Module 4

COUNSELING SKILLS FOR THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

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Module 4

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Module 4  — Unit 1 SELF-CONCEPT OF THE COUNSELOR
Counseling skills for the prevention of mother-to-child transmission of HIV

Use the ‘Counseling’ set of transparencies to present the information for this session. Use the transparency at the point indicated in the text with a flag, title and number.

Objectives

Introduce the module by presenting the learning objectives below in a mini-lecture using the transparency.

General

By the end of the module, participants will have basic knowledge of counseling skills and knowledge needed for voluntary counseling and testing for prevention of mother-to-child transmission of HIV and will be able to supervise and support other staff.

Specific

The participants will be able to

⇒ explore and have an understanding of who they are, their values, sex attitudes, fears, prejudices, weaknesses and strengths
⇒ describe basic information on MTCT and HIV/AIDS
⇒ describe and demonstrate basic counseling skills
⇒ describe the guidelines for pre- and post-testing clients for HIV and ongoing support for clients after testing
⇒ describe challenges that clients face when coming for VCT for the prevention of MTCT of HIV
⇒ describe possible challenges that the counselor or counseling aide may face when working with clients coming for VCT for the prevention of MTCT of HIV
⇒ explain how to self-assess
Unit 1

Self-concept and self-perception of the counselor

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Training of health workers for VCT

Counselors must be adequately trained to provide HIV counseling, given the sensitive and challenging nature of their work. The health workers selected for the VCT for MTCT interventions course should either undergo or have undergone a counseling course of at least certificate level.

Training methods

- Introduce subtopics through short lectures.
- Have participants do group work and brainstorm to link knowledge with their experiences.
- Role-play typical selected problems and interventions.
- Voluntarily share personal experiences.

Media to be used

- Prepared transparencies
- Flip charts
- Reading text

How session will be assessed

The facilitator and other colleagues will observe the participants during the class role-plays and give them feedback. The participants will also complete pre- and post-training written evaluations to show what they have learned.

Self-awareness

Introduce this subject by providing the information below in a mini-lecture.
The counselor as a person

Counseling differs from many occupations, in that its main tools are people. Counselors and clients bring many characteristics into a session and experience many thoughts and feelings during it. Counselors are first of all people and secondly they are counselors. They have their own weaknesses, strengths, fears, anxieties, doubts and certainties. All these can either hinder or facilitate their work with clients. Counselors must therefore continuously engage themselves in self-exploration to be aware of themselves, how others affect them, and the effect they have on others. The self-concept is one way that counselors may attempt to understand themselves.

Ask the participants to apply the self-concept quiz below on themselves individually.

Self-concept quiz

This is not a test. There are no right or wrong answers. You will not have to show what you’ve marked to anyone if you don’t want to. Tick in the left box the statements below that describe you most of the time. For each statement that describes you, tick the box that represents how you feel about being like that.

<table>
<thead>
<tr>
<th>I like being like this</th>
<th>I am indifferent</th>
<th>I dislike being like this</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am happy</td>
<td></td>
<td></td>
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<tr>
<td>I am a mess</td>
<td></td>
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<tr>
<td>I am successful</td>
<td></td>
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<tr>
<td>I am a slow learner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am clumsy</td>
<td></td>
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<tr>
<td>I am respectable</td>
<td></td>
<td></td>
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<tr>
<td>I am a good parent</td>
<td></td>
<td></td>
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<tr>
<td>I am attractive</td>
<td></td>
<td></td>
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<tr>
<td>I am a good lover</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am a bore</td>
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</table>
Module 4 — Unit 1  

**SELF-CONCEPT OF THE COUNSELOR**

<table>
<thead>
<tr>
<th></th>
<th>I like being like this</th>
<th>I am indifferent</th>
<th>I dislike being like this</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am a loser</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am conscientious</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I am a cheat</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I am an introvert</td>
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<td></td>
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<tr>
<td>I am a daydreamer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am an optimist</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>I am reliable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am a good friend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am moody</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am sociable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am religious</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I am intelligent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am weak willed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am a loner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am kind</td>
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<td></td>
</tr>
</tbody>
</table>

😊 After the participants have completed the quiz, ask anyone who wishes to share their responses to the quiz with the group to do so. Emphasize, however, that ‘you do not have to share if you are not comfortable doing so’. When a volunteer shares responses, discuss what each reflects in self-awareness, using the information below.

Some of the statements above may help you to understand what your self-concept is.

The self-concept can be considered as made up of two components: the statements that you ticked (in the left-hand box) are part of your self-picture or self-image. The right-hand box that you ticked determines your self-esteem, self-worth or degree of self-acceptance.

Many other statements could have been chosen. The list here is just a random sample.
Self-concept model

The graphic model and its explanation

The self-concept model is a map or illustration that can enable people to understand themselves better.

