THE IMPORTANCE OF SEXUAL SELF-AWARENESS:

A BRIEF GUIDE, ASSESSMENT AND TRAINING PROGRAM FOR HIV TESTING COUNSELORS

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DISSERTATION APPROVAL

This dissertation, submitted by Listron Mannix, has been read and approved by three committee members. The final copies have been examined by the Dissertation Committee and the signatures which appear below verify the fact that any necessary changes have been incorporated and that the dissertation is now given the final approval with reference to content, form and mechanical accuracy. The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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VITA

Listron Mannix received his Masters of Social Work degree from Florida Atlantic University in Boca Raton, Florida. He completed his baccalaureate degree in Psychology also at Florida Atlantic University in Davie, Florida. Listron works for a non-profit organization known as The Pride Center at Equality Park in Wilton Manors, Florida where he is the Expanding Testing Initiative Manager for HIV Testing and Prevention Outreach Programs.

Listron has worked in the field of HIV/AIDS since 1996. He started on the Caribbean island of Antigua, where he developed a Peer Health Educators program focused on sex, HIV/AIDS and self-esteem. After leaving the island to further his education, in 2006 Listron started working at the Gay and Lesbian Community Center (GLCC), in Fort Lauderdale, Florida (now known as The Pride Center at Equality Park in Wilton Manors, Florida) as a part-time youth HIV testing counselor. While working part-time, he was offered a full-time position working at another non-profit organization known as Broward House in Wilton Manors, Florida as a Program Specialist focused on educating and testing young men ages 18-30. With this experience he was recruited to volunteer for 3 months in London, England to assist with building an HIV testing, education and prevention program focused on men of colour. As Listron continues his journey, he is focused on working internationally in management and capacity building in HIV/AIDS, sexually transmitted diseases (STDs), safer sex practices and promoting sexual self-awareness in HIV testing counselors.

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ABSTRACT

After working in the field of HIV/AIDS for seventeen years, the writer was compelled to write this dissertation and develop a guide for people who conduct HIV testing and counseling. This guide will focus on enhancing sexual self-awareness for HIV testing counselors (HTC) who are certified to conduct and provide HIV testing and counseling, but can also be applied in other counseling practices. The objective of this dissertation is to present a continuation of an existing education program for HIV testing counselors, and to increase their knowledge and sexual self-awareness, which will improve the quality of HIV Testing/Counseling. This dissertation serves to bridge a gap in the available knowledge to promote healthier and safer sexual behavior, while breaking down stereotypes and preventing undue harm to the patients being served. Six counseling skills are highlighted in order to create the sexual self-awareness assessment (SSAA).

There were a few limitations of this dissertation such as the term “sexual self-awareness”, is not a commonly used term, which forced the writer to develop a definition for the purpose of this dissertation. The writer also observed that there is a lack of research and programs that focus on supplemental training’s for HIV testing counselors (HTC) to build sexual self-awareness and enforcement of testing skills. The limitations presented are address in this dissertation.

PREAMBLE

The information and assessment in this dissertation can be applied to any counseling arena. This dissertation will focus on HIV prevention counseling following the Center for Disease Control and Prevention's (CDC) guidelines. According to the CDC, HIV testing can be done in any setting where; existing personnel can be effective counselors if they have the desire and appropriate training to employ the essential counseling elements. Advanced degrees or extensive experience are not necessary for effective HIV prevention counseling – (CDC Revised Guidelines for HIV Counseling, Testing, and Referral, 2001). Florida currently requires HIV Testing Counselors to complete three days of training. Trained counselors work with patients in diverse communities, and they are exposed to diverse sexual attitudes and orientations. After reviewing the present Florida issued HIV/AIDS 500/501 Participation Training Guide, it appears that the curriculum is lacking information and training for developing sexual self-awareness.

The intention of this paper is not to harm, offend, or criticize a model or program that is already in place, but to emphasize the importance of a topic that is not fully incorporated into the finalized training for state-certified HIV testing counselors, and to focus on this group who provides HIV prevention counseling. Also, to make them testing counselors aware, and to confront and address their own biases and discomfort in discussing sex and sexuality before they can effectively help others.

INTRODUCTION

HIV/AIDS has been a worldwide epidemic that impacts us all. The Center for Disease Control and Prevention (CDC), with the collaboration of local Departments of Health (DOH) and Community Based Organizations (CBO), has joined forces to provide funding to combat this epidemic. The CDC has developed many prevention and risk reduction models/programs. The main prevention program utilized is the Counseling, Testing and Referral program (CTR), also known as HIV/AIDS 500/501 certification. The purpose of the training is to educate and inform individuals who want to become HIV testing counselors (HTC) on the greater understanding of HIV/AIDS, testing concerns, and personal risk (The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide, 2008). The objective of this program is to recruit, counsel, and test and link patients to health care. While this program is focused on the patients receiving testing, the HIV testing counselors (HTC) who provide this service are currently not provided with continuing education to further address their personal perceptions and attitudes towards sex and sexuality.

Awareness of one's sexual self is as important for the counselor as having a good understanding of HIV/AIDS, STI transmission and learning basic counseling skills. Through research, the writer defines sexual self-awareness as a foundation of communication that involves the ability of standing back from oneself and becoming aware of one's sexual values, beliefs, and perceptions of sex. In the HIV testing arena this awareness becomes paramount for HIV counselors since they will counsel people whose sexual orientation may differ from their own, and/or be similar to their own.

Ethically, self-awareness serves as a foundation for thoughtfully rendering decisions and taking actions (Pompeo and Levitt, 2014). Having a familiarity with their own sexual awareness is essential to maintain a successful and effective session with their patients. Despite the broad definition, there is consensus that self-awareness is important to counselor development and counseling efficacy (Pompeo et al, 2014). The writer believes that, in addition to the HIV certification, testing counselors must have access to supplemental trainings that focus on counseling skills, personal development, and sexual awareness. The limited research that does exist on counselor self-awareness demonstrates the benefits of this self-awareness for their patients. For example, patient ratings of counselor helpfulness demonstrate a positive relationship with counselor self-awareness (Pompeo et al). Since there is limited research on how to properly build sexual self-awareness, the writer has selected six counseling skills that have been addressed in the counseling certification course to assist in enhancing sexual self-awareness and becoming most effective in the goal of HIV testing and counseling-risk reduction. These six counseling skills are not the only counseling skills required to be an effective HIV counselor, but the writer has chosen these six skills because of their significance for creating a sexual self-awareness assessment.

Working in the field of HIV/AIDS as an HIV testing counselor (HTC) and currently as an administrator/manager for an HIV testing facility, the writer has observed the need for continued education to assist with assessing and addressing HTC's perceptions and attitudes towards sex and sexuality.

According to the Center for Disease Control and Prevention (CDC) Revised Guidelines for HIV Counseling, Testing, and Referral, (2001), advanced degrees or extensive experience are

not necessary for effective HIV prevention counseling or to become certified as a testing counselor. The guidelines also state that in any setting where HIV testing is provided, existing personnel can be effective counselors if they have the desire and appropriate training, and employ the essential counseling elements. These counselors who receive the certification are required to attend this training once, with an annual update which focuses on programmatic issues. The writer does not disagree with guidelines for becoming an HTC, but believes that additional, supplemental training for counselors (potential and seasoned) is needed to focus on themselves, their sexual biases and the skills they were taught. The writer would refer to these additional training modules as developing sexual self-awareness.

In the HIV certification training cultural awareness is addressed in part, but cultural and sexual self-awareness is an ongoing and continuous issue that must be addressed throughout an HTC's professional growth, which will allow them to interpret and evaluate things in ways that are appropriate to the services they provide their patients. It is vital to acknowledge that appropriate sexual behavior differs from one person to the next. Misunderstandings arise when HTC's apply their perspective to make sense of someone's behavior. This dissertation is the writer's contribution to provide a supplemental training tool that will assist HTC's with building sexual self-awareness when working with their patients.

This dissertation will present six key counseling skills that will assist HTC's in enhancing sexual self-awareness, while promoting more effective methods in achieving an HIV testing and counseling session that will promote risk and harm reduction practices. The skills that are already addressed in the HIV/AIDS 500/501 certification are: knowledge, practice within scope, empathy, understanding stigma, active/reflective listening, and conscious self-disclosure. They

will be further explained and defined to demonstrate the relevance and importance of having a clear and concise approach to testing and counseling. This writer will also incorporate tools that will foster skills that will bring about sexual self-awareness to complement the overall testing session, creating a brief training guide for HTC to develop sexual self-awareness.

The guide will be used as a supplementary tool to the HIV/AIDS 500/501 certification. In creating the sexual self-awareness assessment, the questions were developed by the writer. They are based on the writer's vast experience in testing and counseling and are questions that have been addressed in various trainings the writer has attended. The case studies and examples presented in this paper are sourced from patients who utilized the services of a local HIV testing facility. The patients' names have been changed to ensure confidentiality.

The writer developed the training program to include an assessment and case studies. This interactive sexual self assessment recommends peer discussion, while reinforcing some critical aspects of the training with a focus on their sexual attitudes and beliefs that might interfere with the effective and professional application of their responsibilities to their patients. The writer expects that reading and participating in this supplemental training, will emphasize the need of awareness of personal sexual-self, thereby reducing any potential biases and judgments that a counselor could bring into the session.

In the next section the writer has included a brief description of the process of prevention counseling and HIV testing, which will provide the reader with a clear step-by-step approach to what happens when receiving a rapid HIV Test.

Summarizing Prevention Counseling and HIV Testing

In Florida an HIV Testing Counselor (HTC) is an individual who has participated and completed The Basics of HIV/AIDS Counseling, Testing and Linkage Course (HIV/AIDS 500) and HIV Prevention Counseling Testing and Linkage Course (HIV/AIDS 501) certification, which is presented by a certified trainer. The course covers information on HIV and AIDS and its impacts, counseling skills, and how to refer and link patients to the appropriate services.

It is important to have sexual self-awareness as a certified HIV Testing Counselor because the primary goal of prevention counseling is to identify behaviors that may place a patient at risk for HIV infection and explore ways to reduce that risk (The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide, 2013). The writer strongly believes that for an HTC to perform a successful in-depth personal risk assessment, and to assist patients with developing a concrete, acceptable and achievable risk reduction plan, the testing counselor must be conscious of all personal thoughts and mores to apply appropriate testing practices during the session. The writer will provide an excerpt of a risk-reduction counseling session. The excerpt is an adaptation of a testing and counseling session, modeled after the HIV/AIDS 500/501, adhering to the guidelines of a 20 minute HIV testing and counseling session. In the interest of confidentiality, the patient's name has been changed.

Introduction & Pre-Test Counseling. At the start of a counseling session, the counselor greets the patient and escorts them to the HIV testing office. From the moment the counselor greets the patient, the counselor is attempting to make the patient feel comfortable, while attempting to build a rapport and make the patient feel comfortable. This includes informing the

patient that questions are always welcomed, and that the patient is free to stop the process at any-time if they become uncomfortable. The counselor will remind the patient that the session is confidential, making sure the patient understands the meaning of confidential, i.e. the information discussed will remain between the patient and the counselor, unless the test is reactive/positive or the patient is suffering from severe suicidal/homicidal thoughts. The counselor will request a form of identification (picture and name); and will inform the patient that a referral can be made for any additional testing that is not offered during the testing session, i.e. STI screenings. The HTC will begin the session by asking what the writer refers to as the "magic question". The "magic question" is an open-ended, broad question that will foster a conversation between the HTC and the patient. Typically, the most used question is "what brings you in today for an HIV test?" This open-ended question gives the patient permission to elaborate on their reason for seeking out an HIV test, while allowing the counselor to begin assessing the needs of the patient. The counselor will provide information to the client about the testing process, the window period specific to the HIV test being used, the length of the session, and the potential results; negative, positive and indeterminate, to ensure the client can give informed consent. The HTC will also ask the client to sign a consent form that give permission to the HTC to administer the HIV test. During the session the counselor will assess and discuss with the patient how a negative or positive result will impact them. The session will also include a discussion about the patient's risk factors, and the patient and HTC will identify risky behaviors that the patient might want to work to reduce. The HTC will offer a number of risk and harm reduction options that will lessen the patient's risk of exposure to HIV. The counselor will then administer the test, although this may occur shortly after attaining written consent for the purposes of time management. An experi-

enced HTC might asses the patient without using the state issued data collection form, known as the 1628. This form is usually yellow in color and is provided by the state to collect demographics and behaviors. Patients may find an inexperienced HTC reading directly from the 1628 to help guide the assessment. Whether the HTC reads directly from the 1628 or they have the form memorized doesn't affect the outcome, as long as it is not seen as a barrier to actively listen when assessing the patient. The goal of the "magic question" is to once more allow the patient a chance to express why they are getting tested, and have them talk about the possible risks they were exposed too. During this time the counselor is able to process the information and curtail the session to meet the patient's needs, while helping the patient develop a risk reduction plan, to prevent contracting HIV and STD infections. A noteworthy limitation is the possibility that a patient may not be completely truthful with the HTC.

In response to why are they getting tested, a patient could provide many reasons such as; finding out their spouse or partner is unfaithful or there is a history of infidelity, forced into having sex against their will, never having been tested or been tested in a long time, or if there was/is drug use. There are infinite responses. The counselor must be open to listen, assess and provide a non-biased response. The following is an example of an interaction between a counselor and a patient. Observe the approach the counselor took with the patient. Having a non-biased response made the patient feel more at ease and she shared more details of why she was getting an HIV test.

Mary-Ann was escorted into the office by the counselor and the counselor informed the patient of the testing process and then asked "so what brings you in today, for an HIV test?" The patient responded that she just wanted to get tested; it's been six months since her last test. The

counselor continued "no concerns, unprotected sex, or drug use?" the patient replied "no." As the session progressed, the counselor began to ask detailed questions, "was there a concern when you tested six months prior?" The patient sighed and responded "Okay you got me. What had happened was I cheated on my husband with a very good friend. My last test was when I was pregnant and I slept with the guy about 4 months ago and I haven't used condoms with either partner. (It is important for the counselor to address the issue related to the patient's risks and not show judgment on the patient's behavior).

