

# **COUNSEOR TRAINING MANUAL**

**AIDSCAP/GPA/WHO Voluntary Counseling and Testing Efficacy Study**

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**Introduction**

This manual is addressed to the counselor trainer/supervisor and is for the purpose of training counselors to deliver the Counseling and Testing Intervention for the AIDSCAP/WHO/GPA Voluntary Counseling and Testing Efficacy Trial. The manual assumes that the counselors being trained already have proficiency in basic counseling skills and HIV/AIDS information. Principal Investigators are responsible to assess the counselors and to provide any remedial training necessary. Principal Investigators have been provided with the U.S. Centers for Disease Control *Manual for Counselor Training* and WHO/GPA training materials for this purpose, and may request additional assistance and training materials from the Center for AIDS Prevention Studies as needed. Training updates and additional materials will be provided throughout the study as well.

The counselor training requires five days. It is important to allow counselors adequate time to process the information, engage in the training exercises and to discuss (debrief) the training exercises. The purpose of the training is to familiarize counselors with the study and the study procedures, and also to build trust and communication among the counselors so that they might support each other in delivering quality counseling services throughout the study. The training course also provides an opportunity for the counselor supervisor to observe counselors' basic counseling and HIV counseling skills and to note any additional training that may be needed.

**Outline of the Counselor Training Manual**

Day 1-Morning	Introductions, How is HIV Counseling Different?
Day 1-Afternoon	Procedural Overview, Confidentiality
Day 2-Morning	The Client-Centered Counseling Approach Conducting an Individualized Risk Assessment
Day 2-Afternoon	Developing an Individualized Risk Reduction Plan Condom Demonstration Training
Day 3-Morning	Preparation for Testing (Pre-Test Counseling)
Day 3-Afternoon	Giving Test Results (Post-Test Counseling)
Day 4-Morning	Giving Test Results: Emotional Coping and Additional Behavioral Rehearsal
Day 4-Afternoon	Counseling Couples
Day 5-Morning	Special Counseling Situations
Day 5-Afternoon	Administrative Tasks, Procedural Review On-Site

## **Agreements**

Because the training includes exercises in which the counselors may disclose personal information and are expected to demonstrate and practice counseling skills, certain agreements or rules must apply to the training group. Instruct counselors on the importance of respecting the confidentiality of other counselors during training and of learning to tolerate differences of opinion within the training group. Because listening with empathy and acceptance and protecting confidentiality are two skills required to conduct the intervention, demonstrating and practicing in the training group provides teaching opportunities. Full participation in all training exercises is expected; however, should a counselor choose to pass on a specific question or activity, this decision must be respected by the training group.

## **Introductions (Day 1- Morning)**

Instructions to the trainer:

Counselors will be working together over the course of the research study, and HIV counseling can be challenging and stressful. Consequently, it is useful to foster a sense of group cohesion among the counselors and to encourage them to be open with each other. This team rapport will be useful as counselors begin their work and require each other's support. The introduction exercises also allow you to assess counselors' basic skills and to practice such skills as active listening and paraphrasing. Choose the exercises most appropriate to your training group, or use similar exercises you are familiar with to reach the goals outlined above.

### **Introductions (Exercise #1)**

This exercise requires counselors to introduce each other to the group. Counselors break into pairs, interview each other and then introduce each other to the group. This exercise also allows for assessment and feedback of counselors' presentation skills. In interviewing each other, counselors elicit the following information: the person's name, any special meaning of that name, the person's previous experience in HIV counseling and how that person decided to become an HIV counselor. Allow each person to be interviewed for 5 minutes, then switch roles. Reconvene the group and allow each counselor to introduce his/her partner to the group. When everyone has presented, summarize with the following discussion questions:

How comfortable was the experience of interviewing each other?

Were some questions easier to get answers to than other questions? Why?

How comfortable was the experience of presenting to the group?

## Strengths and Weaknesses (Exercise #2)

Counselors break into pairs to interview each other using the following questions. Allow 15 minutes for each person to interview, then switch roles. The job of the interviewer is to elicit opinions and examples from the counselor being interviewed. Reassure counselors that their discussion will not be shared with the group as in Exercise #1.

- Why do you think you will be an effective HIV counselor?
- What concerns do you have about your ability to be an effective HIV counselor?
- What kinds of clients do you expect will be most difficult for you?

When each counselor has interviewed and been interviewed, bring the group back together to discuss their general experience in this exercise without pressuring individuals to reveal the specific strengths and weaknesses they or their partner discussed.

## **How is HIV Counseling Different? (Day 1-Morning)**

This section includes guidelines for a discussion of how HIV counseling is different from other types of counseling and a series of skill-building exercises.

Provide this information to the counselors (short lecture):

While HIV counseling requires some of the same basic counseling skills as other types of counseling, the nature of HIV and AIDS makes this counseling unique. HIV/AIDS related counseling includes prevention counseling and counseling for coping, care and support. Even very experienced counselors have concerns about counseling regarding HIV. Counselors are often particularly concerned about their ability to provide HIV test results to clients, or about their ability to manage the reactions of clients, partners and families to positive test results. Counselors often fear that they do not possess the necessary skills for HIV counseling or that they will be unable to control their own emotional reactions to the work. Engage the counselors in a discussion of how they think HIV counseling is different from other types of counseling.

Using the chalkboard or poster paper, write their responses and suggestions. Make these points:

- HIV counseling requires explicit discussion of sexual practices.
- HIV counseling requires explicit discussion of death and dying.
- Counselors are likely to encounter clients who hold opinions and values very different from their own, and will be challenged to become aware of their own biases and stereotypes that could interfere with effective counseling.
- Giving test results can be emotionally challenging and stressful for counselors.
- HIV counseling requires that the counselor consider the reactions and needs of partners and other family members as well as those of the client.

