positive, take a moment to ground yourself before talking to the client. Focus on keeping your voice, facial gestures, and body posture neutral and relaxed. Remind yourself that this information, however surprising or distressing, will ultimately benefit the client and that clients test because they want to know.

After you disclose the result and the client leaves, take time for yourself. Many agencies have recognized that the increased intimacy and intensity of single-session counseling requires increased support and care for counselors. If possible, take a break after giving a preliminary positive result. Talk with a colleague—or your supervisor—about the session and your feelings.

**How can I help clients manage anxiety when the result is only 20 minutes away?**

A. One way to work with anxiety is to name it. Let the client know what you see by reflecting the feelings your client is expressing. This can help to validate the client’s feelings.

Further, let the client know that anxiety is a normal response to the process of HIV testing and of waiting for results. Follow the client’s lead and explore what the client thinks is the root of the anxiety. Specifically ask about the most recent, compelling risk incident about which the client is concerned. Ground the session by asking the client to tell you the story regarding the incident. If this elevates the client’s anxiety or does not help focus the session, follow the client’s lead by exploring possible test results and how they would impact the client’s HIV risk behavior.

Counselor: A few times you’ve said, “I’m just really nervous.”
Client: Yeah. I am nervous. I don’t know what the result is going to be.
Counselor: Let’s talk about that. What happened that has got you so nervous about getting HIV?
Client: Well, my boyfriend came up positive about three months ago and now I’m worried that I could have gotten it from him.
Counselor: You’ve been through a lot in the past few months. What’s happened since you found out?

In this example, the counselor has acknowledged the client’s anxiety and tried to tie the client’s concern to an event or circumstance that will allow the client to tell their story. If the client continues to be anxious about the results, the counselor could talk about the possible results and how the client would feel about an HIV-negative or a preliminary positive result.

**What happens if a client’s preliminary positive result is followed by a negative confirmatory result?**

A. “Discordant” test results, when a client tests preliminary positive and then HIV-negative on a confirmatory test, come in two types. Both are very rare.

In the first case, a truly HIV-negative client may have a “false” preliminary positive. While the rapid test is exceptional at identifying HIV-negative clients, the test may develop as a false preliminary positive in one out of every 1,000 uninfected people. In the
The result means to the client, particularly any concerns about uncertainty or waiting a week for the final result.

Some sites are using counselors, also trained as phlebotomists, to undertake all aspects of the single-session process. Others use medical staff to administer and interpret the test and counselors to do counseling. How can either approach benefit a client?

There are benefits to each approach. Counselors who do everything—informed consent, sample collection and test administration, and counseling—report a greater sense of intimacy and trust with their clients. They also report a more efficient workflow in the clinic because there is no potential wait for a test technician.

Counselors who do not conduct the test themselves report that the break between informed consent and risk assessment gives both counselor and client time to process their initial interaction and prepare for the risk assessment and disclosure session. These counselors also feel they can focus their attention on the client and not on the technical aspects of the test process.

What are the next advances in rapid testing?

It is likely that there will be advances in rapid testing in the future. For example, the rapid test’s manufacturer, is working on improving the test by extending its shelf life and increasing the temperature range at which it can be performed.

The improvement that is most likely to be available is the oral rapid test. The Food and Drug Administration (FDA) approved the test in March 2004. The test has not been released, however, to enable further research to ensure that the test is as accurate as possible.

Public health officials hope that the oral rapid test will make it easier to access people at high risk for HIV. Since it appears that the only difference between the oral and the blood-based rapid tests will be specimen collection, it is likely that all procedures, including counseling protocols, will remain the same for the oral test.

Conclusion

Over the next few years, the California Office of AIDS expects single-session counseling to become the standard of care. As research continues to refine counseling approaches that empower people to reduce risk, newer technologies such as rapid testing have the potential to make testing more accessible and attractive. Ideally, this will bring more people in to test and to receive the key intervention of testing programs: client-centered counseling.
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