The counselor then began to discuss the window period and questioned if her husband and the man she slept with has been tested. Mary-Ann replied that her husband refuses because he is not stepping out of the relationship and so she is getting tested for her piece of mind. "I know the other guy I messed with since high school, so I am not worried about him either." At this time the counselor observed that Mary-Ann was making and accepting excuses for why both sexual partners have not been tested. The counselor stated to Mary-Ann, it appears to me that if you weren't really worried, then you wouldn't have come to get tested. Mary-Ann agreed and stated that she is somewhat concerned, because she has stepped out of her marriage, she is aware that her husband could as well and they don't use condoms. The counselor congratulated Mary-Ann, for coming in to get tested and taking care of herself. Then the counselor questioned Mary-Ann about what steps she will be taking to help reduce risk. "Well first I am not sleeping with that guy again" Mary-Ann said while she laughed. The counselor then responded what if you do? "I won't, but if I get the itch I will have a conversation with him about HIV testing and condoms usage. I should also try and convince my husband to get tested without telling him about the incident" Mary-Ann replied.

The counselor offered Mary-Ann condoms, which she refused and stated that she couldn't take condoms home because her husband might suspect something. The counselor suggested using condoms with her husband in sex play and also recommended the female condom. Mary-Ann laughed and replied "I like that idea. It could be like we are dating again and maybe then I could bring up testing". The counselor again congratulated and thanked Mary-Ann for getting tested. The counselor then reminded Mary-Ann about the window period and answered her additional questions.

As demonstrated in the example, an HTC allows the patient to guide them through their personalized risk reduction plan. To end the session the counselor would summarize what the patient said, while providing updated information. Note: during the session the counselor's personal opinions of the patient's behaviors were not voiced.

Post-Test Counseling (negative results). In most cases, after the patient is tested the HTC may ask the patient to wait the remaining time in the waiting area if the patient doesn't have additional questions or concerns. The counselor might also provide the patient with materials about HIV/AIDS, STI's and condoms. Once the results are available, the counselor will call the patient and will immediately give the results to the patient, and explain what the results mean. At this time the HTC might, discuss a re-test if the patient was in the window period, and discuss a follow-up appointment. Then the counselor reviews the patient's personalized risk reduction/elimination activities of the risk plan and addresses any additional questions or concerns the patient may have. The HTC reminds the patient about condom usage and provides supportive information, which includes websites, phone numbers, and addresses for referral and linkage.

Post-Test Counseling (positive results). Once the HTC has reviewed the final results, they will retrieve the patient and will immediately give the results. HTC are trained to pause for a moment and allow time for the patient's reaction.. Once the patient is ready to engage in a conversation about the results, the HTC will discuss the follow-up steps to seeing a doctor (link to care) and actively engage community service providers to help set appointments for the patient once the patient has acknowledged and approved the referrals. The HTC reviews the patient's personal risk reduction/elimination of risk plan, emphasizes the use of condoms, so not to infect others. The HTC discusses with the patient options on how to inform past and present partners about their HIV status, and let the patient know that the local Department of Health will contact them to further assist them with partner notification services. The HTC will then address any additional questions or concerns the patient may have and provide all available support services. They will then assess the patient's emotional and mental state before allowing them to leave the testing office. Once the confirmatory results are given to the patient, the HTC is required to follow up with the patient to ensure they have sought out supportive services, and document the patient's first doctor's appointment, and confirm the patient's attendance.

According to The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide, 2013, the six steps of HIV prevention counseling are:

1. Introduce and orient the patient to the session
2. Identify the patient's personal risk behavior and circumstances
3. Identify safer goal behaviors
4. Identify patient action plan (risk reduction plan)

5. Make linkages and referrals

6. Summarize and provide support

The overall goal of HIV prevention is to support individuals in making changes that will reduce their risk of exposure to HIV, or transmitting HIV. Counseling sessions are tailored to address the personal risk of the patient, rather than providing a predetermined set of information unrelated to the patient's situation (The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide, 2014).

In the literature review the writer will define sexual self-awareness, the benefits relevant to the patient and the counselor, present the counseling skills and their relevance to being sexually self-aware, and then present the sexual self-awareness assessment (SSAA) and training guide.

LITERATURE REVIEW

A literature review was conducted using an electronic database for articles published about sexual self-awareness and training models. During the search, the writer found articles to demonstrate resources available to the 'counseling' profession to build sexual self-awareness. Most of the articles focused on nurses and medical students. The writer located one article that provided a sexual training guide for counselors, in the field of psychology, while other articles focused on nurses. The result of the literature review was that there is no comprehensive training or assessments that focus on building sexual self-awareness for HIV testing counselors.

Landis, Miller and Wettsone (1975) developed sexual awareness training for counselors in the field of psychology. This study was developed after collecting data from eleven APA- approved clinical psychology programs and twenty-one APA-approved counseling psychology programs. The study researched whether programs included sexual awareness training as part of their counselor/psychologist education program. The results of the study indicated that there were only one of the eleven APA-approved clinical psychology programs and four of the twenty-one APA-approved counseling psychology programs that included specific sexual awareness training as part of the program.

The training seminar is described as an intensive weekend experience designed to focus the attention of the participants on their own sexual attitudes, feelings and behavior (Landis et al, 1975). This training only focuses on self-awareness and does not emphasize on the counselor's sexual knowledge or counseling skills (Landis et.al). The four content areas emphasized are: sensuality, male and female masturbation, homosexuality and heterosexuality.

The following are additional surveys and assessments focused on nurses and medical students, but does not assess nor address building sexual self-awareness for HTCs. Reynolds and Megnan (2005) developed a Sexual Attitudes and Beliefs survey, which measures the attitude of sexual health care, focusing mainly on the attitude toward sexual health care. Miller and Lief (1979) developed The Sex Knowledge and Attitude Test (SKAT), which is used mostly with medical students and nurses, and is designed to measure the knowledge, attitudes, and degree of experience in a variety of sexual behaviors. This test was developed to be used as a human sexuality course evaluation (Kim, Kang and Kim 2011). Kim et al developed the Sexual Health Care Scale-Attitude (SHCS-A), this was created to evaluate attitudes towards sexual care in oncology nurses.

In developing The Sexual Self-Awareness Assessment (SSAA) the writer focused on having content on both sexual knowledge and counseling skills; due to the potential lack of professional counseling skills of HTCs. An ongoing assessment of an HTC's sexual health knowledge and attitude could be beneficial to ensure their competency and consistency, while reinforcing the counseling skills presented in the HIV/AID 500/501 certification course. These efforts are to ensure an HTC's ability to provide effective risk reduction counseling and unbiased feedback.

The SSAA has not been tested for validity and reliability. The SSAA will be given to a small sample size of HTCs using a focus group. After the SSAA focus group is complete, each HTC who attended would be given the opportunity to provide feedback verbally and in writing. The results will be recorded and presented in the conclusion and recommendation section, and can be found in the appendix.

Sexual Self-Awareness for HIV Testing Counselors

The CDC has recommended that HIV Prevention counseling be conducted with a client-centered approach aimed at personal risk reduction. Each counseling session is to be tailored to address the personal risk of the patient, rather than a predetermined set of information unrelated to the patient's situation, nor allowing the session to be distracted by patient's additional issues (The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide, 2014). Hill-Sakurai, Lee, and Shore (2014) stated that medical students must be prepared to discuss intricate details of sexuality with a diverse range of patients. Thus, students must consider their own attitudes towards sexual issues, and reflect on how they might respond in unexpected clinical scenarios. In HIV prevention counseling, the topic of sex and sexuality becomes the foundation of the session and without sexual self-awareness, barriers could easily develop and the session would be deemed ineffective.

HTC must be aware that their cultural beliefs and experiences could influence and affect the counseling session. According to Arrendo (1996), culturally skilled counselors believe that cultural self-awareness and sensitivity to one's own cultural heritage is essential. Arrendo also states that culturally skilled counselors are aware of how their own cultural background and experiences have influenced attitudes, values, and biases about psychological processes, culturally skilled counselors recognize their sources of discomfort with differences that exist between themselves and patients in terms of race, ethnicity and culture.

The Effects of Lack of Sexual Self-Awareness

Hill-Sakurai et al (2014) reports it is a special challenge that medical students need to both learn a set of interviewing skills and develop sensitivity to the vast array of personal attitudes and beliefs about sexuality present in the United States. Students must consider their own attitudes towards sexual issues and reflect on how they might respond in unexpected clinical scenarios. An advanced degree or extensive experience is not necessary for effective HIV prevention counseling (CDC Revised Guidelines for HIV Counseling, Testing, and Referral, 2001). This writer argues that it is extremely important for HTCs to receive continuing education, which focuses on the counseling skills taught in the HIV certification training, and being sexually self-aware. This will in turn allow HTCs to conduct a self-assessment on sexual beliefs and values.

When starting a dialogue about the effects of lack of sexual self-awareness, addressing and understanding countertransference are important in developing sexual self-awareness. Countertransference refers to thoughts, feelings and behaviors that counselors experience in relation to their patients (Watkins, 1985). Although it might sound foreign and perhaps irrelevant, it draws attention to the counselor's attitudes and behavior, and the impact that has on the counseling session (Watkins). Countertransference is stated to be the displacement onto the patient of emotional material which in actuality stems from the counselor's internal representations of an important person from their past. This could also be seen as a counselor's unconscious reaction toward a patient. Countertransference is also significant because it derives from some type of counselor identification with the patient (Watkins). The counselor's identification with the patient can be positive or negative, and can result in the manifestation of constructive or destructive Countertransference behaviors. Watkins states that Countertransference is viewed as inappropriate and

bad; it is a phenomenon that the counselor must overcome and work against vigorously. Overall, the ideal counselor attitude to a patient is of a neutral nature.

A counselor's lack of sexual self-awareness can also lead to other psychological defense mechanisms such as projection. Projection is a phenomenon that takes place when a person attributes his or her own characteristics to another person. Sigmund Freud argued that projection is a way of avoiding uncomfortable repressed feelings. In modern psychology, the feelings do not necessarily have to be repressed to constitute projection. Projection is a powerful defense mechanism that provides powerful protection against feelings one does not wish to deal with. As part of projection, a person attributes feelings, motives, or attitudes they find unacceptable in themselves to someone else. In relation to a therapeutic or counseling session, projection could be seen as a barrier to conducting an effective session based on the counselor's lack of awareness and behavior.

The example presented below will demonstrate an interaction between a counselor and a patient, and how the lack of sexual self-awareness can affect the counseling session.

Example 2

A young and popular sex worker enters an HIV testing facility. He is being tested by a counselor; a retired investment banker, who also in his early life had sex for money, drugs and other items. In the beginning of the session, the counselor recognized the young man (as a sex worker) and proceeded with the session. During the session the counselor began to tear up. The young man became frightened assuming the worst. When the young man questioned the counselor about his test, the counselor replied, trying to reach for the young man's hand "it is looking

good so far, but I am worried about you". The young man looks puzzled and asks why. "Well a good looking man like yourself selling your body for money, it hurts my heart, and you shouldn't be doing that. You look like a smart man, why are you not in school?" The young man is instantly offended and walks out of the office, without results or a prevention counseling session.

After the young man expressed his discontent of feeling judged, he was assigned to another counselor. When approached to discuss the incident, the counselor expressed that he was offended and stated "I am three times his age and I saw a little of myself in him when I was his age. I only wanted to help and shake him out it"

The prevention counselor lost focus due to his personal beliefs. Instead of focusing on the young man's immediate risks or his reason for getting tested, he focused on an issue he is not qualified nor trained to do. When conducting the assessment (as a prevention counselor) and finding out the young man is a sex worker, the recommended first question could be "do you always use a condom?" Then begin to curtail the counseling session on patient's responses so the HTC can help the patient reduce their risks, without making judgments about their sexual Behaviors.

Counseling Skills

In this section the writer will define and demonstrate the six counseling skills (knowledge, practice within scope, empathy, understanding stigma, active/reflective listening and conscious self-disclosure) that are relevant to a counselor developing sexual self-awareness. The writer will then introduce the assessment and training program. As discussed earlier in this paper, due to the potential lack of professional counseling background, an ongoing assessment of

an HTC's sexual health knowledge and attitude towards sex could be beneficial to ensure their competency and consistency. Reinforcing the counseling skills presented in the HIV/AID 500/501 certification course is to ensure the counselor can provide effective risk reduction counseling.

Counseling Skill 1: Knowledge

Introduction for HIV Testing Counselors. In this section the writer's goal is to present basic and updated information that an effective HIV testing counselor (HTC) should already possess. While providing counseling to a patient, meeting patients where they are is most effective (this will be addressed further in the active/reflective listening section of this paper). The writer also encourages the HTC to present information in its simplest form to patients. An HTC must have an understanding that the patient will have an opposing view of their own and HTC should most importantly work within the guidelines of an HIV Prevention Counselor. The information presented in this section is information on HIV/AIDS, which is crucial to the process of understanding and creating sexual self-awareness.

Since the early 1980's, there has been a great deal written about AIDS. In 1981, the first case of AIDS became known to the Center of Disease Control and Prevention (CDC), because several otherwise healthy homosexual and bisexual men in California and New York were becoming sick with rare opportunistic diseases (The Basic of HIV AIDS Counseling, Testing and Referral Participant Guide, 2008). On June 5, 1981, two daily newspapers published articles about an unusual outbreak of a rare form of skin cancer among young homosexual men. One of the physicians interviewed at the time noted that the patients had defects in their immune sys-

tems (Miller 2012). Due to the severity of the disease and the population it affected, it was then labeled GRID, Gay-related Immune Deficiency. It wasn't until 1984 that the Human Immunodeficiency Virus (HIV) was determined to be the cause of AIDS. Many HIV/AIDS patients also became victims of violence and discrimination (Miller 2014). Although the term GRID is no longer used, the writer has observed that there are cultures, people, and races that still define and think as HIV/AIDS as a "Gay Man's Disease". HTCs that enforce this way of thinking present another barrier to effectively educate people on prevention of HIV/AIDS.