### Values clarification (Exercise #3)

The purpose of this exercise is to practice listening and paraphrasing opinions, even if these opinions are different from your own. (If necessary, remind counselors that paraphrasing is defined as repeating or reflecting in your own words what the client communicated without adding information, advice or opinion). Counselors break into pairs and share with each other their opinions about the following controversial statements and why they hold these opinions. (You may choose other statements more appropriate to your training group). The role of the listener in this exercise is to listen to the other counselor's opinions without speaking, and then to paraphrase what was said. Reassure counselors that they will not be required to share their personal opinions with the entire group. Each counselor spends 10 minutes in the role of listener and 10 minutes in the role of sharing his or her opinions. Consider these statements for discussion:

- It is acceptable for men to have many sexual partners.
- It is acceptable for women to have many sexual partners.
- A woman who tests positive for HIV should not have any more children.
- Parents should not allow their daughters as much sexual freedom as they allow their sons.
- Children should be taught about sexually transmitted diseases and AIDS in school.
- It is acceptable to have sex for pleasure only.
- It is acceptable for a man to have extramarital sex.
- It is acceptable for a women to have extramarital sex.
- People with HIV should not have sex.
- Parents should teach their teenage children how to use condoms.
- If a wife wants to use condoms for HIV prevention, but her husband does not want to use condoms, the wife has a right to refuse sex with her husband.
- It is acceptable for men to have sex with other men.
- It is acceptable for parents to encourage their sons to have sex before they are married.

After each person has had the opportunity to give their opinions and to listen and paraphrase, reconvene the group for discussion. Consider these questions for discussion:

What was your experience of sharing your opinions with your partner?

What was your experience of hearing and paraphrasing opinions that differ from your own?

Did you become aware of any of your own values and attitudes that may affect your HIV counseling?

How do counselors prevent their personal values from impacting HIV counseling in a negative way?

Because HIV counseling involves discussion of sensitive issues that reflect personal values and attitudes, it is important for HIV counselors to be aware of their own values and know what their reactions may be when they hear opinions different from their own. The goal of client-centered counseling is to provide information in a non-judgmental atmosphere.

#### Sexual Words Desensitization (Exercise #4)

Explain to the group that HIV counseling requires explicit discussion of sexual behavior. In this exercise the group is to try to list all of the various sexual behaviors that are practiced in this country. These may be sexual behaviors the counselor knows of personally or behaviors that they have read about or heard about from clients in the past. List all behaviors on the chalkboard or on poster paper. When the group has exhausted their knowledge of sexual behaviors, ask the following questions of the group.

- What was it like for you to hear and say these words? Were you aware of any reactions?
- Do you know what all of these words mean? Would you be willing to ask what these words mean if you did not know?
- How likely is it that each of these behaviors would transmit HIV? Do all of the counselors agree about the risk of each behavior?

Work with the group to define the sexual behaviors listed and to engage the counselors in a discussion of the relative risk of various behaviors for transmitting HIV.

End this section with a discussion of coping and 'burnout'. It is important to acknowledge that HIV counseling can be stressful and to encourage counselors to be aware of signs that they are overworking or not coping well. Counselors must also be aware that they are not expected to help clients deal with all of their needs. Clients may be referred to referral sources in the community as needed; it is important that counselors be familiar with these resources. It is important for counselors to ask for help when they need help, use supervision to discuss their concerns about the work, be aware of their own biases and stereotypes, learn to be assertive and to set limits with other staff and with clients, and to continue learning new skills and requesting feedback on their work throughout the study.

### **Overview of Intervention Procedures (Day 1-Afternoon)**

Begin the afternoon by asking if there are any questions or additional comments about the training exercises in the morning. If not, explain that the purpose of the afternoon is to review the study procedures and to discuss confidentiality.

Provide copies of the Intervention Procedures section of this Procedure Manual . If necessary, allow counselors time to read the intervention procedures carefully before proceeding. Alternatively, counselors may be given this assignment prior to Day 1 or for the previous evening. Remind counselors that they will have the opportunity to ‘walk-through’ the procedures at the site on the last day of training. The following is a summary of the counseling intervention procedures:

Counselors receive clients from the administrator who has just completed the randomization procedure. The counselor first confirms that the client has received informed consent and has been assigned to the counseling and testing intervention. The client is then taken to the counselor's office for pre-test counseling. The counselor then proceeds with pre-test counseling including *individualized risk assessment* and *developing an individualized risk reduction plan*. The counselor then proceeds with *preparation for testing*. Although pre-test counseling is expected to be completed in a single session, the counseling and testing intervention may include additional pre-test sessions. When the counselor is assured that the client has no additional questions or concerns, the client has his/her blood drawn and a post-test appointment is scheduled 2 weeks later. At this time the client is given a supply of condoms. The client returns in two weeks for *post-test counseling*. When the client is ready to receive their test result, the counselor *gives the test result* and reviews the client’s risk reduction plan and plans for coping and support as needed. The counselor offers all clients an additional post-test counseling session and provides appropriate referrals if needed. The counselor then completes the Counseling Contact Form and returns all client materials to a secure area. It is anticipated that counseling sessions will last approximately 30 minutes each. Clients may return to the center as often as desired for additional follow-up visits after receiving their test results.

#### Discussion Notes:

Review the procedures as outlined in this Procedure Manual.. Ask the counselors if they have any questions or clarifications about the procedures. List the various skills (in italics above) that they will learn over the next 4 days in order to conduct the intervention and briefly define each skill. Acknowledge that some of these skills are new to them and that they will be given opportunity to practice each new skill.

## **Confidentiality (Day 1-Afternoon)**

Note to the trainer:

It is critical to the success of the study that counselors keep client information confidential or private. It is important that counselors understand the concept of confidentiality and agree to keep client information private. Participants in the study will be reassured repeatedly that all information that they provide about themselves and their participation in the study will be kept in the strictest confidence. Engage the counselors in a discussion of the why confidentiality is important, the definition of confidentiality, the definition of a breach of confidentiality and how confidentiality will be maintained.