The model of self-concept is like a map or an illustration that can help people understand themselves better. It is divided into four equal and interrelated parts: self-image, ideal self, body image, and self-esteem.

The four parts of the self-concept have three intrinsic circles superimposed on them: the public, the private, and the hidden domains.

Public domain

All the information here is public or can easily be made public by the person. The person here has little control over personal information such as, sex, age, race, colour, tribe, residence, occupation.

Private domain

Information here is confidential. The person has control over what to tell others and discloses this information to only a chosen few. It includes secrets or intimate thoughts such as ‘I am a loser, a failure, rich, in love with . . ., hate . . ., am poor’.
Hidden domain

Information here is not in the person’s awareness. It is information from early childhood memories, which may be painful, embarrassing or humiliating to remember and so the person has learned to repress it deeply in the unconscious. Examples here are incest and sexual abuse in childhood. This person may need professional help from a known psychoanalyst.

Self-image

Self-image comprises the statements that describe who we are, for example, ‘I am a counselor, a nurse, a mother, a wife, a grandmother, HIV positive. I am bright, foolish, clever, patient, jealous, a good cook, lazy, hardworking, impatient.’

Ideal self

Every person has someone they would like to be like or something they aspire to have, for example, ‘I would like to be rich, married, a mother, a responsible father, an employer. I would like to complete college, build or buy a house, get a promotion, look nice. I would like to be rich, slimmer, fatter, attractive.’

Body image

. . . is what we think our body looks like. How we think our body looks is not always straightforward or acceptable to us. Some people are not happy with their body weight or size or shape despite being told that they are all right. They may not like the fact that they are too thin, fat, short, tall, dark or light complexioned, have straight or curly hair.

Self-esteem

After knowing ourselves it is important to find out what we like about who or what we are. This is our total worth or our pride, values, enjoyment or respect about ourselves.

If both our self-image and our body image correspond with our ideal self, then our self-esteem is reasonably high. If our public domain and private domain are not much different, meaning that we are open and have nothing much to hide from people, then our self-esteem is also high.
Psychosocial consequences of HIV among women

This part of the module should be taught by a trainer who is familiar with the needs of women in relation to HIV/AIDS, preferably a counselor working with an AIDS service organization. As you present the following information, pause at each transparency to ask participants to share their experience as providers. Write each response on a flip chart and ask the other participants to comment as appropriate.

Vulnerability of women

The number of infected women worldwide is growing rapidly, and many more are dying of AIDS while young in comparison with men or with the numbers of children. Women are more vulnerable to AIDS because . . .

⇒ they lack access to means of prevention, health care and support
⇒ there is economic and social inequality between men and women

Also, for women, there are implications of mother-to-child transmission during pregnancy, birth and breastfeeding.

Women’s concerns

Women’s concerns regarding HIV infection

Women often discover their status by accident, after the spouse or partner or child is already symptomatic. The woman in this case has to deal with a double crisis—that of the spouse or child’s illness as well as her own.

Women are often wrongly accused of having brought the infection into the family. Hence, women testing positive may have fears of being isolated or abandoned by family and friends. Many times these fears are real.

The woman’s infection may be the first indication that she or her partner has had another partner, and disclosure of this within the family unit may be traumatic.

Fear of social stigma, abandonment by family, friends and community, and
extreme feelings of isolation and loneliness may compel a woman to keep her condition secret. Infected women may be extremely concerned about the welfare of their children and underestimate their own needs. Some may fear that their children will be taken away.

Infected women may have to make tough and often painful decisions about their personal lives. Such decisions include

- who will take care of their children after their own death?
- whether to invest in antiretroviral drugs
- whether to avoid pregnancy
- whether to breastfeed
- contraception options

A woman may risk conflict with her spouse, abandonment or even violence—for example, if she asks her sexual partner to use condoms. Some infected women will risk getting pregnant or keeping a pregnancy because of the great importance her culture places upon childbearing.

The woman’s family is bound to be affected, and some in her family may feel betrayed or resent the infected person’s irresponsibility in jeopardizing the health and life of other family members. In some instances, the infected woman may leave or her natural family may abandon her. Issues of intimacy and trust may arise, and questions have to be addressed of whether sexual relations should continue and whether condoms will be used. In cultures where women are considered subordinate to their husbands, there are possibilities of further transmission if sexual relations are forced. Fear of social stigma may force the family into a conspiracy of silence, which may impose an emotional strain on the family. Family members may also for the first time discover that the woman is a commercial sex worker and feel embarrassed and resentful.