Receiving a positive/reactive HIV test result no longer means the death sentence it once was, nonetheless, it dramatically changes the lives of those who contract it. The first antiretroviral drug treatment Zidovudine or AZT - was fast tracked to approval in 1987, but even so, HIV/AIDS had become the number one cause of death in the United States by 1992, affecting not just homosexual men, but women, drug users, those with hemophilia and people in prison (Miller, 2012).

Today HIV/AIDS is still considered an epidemic, but patients live longer and have a reasonable chance of halting disease progression if they receive an early diagnosis and remain engaged in regular care and monitoring (Miller 2012). Looking back, in 1995 a new class of drugs known as Highly Active Antiretroviral Therapy (HAART) hit the market, which led to a dramatic decline in deaths which was not a cure. The progression of research in preventive care for people at high-risk for contracting HIV has also hit a milestone when the FDA approved and CDC implemented guidelines to a new drug, Truvada (tenofovir/emtricitabine). This drug is approved for those who are at high-risk of contracting HIV and who now can take the drug as preventative measure, also known as pre-exposure prophylaxis (PrEP).

In reference to risk reduction methods over the years, the CDC and other health entities has discussed and recommended boys and men to get circumcised to reduce the risk of contracting HIV, which will also lower the risk of their sexual partners to be infected. According to the Rabin, R (2014) the federal health official proposes that doctors should start telling sexually active teenage boys who aren't circumcised that if they have the surgery, they can reduce their risk of contracting HIV and other sexually transmitted infections from their female partners. A similar recommendation has also been proposed by the CDC that counseling is urged for adult heterosexual men who remain uncircumcised.

Rabin (2014) reported that male circumcision has been associated with 50 to 60 percent reduction of HIV transmission, as well as a reduction in sexually transmitted infection such as herpes, bacterial vaginosis and the human papilloma virus (H.P.V), which cause penile and cervical cancer. It is also emphasized that circumcision does not entirely eliminate the risk of infections; using condoms from start to finish is the most appropriate precaution for circumcised an uncircumcised men.

The role of an HTC is to beware and have up to date information on risk reduction methods that will enforce one of the goals of an HTC, which is to provide accurate information so their patients can make informed decisions.

Defining HIV and AIDS. According to the U.S. U.S. Department of Health (2012) **HIV** is **H**uman – This particular *virus* can only infect human beings. **I**mmunodeficiency – HIV weakens your *immune system* by destroying important cells that fight disease and infection. A "deficient" immune system cannot protect you. **V**irus – A virus can only reproduce itself by taking

over a cell in the body of its host. In other words the virus cannot live outside of the body, it requires a host to live and duplicate. U.S. Department of Health also stresses that it is important to understand that your body's immune system can fight off most viruses, such as the common cold or flu. But in the case of HIV, the immune system can't seem to fight it; hence the language that is usually used for patients to understand this is "your body is fighting a losing battle".

It has also been proven that HIV can hide for long periods of time in the cells of the body and can attack key parts of the immune system, which includes T-Cells or CD4 cells (white blood cells-which fight infections and diseases) according to U.S. Department of Health (2012). The writer has observed that terms such as "hiding" and "dormant" is mostly misunderstood among people in many communities. It is taken to mean that the virus no longer exist in a person who previously tested positive. By replacing the terms stated above with "undetectable viral load", the writer believes that a lay person would have a better and more accurate understanding of characteristics of the virus. The U.S. Department of Health (2009) states that even when the viral load in your blood is undetectable HIV can still exist in semen, vaginal and rectal fluids, breast milk and other parts of the body, and also doesn't guarantee that you won't transmit HIV to someone else.

It is important to stress the importance of getting tested within the two and half weeks to three months window period of the time of their exposure (this will be explained later). If testing is delayed beyond the window period, research shows that over time as the HIV invades the body and attacks the white blood cells, it duplicates itself and destroys them, and then the body can't fight the infection and diseases anymore (U.S. Department of Health, 2012) which could then lead to AIDS.

According to U.S. Department of Health (2012) AIDS is defined as follows: **A**cquired – AIDS is not something you inherit from your parents. You **acquire** AIDS after birth, **I**mmuno – Your body's immune system includes all the organs and cells that work to fight off infection or disease. **D**eficiency – You get AIDS when your immune system is "deficient," or isn't working the way it should. **S**yndrome – A syndrome is a collection of symptoms and signs of disease. AIDS is a syndrome, rather than a single disease, because it is a complex illness with a wide range of complications and symptoms. Acquired Immunodeficiency Syndrome (AIDS) is the final stage of HIV infection. People at this stage of HIV disease have badly damaged immune systems which put them at risk for opportunistic infections (OIs) (U.S. Department of Health, 2010). When conducting a risk reduction session the writer believes it may be deemed helpful to discuss the difference between how you contract HIV and develop AIDS. The writer has found it helpful to correct language such as "AIDS Tests", and to restate the type of test being administered as an HIV Test.

It is also helpful to explain how AIDS is diagnosed "one will be diagnosed with AIDS if one has one or more Opportunistic Infections (OI), certain cancers, or a very low number of CD 4 Cells. According the U.S. Department of Health (2012) a CD4 count of fewer than 200 cells/mm3 is one of the qualifications for a diagnosis of AIDS. Although, over the years many have died from AIDS or complication of AIDS, we now know that HIV/AIDS is manageable and with proper care and treatment you can prevent death (although people continue to die of AIDS-related complications).

The Origin of HIV/AIDS. There have been many "theories" presented over the years about the origin of HIV. Scientists believe HIV came from a particular kind of chimpanzee in

Western Africa. Humans probably came in contact with HIV when they hunted and ate infected animals. Recent studies indicate that HIV may have jumped from monkeys to humans as far back as the late 1800s (U.S. Department of Health, 2012). In the writer's experience there are still many myths or misconceptions about the origin of HIV. Some believe HIV is man-made (either accidental or deliberate), others believe HIV may have existed for many years as a harmless virus that subsequently mutated into the disease-causing agent first recognized in the early 1980's. The writer encourages HTC to reinforce facts. The writer also suggests that it is important to learn from the past but for the purpose of this dissertation the focus will be on the present, and understanding how the virus is transmitted and what we as individuals can do to prevent the spread HIV (The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide, 2008).

Transmission of HIV/AIDS. HIV is transmitted between humans primarily through unprotected sexual contact. There are five body fluids that contain high levels of HIV: blood, semen (cum), pre-seminal fluid (pre-cum), vaginal fluids/secretion and rectal (anal) mucous (U.S. Department of Health, 2012). There is one body fluid that is not necessarily sexual but can transmit HIV: breast milk.

There are other body fluids and waste products—such as feces, nasal fluid, saliva, sweat, tears, urine, or vomit—that don't contain enough HIV to infect you unless they have blood mixed in them and you have significant and direct contact with them(U.S. Department of Health, 2012). Non-sexual fluids are important to discuss, because there are a lot of myths related to these body fluids, which can prove to be barriers for people to be effectively educated.

Modes of Transmission (U.S. Department of Health, 2012)

- During sexual contact (blood, semen (cum), pre-seminal fluid (pre-cum), vaginal fluids/secretion and rectal (anal) mucous)
- During pregnancy, childbirth, or breastfeeding (breast milk)
- As a result of use of injection drugs (blood)
- As a result of occupational exposure (blood)
- As a result of a blood transfusion with infected blood or an organ transplant from an infected donor: Screening requirements make both of these forms of HIV transmission very rare in the United States.

The Importance of HIV Prevention Counseling & Testing. The National HIV/AIDS Strategy for the United States, The Center for Diseases Control and Prevention (CDC) provides national leadership and support for the implementation of a high-impact prevention approach to reducing new HIV infections by using combinations of scientifically proven, cost-effective, and scalable interventions and prevention strategies directed towards the most vulnerable populations in the US who are most affected by, or at greatest risk for, HIV infection (U.S. Department of Health, 2014).

U.S. health officials say that teenagers and most adults should be tested for HIV, the virus that cause AIDS (Harvard Reviews of Health News 2011). According to the article HIV tests should be routine but voluntary for people ages 13 through 64. Testing could lead to early treatment and help stop the spread of the virus (Harvard). HIV Counseling took on many forms over the years. The first Voluntary Counseling and Testing (VCT), started around 1985, about four

years after the first cases of AIDS in the United States were identified (Frey 2009). At that time most individuals who sought HIV testing were gay men; about 20 percent of those who tested proved to be infected. At that time the focus was on helping infected persons cope with short-term emotional shock of a positive diagnosis… and end of life care. Then in 1991, HIV counseling shifted, after Magic Johnson, a heterosexual basketball star, was diagnosed with HIV. As a result of the publicity given to his diagnosis, large number of heterosexual men and woman began to seek HIV testing (Frey).

The hope is that by offering testing to everyone, people who are infected with the virus and do not know it will learn their status and begin to take necessary precautions when having sex with others, and will receive medical treatment to suppress the virus (Harvard Reviews of Health New 2011). Although progress is being made, including the CDC's implementation of PrEP (Pre-Exposure Prophylaxis), it is with the utmost importance that every person who is engaging in sexual activity be tested at least once a year.

Counseling Skill 2: Practice within Scope

When conducting HIV prevention counseling, the HIV testing counselor (HTC) must remember to approach each session with a client-centered approach aimed to reducing personal risk. The writer stresses how important it is for an HIV prevention counselor to conduct the counseling and testing within the within the scope of their practice, for example to stay within the guidelines of the HIV/AIDS 501. The Basics of HIV/AIDS Counseling, Testing and Referral Participant Guide 2013, states that counseling sessions should be tailored to address the personal risk of the patient rather than to provide a predetermined set of information unrelated to the pa-

tient's situation. In any professional occupation, one must provide services and represent themselves as competent within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience. An HTC may have other skills or be educated in another counseling arena. It is important to remember to follow the guidelines of an HTC, and focus on the patient's personalized sexual risks, address the risks, and assist with developing a risk reduction plan. If the patient reveals other barriers or issues, one should provide supportive resources and refer the patient to the appropriate agency or professional individual. Example three will demonstrate how a twenty-minute prevention counseling session, could inappropriately develop into an hour-long session.

Example 3

Kyle enters a testing office and is greeted by a friendly counselor. The prevention counselor, who is a retired therapist, picked up that Kyle had a lot on his mind. The counselor informed Kyle of the confidentially of the tests and his right to withdraw at any time. Then the counselor obtained informed consent, by allowing Kyle to read and sign the confidentiality and initiation of services documents. The counselor then proceeded to ask "what brings you in today?" Kyle proceeded to explain that he found out his girlfriend has been cheating on him, and she is also getting back into her old habits of 'shooting up'. The counselor proceeded to ask "and how does that make you feel?" the prevention session then turned into how to handle his break up and discussing if he should be dating again, instead of focusing on the fundamentals of HIV prevention counseling.

Observe that the counseling session became sidetracked by the patient's additional issues unrelated to HIV. If there are additional issues or barriers brought up in the session, a prevention counselor should be equipped to provide linkage and referral to a professional service directed at addressing the specific issues the patient may have identified (The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide, 2013).

Counseling Skill 3: Empathy

Effective Counseling: Understanding Empathy In addition to having sexual self-awareness while conducting HIV prevention counseling, the HTC must also have developed and understand empathy in order to maintain an effective counseling session. Empathy is an encouraging word, but more than that, expressing empathy also includes visual, auditory, and tactile communication. Empathy includes the ability to imagine what another person is thinking and feeling. It has been called the primary quality for effective communication (Crews 1979). Empathy can also be seen as a deep understanding for one person's feelings aside from their own. In the field of counseling this might be the driving force for people seeking to become an HTC. The writer has interviewed many people who desire to be part of the HIV field as an HTC, and when asked what their main reason, they typically respond with their desire to help. They've had past experience with HIV/AIDS, and their hope is to make a change in someone else's life whose been affected by the epidemic. While providing HIV testing and counseling, it is crucial that the HTC sets aside their personal needs or feelings from the session and treat the patient with dignity and respect while remaining empathetic to their needs.

Crews 1979 continues that empathy is more than a positive regard or a sense of caring. It is not necessarily innate in those who choose a helping profession like nursing. It is not the same as emotional involvement or compassion. This kind of insight is a creative act of both mind and body. It is an intellectual act because it requires appraisal of another person's behavior; first as the patient sees it, and secondly as a reenactment of how you see it. Empathy is forming a thought and then an action with the benefit of both points of view.

According to McGoran (1978) it is difficult for any person to seriously look at themselves, not through tinted glasses as they might wish, but actually as others see them. This is an uncomfortable task for all and impossible for some…Before help can be provided to others one must first be comfortable with themselves, and must be able to help themselves.

Counseling Skill 4: Understanding Stigma

Stigma related to HIV/AIDS. Stigma and discrimination have been associated with HIV/AIDs since the epidemic first began in the early 1980's, and while there has been global initiatives to address HIV-related stigma the goal of eliminating it is far from being achieved (Visser, 2009). Stigma affects not only the public at large but HIV testers as well.

Addressing stigma as an ongoing practice is important to HIV testing counselors, and for people who care for people living with or affected by HIV. This continued self-actualization process can prevent and eliminate the possible threat that stigma poses on people that work with people suffering the effects of this epidemic. Stigma is best described as a social construction of a deviation from an ideal or expectation that results in a powerful discrediting social label that negatively affects the way individuals view themselves or are viewed by others (Visser). **Stigma**

is often seen as a sign of disgrace or shame and is described as a process of devaluation. **Discrimination, the result of stigma,** involves treating someone in a different and unjust, unfair or prejudicial way (Osborne, 2009).

Addressing and proactively dealing with HIV requires an unprecedented level of honesty (Osborne). Osborne reminds us that stigma and discrimination against people associated with (or living with HIV) is often cited as one of the primary hurdles in addressing prevention and care issues and is a stumbling block in ensuring access to essential services.

Certified HIV testing/prevention counselors interact with people from different cultures, sexualities, and races and it is important to have a greater understanding of stigma and counter its effects (Visser). Visser reports that in order to accomplish this, there first needs to be ways to measure and assess stigma. This task is complex, because stigma is context and time specific and is perceived and experienced differently from different perspectives. The infected individual has a subjective experience of feeling stigmatized; the non-infected individual has an outsider's perspective and holds personal beliefs and feelings towards those with HIV. Each attributes a level of stigmatizing attitudes to others.