Provide the following information for discussion (short lecture):

It is extremely important that participants' privacy or confidentiality be protected. Participants' serostatus is to be considered the most confidential of information and must be protected at all times. Counseling must be conducted in private where the conversation between the participant and counselor cannot be overheard. All record forms, even those identified only with a participant number, must be kept in locked file drawers at all times when they are not in use. Discussions between counselors and counselor supervisors, including case discussions in supervision, will protect the privacy of participants by not referring to the participant by name. Participant confidentiality will also be protected in conversations between counselors and other project staff. Breaches in participant confidentiality may be grounds for dismissal of counselors and other staff.

Discussion Notes:

- Participant's confidentiality is protected and maintained through the professional behavior of counselors. Counselors do not discuss clients outside of supervision or consultation with each other. When clients are discussed, it is for the purpose of supervision, quality assurance or to seek assistance in providing counseling services. Client's names are not used in these discussions. Do not discuss clients in public places or with anyone not employed by the study.
- Participants' confidentiality is maintained through the maintenance of an appropriate, private environment for counseling and supervision. Instruct counselors not to allow interruptions during counseling sessions and to hold all sessions in the office with the door closed to insure privacy. Seating arrangements should facilitate communication (chairs for client and counselor of equal size and height without a desk between them). Counseling should occur in a comfortable, pleasant room - encourage counselors to decorate and maintain their offices. Supervision should occur in a private office as well.

## **The Client-Centered Counseling Approach (Day 2-Morning)**

Start the day by asking if there are any questions or comments from the first day's exercises or training material. If not, proceed with this description of the client-centered counseling model.

Provide the following information for discussion (short lecture):

One way of attempting to change HIV risk behavior is to provide information about HIV, how it is transmitted and how transmission can be prevented. It is unclear if this is the most effective method of helping clients to change their risk behavior. The client-centered approach to HIV counseling was designed to decrease the emphasis on education, persuasion and test results in favor of personalized risk assessment and the development of a personalized risk reduction plan for each client. The emphasis in client-centered counseling is on developing a risk reduction plan for each client that takes into account that client's emotional reactions, interpersonal situation, social/cultural context, specific risk behavior and readiness to change. The content of the counseling sessions and the amount of counseling that each client receives is determined by their level of knowledge and their specific, personal concerns about HIV/AIDS. Rather than providing standardized information about HIV/AIDS, the counselor solicits information about what the client already knows or has heard and then corrects misperceptions and provides additional information through discussion. The counselor also assists the client to cope with emotional reactions and to cope with the consequences of their HIV risk behavior.

The client-centered approach to HIV counseling has been adapted for this research study. In usual practice, the client and counselor weigh whether taking the HIV antibody test at this time is consistent with the client's personal risk reduction goals. In this research study, however, all participants have indicated their willingness to be tested by consenting to join the study. While time is allotted to discuss the implications of receiving test results, and participants are free to leave the study at any time, the decision of whether or not the participant will be tested now or later is determined by random assignment to treatment condition (HIC or CT).

The goal of client-centered HIV counseling is to develop an individualized risk reduction plan, to facilitate the participant to enact this plan, to help the participant cope with the emotional reactions to HIV counseling and testing and to help the participant cope with interpersonal and familial consequences of HIV counseling and testing. Following the counseling intervention, participants are expected to have increased their accurate knowledge about HIV/AIDS, to have accurately assessed their risk for HIV and to have an individualized risk reduction plan. One goal of the counseling intervention is behavior change; participants are counseled with the goal

of reducing their risk behavior. Toward this goal, participants are also expected to increase in their belief in their ability to change their HIV-related sexual behavior risk and to gain or improve behavioral skills associated with risk reduction (e.g. condom skills, negotiation skills, etc.). The counseling intervention is also expected to help the participant to cope with the emotional, interpersonal and other consequences of engaging in HIV counseling and specifically of learning their HIV serostatus.

The spirit of the intervention is interactive and respectful of participants' circumstances and readiness to change. Rather than telling clients about HIV, counselors first ask clients what they know or what they have heard, and correct their misperceptions through discussion. Rather than telling clients how to reduce their HIV-related risk behavior, counselors elicit from each client an individualized risk profile and, through discussion, assist the client in developing a specific risk reduction plan. This type of counseling takes more time; counselors must allow sufficient time to complete each step of the counseling intervention and not appear rushed or hurried.

Engage the counselors in a discussion of the client-centered counseling approach and how it compares to the types of counseling they have done in the past using these discussion questions:

- How is the client-centered counseling model different from counseling you have done in the past? How is it different from HIV counseling you have done in the past?
- In what ways will this counseling approach be more difficult for you? Easier for you?

#### Advice versus Information (Exercise #5)

To conduct effective HIV counseling it is important for the counselors to understand and to practice the difference between giving advice and giving information. Begin the exercise by asking the group to differentiate giving advice and giving information, and to provide some examples of each. For the exercise, ask for a volunteer to play the counselor and a volunteer to play the client while the rest of the group observes. First, the client asks questions and the counselor responds with advice-giving (e.g. you should do this, why don't you do that, it would be better for you to do it this way). Break after a few minutes and ask the group to note their reactions to the role-play. Next, the client asks questions and the counselor responds by giving information without advice or opinions. Break after a few minutes and ask the group to note their reactions to this role-play, particularly any ways in which the two role-plays felt different.

### Discussion Notes:

Even very experienced counselors are drawn into giving advice, particularly when the client is distressed. In the case of HIV counseling, advice-giving is not helpful because of the sensitive nature of the behaviors involved and the possibility that the client and counselor do not share the same values about these behaviors. If clients perceive that the counselor is judging their behavior, they may be reluctant to disclose further, and it will be very unlikely that the counselor will have the opportunity to help the client reduce their risk. Encourage further discussion about the difference between advice-giving and information-giving, and ask counselors to discuss situations when it may be difficult for them to refrain from giving advice (telling the client what to do). Discuss ways in which giving information can be a powerful intervention.