It is thus evident that the infected woman has many concerns and therefore needs a lot of support from family members, friends, professionals and the community in general. Since ‘prevention is better than cure’, it is important that the woman is helped to protect herself from getting HIV and therefore from infecting others or facing some of the painful consequences mentioned. One of those likely consequences is transmitting the virus to her unborn child.
Common emotional reactions in an infected woman

😊 Brainstorm with the participants, amplifying the points that follow.

The infected women is likely to feel—

⇒ anger towards the person who may have infected her
⇒ grief at her loss of health and status, changed body image and sexuality, the possibility of having to give up having children and of dying and leaving her children alone
⇒ guilt relating to how she may have been the cause of illness in her own family, particularly in her children
**Objectives**

As a participant you will be able to . . .
- explore and understand your own values, attitudes, fears, prejudices
- describe information on MTCT and HIV/AIDS
- demonstrate counseling skills
- describe challenges faced by HIV clients and counselors
- explain how to self-assess

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**Self-awareness**

- The main tool for counseling is people
- People have many characteristics, experiences, feelings, which can hinder or facilitate work
- People need to self-explore

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**Self-concept model**

![Self-concept model diagram]

- Self-image
- Body image
- Ideal self
- Self-esteem
Vulnerability of women

Women often—
◆ lack access to services
◆ suffer from socio-economic inequality

Women must also bear the implications and responsibility of mother-to-child transmission

Women’s concerns

◆ Double crisis of self plus child or husband
◆ Fear of isolation and rejection
◆ Worry about welfare of children
◆ Tough and painful decisions
  – invest in antiretroviral drugs?
  – avoid pregnancy?
  – avoid breastfeeding?
  – risk conflict with spouse?
Unit 2

Introduction to HIV/AIDS counseling

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Introduction to HIV/AIDS counseling

Present the following information below and pause at each transparency to ask participants to share their experience as providers. Write the responses from each participant on a flip chart and ask other participants to comment as appropriate.

General counseling

Counseling is a vital part of HIV/AIDS care and a fundamental part of good clinical management. There are many definitions of counseling. One is ‘a skilled system of helping individuals to explore personal issues, for them to make decisions and put plans into action’.

The British Association of Counseling defines counseling as ‘the skilled and principled use of relationships that develop self-knowledge, emotional acceptance and growth, and personal resources. The overall aim is to live more fully and satisfyingly. Counseling may be concerned with addressing and resolving specific problems, making decisions, coping with crises, working through feelings and inner conflict, or improving relationships with others. The counselor’s responsibility is to facilitate the client’s work in ways that respect the client’s values, personal resources, and capacity for self-determination.’

Counselors are trained in the theories of counseling and are perceived by both recipient and themselves as the recipient’s counselor.

Are you counseling or using counseling skills?

Counseling vs using counseling skills

Use the information below to outline the differences between ‘doing counseling’ and ‘using counseling skills’.

Counseling is often confused with using counseling skills. Doing counseling and using counseling skills are not one and the same thing. Counseling, however, involves using counseling skills.
Definition—One is said to be using counseling skills and not doing counseling when

⇒ counseling skills are being used in the course of their day-to-day work
⇒ counseling skills are being used to enhance the everyday role of nurse, doctor, social worker, teacher, priest, clerk and so on
⇒ counseling skills are used to enhance communication with someone but without taking the role of the counselor
⇒ the recipient perceives the person using the skills as acting within one’s functional or professional role, not the role of a counselor

Counseling skills are distinguished from ‘listening’ or ‘counseling’ but contain elements of both activities. The distinction is if the intention of the user is to enhance the performance of the functional role of line-manager, nurse, doctor or another. Neither the client nor the helper in this case sees the helper as the client's counselor. The helper is not necessarily trained in counseling but probably in counseling skills.

Only when both recipient and helper explicitly contract to enter into a counseling relationship does the activity cease to be ‘using counseling skills’ and becomes ‘counseling’.

Other helping skills

Give a mini-lecture using the following information to discuss other forms of helping skills, different from counseling skills, that providers use in their work. Ask participants to share work experiences when they have used one or another of these skills.

There are various ways of helping. The following are practised along with counseling skills.

⇒ giving general advice
⇒ giving information
⇒ befriending or being a buddy
⇒ advocating for client
⇒ intervening temporarily in a crisis for those unable to act for themselves
⇒ educating

The following can be used independently as a part of a counseling relationship:
⇒ giving personal information to address client’s needs
⇒ obtaining informed consent, helping solve problems, assisting in decision making

Difference between counseling and education

Ask the participants to brainstorm about the differences between counseling and education. Write the information on a flip chart using a table similar to the one below. Encourage all who make an input by writing down their contribution. At this stage, there are no right or wrong answers. When it appears there are no more contributions, use the table following to fill in information gaps.