The World Health Organization (WHO 2011) reports that men who have sex with men (MSM) are twenty times more likely to be HIV positive than the general population. Often they are reluctant to approach HIV prevention and treatment services due to the stigma and discrimination they face, and in some countries because same-sex relationships are illegal. In the US (more-specifically Florida) combating the effects of HIV, adherence to prescribed medication is a struggle. This is influenced by the fact that the populations (blacks, undocumented, MSM) in-

fected by HIV already feel stigmatized and discriminated, so seeking services becomes an obstacle.

Addressing Stigma related to HIV/AIDS. There is much that has already been done in recent years to educate people about HIV; there is a need now to change attitudes within communities (Visser). Awareness of stigmatizing attitudes and behavior, and efforts to increase HIV-knowledge and reduce fears need to be incorporated into all interventions. But increasing knowledge alone is not sufficient as this now tends to be fairly high (Visser). Instead, information should be provided in an interactive manner that allows for it (stigma) to be personalized, and issues that cause anxiety and discomfort to be addressed (Visser). The writer agrees with and argues the same point in reference to counselors having sexual self-awareness. Osborne reminds us that stigma and discrimination against people associated with or living with HIV is often cited as one of the primary hurdles in addressing prevention and care issues, and is a stumbling block in ensuring access to essential services.

All too frequently, stigma and discrimination are grouped together as one concept. They do have similarities, but they are not necessarily dealt with in the same manner. Osborne reports while they (stigma and discrimination) are related and interlinked, the actions to understand and address each of the individual elements are as different and multifaceted as the HIV/AIDS epidemic itself.

The fourth example is an experience that an employee had as a testing patient and wanted to share the disappointment he felt afterwards. He expressed that the HTC made him feel stigmatized and discriminated against. At the time, he just found out he was HIV positive and didn't

know who to turn to. After ignoring his HIV status for a long time, he decided to become proactive and be part of the solution by becoming an HTC.

Example 4

I went to a local and well-known HIV testing location, and of course I was sweating through my shirt. I answered all the questions truthfully - which was a sign to me I was honestly afraid about my drug use, my very over active sex life for money and my quick fixes. The counselor took my blood and asked me to wait outside. It was the longest twenty- two minutes of my life, but I figured something was wrong when he didn't call me in at twenty minutes. I finally got called into the office and the counselor proceeded to tell me that I am HIV positive. Of course I was in disbelief and he must have read my expression and followed up with the statement "well it's your fault, you are a gay man, and you should know to protect yourself". I was devastated, I tried to put a smile on my face with my eyes welding up with tears, I got the information he presented and left the office. On the way out I saw a large bin and dumped everything the counselor gave me and found my dealer for a night to celebrate.

In addition to understanding stigma and discrimination, Osborne suggested ten things to do to address and assist with the breakdown of HIV-related stigma and discrimination for professionals working with people living with HIV (PLHIV):

1. Remain updated on the latest developments around HIV. Patients look to HIV testing counselors to provide accurate information on new developments in the epidemic. There are still a lot of myths and misunderstandings surrounding HIV care, prevention, management, and how HIV is contracted. Building on one's knowledge is most important to fight stigma, attending

HIV/AIDS conferences, community meetings, and any available informational session should be on the agenda to ensure that what the writer refers to as "old school" information, can be removed from the conversation among individuals (including HTCs) and within communities. A few common examples the writers hears all too often are; "It can take ten years before you can find out you have AIDS" and "some people are just carriers of AIDS, It lays dormant in the body and hides". It is also important for HTCs to have an accurate understanding of the difference between HIV and AIDS, knowing what the window period is, reinforce getting tested to know your status and assist with developing a risk reduction plan to prevent contracting HIV. The writer believes it is important to talk with patients on their definitions of the terms "carrier" and "dormant". In most instances, the writer found that these terms gave individuals the green light to engage in unprotected sex. The writer emphasizes the fact that people who are HIV positive will always be HIV positive until a legitimate cure is found. Being undetectable does not mean that person does not have HIV/AIDS; it simply means it is harder for the person who has HIV/AIDS to infect another person. Patients should feel empowered to form their own risk reduction goals, and by having them talk about it HTC they are more likely to live out their goals they have set for themselves.

2. Practice what is preached. A mentor of the writer once said: *we (people in public health) are the worst at practicing what we preach. We think that we know it all, and in turn, take more risks.* The writer argues that an HTC could potentially take on this poorly- adapted notion, which can lead to inappropriate counseling during a testing session. HTCs are there to empower their patients when developing goals to reduce risk, and while doing so, honor the patient's self-determination.

3. Acknowledge and address the stigmatizing attitudes we may harbor about some behaviors or people who are particularly vulnerable to HIV. Osborne states that because the roots of HIV-related stigma and discrimination run deep, we need to create spaces to confront and talk openly about feelings and attitudes about issues and behaviors that are all too often silenced or taboo. One of the writer's goals in creating a Sexual Self-Awareness training and guide is to provide HTC's a safe space to confront and discuss in an open dialogue feelings and attitudes about sex, sexuality, and HIV/AIDS, which will help reduce stigma and increase an HTC's ability to work with and relate to the patients they serve.

4. Meaningfully engage with people living with HIV to better understand and change attitudes. In other words, actively listen to your patients, with no judgments, and keep an open mind. If one works with patients who are HIV positive, it is important to remember that each individual is unique and should be treated as such. The interactions with each individual should build on the awareness that epidemic is ever changing.

5. Confront personal complacency and "fight like hell for the living". Osborne points out that we should no longer hide behind ignorance and silence.

6. Work in Partnership. Finding your niche in addressing HIV-related stigma should include the creation of core partnerships. For example working with or forming an alliance with an organization that addresses HIV-related issues.

7. Sensitize all health and social service workers to discrimination and act against it. This process starts with HIV testing counselors.

8. Become an active citizen through involvement in a campaign to protect and safeguard the rights of PLHIV. The writer has had many impactful opportunities to actively working within a community-based organization (CBO). Being actively engaged in the fight against stigma and discrimination is one of the ways to understand one's own feelings towards a number of sensitive issues (Osborne 2009).

9. Ensure that a supportive legislative environment exists so that discrimination can be tackled. Living in South Florida and working for a non-profit LGBTQ community center, the writer has encountered many political representatives and activists fighting for the rights of PLHIV. An important role of an HTC is to listen to the needs of patients, and support legislative actions that could benefit their lives.

10. Develop and implement a robust and innovative workplace policy and program. The writer feels that implementing a training guide in the workplace is a good starting point.

Stigma begins and ends with each of us. The real battle must be fought by ensuring individuals have the ability and skills to live, love and find the light that glows in the very shadow of this epidemic (Osborne).

In the fight against stigma and discrimination, the writer believes that an HTC has an additional role to assist their patients with access and adherence. B. Akshaya Srikanth, K.Purushothama Reddy, K.Narotham Reddy, Aditya Hari, and A. Abhijeet 2012, state that the purpose of the patient counseling is to understand the needs of the patients and problem solving skills of the patient for the purpose of improving adherence, maintaining quality of health and life. In the case of an HTC, they are seen as the first step in forming a rapport with the patient.

As seen in example four, after the patient received the positive results and didn't have a positive or supportive experience, taking care of himself became a lesser priority. On the other hand, someone who is in medical care may face other factors and as an HTC one can assist with understanding the issues and referring the patient to supportive services (practice within scope). Providing reassuring information and positive attitude may save a life, and may lessen the stigma of being HIV positive.

Counseling Skill 5: Active/Reflective Listening

CareNotes, 2013 defines active listening as a way of listening closely to what a person has to say. Giving a person their undivided attention is a key component of active and reflective listening. By showing interest and appreciation for their thoughts and concerns, a commitment is made to the patient, allowing them to speak without interruption. Active listening promotes trust between two people, and the patient may view the HTC as a confidant who will listen without judgment.

By summarizing what the patient said and saying it back to them, the HTC is demonstrating reflective listening skills. This demonstrates to the person that they are understood. The more the counselor learns about what is plaguing the patient, the better the chance for the counselor to work with the patient on forming solutions to the stated problem. CareNotes, 2013 proposes a few examples:

- Clarify things that are confusing to you or that you do not understand. You may say "I am not sure I understand, can you tell me more?"

- Admit that you do not have a clear understanding yet and ask the person to clear up the meaning, repeat, or explain.

- Paraphrase the person's message using simple, brief words. This lets you check with the person if you understood the basic message. You may use a phrase such as "Sounds like you are saying . . ." to start your paraphrase.

Although components of active and reflective listening (reflective feelings) are addressed in the training manual, the writer believes that these components are especially important in developing sexual self-awareness. Effectively engaging in active and reflective listening allows the counselor to explore and learn about a person's thoughts, which in turn assists them with better understanding their patient and removing personal thoughts and feelings from the session.

The writer also believes that (corresponding with active/reflecting listen) being aware of non-verbal cues is important. The Basics of HIV/AIDS Counseling, Testing and Referral Participant Guide 2013, state that there are six nonverbal principals of which a counselor should be aware before talking with a patient. They are eye contact, facial expressions, posture, body orientation, touch and physical environment (these can be reviewed in the 500/501 HIV/AIDS participation manual). In addition, the writer stresses that HTCs need to be aware that nonverbal cues regarding communication are necessary to conduct a successful counseling session.

Meeting Patients Where They Are. To be a highly effective active listener it is important to relay information to patients in a manner that they can understand. There are many terms/language that we are given in our trainings and we must be aware that all populations will not comprehend or relate to. Rather than covering a rehearsal list of HIV 101 items in the coun-

seling session, the counselor should determine the patient's current knowledge level regarding HIV/AIDS (The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide, 2013). In other words meet the patient where they are.

How can you achieve this goal? It is important to engage the patient, by asking open-ended questions throughout the session, by asking about their knowledge on HIV transmission or one of the writer's preferred questions, "share with me what you know about HIV/AIDS…anything at all." These questions give the counselor the opportunity to clarify any misinformation the patient has and confirm the correct information (The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide 2013).

Counseling Skill 6: Conscious Self-Disclosure

If an HTC was trained as a professional counselor, the HTC might be resistant to self-disclosing because it is seen as an unethical practice. The writer agrees, but would also argue that self-disclosure can be a helpful tool if used with caution.

Self-disclosure is a communication phenomenon which has become the interest of inquiry because it can be interpreted as a helpful tool that allows the HTC to build rapport and create a sense of common ground with the patient. Having its roots in clinical psychology, self-disclosure has long been of interest to researchers in communication, and several well-established research areas have emerged (Littlejohn, 2009). Self-disclosure can be seen as an expression of personal information that is of a descriptive, affective, or evaluative nature (Littlejohn). For counselors, self-disclosure has been regarded as a viable counseling behavior specifically: the amount of information shared the intimacy level of the shared information and the

time spent disclosing the shared information. Opinions about counselor self-disclosure have varied over time (Watkins, 1990). Some studies have contrasted positive versus negative or personal versus demographic self-disclosure. Positive statements involve the sharing of favorable information about one's experiences or the sharing of experiences congruent with patient's experiences, whereas negative statement refers to the opposite. Personal disclosures have been defined as intimate sharing; demographic disclosures have been defined as non-intimate sharing (Watkins). So should one self-disclose when working with a patient? The writer has no definitive answer, but based on experience has found self-disclosure useful when working with patients-when used effectively (see scenario 2, in example 5).

The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide 2013, states that a counselor may choose to disclose some personal event or situation to the patient that helps with the patient's situation. Counselors must be aware that self-disclosing has advantages and disadvantages. Example five demonstrates both points:

Example 5

An HIV testing counselor, who has been HIV+ for 10 years, sits with a patient who shares their fear of contracting HIV. The counselor, (in hopes to comfort the patient) begins to explain to the patient, that people are living longer lives, some people even reported being healthier and happier. The patient doesn't seem convinced "I had an uncle who died from AIDS, and he was not healthy or happy". The counselor then explains what it takes to be healthy living with HIV. "It's a manageable disease, and if your results are positive I can link you to services

that can help you to make it manageable". The counselor completed the pre-counseling session, conducted the rapid test and then ready to give results.

Scenario 1 (non-disclosure): "Your results are negative!" The patient gave a sigh of relief; the counselor allowed the patient to take in the news then began to provide post test counseling, reminding the patient about the window period, and risk reduction.

Scenario (disclosure) 2: Your results are showing preliminary positive (reactive). The patient stares at the counselor blankly, the counselor waits for the patient to respond. The patient then looks at the counselor and asks "what I am going to do now?, no one is ever going to love me with this disease" The counselor then replied to the patient, "what we are going to do is confirm these results, and if you are ready I can link you to our health navigator who will assist you with getting into care. As I said, HIV is manageable, if you get and stay in-care, the hard part is over and now you know and we are going to assist you in staying healthy", the counselor replied in a soothing voice. "By the way, you being HIV positive does not exclude you from being loved, but I understand why you feel this way. I would like to share with that I tested positive 10 years ago, and it is possible all the thoughts running through your head, I might have felt as well. But once I took control of my life and I stayed in care, I believe I am the healthiest I have ever been, and my boyfriend of 7 years, who is negative, loves me for me and we don't even talk about my status anymore. We know to protect ourselves and he is even researching about the Pre-Exposure Prophylaxis (PrEP) program. The patient, still unsure, agrees to meet with the health navigator and the counselor who self-disclosed, only hopes sharing his experience gives the patient more confidence to move forward.

The writer is optimistic that the reader understands the importance of having a sexual self-awareness when conducting an HIV counseling session. As stated developing sexual self-awareness is not limited to the six skills presented. The writer selected the six in order to build the assessment and develop the brief guide to reinforce counseling skills for HIV testing counselors.