### **Conducting an Individualized Risk Assessment (Day 2-Morning)**

(see also Unit 1 of CDC manual)

Provide the following information (short lecture):

Client-centered HIV counseling is distinguished by the development of a personalized risk reduction plan for each client. In order to create this plan, the client's individual risk situation must be assessed. This risk assessment includes gathering information about the participant's sexual and other risk behavior as well as their emotional, interpersonal, social and resource situation. The counselor may initiate the assessment by asking the client what he or she knows about the ways in which HIV can be transmitted. Readiness to change risk behavior and perceived self-efficacy (ability) to change risk behavior are also assessed.

### Risk Assessment Questions (Exercise #6)

Ask the counselors to generate a list of all the questions they might ask a client in the process of conducting an individualized risk assessment. List the questions on the chalkboard or on poster paper. Be sure that the list of questions includes questions about behavior as well as questions about the client's emotional state, resources and readiness to change. Note that open-ended questions ('Tell me more about the sexual relationships you are having now') are generally more productive than closed-ended questions ('How many sexual partners do you have?') for eliciting detailed information and for showing interest without judgment. It may be useful to categorize questions as they are listed by the group as questions about emotions, behavior, social support/peer norms, previous behavior change efforts and questions about the client's environment (finances, living situation, job situation, etc.).

### Risk Assessment Role-Play (Exercise #7)

After the counselors have exhausted the list of potential questions, ask for a volunteer to be the client and a volunteer to be the counselor. Ask the 'client' to assume the role of a client they have worked with in the past, and to be interviewed by the counselor for the purpose of assessing risk. Allow the counselors to take turns interviewing this 'client', encouraging each to build on what the was asked by the previous counselor. Keep each counselor's interaction with the 'client' short (a few minutes). When each counselor has had a chance to interview the client, start the discussion by asking the client to report on their experience of being interviewed. Next, engage the entire group in a discussion of the client's risk assessment, challenging the group to summarize this client's risk for HIV.

#### Discussion Questions:

- What are this client's HIV-related risk behaviors? Which are most likely to put him or her at risk for HIV infection or for infecting others with HIV?
- Does the client have any resource limitations that might hinder his or her efforts at behavior change?
- Does the client have any resources (human, psychological, environmental) that might help him or her to change risk behavior?
- As the counselor, what was your experience of asking the client questions about their risk behavior? Were some types of questions easier or more difficult than other types of questions?

[Note: Exercise #7 should be repeated as time and interest allow, giving different counselors the opportunity to role-play a particular client and in that role to give other counselors feedback about their interview questions and style. From this exercise the counselor trainer/supervisor should choose several client stories to be used in the next exercise].

### **Developing an Individualized Risk Reduction Plan (Day 2-Afternoon)**

Provide the following information for discussion (short lecture):

After the risk assessment is completed, the counselor asks the participant to propose some ideas about how to reduce their own risk for exposure to HIV. At this point the counselor may initiate the discussion of risk reduction by listing several alternative risk reduction strategies for the participant to consider. For each risk reduction behavior, the counselor assesses internal and external barriers to change, perceived efficacy to enact the new behavior, readiness to change and the availability of resources to change. In supporting the participant's enactment of the personalized risk reduction plan, the counselor will acknowledge and support the client's strengths (e.g. social support, self-efficacy, previous success in changing behavior) and offer

problem solving in areas of concern or expected difficulty in enacting the plan. If condom use is part of the risk reduction plan, the counselor asks the client to tell what they know about condoms and invites the client to practice putting a condom on the penis model before the counselor conducts a condom demonstration. If the client does not mention condoms, the counselor may introduce this topic as information that is useful to have whether or not the client is planning to use condoms now.

Finally, the counselor elicits a commitment from the client to make specific behavior changes before the next counseling session. The risk reduction plan should be challenging, but not so difficult that the client will fail to complete it or become frustrated. It can be useful to provide several goals, some that are easy to attain and some that are more difficult to attain. It can be useful to break the new behavior into steps and encourage the client to change his or her behavior one step at a time. If the client can read and is not concerned about the privacy of this information, the risk reduction plan may be written and given to the participant to take home.

#### Risk Reduction Plan Practice (Exercise #8)

Using client descriptions from Exercise #7, resume practice with the purpose of developing an individualized risk reduction plan for each client. The counselor's task is to ask the client how he or she would like to reduce their risk, listen without judgment to the client's plan, provide feedback on the client's plan in the form of additional information, and suggest additional or alternative risk reduction plans (if appropriate). Allow the counselors to take turns interviewing each client, encouraging each to build on progress by the previous counselor. Keep each counselor's interaction with the client short (a few minutes). When each counselor has had a chance to interview the client, start the discussion by asking the client to report on their experience of developing a risk reduction plan. Next, engage the entire group in a discussion of the client's risk reduction plan, challenging the group to critique the plan and to assess the likelihood that the client will succeed in changing his behavior and that this behavior change will indeed reduce the client's risk to become infected or to infect a partner with HIV.

[Note: Exercise #8 may be repeated as time and interest allow. The trainer may also take this opportunity to provide feedback to the counselors regarding their basic counseling skills, non-verbal communication and HIV/AIDS knowledge as appropriate].

## **Condom Demonstration Practice (Day 2-Afternoon)**

### Condom Attitudes (Exercise #9)

[Remind counselors that all participants will be given condoms at the end of the first pre-test counseling session].