<table>
<thead>
<tr>
<th>Counseling is</th>
<th>Education or guidance is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plans</td>
<td>Directives</td>
</tr>
<tr>
<td>Choices</td>
<td>Guidance</td>
</tr>
<tr>
<td>Client</td>
<td></td>
</tr>
<tr>
<td>Options</td>
<td>Information</td>
</tr>
<tr>
<td>Decisions</td>
<td>Teaching</td>
</tr>
</tbody>
</table>

The heart of psychotherapy
Affective, value oriented, deals with perception, motivation, needs and feelings
More personal, intimate, less structured, interpersonal, private and confidential
Largely emotional, flexible, less didactic
Usually initiated by client

The body of psychotherapy
Knowledge based, deals with facts, principles, methods and cognition
Less personal, less intimate, usually structured and more public
Informative and didactic
Usually initiated by counselor
What is HIV/AIDS counseling?

HIV/AIDS counseling is applying the general principles of counseling to a specific situation to help someone to cope with the issues and concerns arising from actual HIV infection or the possibility of being infected or from caring for someone in either of these situations. The process includes evaluating the personal risk of HIV transmission and encouraging preventive behaviour.

Why is HIV counseling necessary?

Brainstorm with the participants and fill in information gaps using the following information.

HIV/AIDS is a life-threatening illness and the issues involved in HIV/AIDS infection may be painful, frightening, and threatening to patients and health care staff. Counseling is necessary.

- The infection with HIV is lifelong and has no cure.
- AIDS is almost always fatal. Patients, lovers and families have to cope with this reality and adjust to acute, chronic and terminal illness.
- HIV is infectious, and it is likely that the person infected with the virus will remain infected and infectious for life. Clients should be made aware of the importance of avoiding reinfection with HIV and new infections such as STDs as well as protecting others.
- Those most at risk are the young, and a diagnosis of HIV may mean a loss of independence physically, psychologically and socially. Issues of sex and sexuality, normally not easily or comfortably addressed, must be addressed.
- Fears arise from the uncertainty of unpredictable medical conditions and the reactions of the people close to them.
- Information is conflicting and knowledge incomplete about the prognosis, care and prevention of HIV.
- Infected persons and those closest to them are likely to have a broad range of physical, psychological and social needs and problems. Some of the issues requiring adjustment involve housing, finance, treatment and resuscitation.
- Good management can help contain these problems. Individuals, their families and even the community can get help on how to live and to cope
with their problems. When difficulties are identified early, plans can be made and appropriate referrals made ahead of crises. Some psychiatric problems may even be avoided.

- Coordination is needed. Since HIV/AIDS affects many parts of the body, it is likely that many medical specialists will be seeing the same client, and this is likely to confuse the client at times.

- Counseling provides the support needed to bring and sustain changes in risk behaviour.

- Since knowledge alone is not enough, counseling helps the client find new and perhaps different approaches to safer sex and responsible social relationships. Behavioural change can prevent a person from acquiring HIV infection or transmitting it to others.

- Counseling helps those infected to live with the infection. They are helped to deal actively with their problems to lead more fulfilling lives. They can keep control over their lives by learning to solve their problems and make their own decisions.

Who is an HIV counselor or counselor aide?

The HIV counselor or counseling aide

The counselor or counseling aide is anyone who intentionally takes the role of providing counseling about issues related to HIV infection, whether this role is temporary, alternating with other helping roles, or is full-time, to the exclusion of other forms of helping.

Who should counsel?

Counseling in HIV/AIDS infection can be either a full-time commitment or a part-time caring role of health care professionals in the hospital, community, or blood transfusion centre. These professionals include nurses, social workers, counselors, psychologists and therapists, religious workers, community-based workers, community members, friends and family members, members of AIDS organizations, and people with AIDS.

The person doing HIV/AIDS counseling must be fully trained in in-depth counseling or in counseling skills as well as in HIV/AIDS counseling.
Triangle of counseling providers

Discuss the definition of counseling using the transparency and the following information.

The person should have a genuine interest in working with and helping people with HIV/AIDS and most important of all should have the necessary qualities of a good helper. Specialist HIV/AIDS counselors should be appointed to deal with the complicated and time-consuming client issues in clinical settings.

Triangle of providers of HIV counseling

Providers who have received in-depth training in counseling theory and practice—450 hours of diploma or degree work in counseling plus HIV/AIDS counseling

Providers who have received training in counseling theory and practice—150 hours of training with a certificate in counseling course plus training in HIV pre- and post-test counseling

Providers who have received short training courses to help people concerned about HIV—20–30 hours of basic counseling skills and HIV awareness

Who is HIV/AIDS counseling for?

Brainstorm with the participants using the information below.