In the following section, the writer will introduce the sexual self-awareness assessment, the case studies, and the trainer's guide. The writer would like to restate that the assessment has not been tested for validity, but the writer was able to conduct a focus group with a group HIV testing counselors, with various skill levels in order in acquire feedback

Sexual Self-Awareness Assessment

Introduction to Sexual Self-Awareness Assessment. The training guide was developed around the sexual self-awareness questions provided. Each question addresses one or more of the six key counseling skills and allows the trainer to assess the participant. In the trainers' assessment, the goal is to provide reconfirmation of the importance of having sexual self-awareness utilizing knowledge, practicing within scope, empathy, understanding stigma, active/reflective listening, and conscious self-disclosure. The trainer allows the participant twenty minutes to complete the assessment, and then will listen to each participant's answers, with their explanations. This could lead to a group discussion, and differences of opinions may arise. It is the trainer's job to try and stay focused on the question and provides feedback, based on the guidelines of an HTC and the keys points given in this guide.

Note each participant must participate in providing an answer and contributing to the discussion. This accounts for the required small group size and allows each participant to interact with the trainer and participants.

Group Size. The recommended group size to conduct an effective training should not exceed twelve participants. An ideal number is between six and ten. The smaller the group, the more quality time and opportunity is offered to participants to practice their skills and engage in meaningful dialogues on their development of their sexual self-awareness. The curriculum consists of individual and group interactive activities that foster participant interaction.

Set up and Break Down. The Sexual Self-Awareness Guide has twenty interactive questions and two case studies. The two day training is divided into six sections; four sections will utilize five questions each. An hour and 45 minutes is allotted for participants to complete the

questions and the trainer(s) to facilitate a discussion on the answers given. The case studies are allotted an hour to read and then answer the follow-up questions.

The alternative one day training is divided into 4 sections; three sections will use six questions and allotted 2 hours for participants to complete the questions and the trainer(s) to facilitate a discussion on the answers given. The case studies are allotted an hour to read and then answer the follow up questions. Reminder: The trainer(s) goal is always guide the group participants to being honest and non-confrontational about the answers presented. The trainer (s) must review each answer with the participants and develop a list of the answers shared, which can be utilized in closing section of the day. Presented in the tables is the trainer(s) agenda and guide for the two-day and alternative one-day training (Tables 1, 2 and 3).

TIME FRAME	**SEXUAL SELF-AWARENESS ASSESSMENT AGENDA: TWO DAY TRAINING-DAY 1**
8:30 a.m. – 8:45 a.m.	Welcome and Introduction • Reason for Training • Ice Breaker • Ground Rules
8:45 a.m. – 9:00 a.m.	Review of Sexual Self-Awareness Key Counseling Skills • Knowledge • Practice With-in Scope • Empathy • Understanding Stigma • Active/Reflective Listening • Conscious Self-Disclosure
9:00 a.m. – 10:45 a.m.	Sexual Self-Awareness Assessment Section 1: Scale Questions *(Instructions: To answer the questions with an asterisk (*), use the **Key: 1=Minimal 2=Moderate 3=High.**)* 1. On a scale from 1-10 (with 1 being the highest) how do you rank your performance as a counselor? Please explain.

	2. What is your comfort level when talking about sexual behaviors different from your own?* 3. How would you rate comfort level using terms such as Penis, Vagina, Anus?* 4. How would you rate your ability to counsel someone who has stated that they have put their partner (married or otherwise) at risk for HIV and STIs?* 5. What is your comfort level with counseling a patient who tests positive for HIV?*
10:45 a.m. – 11:00a.m.	BREAK
11:00 a.m. – 12:00p.m.	Case Study: Matilda
12:00 p.m. – 1:00 p.m.	LUNCH
1:00 p.m. – 2:45 p.m.	Sexual Self-Awareness Assessment Section 2: Strongly Agree or Strongly Disagree *Instructions for setup: Create two signs; Strongly Agree and Strongly Disagree and place them at opposite sides of the room.* 1. As an HTC I must create the patients risk reduction plan. 2. I feel comfortable disclosing_____ in a counseling session.

	- My status - My sexual orientation - My life experiences 3. I feel comfortable and equipped to counsel/interact with - A sex worker/prostitutes - A homeless person - A gay, lesbian or bisexual person - A transgender person 4. I prefer not to discuss my patient's sexual orientation/sexual behaviors during the counseling session. Please explain. 5. I believe someone who is transgender, gay or bisexual are at a higher risk of exposure to HIV. Please explain.
2:45 p.m. – 4:45 p.m.	Sexual Self-Awareness Assessment Section 3:Written Responses 1. How do you define sex? 2. What are the benefits of using open-ended questions? Give examples 3. What are your feelings about someone who acknowledges that they

	put themselves at risk? 4. What is your definition of a high-risk behavior? 5. What are your feelings about a patient reporting they have numerous sexual partners in a year?
4:45 p.m. – 5:00 p.m.	Closing • Wrap up • Questions and Answers (Parking Lot)

Table 1. Two Day Trainer's Agenda and Guide –Day 1

TIME FRAME	SEXUAL SELF-AWARENESS ASSESSMENT AGENDA: TWO DAY TRAINING-DAY 2
8:30 a.m. – 9:00 a.m.	Participant Summary • Review previous day discussions
9:00 a.m. – 10:00 a.m.	Case Study 2: Alexus
10:00 a.m. – 10:10a.m.	BREAK
10:10 a.m. – 11:45a.m.	Sexual Self-Awareness Assessment Section 4: Final Questions 1. What is your comfort level for counseling someone who is 13 years old, and has stated that they are having sex with someone who is 31 years old?* 2. What language could be heard as judgmental from a patient's point of you? 3. How would you rate your ability to separate your religious/faith beliefs from a counseling session?* 4. What is your comfort level for counseling someone who is married and is having sex outside of the relationship?* 5. What is your ability to use neutral and non-biased (language) when discussing sexual behaviors with a patient.*
11:45 a.m. – 12:30p.m.	Closing • Wrap Up • Answers and Questions (Parking Lot)

Table 2. Two Day Trainer's Agenda and Guide –Day 2

TIME FRAME	SEXUAL SELF-AWARENESS ASSESSMENT AGENDA: ALTERNATIVE ONE DAY TRAINING
8:30 a.m. – 8:45 a.m.	Welcome and Introduction • Reason for Training • Ice Breaker • Ground Rules
8:45 a.m. – 9:00 a.m.	Review of Sexual Self-Awareness Key Counseling Skills • Knowledge • Practice With-in Scope • Empathy • Understanding Stigma • Active/Reflective Listening • Conscious Self-Disclosure
9:00 a.m. – 11:00 a.m.	Sexual Self-Awareness Assessment Section 1: Scale Questions *(Instructions: To answer the questions with an asterisk (*), use the **Key:*** ***1=Minimal 2=Moderate 3=High.)*** 1. On a scale from 1-10 (with 1 being the highest) how do you rank your performance as a counselor? Please explain 2. What is your comfort level when talking about sexual behaviors different from your own?* 3. What is comfort level with counseling a patient who tests positive for HIV?* 4. What are your feelings about a patient reporting they have numerous sexual partners in a year? 5. How do you define sex?

	6. I believe someone who is transgender, gay or bisexual are at a higher risk of exposure to HIV. Explain why.
11:00 a.m. – 11:15a.m.	BREAK
11:15 a.m. – 12:15p.m.	Case Study 1: Matilda
12:15 p.m. – 1:30 p.m.	LUNCH
1:30 p.m. – 3:30 p.m.	Sexual Self-Awareness Assessment Section 2: *Instructions for setup: Create two signs; Strongly Agree and Strongly Disagree and place them at opposite sides of the room.* 1. I feel comfortable disclosing_____ in a counseling session. - My status - My sexual orientation - My life experiences 2. As the HTC I must create the patients risk reduction plan. 3. I feel comfortable and equipped to counsel/interact with - A sex worker/prostitutes - A homeless person - A gay, lesbian or bisexual person

	- A transgender person 4. What language could be heard as judgmental from a patient's point of you? 5. How would you rate your ability to separate your religious/faith beliefs from a counseling session?* 6. What are your feelings about someone who acknowledges that they put themselves at risk?
3:30 p.m. – 4:30 p.m.	Case Study 2: Alexus
4:30 p.m. – 4:45 p.m.	Closing • Wrap Up • Answers and Questions (Parking Lot)

Table 3. Alternative One Day Trainer's Agenda and Guide

Sexual Self-Awareness Assessment Trainer's Answers/Guide: Standard Two Day Training

SSAA Trainer's Answers/Guide: Section 1

1. **On a scale from 1-10 (with 1 being the highest) how do you rank your performance as a counselor? Please explain**

Question 1 on a scale from 1-10 (with 1 being the highest) how do you rank your performance as a counselor and why, begins the self-assessment process for each participant. It allows the participants to assess and rates their overall counseling skills. The trainer should revisit and reinforce the positive skills presented by each participant. If there were inappropriate and negative responses shared, the trainer should explore those answers with the participants, facilitate a conversation in search of the correct answers, and provide feedback. Talking points: discussing the six key elements: knowledge, practicing within scope, empathy, understanding stigma, active/reflective listening, and conscious self-disclosure.

2. **What is your comfort level when talking about sexual behaviors different from your own?**

Question 2 is exploring the participants comfort level in discussing sexual preferences that maybe different from their own. The hope is that each participant ranges from moderate to high. Talking points: the role of an HTC includes interacting with people from different sexual backgrounds and applying the knowledge, empathy, active listening and most importantly understanding stigma.

3. **How would you rate your comfort level using terms such as Penis, Vagina, Anus?**

Question 3 is exploring the basic comfort level of the participants, using terms/language that is relatable to the patient. Talking points: An HTC may have to utilize terms that are more relatable to the patient; penis, vagina, and anus might be terms that the patient doesn't relate to. So an HTC must be equipped to use terms such as dick, cock, pussy, and ass. It is important to meet the patient where they are, and by applying knowledge and active/reflecting listening into the session, you could make a bigger impact in reducing the patients' risk in contracting HIV and other STD's.

4. **How would you rate your ability to counsel someone who has stated that they have put their partner (married or otherwise) at risk for HIV and STIs?**

Question 4 is getting the HTC ready to address a topic that is seen too often in a counseling session. HTC could become 'heated' or upset with hearing the patient share this information. The trick is to remember that applying knowledge, practicing within scope, empathy, understanding stigma, active/reflective listening, and conscious self-disclosure is important with this patient. The HTC should focus on the patient in session and during the risk reduction planning, listen for steps on either informing the patients partner(s). Remaining nonjudgmental (understanding stigma) is essential to continue helping the patient form a risk reduction plan. If the patient's results are positive, as the HTC discussing partner counseling referral service should become a priority or informing the patient that they could bring their potentially infected partner to get tested. Remember the patient may already feel some guilt, an HTC should remain neutral and

provide the patient with referral resources and not allow the patient to feel guiltier. Utilizing empathy is also important.

5. **What is the comfort level with counseling a patient who tests positive for HIV?**

Question 5 is addressing a part of the session that some HTC may see as an anxious experience. Remember one of the responsibilities of an HTC is locating newly diagnosed positives and linking them to medical care. The two key elements to focus on is understanding stigma, not allowing the patient to feel stigmatized or discriminated against because of their status, while providing empathy to give the patient the support they may need. Reminder that HIV is a manageable disease and being HIV positive is not what it used to be a decade ago. Conscious self-disclosure may also apply in this discussion, allowing the HTC to disclose their status during a post positive test counseling session should only be done if it is seen as helpful to the patient's session.

SSAA Trainer's Answers/Guide: Section 2

1. **As an HTC I must create the patient's risk reduction plan.**

Question 1 although question one might seem irrelevant, it is a good reminder for HTCs that they are there to guide patients in developing a plan and should never create a risk reduction plan to suit their own needs. During the session, the HTC should remember to apply knowledge, practice within scope, understanding stigma, and active/reflective listening. This will assist the HTC in not forcing their personal feelings/suggestions onto the patient, and allowing the patient to voice their needs, and work on their next steps. The HTC shouldn't have any input, but allow the patient to create their plan and as possible assist and/or challenge to make sure it is reachable

based on the patient's report. For example, patient risk reduction plan states "I am no longer going to worry about HIV, because I am no longer having sex with anyone". As the HTC, you could confront the patient by stating "Well, let's say you meet a man/woman who you connect with and sex is brought up in discussion, how would you have handle that situation?"

2. **I feel comfortable disclosing_____ in a counseling session.**

- **My status**
- **My sexual orientation**
- **My life experiences**

Question 2 is addressing conscious self-disclosure. Each participant might have a different response to the question; there is no right or wrong answer. It is important for the HTC to remember that self-disclosure should only be used if it can be seen as healthy and helpful to the patient's session. Relating personal information shouldn't be used to brag or share information about yourself, it must relate to the patient's needs and be seen as supportive.

3. **I feel comfortable and equipped to counsel/interact with**

- **A sex worker/prostitutes**
- **A homeless person**
- **A gay, lesbian or bisexual person**
- **A transgender person**

Question 3 addresses understanding stigma and practice within scope. As an HTC, there is no way to predict who will enter the office or seek out additional services. An HTC must be

aware of the patient's presence and utilize active/reflecting listening to assist the patient; this most times includes providing information of safe sex practices, creating a risk reduction plan and of course finding out their HIV status. Focusing on knowledge and giving the information simply to all populations will assist the HTC not to focus on who the patient is but on the risks they are taking and how can the patient reduce or eliminate the risk. This does not include stating, "well maybe you should find a more respectable job" or "being gay you are most likely to contract HIV and AIDS." Also utilizing practice within scope as an HTC is important.

4. **I prefer not to discuss my patient's sexual orientation/sexual behaviors, during the counseling session**. **Please explain.**

Question 4 addresses whether an HTC can assist their patient without understanding their risk (active/reflective listening). This question addresses the importance of understanding stigma; in this case homosexuality. As an HTC, you may not personally agree with someone's sexual orientation, behaviors, or preferences, but it is important to remember the session is not about you and the patient is in your office because some form of help is needed.

5. **I believe someone who is transgender, gay or bisexual is at a higher risk of exposure to HIV. Please explain.**

Question 5 addresses understanding stigma and knowledge. There are still people who believe that because they are "straight" (meaning their sexual partners are of the opposite sex) that they cannot contract HIV/AIDS. The other belief is if someone identifies as gay or bisexual that they are at higher risk for contracting HIV. As an HTC, discussing risk should be based on what the patient's have discussed and the sexual practices they partake in. If someone is engag-

ing in unprotected vaginal or anal sex, they are putting themselves at risk. Topics such as testing and discussing sexual contracts should also be involved in the counseling session.