Begin this section by asking the counselors to tell you all of the negative things they have heard about condoms and about using condoms. This may include their own concerns about condoms, condom myths (misperceptions about the function, safety or effectiveness of condoms) they have heard from clients or other sources, or negative experiences with condoms that they have had or have heard about. List all of these negative statements about condoms on the chalkboard or on poster paper. Engage the counselors in a discussion of their reactions to hearing these negative statements about condoms and condom use, and ask them how they might respond to hearing these statements from a client. Acknowledge that all clients will not choose condoms as their risk reduction strategy, but that all clients must make an informed decision and have the opportunity to learn about condoms. [Note: This discussion and the following exercise is also an opportunity to reinforce the difference between giving advice and giving information as outlined in the exercise yesterday].

Following this discussion, have counselors break into pairs to role-play listening to negative attitudes toward condoms and providing information. One counselor plays the client who had already agreed that condoms would be useful in reducing risk, but is reluctant to try them stating some of the negative statements about condoms on the chalkboard. The role of the counselor is to listen without judgment and to provide information about condoms without giving advice. When each person has had the opportunity to be both client and counselor for 5 minutes, reconvene the group for discussion.

#### Discussion Questions:

- What was your experience as the client? As the counselor?
- Was it difficult to avoid giving advice about condoms to the client?
- Did you find that you had enough information about condoms and condom use to assist the client in making an informed decision about using condoms?
- What additional information about condom and condom use would you like to have?

## Condom Demonstration Practice

Note to trainer:

Counselors must be proficient in demonstrating correct condom use with a penis model. Each counselor must practice demonstrating condom use and receive feedback from the counselor trainer/supervisor and from other counselors. Begin this section by modeling a condom demonstration. Next, ask for a volunteer to be a client requesting more information about condoms, and role-play demonstrating condom use in the context of a counseling interaction. Next, ask for volunteers to demonstrate condom use. Be sure that each counselor has the opportunity to practice the condom demonstration. Provide feedback on demonstration technique and encourage the counselors to encourage and critique each other .

### **Preparation for Testing (Pre-Test Counseling) (Day 3-Morning)**

[Note: The counselor trainer/supervisor is strongly encouraged to review lab procedures with the counselors at this time to prepare them to answer clients' questions. It is not unusual for clients to have concerns about the accuracy of the test and to ask specific questions about the lab procedures that are used. Clients are often concerned that precautions be taken to avoid mislabeling blood samples or test results. In order to reassure clients, the counselors must be completely familiar with lab procedures.]

Provide this information to counselors (short lecture):

The counselor engages the client in pre-test counseling by first asking the client what they know about the antibody test and by asking about any previous testing experiences. The counselor provides information about the test as needed and corrects any misconceptions about testing and/or test results. The meaning of a negative test result and a positive test result are explicitly stated (including an explanation of the 'window period'). Clients are asked to make a specific plan of action in the case of a negative test result or in the case of a positive test result, including what they are planning to do while waiting for the test result and who they are planning to share the test result with. The interpersonal implications of a negative or positive test result for that client are also discussed at this time, including whether the participant is aware of his/her partner's serostatus. When scheduling the post-test counseling appointment, the counselor negotiates a specific plan for the participant to return for test results, and solicits a personal commitment from the client to return. Pre-test counseling is intended to be completed in the first counseling session. Additional pre-test counseling sessions may be provided if the participant is unsure or has additional questions about antibody testing.

It is critical that the counselor get a commitment from the client to return for test results. This is accomplished by 1) acknowledging that the client may be anxious about returning for results, and developing a plan to cope with anxiety about returning (such as bringing a friend, or talking with someone about their plans to return for test results on a specific date); 2) reassuring the client that the test result will be held in the strictest confidence; 3) soliciting reasons from the client why he or she may benefit from knowing their serostatus, and; 4) providing an appointment to return for test results.

### **Giving Test Results (Post-Test Counseling) (Day 3-Morning)**

(see also Unit 5 of the CDC manual)

Provide the following information for discussion (short lecture);

Two post-test counseling sessions are suggested, although many clients will choose to have a single post-test counseling session. Clients may then return for as many additional counseling sessions as they need. The first post-test counseling session begins with the disclosure of test results. Counselors disclose test results in a direct, neutral tone of voice and to wait for the client's reaction before proceeding. While the progression of the first post-test counseling session depends on the client's test result and their emotional reaction to receiving the test result, in general the counselor will assist the client to understand the meaning of the test result, assess and assist with the client's emotional reaction to the test result and work with the client to modify their risk reduction plan as needed.

In the post-test counseling sessions, for participants who are HIV positive, the counselor will assist in making a plan to inform partners and will provide appropriate referrals for medical and social services. Implications of the positive result will be discussed and the individualized risk reduction plan will be reviewed with the goal of preventing re-infection and protecting partners. Participants who test positive will be asked to provide a second blood sample for retesting. This is standard procedure to ensure the accuracy of the test result. For participants who are HIV negative, the implications of the negative test result will be discussed and the individualized risk reduction plan will be reviewed with the goal of preventing HIV infection. Additional sessions with the counselor may be offered for emotional support and to further support the risk reduction plan or overcome identified barriers to changing behavior. All participants will be informed of additional counseling services available at that Counseling Center and /or referred to community resources if they are in need of services that are not available at the Counseling Center.

### Fears About Giving Test Results (Exercise #10)

Most counselors start out with a lot of fears about telling clients their HIV status. Giving positive test results can be difficult and uncomfortable for counselors. Counselors fear that they will not know what to say or what to do, or that they will have an emotional reaction that will not be helpful to the client. Begin this exercise by asking counselors to write three of their fears about giving test results on small cards or slips of paper. The trainer then shuffles the cards and distributes them to be read by the counselors. Lead the counselors in a discussion of each concern or fear, noting whether that fear is related to lack of skills, lack of knowledge or fear of personal reactions to the client's test result. Ask the counselor reading the fear to note what would be required (training, supervision, support, additional information, etc.) for the counselor to cope with or to overcome that fear. Remind counselors of the need to have good referral resources and to maintain accurate, up-to-date information about references. Common counselor fears include the fear that the client will commit suicide, that the client will harm someone else or that the client will leave the session and not return. Reassure counselors that these fears will decrease as their experience giving test results increases, and that they will have an opportunity to practice crisis intervention skills as well as to practice giving test results.