All sexually active people in all countries of the world who engage in unprotected sexual intercourse are to some extent at risk of contracting HIV infection. HIV/AIDS counseling is for individuals, couples, families and groups, referred to as 'clients'. Those who need counseling include
⇒ those who are physically unwell and want to know their HIV status
⇒ those who are apparently well but worried about HIV/AIDS
⇒ the family and close friends or colleagues of the patient
⇒ children with HIV and AIDS
⇒ those with HIV and their partners
⇒ those seeking help because of past or current risk behaviour
⇒ those experiencing difficulties with issues such as employment, housing and finances as a result of HIV infection
⇒ those at all stages of illness related to HIV/AIDS
⇒ those found to be HIV antibody positive in the routine screening of donated blood

When to counsel

😊 Brainstorm with the participants and fill in information gaps using information below.

Counseling should begin whenever people express concerns or ask for information about HIV and also when a health care professional identifies a problem:

⇒ before an HIV test (pretest)
⇒ on receiving HIV results, regardless of whether the test is negative or positive (post-test)
⇒ during follow-up for those who are HIV antibody positive and asymptomatic
⇒ during follow-up for those who are HIV antibody positive and becoming unwell
⇒ during clinical care for those with AIDS-related conditions
⇒ when treatment and investigations are being considered
⇒ at times of crisis for the patient or their close contacts
⇒ at the stage of terminal illness when the patient, close contacts and family may have special counseling needs
⇒ after a death, when relatives, close contacts and others may benefit from bereavement counseling
Where to counsel

😊 Brainstorm with the participants, then fill in information gaps using information below.

The location of the counseling room is important and can influence what happens in the session. Often, clients find it easier to confront and discuss the emotionally charged issues of love, sex, HIV/AIDS and death in privacy, away from possible interruptions and preferably in a pleasant atmosphere. The room could be in the hospital, a health centre, a special clinic, a school, a church, or the patient’s home.
General counseling

Counseling is a skilled system of helping individuals to explore personal issues, for them to—
- make decisions
- cope with crises
- work through feelings
- work through inner conflicts
- improve relationships with others

Are you counseling or using counseling skills?

- Counseling uses counseling skills.
- We use counseling skills in the course of our day-to-day work.
- Counseling skills help to enhance our roles as health workers, teachers, priests, managers, parents.
- Using counseling skills becomes counseling only when both recipient and helper enter into a contract.

Other helping skills

- giving general advice
- giving information
- befriending, being a buddy
- advocating for client
- intervening temporarily in a crisis
- educating
**What is HIV/AIDS counseling?**

- Applies general principles to HIV situation
- Helps cope with HIV infection
- Copes with possibility of infection
- Copes with person’s need for care
- Evaluates personal risk
- Facilitates preventive behaviour

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**Who is an HIV counselor or counselor aide?**

Can be anyone who intentionally takes on the role of HIV counseling—
- Temporary
- Alternating with other duties
- Full time
- Trained in counseling or counseling skills
- Genuine interest
- Specialists for complicated cases
Triangle of counseling providers

- Diploma & degree counselors
  - 450 hours of training

- Certificate counselors
  - 150 hours of training

- Providers with counseling skills
  - 20–30 hours training
Unit 3

The process and practice of counseling

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The process and the practice of counseling

Map of counseling territory

Counseling is a relationship that is safe, client-centred and dynamic. Within it, a range of skills and techniques are used to initiate a process of positive change, from-

⇒ dissatisfaction to satisfaction
⇒ pain to comfort
⇒ low esteem to high esteem
⇒ poor social skills to good social skills

Process of counseling

Counseling can be seen as a process that takes place within a relationship. In analysing this process, it is often split into three stages. Gerard Egan’s *The Skilled Helper* is a widely recognized source of information on these three-stage models.¹

Exploration stage

Stage 1—Exploration: the beginning stage

This is the stage in which the counselor helps the client clarify their current state of affairs in terms of difficulties, problems, issues, concerns, and undeveloped opportunities. The aim here is to establish a relationship with the client so that they feel safe enough to explore the issues that they face by identifying and clarifying problem situations, unused opportunities and the key issues calling for change. The client is helped to tell their own story, to break through blind spots that prevent them seeing themselves, their problem situations and unused opportunities as they really are and that prevent them from successfully carrying out the work of the helping process. The client is then helped to choose the right problems or opportunities to work with. The counselor uses the skills of active listening, reflecting, empathy, genuineness and

respect. It is essential to concentrate on the client’s agenda, not to impose one’s own agenda or try to satisfy one’s own curiosity. Stay with the client. The counselor should also help the client to be specific and focus on core concerns.

? Client’s question—What are my problems, issues, concerns and undeveloped opportunities?