SSAA Trainer's Answers/Guide: Section 3

1. **How do you define sex?**

Question 1 addresses how each participant defines sex. This question is important to remind the participants that sex can be defined in many ways. Applying active/reflecting listening is important in the counseling the session to understand how the patient defines sex. This could deviate from vaginal, anal and oral. The trainer can share their personal experience, for example, *"I had a patient/client who started dating an older dominant man. My patient explained to me that his 'sir' really enjoys fisting him and wants to progress to punch fucking. Although I had some idea of what that meant, I requested an explanation of the sexual act. The patient explained what that meant than expressed his excitement to please his partner. We discussed the risks and spoke about how he can reduce or eliminate risk. Of course my first question was to ask when was the last time his sir had an HIV test?" It is important to remember that an HTC must remain nonjudgmental.*

2. **What are the benefits of using open-ended questions? Give examples**

Question 2 addresses one of the basic counseling skills discussed in the certification training. The benefit of using open-ended questions is a way to find out more information without interrogating the patient, and gets the patient to go beyond giving yes or no answers. An open-ended question invites the patient to answer in a more straightforward manner and it is more difficult for him/her to answer untruthfully. Questions that begin with who, what, where,

when, why and how are said to be best (The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide, 2013). Also, by using open-ended questions, the counselor is less likely to sound judgmental. Examples: "What brings you in today?" instead of "Are you here for an HIV test" and "How many sex partners have you had in the past twelve months?" Instead of "do you have a lot of sex partners?"

3. **What are your feelings about someone who acknowledges that they put themselves at risk?**

Question 3 brings the counselor's personal feelings and thoughts into the counseling session. The trainer must remind the participants of the importance of understanding stigma, applying knowledge, active/reflective listening and practicing within scope. As an HTC, the focus is on risk reduction/elimination. There are many reasons why a patient would put themselves at risk. It may not always be intentional or by choice, but it is important to provide resources/referral for the patient who might identify as high-risk. Discussing prevention tools such as Pre Exposure Prophylaxis (PrEP) and effective condom usage could be beneficial to the patient. Most importantly listen to the patient's reasoning and build your session around it. Remind the participants about Matilda (case study) and how important it is for the patient not to feel judged, but empowered to protect themselves.

4. **What is your definition of high-risk behaviors?**

Question 4 is a trick question for the participants. High-risk behaviors can vary by who you are counseling. A patient who is has many sexually partners is just as high-risk as someone who is married to someone who refuses to get tested and not use condoms, this may also include

someone who sharing and injecting drugs. In the counseling session, defining a high-risk patient should be more internal or sometimes a patient will tell you that because of their lifestyle they are at high-risk. Focus on understanding stigma, active/reflective listening, and knowledge.

5. **What are your feelings about a patient reporting they have numerous sexual partners in a year?**

Question 5 pushes the participants to again keep judgments to themselves, which in turn allows the patient to feel open to discuss their sexual relations (of course not in detail) and the HTC can then provide appropriate counseling for patient. Talking points: understanding stigma, practice within scope and knowledge.

SSAA Trainer's Answers/Guide: Section 4

1. **What is your comfort level for counseling someone who is 13 years old, and has stated that they are having sex with someone who is 31 year old?**

Question 1 addresses a few issues which a HTC could potentially confront. The HTC must remember practicing within scope, understanding stigma, knowledge, and sometimes conscious self-disclosure. CDC recommends HIV testing for anyone 13 and above as part of their medical routine. Recall the final case study with Alexus; she didn't present herself as a victim or being abused, but seeking information for herself. It is a safe bet to assess for abuse and/or domestic violence, especially with young patients who are sexually active. Providing information simply (knowledge) to any patient would be most effective. When counseling someone this young, it may be best to seek supervision to express any concerns. Practice within scope is also an im-

portant reminder. Here are a few questions that you could ask yourself: What is my agency policy for reporting such situation? Why is the patient in my office? Is he/she forced to be here? Can I provide the service they deserve, in reference to developing a risk reduction plan? What resources could I provide? In conclusion, you much follow the policies and guideline of your profession. For example, as a social worker you are a mandated reporter. Next, familiarize yourself with the agency/organizations policy on such a situation. Inform this patient of the policy you are following, to be transparent and upfront. Still focus on the patient's personal risk behaviors and circumstances, identify safe goal behaviors, develop a risk reduction plan, provide resources and support to the patient (this could mean just providing condoms).

2. What language could be heard as judgmental from a patient's point of you?

Question 2 is a review of using open-ended questions. The benefit of using "open-ended" questions is you can subtly retrieve an answer from a patient that can go beyond a simple yes or no. An open-ended question invites the patient to answer in a more straightforward manner and it is more difficult for him/her to answer untruthfully. Questions that begin with who, what where when, why and how are said to be best (The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide, 2013). Also, by using open-ended questions, the counselor is less likely to sound judgmental. Examples: "In the last twelve months, have you had anal sex with a man?" instead of "You're not gay or are you gay?" and "How many sex partners have you had in the past twelve months?" Instead of "do you have a lot of sex partners?"

3. **How would you rate your ability to separate your religious/faith beliefs from a counseling session?**

Question 3 addresses a topic that potentially could be confronted in a counseling session, either by HTC or patient. Understanding stigma becomes the focus of attention in this question, as well as meeting the patient where they are. An HTC must respect the patient's beliefs and not force their own upon the patient. For example, An HTC should avoid statements such as "your body is a temple, why are allowing so many men to enter it" or "homosexuality is a sin, Leviticus 18…" It is important to remember that each patient comes from different cultural, spiritual and religious background and utilizing active/reflective listening results in a better understanding of the patient's situation in key. Focus on developing the risk reduction plan and provide resources to further assist the patient. Refrain from using religious language in the session such as "Gods will be done, whatever the results are". If you and the patient share similar believes this can be used to build rapport, but remain positive and non judgmental. *Example: Patient enters the office and states, I already prayed about this test and I believe Jesus is going to spare me. The counselor replied, "What brings in you into the office today?" After the patient explains their situation, the HTC provides information based on the patient's risk intake. The patient requests "can we pray one last time? It will make me feel better." The HTC agrees and they bow their heads to pray.*

4. **What is your comfort level for counseling someone who is married and is having sex outside of the relationship?**

Question 4 is a review question about keeping judgments to oneself. Although as the HTC you may be thinking "cheating bastard", you must listen and focus on the patient in session. Assess your patient's needs, discuss their risk reduction plan and be prepared to discuss sexual agreements/contracts. It could be important to discuss the sexual agreement between the partners and as the HTC be comfortable to hear that having additional partners is their sexual agreement. The HTC could also explore condoms usage and HIV testing practices. *Example: a young man walks in to get an HIV tested. He reports that he has been tested 2 months ago, but had a few "slip ups" when his wife wasn't close by and couldn't bring himself to tell her. The HTC noted the young man stated "close by"; then proceeded to ask the patient what is his sexual agreement with his wife. The young man reported that he and his wife are considered swingers, but agreed to always use condoms with other partners. The counselor questioned if the agreement included all sexual acts. The young man appeared confused and questioned what other sexual acts there could be? The HTC followed up by asking about the slip up and what that entailed. The young man replied "while I was messing around (kissing and grinding on a female partner), I realized she had guided my dick into her pussy, it felt so good, I didn't stop, but I didn't cum inside her. The counselor smiled and replied, "I was trying to assess what was the slip up, and I could have assumed you were referring to oral sex." The young man replied," you could contract HIV from oral sex….?"*

Remaining nonjudgmental (understanding stigma) is most important, along with continuing to help the patient form a risk reduction plan. If the patient results are positive, discussing

partner counseling referral service should become a priority for the HTC along with informing the patient that they could bring their potentially infected partner to get tested. Remember the patient may already feel some shade of guilt. An HTC should remain neutral and provide the patient with referral resources and not allow the patient to feel guiltier. Applying empathy is important.

5. **What is your ability to use neutral and non-biased (language) when discussing sexual behaviors that a patient**?*

Question 5 is a review of using open-end questions, nonjudgmental language and focusing on knowledge. It is also important to remember verbal and nonverbal communication; eye contact, facial expressions, posture, body orientation, touch and the psychical environment. The overall take away is not to present as judgmental and be careful with using terms that could offend the patient.

Sexual Self-Awareness Assessment Trainer's Guide: Alternative One Day Training

SSAA Trainer's Answers/Guide: Section 1

1. **On a scale from 1-10 (with 1 being the highest) how do you rank your performance as a counselor? Please explain_____**

Question 1 on a scale from 1-10 (with 1 being the highest) how do you rank your performance as a counselor and why, begins the self-assessment process for each participant. It allows the participants to assess and rates their overall counseling skills. The trainer should revisit and reinforce the positive skills presented by each participant. If there were inappropriate and nega-

tive responses shared, the trainer should explore those answers with the participants, facilitate a conversation in search of the correct answers, and provide feedback. Talking points: discussing the six key elements: knowledge, practicing within scope, empathy, understanding stigma, active/reflective listening, and conscious self-disclosure.

2. **What is your comfort level when talking about sexual behaviors different from your own?**

   Question 2 is exploring the participants comfort level in discussing sexual preferences that maybe different from their own. The hope is that each participant ranges from moderate to high. Talking points: the role of an HTC includes interacting with people from different sexual backgrounds and applying the knowledge, empathy, active listening and most importantly understanding stigma.

3. **What is your comfort level with counseling a patient who tests positive for HIV?**

Question 3 is addressing a part of the session that some HTC may see as an anxious experience. Remember one of the responsibilities of an HTC is locating newly diagnosed positives and linking them to medical care. The two key elements to focus on is understanding stigma, not allowing the patient to feel stigmatized or discriminated against because of their status, while providing empathy to give the patient the support they may need. Reminder that HIV is a manageable disease and being HIV positive is not what it used to be a decade ago. Conscious self-disclosure may also apply in this discussion, allowing the HTC to disclose their status during a post positive test counseling session should only be done if it is seen as helpful to the patient's session.

4. **What are your feelings about a patient reporting they have numerous sexual partners in a year?**

Question 4 pushes the participants to again keep judgments to themselves, which in turn allows the patient to feel open to discuss their sexual relations (of course not in detail) and the HTC can then provide appropriate counseling for patient. Talking points: understanding stigma, practice within scope and knowledge.

5. **How do you define sex?**

Question 5 addresses how each participant defines sex. This question is important to remind the participants that sex can be defined in many ways. Applying active/reflecting listening is important in the counseling the session to understand how the patient defines sex. This could deviate from vaginal, anal and oral. The trainer can share their personal experience, for example, *"I had a patient/client who started dating an older dominant man. My patient explained to me that his 'sir' really enjoys fisting him and wants to progress to punch fucking. Although I had some idea of what that meant, I requested an explanation of the sexual act. The patient explained what that meant than expressed his excitement to please his partner. We discussed the risks and spoke about how he can reduce or eliminate risk. Of course my first question was to ask when was the last time his sir had an HIV test?" It is important to remember that an HTC must remain non-judgmental.*

6. **I believe someone who is transgender, gay or bisexual is at a higher risk of exposure to HIV. Please explain.**

Question 6 addresses understanding stigma and knowledge. There are still people who believe that because they are "straight" (meaning their sexual partners are of the opposite sex) that they cannot contract HIV/AIDS. The other belief is if someone identifies as gay or bisexual that they are at higher risk for contracting HIV. As an HTC, discussing risk should be based on what the patient's have discussed and the sexual practices they partake in. If someone is engaging in unprotected vaginal or anal sex, they are putting themselves at risk. Topics such as testing and discussing sexual contracts should also be involved in the counseling session.

SSAA Trainer's Answers/Guide: Section 2 Alternative One Day

1. **I feel comfortable disclosing_____ in a counseling session.**

- **My status**
- **My sexual orientation**
- **My life experiences**

Question 1 is addressing conscious self-disclosure. Each participant might have a different response to the question; there is no right or wrong answer. It is important for the HTC to remember that self-disclosure should only be used if it can be seen as healthy and helpful to the patient's session. Relating personal information shouldn't be used to brag or share information about yourself, it must relate to the patient's needs and be seen as supportive.

2. As the HTC I must create the patients risk reduction plan.

Question 2 although question one might seem irrelevant, it is a good reminder for HTCs that they are there to guide patients in developing a plan and should never create a risk reduction plan to suit their own needs. During the session, the HTC should remember to apply knowledge, practice within scope, understanding stigma, and active/reflective listening. This will assist the HTC in not forcing their personal feelings/suggestions onto the patient, and allowing the patient to voice their needs, and work on their next steps. The HTC shouldn't have any input, but allow the patient to create their plan and as possible assist and/or challenge to make sure it is reachable based on the patient's report. For example, patient risk reduction plan states "I am no longer going to worry about HIV, because I am no longer having sex with anyone". As the HTC, you could confront the patient by stating "Well, let's say you meet a man/woman who you connect with and sex is brought up in discussion, how would you have handle that situation?"

3. I feel comfortable and equipped to counsel/interact with

- **A sex worker/prostitutes**
- **A Homeless person**
- **A gay, lesbian bisexual**
- **A transgender person**

Question 3 addresses understanding stigma and practice within scope. As an HTC, there is no way to predict who will enter the office or seek out additional services. An HTC must be aware of the patient's presence and utilize active/reflecting listening to assist the patient; this most times includes providing information of safe sex practices, creating a risk reduction plan

and of course finding out their HIV status. Focusing on knowledge and giving the information simply to all populations will assist the HTC not to focus on who the patient is but on the risks they are taking and how can the patient reduce or eliminate the risk. This does not include stating, "well maybe you should find a more respectable job" or "being gay you are most likely to contract HIV and AIDS." Also utilizing practice within scope as an HTC is important.

4. **What language could be heard as judgmental from the patient's point of you?**

Question 4 is a review of using open-ended questions. The benefit of using "open-ended" questions is you can subtly retrieve an answer from a patient that can go beyond a simple yes or no. An open-ended question invites the patient to answer in a more straightforward manner and it is more difficult for him/her to answer untruthfully. Questions that begin with who, what where when, why and how are said to be best (The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide, 2013). Also, by using open-ended questions, the counselor is less likely to sound judgmental. Examples: "In the last twelve months, have you had anal sex with a man?" instead of "You're not gay or are you gay?" and "How many sex partners have you had in the past twelve months?" Instead of "do you have a lot of sex partners?"