### How to give test results (short lecture):

Begin the post-test session by asking how the client has been the past two weeks and congratulating the client for returning to hear their test result. Ask the client if they have any questions, understanding the most clients will want to hear their test result as soon as possible. When the client is ready, give the test result in a neutral tone of voice, and *wait for the client to respond* before proceeding. For a positive test result, say 'your test result was positive; that means you are infected with HIV', and for a negative test result say 'your test result was negative; that means we did not detect any antibodies for HIV'. It is important to ensure that the client has understood the test result and integrated the information cognitively, emotionally and behaviorally before proceeding. Assess cognitive understanding by asking the client to tell you what the test result means, checking for any misperceptions or misinformation. Assess emotional understanding by asking the client how he or she is feeling at that moment, and allowing expression of emotional reactions. Proceed to behavioral integration only when the client is ready to talk about what they are planning to do next. Behavioral integration requires that the client make an immediate plan (ask 'what are you planning to do when you leave here today?') as well as plans for partner notification, modifying the risk reduction plan or other behavioral changes depending on their test result and the client's situation.

There is a wide range of possible client reactions to a positive test result, ranging from resignation to severe shock and disbelief. Some clients respond by assuming that they will immediately become ill and die. It is important to remind clients of the difference between HIV and AIDS, and to explicitly say that it is possible to remain healthy for a long period of time with HIV. Ask the client what they are planning to do when they leave the session and, if necessary, remind them of the plan they made in the pre-test session for what they would do if their result was positive. Assess the client's social support and plans for partner notification. Although clients who receives positive test results is not likely to be concerned about safer sex in the first post-test counseling session, it is necessary to remind clients of their risk reduction plan and to remind them that it is still necessary to protect their partners and to protect themselves from re-infection.

Although the test is accurate, participants who test positive will be asked to provide a second blood sample for retesting. This is a standard procedure to ensure the accuracy of all test results. Tell the participant: 'In the case of a positive test result, it is our standard procedure to draw your blood again and re-check the result. Although we re-check all positive test results, the test is accurate and you must assume that you are infected with the virus'. Do not describe the second test a 'confirmatory', as this suggests that an alternative test procedure will be used. This is not the case; the second sample is tested using the same procedure used to test the first sample. It is also important not to tell the participants that their blood is being re-drawn and re-tested to check for lab errors, as this may cause the participant to doubt all results provided in the study. The counselor is advised to negotiate a specific plan to return for test results and additional counseling, and may suggest that the client return with his or her partner. Some individuals who test positive will refuse to have their blood re-drawn because they are sure that the result is accurate (they may be symptomatic or have lost a spouse or sexual partner to AIDS).

There is also a range of potential client responses to a negative test result. Counselors must not assume that clients will react with relief and happiness to a negative test result. Consider engaging the counselors in a discussion of circumstances in which a negative test result would be problematic for a client, and restate the importance of delivering the test result in a neutral tone of voice. Clients who receives negative test results often tell the counselor that they will stay safe by not having sex anymore. While acknowledging the client's intention not to have sex, the counselor must be sure that each client has sufficient skills and a plan to protect themselves from sexual transmission. Counselors are also encouraged to ask clients who tested negative if they intend to tell their partner that they were tested and to engage the client in planning how to discuss risk reduction with their partner.

After the client's serostatus is known, the counselor may want to work with the client to revise the risk reduction plan. Counselors must be aware, however, of the window period and remind clients of the need to be re-tested if they receive a negative test result but have engaged in any HIV risk behavior in the past 6 months. If the client has had any exposure in the past 6 months, their negative test result could indicate that they are infected but not yet showing antibodies to the virus. Encourage all participants who receive a negative test result to consider the possibility that they could be infected and not yet showing antibodies to HIV.

Clients are welcome to return to the center as often and for as many post-test counseling sessions as they would like. For example, clients may return for assistance in enacting their risk reduction plan, for emotional support, for assistance with interpersonal conflicts or issues related to planning for the future or for referrals.

### **Giving Test Results: Emotional Coping/Additional Behavioral Rehearsal (Day 4-Morning)**

#### Emotional Coping (Short lecture)

As HIV counselors we are aware that there may also be negative as well as positive effects of HIV counseling and testing. Negative outcomes of HIV counseling and testing can occur as a result of stigma associated with receiving HIV services, or as the result of the trauma of receiving HIV test results. Consequently, clients must be given the opportunity to integrate the information about their HIV risk and about their serostatus emotionally as well as cognitively and behaviorally. This can be accomplished by allowing clients to express their reactions to the experience of counseling and testing and responding with non-judgmental listening or information-giving. Even given the opportunity to express and integrate emotional reactions, however, some clients will be unable to cope with this experience and will require intervention. Clients may express their inability to cope verbally (by saying they do not know what to do, describing feelings of hopelessness or a desire to hurt themselves or to hurt someone else) or behaviorally (by isolating themselves socially or refusing to continue with activities of daily living). In this case, the counselor is more directive and involves the client's support network more directly. The first step of providing intervention is the assessment of risk. Ask specific questions to determine whether the client is having thoughts about harming themselves or anyone else. The counselor must also assess if this client has a history of harming themselves or of harming other people or if the client has suffered any other recent losses or traumas (as these circumstances increase the risk that the client will actually harm himself).

If the client is having thought about harming himself or others, the counselor must ask specific questions to determine if there is a plan and if the client has the means to pursue this plan. If there is a specific plan, the counselor is responsible to contract with the client and with his family and other significant others to prevent harm. Counselors are often reluctant to ask specifically about such plans for fear that asking will give the client the idea to harm himself; this is not true. Often clients who are uncertain of their ability to cope are relieved to be asked these questions as these questions indicate that the counselor is sincerely concerned and listening.