Understanding stage

Stage 2—Understanding and insight promoting new perspectives

This stage is also the stage of looking at the preferred scenario, also called the middle stage. Now that rapport has developed and the client has aired some of the issues, a greater depth of understanding can be reached. The preferred scenario or preferred state of affairs helps clients determine what they need and want. It spells out possibilities for a better future and culminates in the client’s agenda for change fashioned from those possibilities. The client’s commitment in pursuing substantial priorities or goals is encouraged from the start.

The skills of stage 1 are still appropriate, with extra skills needed to draw together themes, offer new perspectives, provide accurate empathy, work in the here-and-now, promote self-disclosure, help set appropriate goals, and be genuine in support. The core conditions are still essential here as change involves risk. The client must feel supported, yet challenged, to face the difficulties ahead. By the end of stage 2, the client will have an idea of how they want to change.

? Client’s question—What do I need or want in place of what I have?

Action

Stage 3—Action

The aim here is to develop goal-accomplishing action strategies by helping clients discover how to get what they want. It defines the work that needs to be done to translate priorities into problem-managing accomplishments. The key tasks here are to help the client find a realistic set of choices, make decisions and formulate an action plan, and to assist the client to implement the plan.
• Clients need to be helped to see that there are different ways of achieving their goals or possible actions leading to them.

• They then need to be helped to choose best-fit strategies according to their talents, resources, styles, temperament and timetable.

• Clients next need help to craft a plan and organize the actions they are going to take to accomplish their goals.

Remember, it is the client who chooses the course of action, and the counselor needs to know different decision-making strategies and problem-solving techniques to help the client do this. In some models the action or implementation stage is left to the end while in some it is acknowledged that clients need to act right from the beginning, both within the counseling session and in their real day-to-day worlds.

Client’s question—What do I do to get what I need or want?

It is helpful to continually evaluate how the client and the counselor are doing. The above model is simplistic but useful as a guide. Counseling involves a wide range of skills and techniques that will be appropriate at different times.

The counseling process is not a linear one; that is, it does not necessarily follow the mentioned stages in order. The counselor needs to be aware of which stage the client is at, and when it is appropriate to facilitate moving the client to the next stage. This decision is the client’s, though; the counselor offers guidance but does not make the decisions.

Key components of a counseling session

Counseling environment

The counseling environment or room should be a quiet and private place with no noise or interruptions. It should be clean, in cool colours and with comfortable seats that demonstrate equality and not dominance.

Welcoming of the client

Clients appreciate a warm and friendly welcome from counselors who are genuine and interested in them, and this is what counselors should offer their clients when they come for counseling.
Contract

Only when there is a clear contract between client and counselor does the interaction become counseling rather than using counseling skills. If ‘helping’ is to be a collaborative venture, then both parties must understand what their responsibilities are. The client and the counselor in a process referred to as ‘structuring’ should arrive at similar perceptions of the role of the counselor, an understanding of what occurs in counseling, and an agreement on what outcome goals are to be achieved.

Confidentiality

Confidentiality is one of the most important things that clients appreciate and expect of a counselor. Counselors get access to privileged information about clients, and they are duty bound to keep it all confidential to safeguard the client’s welfare. When clients know and trust that what they disclose about themselves will remain confidential, they are less likely to withhold anything, and in this way they are able to get more help with what is disturbing them.

Counselors must keep information related to counseling services confidential unless disclosure is in the best interest of the client, is required for the welfare of others, or is required by the law. When disclosure is required, only information that is essential is revealed. The client should be informed about these conditions before taking the HIV test. Clients’ records, audio- and videotapes must be treated with confidentiality and stored safely. Clients must give consent for anyone to observe or listen to the sessions, tapes or records. Clients’ identity must be disguised when any material is used for training, research or publication.

Qualities and personality of a good counselor

Have participants carry out the following exercise on the qualities of a good counselor:

• Consider when you had what seemed at the time to be a difficult problem, causing you real concern. If you cannot remember such a situation, then imagine it.

• In your mind, identify someone you would have been confident to approach to help resolve the problem.
• Think of the qualities that this person has that you admire or that would make you go to him or her.

✎ List the qualities of this person as you identify them.

These are among the qualities of a good counselor, and underlying the skills are these attitudes, which will be instinctively recognized by the client.

Research has shown that what helps people make changes for the better in their lives is not so much the expertise of the counselor but more the relationship that is created, which allows the client to take on the responsibility of making the necessary decision or solving the problem.

Counseling relationship

A helping relationship

The relationship between client and helper is important and central to helping.

Carl Rogers in his humanistic approach claimed that the quality of the relationship with respect to the unconditional positive regard, accurate empathy, and genuineness offered by the helper and perceived by the client was both necessary and sufficient for therapeutic progress. Such client-centred counselors help clients to understand themselves, liberate their resources and manage their lives more effectively.