5. **How would you rate your ability to separate your religion/faith beliefs from a counseling session?**

Question 5 addresses a topic that potentially could be confronted in a counseling session, either by HTC or patient. Understanding stigma becomes the focus of attention in this question, as well as meeting the patient where they are. An HTC must respect the patient's beliefs and not force their own upon the patient. For example, An HTC should avoid statements such as "your

body is a temple, why are allowing so many men to enter it" or "homosexuality is a sin, Leviticus 18…" It is important to remember that each patient comes from different cultural, spiritual and religious background and utilizing active/reflective listening results in a better understanding of the patient's situation in key. Focus on developing the risk reduction plan and provide resources to further assist the patient. Refrain from using religious language in the session such as "Gods will be done, whatever the results are". If you and the patient share similar believes this can be used to build rapport, but remain positive and non judgmental. *Example: Patient enters the office and states, I already prayed about this test and I believe Jesus is going to spare me. The counselor replied, "What brings in you into the office today?" After the patient explains their situation, the HTC provides information based on the patient's risk intake. The patient requests "can we pray one last time? It will make me feel better." The HTC agrees and they bow their heads to pray.*

6. **What are your feelings about someone acknowledges they put themselves at risk?**

Question 6 brings the counselor's personal feelings and thoughts into the counseling session. The trainer must remind the participants of the importance of understanding stigma, applying knowledge, active/reflective listening and practicing within scope. As an HTC, the focus is on risk reduction/elimination. There are many reasons why a patient would put themselves at risk. It may not always be intentional or by choice, but it is important to provide resources/referral for the patient who might identify as high-risk. Discussing prevention tools such as Pre Exposure Prophylaxis (PrEP) and effective condom usage could be beneficial to the patient. Most importantly listen to the patient's reasoning and build your session around it. Remind

the participants about Matilda (case study) and how important it is for the patient not to feel judged, but empowered to protect themselves.

Sexual Self -Awareness Assessment: Case Studies

The case studies were designed to give the participants of the training program an understanding of the effects of having a lack of sexual self-awareness and to enable them to potentially build their skills and underscore the problems they may encounter in the practice setting. The case studies take place in a counseling setting with different characters. The case studies have a series of questions that will challenge the participants to discuss the positive and negative aspects of the event. Role-playing is not required. Note: The presented scenarios are recorded from the writer's current employment; the names have been changed to maintain confidentiality.

Case Study 1: Matilda

Matilda is an attractive and passable 32 year transgender woman (male to female). Matilda lost her job as a waitress and started working at a popular strip bar that caters to men who enjoy the company of transgender women. Matilda enjoys stripping, but she has also been aware that she could make extra money if she indulges in sexual favors with the patients who seek private dances. Matilda has never been tested for HIV nor talked to anyone about risk reduction behavior.

A few weeks working at the bar, Matilda fell on some hard times and needed to make fast money to cover some unexpected expenses. Matilda began to sleep with several men a day and some without condoms. One afternoon one of Matilda's co-workers shared that she was recently

diagnosed with HIV. The co-worker shared that she is sure she caught it from a certain patron who Matilda is seeing. Matilda, who had never been tested, decided to get tested for HIV and STD's.

Matilda enters the testing office with a brave face and the HTC started the counseling session "Hi I am Jose and I will be your testing counselor. What brings you in today for an HIV test?" Matilda shares her story with the HTC almost in tears. After hearing Matilda's story the HTC reached for Matilda's hand, "I am HIV positive, I am very healthy and very single" he says with a smile. Jose proceeds to share with Matilda that he is recently divorced from his wife, who he believes infected him. Jose then stated "So Matilda, it sounds like it has been a rough few weeks for you, but I am happy to see that you came in for an HIV test. Again I am HIV positive and wouldn't wish this on my worst enemy." Matilda laughed nervously and replied "How long have you been HIV positive, are you gay? The tester responded "No I am straight." During the counseling session, the tester began to question Matilda about her private life; where she worked, what she charged men who wanted more than a dance, and has she had bottom surgery? Matilda began to move uncomfortably in her chair, but she had never gotten an HIV test, so assumed the questions were part of the HIV testing process.

Case Study 2: Alexus

Alexus had a strange feeling that her 31 year old boyfriend might be cheating on her, so she decided to get an HIV and STI test. Alexus is short in stature, well developed and speaks very maturely. She sits in the counselor's office. "Hi, My name is Blake, what brings you in today for an HIV Test?" Alexus explains her situation. "I have been dating this guy for almost a year and

we don't live together (for obvious reasons-she assumes the HTC is aware of her age) but sometimes when I'm with him, he seems distant. Now the sex is great, and he is everything I want in a man, tall, dark, handsome, kinda nerdy and for the most part treats me very good. My parents would kill me if they knew we were even dating." The counselor then requested her ID to start the testing process while asking her if they use condoms. Alexus replied "I don't have an ID, but I have my school ID and we use condoms sometimes." During the session the counselor found out that Alexus is 14 and her partner was a man in his 20's. The counselor proceeded to engage Alexus, but stated "if we are going to continue, please don't share the name of your partner and we will continue with the counseling session". Alexus agreed and proceeded to share her concerns with counselor.

Case Study Follow Up Questions

What did the counselor do well?

What did the counselor not do so well?

Did the HTC demonstrate Sexual Self-Awareness?

What testing skills would most benefit the HTC?

Was there an alternative way to handle the patient's situation?

Case Study Trainer's Answer/Guide

Case Study 1: **Matilda**.

Overall in the case study the HTC made the session about himself and appeared distracted. Jose seemed to ask the right questions but had inappropriate follow through. The trainer must remind the participants of the important of practicing within scope, applying knowledge, understanding stigma knowledge and active/reflective listening. The HTC should focus on risk reduction/elimination. Jose could have missed an opportunity to empower Matilda to protect herself and provide referrals to additional resources, for STD testing, condoms and possible additional counseling. It was important for Jose to be more sexually aware and not allow his inquisitions to distract from the session or make Matilda feel judged or uncomfortable.

Case Study 2: Alexus

Overall the HTC must remember to apply knowledge, practice within scope, understanding stigma, and sometimes conscious self-disclosure. CDC recommends HIV testing for anyone 13 and above as part of their medical routine. It is a safe bet to assess for abuse and/or violence especially with young patients who are sexually active. Proving information to young patients (sometimes any age), providing information simply (knowledge) could be most effective.

An HTC must be aware of their comfort level when counseling someone this young. It may be best to speak with your supervisor to address any concerns. Practice within scope is an important reminder to address the patient in the 'here and now', but before you enter the counseling session there should be a few questions you could ask yourself: Does my agency have a policy in place for such a situation? Why is the patient in my office? Is he/she forced to be here?

Could I provide the service they deserve in reference to developing a risk reduction plan? What resources could I provide?

In conclusion, you must follow the policies and guideline of your profession, for example as a social worker you are a mandated reporter. Next, familiarize yourself with the agency/organizations policy on such a situation. Inform this patient of the policy you are following, to be transparent and upfront. Still focus on the patient's personal risk behaviors and circumstances, identify safe goal behaviors, develop a risk reduction plan, provide resources and support to the patient (this could simply mean condoms).

Discussion and Feedback of Sexual Self-Awareness Assessment

The writer was given the opportunity to host a focus group, in order to get input on the training guide. The writer was able to recruit ten HIV Testing Counselors (HTC) who participated in a mock implementation of the one day alternative Sexual Self-Awareness Assessment and Training. The group included five HTCs who had been certified for 3 months or less and five HTCs who have been testing for two years or more.

In the beginning of the focus group, the writer instructed the participants to be open and provide any input during the training. This extended the time of the training and sparked relevant dialogue of the important of the training. The writer also informed the participants that an online survey will be submitted for additional feedback and once again to be open and detailed as they possibly can.

Each participant was very engaged (as the program requires) in the discussions of the assessment and case studies. Throughout the training the participating HTCs (through the assessment) revealed very personal feelings that they knew potentially could affect their session, but never thought to address it or the impact it may have on the patient or the counseling session. For example how their religious and cultural beliefs could have shaped how they responded to questions presented by patients. During the mock implementation, the writer observed that, across the board, the participants became very passionate about addressing the counseling skills. They voiced that the questions in the assessment were relevant to scenarios they had to address or they heard other counselors has voiced in concern. The group overall stated the assessment could be more interactive, for example exchanging the answers of each participant, to allow others to defend an opposite view. This idea could be implemented into one of the sections in the training curriculum.

After the focus group, the writer collected the feedback to further understand the impact and relevance of the Sexual Self-Awareness Training. The questions were developed by the writer and edited by the chair of the dissertation committee, then emailed to the each participant through surveymonkey.com . The questions were as followed:

1. Was the purpose of the focus group/training explained?
2. In your opinion was the focus group/training effective?
3. How could this program be more effective?
4. In your opinion was the training: Too Long, Too Short or Needs to be expanded.

5. Did the focus group/training impact your effectiveness as an HIV Testing Counselor and please describe your experience participating in the focus group/training.

6. Please provide any additional feedback on the focus group/training

The writer received 8 out of 10 responses from the survey and recorded the responses in appendix H.

CONCLUSION AND RECOMMENDATIONS

This dissertation addresses the need for supplemental training for HIV testing counselors (HTC) and the importance of sexual self-awareness in counseling. This writer combined components of counselor sexual self-awareness and counseling skills to create a guide and assessment that would address the need for continuing education and supplemental trainings for HTC.

The writer sees the role of an HTC as an important one, providing accurate and nonbiased information to patients who seek out knowledge on how to combat the epidemic of HIV/AIDS. In addition, the purpose of this paper is to underline the importance of testing and counseling being utilized, within the guidelines of HIV testing and counseling certification. The writer hopes that incorporating a supplementary training that focuses on HTC sexual self-awareness and their counseling skills can potentially improve the effectiveness of each counseling session.

HTCs are exposed to patients from various cultures, races, ethnicities and gender identities that may differ from their own and being self-aware will assist the HTCs to approach each patient with an open-mind. Hill-Sakurai, Lee, and Shore (2014) stated that in practice we must be prepared to discuss intricate details of sexuality with a diverse range of patients. Thus, it is important to consider, in HIV counseling, our own attitudes towards sexual issues and reflect on how you might respond in unexpected clinical scenarios.

The motivation to create a training guide to assist HTC and possibly anyone in a counseling profession was developed over the years of working with people who are at high-risk for contracting HIV and those people who have been newly infected. The writer believes in provid-

ing knowledge and having a familiarity with your own sexual awareness is essential to maintain a successful and effective session with patients.

As stated, the writer was given the opportunity to implement the supplemental training to a group of HTC in the form of a focus group. The overall feedback of what the training provides was well received (see appendix H).

The writer's goal is to hopefully expand upon the presented training curriculum and to globally implement this supplemental training to all HIV Testing Counselors.

APPENDICES

APPENDIX A:

CURRICULUM FOR SEXUAL SELF-AWARENESS TRAINING

Introduction. The training program includes the following components: The Sexual Self-Awareness assessment (SSAA), the training outline, and two case studies. The training will be completed on a one-time basis or as needed in one or two days. Note that the participants for the training are anyone who is providing HIV testing and counseling, but also could include persons with experience providing counseling or with a baseline of clinical skills. The goal of this manual is to guide trainers in training HIV prevention counselors to implement the SSA. The foundation of the curriculum is taken from HIV/AIDS 500/501 course, so it important to understand that we are building on the existing counseling skills of HIV testing and counseling, the overall intension to apply sexual-self awareness into each session to assist with enhancing counseling skills, which in turn helps to increase the ability for counselors to conduct risk reduction counseling by understanding the true focus of the session: the patient in their chair.

The guide is centered on six key counseling skills to build sexual self-awareness: knowledge, practice within scope, empathy, understanding stigma, active/reflective listening, and conscious self-disclosure. Most of the counseling skills are addressed in the HIV/AIDS 500/501 participation guide for HIV testers. This manual will continue to utilize and build on those skills to assist with developing sexual self-awareness. The questions for Sexual Self-Awareness Guide (SSAG) are used to guide the curriculum in tandem with the case studies.

Trainers Qualifications:

This course requires one or more trainers to conduct course. Trainer(s) must be practicing as a HTC for more than two consecutive years; to demonstrate experience. The selection of who could be a trainer can be determined by local U.S. Department of Health or any governing health organization e.g. CDC, WHO etc.

Note to Trainers

- All participants must be present for the entire training. Certificates shall not be provided to participants who do not attend the entire course. In the event of an emergency preventing the participant from completing the course, the participant should negotiate with the trainer to complete the missed segments at a future course and then be given the certificate. Note that this is critical for ensuring the quality of implementing the Sexual Self-Awareness Training.

- The trainer should ensure training sessions commence on time and request all participants to arrive on time. There is much material to be covered each day, and it can be very disruptive to have participants arrive at the training sessions when the sessions have already begun.

- It is important to maintain confidentiality at all times. Trainers are urged to ask all participants to maintain the confidentiality of all fellow participants.

- Trainers should encourage participants to respect individual differences. Participants frequently come from different ethnic and cultural and lifestyles, beliefs, personal experiences and expertise.

- Participants should be encouraged to listen carefully and with empathy, and respect each other's contributions, opinions, and experiences. The trainer should explain that it is important in the training, and as professionals, to practice active listening by allowing each other to share their own experiences and opinions with the group.

- Trainers should create an environment in which each participant feels comfortable asking questions. Participants need to be able to ask questions about what they do not understand.

- In the field of HIV/AIDS there are constant changes in transmission patterns, treatment, perceptions, attitudes, etc.; participants should be reminded to consistently update their information regarding HIV and AIDS. As providers, it is important to keep abreast of changing information. With the latest information, resources and treatments available, a better service can be provided to the patient.