Interventions when clients are unable to cope with emotional reactions may include any of the following techniques:

- Identify, explore and validate the client's ability to cope with past crises. It is very reassuring to clients to be reminded that they have coped with and solved personal problems in the past, and to be reminded of the specific techniques that they used to solve the previous crisis. Such a discussion also provides the counselor with clues in assisting the client to cope with the present crisis.
- Assist client with concrete problem solving techniques. Using any information from the discussion of how the client solved previous crises, the counselor suggests specific problem solving techniques e.g. talking with family members or trusted friends, seeking spiritual guidance, seeking medical consultation, etc. The counselor also encourages the client to make a specific short-term plan and elicits a personal commitment to follow this plan and report back to the counselor, e.g. asking the client what he or she is planning to do when leaving the session and making a return appointment with the counselor. The counselor also engages the client's significant others to assure that the plan is enacted and that the client returns for follow-up.
- Encourage the client to express their feelings about the current situation during the counseling session, and then redirect the client's attention to taking action and problem solving. Ask the client to identify their options and to choose a course of action, e.g. ask the client what they might do after leaving the session and ask the client to choose one specific course of action.
- Encourage the client's utilization of existing social support.
- Provide the client with appropriate referrals to community resources.
- In the case that a client does not respond to these techniques or refuses to engage in a contract with you to return for additional counseling, the counselor may need to ask for psychiatric consultation or to consider hospitalization. In this case, the counselor is to immediately contact the counseling supervisor for guidance.

### Emotional Coping Role-Plays (Exercise #11)

The counselor supervisor begins this exercise by asking the counselors to think of different situations that might result in a client being unable to cope (situations that might induce a crisis). Write these situations on the chalkboard or on a poster paper. Some examples might be a client who receives a positive test result, a client who receives a negative test result despite having a spouse who is seropositive, or a client who realizes for the first time that his or her behavior has placed them at risk for HIV. The counselor trainer/supervisor asks for a volunteer to be the counselor and chooses a client situation to role-play. The trainer then plays the client in such a manner to give the counselor opportunity to use the intervention skills outlined above. Keep each client role-play short (about 5 minutes), and give counselors feedback after each role-play. Encourage counselors to discuss their reaction to being unable to help a client and having to call for consultation, back-up or to make a referral. Use this opportunity to remind counselors that there are limits to their ability to help clients, and to encourage their awareness of the need to set limits on their time and emotional investment.

### Additional Behavioral Rehearsal

It is important that each counselor have the opportunity to practice giving at least one negative and one positive test result and to receive feedback from the other counselors and from the trainer. Counselors can become anxious about this exercise; remind them of the exercise yesterday in which fears about giving test results were discussed. Remind counselors that they will feel more comfortable with practice and skill-building which is the purpose of this exercise.

### Giving HIV Test Results (Exercise #12)

Begin this exercise by asking for a volunteer to be the client and a volunteer to be the counselor to practice giving a negative test result. The rest of the group observes the interaction and provides feedback to the counselor regarding the content and delivery of his or her interaction with the client. After each participant has had the opportunity to practice giving a negative test result, ask for a volunteer to role-play giving a positive test result and a volunteer to role-play the client. (Note: The experience of role-playing a seropositive client can also be emotionally challenging. Be sure to allow adequate time to discuss the reactions of the 'clients' as well as the 'counselors' to the positive test result role-play). Continue practicing giving positive test results until each counselor has had the opportunity to give a positive test result.

## **Counseling Couples (Day 4-Afternoon)**

Provide this information for discussion (short lecture):

Some percentage of subjects will be recruited into the study as couples; those who enter the study as a couple may be counseled together. First, the counselor assures that each individual has given their consent for counseling and testing, and that each individual is aware that they are expected to disclose their test results to their partner. At least some part of pre-test counseling is to be conducted separately to give each partner the opportunity to honestly assess their risk behavior alone with the counselor. Test results are given individually first, then the members of the couples are facilitated by the counselor to share their test results with each other at the counseling center. After the disclosure of test results, post-test counseling may proceed with both partners present. Individuals who are reluctant to disclose their test result to their partner will be counseled and encouraged to disclose with the assistance of the counselor. Counselors must be aware, however, that they may not disclose an individual's test result without their permission.

Couples may be found to be both seronegative, both seropositive or discordant. Couple who are concordant (who have the same serostatus) are often reluctant to use condoms. In the case of concordant seronegative couples, the counselor is challenged to help them assess their risk by discussing whether either of their tests could have been in the window period (that is, if either of them could possibly be infected and not yet showing antibodies) and their current sexual behavior (whether they are having other sexual partners who may pose a risk of infection). In the case of concordant seropositive couples, the counselor is challenged to help the couple understand that their risk of re-infection, pregnancy and the transmission of other STDs may suggest continued condom use. In the case of discordant couples, the counselor is challenged to help the couple develop a long-term plan to protect the seronegative partner from infection. In such cases, the seronegative partner's test is usually in the window period (the seronegative partner is likely to have had unprotected exposure to his or her partner in the past 6 months), and that partner should be encouraged to be re-tested in six months.

In all cases the counselor's role includes assisting each member of the couple to cope with their emotional reactions to their test result and to the test result of their partner. In the case of concordant seropositive couples or discordant couples, it is not uncommon for one partner to blame the other for behavior that may have resulted in infection. While the expression of emotional reactions is necessary and often helpful in risk reduction, counselors must set limits to

prevent partners from verbally or physically abusing each other and re-focus them away from assigning blame to developing a plan for living positively with their couple serostatus.