To create this relationship, according to Rogers and many others, the counselor needs to have three essential qualities. These are considered the core conditions of counseling:

Unconditional positive regard includes respect, warmth and acceptance. Acceptance is the non-judgemental expression of a fundamental respect for the person as a human, and acceptance of a person’s right to their feelings. It includes ‘positive regard’—an ability to treat the client as a person, to take what the client says as of value, and to hold a belief in the dignity of the client. Respect is a way of viewing oneself and others. Acceptance is the ability and willingness to see and accept the client’s explanation of a situation even if it is different or even contradictory to the counselor’s own view.

———

2 Carl Rogers, On becoming a person: a therapist’s view of psychotherapy (Constable,1961) ISBN 0 09 460 440 1
Positive regard includes commitment on the part of the counselor, confidentiality, encouragement toward self-responsibility, and refusal to let the client be dependent on the counselor. Counselors should therefore do no harm, be competent and committed, make it clear that they are for the client, assume the client’s goodwill, not rush to judgement, and keep the client’s agenda in focus.

**Genuineness.** The counselor’s interest must be real, authentic, sincere, congruent, not fake. The self that the client meets should be the real one and not an act put on just for the session. The interest in the client should be sincere, not phoney, and should go beyond professionalism. One’s external expressions should match with the inner experiencing, such that what one says and does reflects what one is feeling or thinking. Avoid overemphasizing the helping role or becoming defensive.

**Empathy** is the act of perceiving the internal frame of reference of another, of grasping the person’s subjective world, or standing in the other person’s shoes without losing one’s own identity. It involves communicating to the client an understanding of their feelings. Listening to someone carefully, struggling to understand their concerns and sharing that understanding with them makes clients feel understood and is one thing they appreciate very much about counseling.

Sometimes empathy is confused with sympathy. Sympathy is feeling sorry for someone and for the situation in which they find themselves—for example, we feel sorry for the victims of tragedies or natural disasters.

### Basic counseling skills

Ask the participants to mention some of the basic counseling skills they know and write these on the flip chart. Do not spend more than 5 minutes on this brief introduction, then quickly proceed with the transparency and the following information.

The counselor uses discrete units of verbal, non-verbal or para-verbal behaviour to help clients through their process of exploration, understanding and action. These are basic communication skills. People use them knowingly or unknowingly every day in their day-to-day life. Counseling skills most commonly used:
Attending is to demonstrate that you are with the client or are visibly tuned in to clients. People appreciate it when others pay attention to them. Being ignored can be painful. Effective attending tells the client that you are listening and it puts you in a position to listen carefully to the client’s concerns. Attentive presence can invite or encourage clients to trust the counselor, open up and explore the significant dimensions of their problem situations. To attend to clients, counselors can use the SOLER skills:

**S** – Sitting squarely facing another person is considered a basic posture of involvement. It usually communicates one’s presence and availability. If for any reason facing the person squarely is too threatening, then an angled position may be more helpful. The quality of your presence is the most important.

**O** – Open posture should be adopted. Crossing the legs and arms can be signs of lessened involvement with others or less availability to them. Open posture may signify that you are open to the client and to what the client is saying. The client sees it as a non-defensive posture. Crossing the legs may not always mean that one is not involved with the client, but what is important is for one to be aware of how your presence communicates openness and availability to the client.

**L** – Leaning forward towards the other at times is a natural sign of involvement. It is a sign of bodily flexibility or responsiveness that enhances the counselor’s communication with the client.

**E** – Eye contact should be maintained, but it should not be confused with staring or glaring. Maintaining good eye contact with a person is another way of communicating your presence, interest and that you want to hear what the other person has to say. Looking away may communicate the opposite. It is helpful for counselors to explore why they may be uncomfortable or unwilling to maintain eye contact with certain clients.

**R** – Being relatively relaxed and natural when doing all of the above is important. This may mean not fidgeting nervously or engaging in distrustful facial expressions. It also means becoming comfortable with your body as a vehicle of personal contact and expression.

If the above internal attitudes are not reflected in your external behaviour, then being respectful, genuine and caring might lose impact. However, these are just guidelines and not rigid rules, and counselors must put into consideration the client’s culture as well as their own.
Active listening

Pair up participants and have them practise listening to each other as they talk about their personal concerns about HIV for 2 minutes each. Then have the group discuss what they experienced both as counselor and as client.