Trainer's Materials Checklist

- ✓ Trainer's Manuel
- ✓ Participant's Manuel includes: description of training, schedule, sexual self awareness assessment/questionnaire, case studies and update resources pertaining to the training and HIV testing and counseling.
- ✓ Training Space: "U" shape set-up recommended for participants
- ✓ Large sheets of paper
- ✓ Scotch tape

- ✓ Markers
- ✓ Power Point (if needed)
- ✓ Strongly Agree and Strongly Disagree signs
- ✓ An Ice Breaker exercise focusing on name, agency, length of occupation, and possibly share something personal

APPENDIX B

Participant's Agenda: Two-Day Training

DAY 1

8:30 a.m.-8:45 a.m. Welcome/Introduction

8:45a.m.-9:00 a.m. Review of Sexual Self-Awareness Key Counseling Skills.

9:00a.m.-10:45 a.m. Sexual Self-Awareness Assessment Section 1: 5 Questions (Scale Responses)

10:45 a.m. -11.00 a.m. **Break**

11:00 a.m. -12:00 p.m. Case Study 1: Matilda

12:00 p.m. -1:00 p.m. **Lunch**

1:00 p.m. -2:45 p.m. Sexual Self-Awareness Assessment Section 2: 5 Questions (Strongly Agree or Disagree)

2:45 p.m. -4:45 p.m. Sexual Self- Awareness Assessment Section 3: 5 Questions (written responses)

4:45 p.m. -5:00 p.m. Questions and answers/Closing

DAY 2

8:30 a.m. -9:00 a.m. Participant's Summary

9:00 a.m. -10:00 a.m. Case Study 2: Alexus

10:00 a.m. -10:10 a.m. Break

10:10 a.m. -11:45 a.m. Sexual Self-Awareness Assessment Section 4: Combination Questions

11:45 a.m. - 12:30 p.m. Wrap-up/Questions and answers/Closing

APPENDIX C

Participant's Agenda: Alternative One Day Training

8:30 a.m. -8:45 a.m. Welcome/Introduction

8:45 a.m. -9:00 a.m. Review of Sexual Self-Awareness Key Counseling Skills

9:00 a.m. -11:00 a.m. Sexual self-awareness Assessment Section 1: 6 Questions

11:00 a.m. -11:15 a.m. **Break**

11:15 a.m. -12:15 p.m. Case Study 1: Matilda

12:15 p.m. -1:30 p.m. **Lunch**

1:30 p.m. -3:30 p.m. Sexual Self-Awareness Assessment part 2: 6 Questions

3:30 p.m. –4:30 p.m. Case Study 2: Alexus

4:30 p.m. -4:45 p.m. Questions and answers/Closing

APPENDIX D

SUMMARY OF COUNSELING SKILLS

Knowledge

HIV Testing Counselors (HTC) should have the basic and advanced knowledge on HIV/AIDS. Providing counseling to a patient, one should meet the patient where they are and should present information in its simplest form. HTC should also have an understanding that a patient could have an opposing view from their own, but it is most important to remember to work with-in the guidelines of an HIV Prevention Counselor.

Practice within Scope

When conducting HIV prevention counseling, HTC's must remember that they must approach each session with a patient-centered approach and aim to reduce the patient's personal risk. Remember the guidelines of the HIV/AIDS 501. The Basics of HIV/AIDS Counseling, Testing and Referral Participant Guide 2013, states that counseling sessions should be tailored to address the personal risk of the patient rather than to provide a predetermined set of information unrelated to the patient's situation.

Empathy

Having sexual self-awareness while conducting HIV prevention counseling; the counselor must also develop and understand empathy, in order to maintain an effective counseling session. Empathy is an encouraging word and also having the ability to imagine what another person is thinking and feeling.

Understanding Stigma

Addressing stigma is important, to allow HIV testing counselors or people who will care for people who HIV+ or at risk, continue the awareness of themselves; which could also relate to their sexual self-awareness. Stigma can be described as a social construction of a deviation from an ideal or expectation that results in a powerful discrediting social label and negatively affects the way individuals view themselves or are viewed by others (Visser, 2009).

Stigma is often seen as a sign of disgrace or shame and is described as a process of devaluation. **Discrimination** involves treating someone in a different and unjust, unfair or prejudicial way.

Active/Reflective Listening

Effectively engaging in active and reflective listening allows the counselor to explore and learn about a person thought, which in turn assists them with better understanding of their patient and removing personal thoughts and feeling from the session. The counselor must also be aware of non-verbal cues to assist with a successful counseling session.

Conscious Self-disclosure

Self-disclosure can be seen as an expression of personal information that is of a descriptive, affective, or evaluative nature (Littlejohn, 2009). For counselors, self-disclosure has been regarded as a viable counseling behavior: the amount of information shared, the intimacy level of the shared information, and the time spent disclosing the shared information.

The Basics of HIV AIDS Counseling, Testing and Referral Participant Guide 2013, states that a counselor may choose to disclose some personal event or situation to the patient that helps with the patient's situation. Counselors must be aware that self-disclosing has advantages and disadvantages.

APPENDIX E

Sexual Self-Awareness Assessment (SSAA): Two-Day Training Questions

Instructions: To answer the questions with an asterisk (*), use the **Key: 1=Minimal 2=Moderate 3=High.**

SSAA Section 1

1. On a scale from 1-10 (with 1 being the highest) how do you rank your performance as a counselor? Please explain.
2. What is your comfort level when talking about sexual behaviors different from your own?*
3. How would you rate comfort level using terms such as Penis, Vagina, Anus?*
4. How would you rate your ability to counsel someone who has stated that they have put their partner (married or otherwise) at risk for HIV and STIs?*
5. What is your comfort level with counseling a patient who tests positive for HIV?*

SSAA Section 2: Strongly Agree or Strongly Disagree

1. As an HTC I must create the patients risk reduction plan.
2. I feel comfortable disclosing_____ in a counseling session.
   - My status
   - My sexual orientation
   - My life experiences

3. I feel comfortable and equipped to counsel/interact with

    - A sex worker/prostitutes
    - A homeless person
    - A gay, lesbian or bisexual person
    - A transgender person

4. I prefer not to discuss my patient's sexual orientation/sexual behaviors during the counseling session. Explain why.

5. I believe someone who is transgender, gay or bisexual are at a higher risk of exposure to HIV. Explain why.

SSAA Section 3: Written Responses

1. How do you define sex?

2. What are the benefits of using open-ended questions? Give examples.

3. What are your feelings about someone acknowledges that they put themselves at risk?

4. What is your definition of a high-risk behavior?

5. What are your feelings about a patient reporting they have numerous sexual partners in a year?

SSAA Section 4

1. What is your comfort level for counseling someone who is 13 years old, and has stated that they are having sex with someone who is 31 years old?*

2. What language could be heard as judgmental from a patient's point of you?

3. How would you rate your ability to separate your religious/faith beliefs from a counseling session?*

4. What is your comfort level for counseling someone who is married and is having sex outside of the relationship?*

5. What is your ability to use neutral and non-biased (language) when discussing sexual behaviors with a patient*

APPENDIX F

Sexual Self-Awareness Assessment: Alternative One Day Training Questions

Instructions: To answer the questions with an asterisk (*), use the **Key: 1=Minimal 2=Moderate 3=High**

SSAA Section 1 Alternative One Day

1. On a scale from 1-10 (with 1 being the highest) how do you rank your performance as a counselor? Please explain.
2. What is your comfort level when talking about sexual behaviors different from your own?*
3. What is comfort level with counseling a patient who tests positive for HIV?*
4. What are your feelings about a patient reporting they have numerous sexual partners in a year?
5. How do you define sex?
6. I believe someone who is transgender, gay or bisexual are at a higher risk of exposure to HIV. Explain why.

SSAA Section 2

1. I feel comfortable disclosing_____ in a counseling session.

- My status
- My sexual orientation

- My life experiences

2. As the HTC I must create the patients risk reduction plan.

3. I feel comfortable and equipped to counsel/interact with

- A sex worker/prostitutes

- A homeless person

- A gay, lesbian or bisexual person

- A transgender person

4. What language could be heard as judgmental from a patient's point of you?

5. How would you rate your ability to separate your religious/faith beliefs from a counseling session?*

6. What are your feelings about someone acknowledges that they put themselves at risk?

APPENDIX G

Case Study 1: Matilda

Matilda is an attractive and passable 32 year transgender woman (male to female). Matilda lost her job as a waitress and started working at a popular strip bar that caters to men who enjoy the company of transgender women. Matilda enjoys stripping, but she has also been aware that she could make extra money if she indulges in sexual favors with the patients who seek private dances. Matilda has never been tested for HIV nor talked to anyone about risk reduction behavior.

A few weeks working at the bar, Matilda fell on some hard times and needed to make fast money to cover some unexpected expenses. Matilda began to sleep with several men a day and some without condoms. One afternoon one of Matilda's co-workers shared that she was recently diagnosed with HIV. The co-worker shared that she is sure she caught it from a certain patron who Matilda is seeing. Matilda, who had never been tested, decided to get tested for HIV and STD's.

Matilda enters the testing office with a brave face and the HTC started the counseling session "Hi I am Jose and I will be your testing counselor. What brings you in today for an HIV test?" Matilda shares her story with the HTC almost in tears. After hearing Matilda's story the HTC reached for Matilda's hand, "I am HIV positive, I am very healthy and very single" he says with a smile. Jose proceeds to share with Matilda that he is recently divorced from his wife, who he believes infected him. Jose then stated "So Matilda, it sounds like it has been a rough few weeks for you, but I am happy to see that you came in for an HIV test. Again I am HIV positive and wouldn't wish this on my worst enemy." Matilda laughed nervously and replied "How long

have you been HIV positive, are you gay? The tester responded "No I am straight." During the counseling session, the tester began to question Matilda about her private life; where she worked, what she charged men who wanted more than a dance, and has she had bottom surgery? Matilda began to move uncomfortably in her chair, but she had never gotten an HIV test, so assumed the questions were part of the HIV testing process.

Case Study 2: Alexus

Alexus had a strange feeling that her 31 year old boyfriend might be cheating on her, so she decided to get an HIV and STI test. Alexus is short in stature, well developed and speaks very maturely. She sits in the counselor's office. "Hi, My name is Blake, what brings you in today for an HIV Test?" Alexus explains her situation. "I have been dating this guy for almost a year and we don't live together (for obvious reasons-she assumes the HTC is aware of her age) but sometimes when I'm with him, he seems distant. Now the sex is great, and he is everything I want in a man, tall, dark, handsome, kinda nerdy and for the most part treats me very good. My parents would kill me if they knew we were even dating." The counselor then requested her ID to start the testing process while asking her if they use condoms. Alexus replied "I don't have an ID, but I have my school ID and we use condoms sometimes." During the session the counselor found out that Alexus is 14 and her partner was a man in his 20's. The counselor proceeded to engage Alexus, but stated "if we are going to continue, please don't share the name of your partner and we will continue with the counseling session". Alexus agreed and proceeded to share her concerns with counselor.

Case Study Follow Up Questions

Case Study 1& 2:

What did the counselor do well?

What did the counselor not do so well?

Did the HTC demonstrate Sexual Self-Awareness?

What testing skills would most benefit the HTC?

Was there an alternative way to handle the patient's situation?

APPENDIX H

Participant's Feedback (Focus Group)

Question 1: Was the purpose of the focus group/training explained

Respondent A: Yes

Respondent B: Yes

Respondent C: Yes

Respondent D: Yes

Respondent E: Yes

Respondent F: Yes

Respondent G: Yes

Respondent H: Yes

Question 2: In your opinion was the focus group/training effective?

Respondent A: Yes

Respondent B: Yes

Respondent C: Yes

Respondent D: Yes

Respondent F: Yes

Respondent G: Yes

Respondent H: Yes

Question 3: How could this program be more effective?

Respondent A: I only able to attend the first half of the focus group, and yet I found it very use-ful.

Respondent B: The program could be more interactive. There was an activity near the end, but more could be added.

Respondent C: More time spent on study/discussion of case studies.

Respondent D: More materials to review.

Respondent E: Perhaps more interactive, but overall it held my attention well.

Respondent F: There was some confusing language in the materials-we discussed as a group how best to change the language to reflect the true nature of the program.

Respondent G: The facilitator did an excellent job in taking notes and suggestions from the group.

Respondent H: It is sufficiently effective.

Question 4: In your opinion was the training: Too Long, Too Short or Needs to be expanded.

Respondent A: No Response

Respondent B: Too Long

Respondent C: Needs to be expanded

Respondent D: Needs to be expanded

Respondent E: Needs to be expanded

Respondent F: Needs to be expanded

Respondent G: No Response

Respondent H: Too Long

Question 5: Did the focus group/training impact your effectiveness as an HIV Testing Counselor and please describe your experience participating in the focus group/training.

Respondent A: I enjoyed the discussions and look forward to using them in my future testing.

Respondent B: I enjoyed participating. I got to know other testers better and examine my own skills and biases.

Respondent C: Gave insight into areas that may need more attention or that have to be refreshed or reminded about.

Respondent D: Already open minded and non judgmental but overall it was good. I would like to see more case studies and or real life scenarios of inappropriate tester behavior.

Respondent E: I found that hearing the opinions and perspectives of others in the group was very helpful in understanding the many different types of patients I see when testing. I can gain a lot more understanding and empathy from hearing the experiences of my colleagues. I also felt that the training encouraged me to open up a bit about some things that I wasn't sure how I would handle if they came up.

Respondent F: Yes; I learned more refined skills from more experienced counselors and was able to take that with me to my clients.

Respondent G: Yes. It provided insight on different skill sets and tools I can use to better asses my clients while being aware of self.

Respondent H: Yes

Question 6: Please provide any additional feedback on the focus group/training

Respondent A: No response.

Respondent B: It a focused and comprehensive training. I believe expanding the course, by including more inactive participation, would help break the ice and the program engaging.

Respondent C: I feel it should be an integral part of a yearly or some update. ALL counselors/testers would benefit from having this information brought to their attention.

Respondent D: No response

Respondent E: The training was a great experience and very beneficial. I felt it covered the counseling aspect of HIV testing much more effectively than the 501 class provided by the health department.

Respondent F: No Response

Respondent G: I think this is an excellent training module and can be expanded upon to utilize different topics quarterly to enhance skill building.

Respondent H: No Response

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