Couples being counseled together should be encouraged to discuss their plans regarding pregnancy and family planning. Counselors are reminded that the question of whether discordant or seropositive couples should have more children is a complicated issue that involves considerations of their health status, resources, family circumstances, spiritual beliefs, etc. While it is not the role of the counselor to tell the couple what to do, the counselor raises the discussion for the purpose of providing information and encouraging communication within the couple. Couples may be referred for family planning services and medical evaluation. It is the responsibility of the counselor trainer/supervisor to make keep referral information current and to assist counselors to make appropriate referrals.

[The counselor supervisor may take this opportunity to assess counselors' knowledge and opinions regarding couples counseling and family planning issues. Additional discussion of the difference between giving advice and giving information may be useful here].

### **Special Counseling Situations (Day 5-Morning)**

Overall, counselors are responsible to know the limits of their competence, attend supervision regularly and to be knowledgeable about referral resources in the community. The following exercise allows counselors to acknowledge the limits of their skills and competencies while providing practice in working with difficult client situations.

#### **Strengths and Weaknesses II (Exercise #13)**

Ask counselors to choose a partner for this exercise (preferably the person in the group that he or she knows least well). Partners interview each other about what kinds of clients are most difficult for them to work with and why. After each counselor has had the opportunity to interview and to be interviewed, the group is reconvened for discussion of their experience in the exercise and examples of difficult client situations. Reassure the counselors that they will not be asked to reveal the content of their discussion regarding difficult clients. After this discussion, each counselor is asked to describe in writing a difficult counseling situation that they would like to see rehearsed. Encourage counselors to describe situations that they honestly believe would be difficult for them, whether or not they believe that this situation would be difficult for most other counselors. Some possible situations are: clients who say they are not going to have sex anymore and do not want risk reduction counseling, clients who are reluctant to share their

serostatus with their partner, clients with alcohol or substance abuse problems, clients who refuse to consider using a condom. The written counseling situations are then shuffled (so that it is not obvious who wrote which situation), and role-plays are conducted as time and interest allows.

### **Administrative Tasks, Supervision, Quality Assurance, Procedural Review On-Site (Day 5-Afternoon)**

- Making Referrals

[Note: Counselor trainers/supervisors at each site are responsible to create a supplement to the procedure manual that lists local referral information.]

A successful referral is one that is clear and specific. Clients are most likely to follow-up on a referral if it is clear to them what the purpose of the referral is and what they can expect to experience when they go to the referral agency. It is always useful to give clients the name of a specific individual to see or contact at the referral agency. Asking the client to provide feedback about the referral allows the counselor to assess whether the referral was successful, and provides information for other counselors about the quality of various referral sources in the community. If the client is able to read, it is useful to write the referral information.

- Tracking the counseling intervention

[Counselors should be given a copy of the Counseling Contact Form for this discussion]

Each participant's utilization of counseling services at the Counseling Center is recorded on the Counseling Contact Form. This form is very important to the success of the study and to providing good counseling services; it is by means of this form that we will know how much counseling each participant received, and it is by means of this form that counselors will know what type of service each client has received and what services they need next. Every time a participant is seen by a counselor, even for a brief visit, the counselor must complete the Counseling Contact Form. A separate form is completed for each individual (even if they are seen together) and for each contact with the counselor. The counselor notes the date of the visit, the client's identification number, whether the client was seen alone or as a couple during that session, whether the client is being seen at baseline, six-month follow-up or 12-month follow-up, whether the session is pre-test (before the client has been given a test result for that six-month period) or post-test (after the client has been given a test result for that six-month period). The

length of time that the client spends with the counselor is also noted by writing in the number of minutes. Finally, the counselor indicates the content of the counseling contact, the type of intervention conducted and types of referrals provided by circling 'yes' or 'no' on the form. For accuracy, it is important to complete the Counseling Contact Form immediately following each session and to give all the forms to the administrator at the end of the day. It is important that the Counseling Contact Forms be on file with the administrator; should your client return at time when you are unable to see them, other counselors will need access to these forms in order to provide appropriate services. Counselors are encouraged not to maintain additional client records or notes because of the risk of loss of client confidentiality. Counselors must be particularly careful to avoid creating notes or records that include client identification numbers, names and/or HIV serostatus.

- Evaluations for Quality Assurance

Each counselor will be periodically reviewed by a visiting evaluator from the Coordinating Center to ensure that the counseling intervention is consistent and complete. Counseling Contact Forms will also be reviewed. The evaluator will observe counseling sessions (with the permission of all participants) and evaluate counselor skills with the Counseling Session Evaluation Form. Periodically, counseling sessions may be audiotaped (with the permission of all participants), and these tapes will be reviewed to evaluate the counselor's performance in delivering the intervention. Client's experiences in counseling and testing may also be evaluated periodically via interviews or surveys to ensure client satisfaction with the counseling services.

- Counselor Supervision

Counselors are expected to attend weekly individual supervision and weekly group supervision. Counselors will be paid for their time attending supervision if that time falls outside the counselor's regular shift. Participants' confidentiality will be respected in all discussions among counseling staff and supervisors by not referring to participants by name, and not discussing details of participants' lives unless it is directly relevant to the supervision of the counselor's work performance. Supervision must occur in a private room or office.

In addition to their weekly individual and group supervision, counselors will attend a monthly inservice presentation on an aspect of HIV counseling selected by the counselor supervisor. These topics may include counseling techniques or updated information on HIV transmission and prevention. These sessions may be presented by the counselor supervisor or by speakers/facilitators from outside the Counseling Center. Attendance to monthly inservice

presentations is required, and counselors will be paid for their time attending these meetings if the inservice is scheduled at a time when the counselor is not on duty.

Explain to the counselors that both group and individual supervision are necessary to maintain the quality of the counseling intervention and to provide them with the support that they will need to provide effective counseling.

#### Procedural 'Walk Through'

Counselors are encouraged to review the procedures at the site. This is particularly important if the counselor training was not conducted at the research site. The counselor trainer/supervisor may want to have other administrative personnel involved in taking the counselors through all of the procedures at the site.