When one effectively attends, one is in a better position to listen carefully to what the client is saying both verbally and non-verbally. Listening seems like a simple concept to grasp and yet it is amazing how often people fail to listen to one another. Active listening helps establish rapport and trust, bridge differences; it helps clients disclose their feelings; it helps gather information and create a base of influence; it helps clients assume responsibility. People want the presence of the other person—not only the physical presence, but also their presence psychologically, socially and emotionally. Complete listening involves

⇒ listening to and understanding the client’s verbal messages
⇒ observing and reading the client’s non-verbal behaviour—posture, facial expressions, movement, tone of voice
⇒ listening to the context—the whole person in the context of the social settings of their life
⇒ listening to sour notes—things the client says that may have to be challenged

Barriers to listening, both internal and external, should be worked on and avoided. The session should be uninterrupted by phones, note taking, noises, visitors, as important information may be lost or the person may not say what the problem is.

A good listener should possess an attitude of respect, tune in to the client’s internal viewpoint, send good voice messages, send good body messages, use openers, small rewards and open-ended questions, paraphrase and reflect feelings, show understanding of context and difference, manage initial resistance and avoid unrewarding ‘don’ts’.

Paraphrasing

Pair the participants and have them practise paraphrasing by one telling the other what they most appreciate about this workshop. After 2
minutes have them change roles. Then have the group discuss what they experienced both as counselor and as client.

Paraphrasing is when counselors repeat what the client has said using different words. It shows comprehension while actively listening and provides mirror reflections that help clarify the original statements and make them more succinct. The paraphrase should begin with ‘you’ to reflect the client’s internal viewpoint.

Reflecting feelings

Pair up the participants and have them practise reflecting the client’s feelings by one telling the other what they feel when they don’t get what they want at work. The ‘counselor’ identifies the feeling of the ‘client’ and reflects it back to the client. After 2 minutes have them change roles. Then have the group discuss what they experienced both as counselor and as client.

The counselor should be able to pick up the client’s feelings. Reflecting feelings involves feeling a client’s flow of emotions and experiencing and communicating this back. Good reflection of feelings picks up these inner messages as well and entails responding to the client’s ‘music’ and not just to the words.

Questioning

Questioning is a skill used to identify, clarify and break problems down into their component parts. It also helps clients to identify their feelings. Open-ended rather than close-ended questions should be used. Open-ended questions give clients considerable choice in how to respond and are aimed at leading into a discussion. Examples are the ‘how’, ‘what’, ‘when’ questions. Closed-ended questions restrict choice and lead to one-word yes or no answers. They should not simply be for the selfish purpose of satisfying the counselor’s curiosity or need. Questions should not be probing or interrogative in nature, such as ‘why’ questions.

Ask the participants to come up with examples of open-ended and close-ended questions. Write them on a flip chart and lead a discussion about them.
Clarification

After brainstorming with the participants, fill in the gaps with the following information.

People are seldom able to explain something factually and in sequence. More probably they go round and in circles, and indeed the first problem they talk about is often not the one that emerges in the end—for example, talking about a problem of lateness at work caused by oversleeping or bad performance at work because of tiredness may uncover some family or health problem that might otherwise have remained hidden. Counselors try to clarify what the client has said and get factual information.

The counselor must never ‘rescue’ the client or take over the client’s problem. It is the responsibility of the client to decide upon and implement their own solution.

Summarizing

Brainstorm with the participants then use the following information to fill in the gaps.

Summarizing pulls the threads together so that the client can see the whole picture and gain greater understanding of it. It helps to ensure that the client and the counselor understand each other correctly. The counselor should review the important points of the discussion and highlight any decisions.

Supporting

Finally having made the decision, the client may need support and encouragement to keep going.

Common counseling mistakes

Have participants brainstorm on common counseling mistakes and then fill in the information gaps using the following.

The principles of counseling are easy to learn but difficult to apply, and counselors can make mistakes, such as—

⇒ controlling rather than encouraging the client’s spontaneous expression of feelings and needs
⇒ judging, as shown by statements that indicate that the client does not meet the counselor's standards

⇒ moralizing, preaching, and patronizing—telling people how they should behave or lead their lives

⇒ labelling, rather than finding out the person's motivations, fears and anxieties

⇒ reassuring unwarrantedly—trying to induce undue optimism by making light of the client's own version of a problem

⇒ not accepting the client's feelings—saying that they should be different

⇒ advising, before the client has had enough information or time to arrive at a personal solution

⇒ interrogating—using questions in an accusatory way; 'why' questions may sound accusatory

⇒ encouraging dependence—in increasing the client's need for the counselor's continuing presence and guidance

⇒ cajoling—trying to persuade the client to accept new behaviour by flattery or deceit

Working with couples

Clients coming for HIV/AIDS counseling should be encouraged, but not forced, to come with their partners or as couples. Counselors need to have some knowledge about how to work with couples. Various approaches or theories govern the practice of couples counseling, for example, psychodynamic, cognitive behavioural and family models.

Couple counseling is encouraged:

• Some people seek counseling as a couple, because they recognize that their problems are rooted in their relationship rather than being attributable to individual issues.

• A change in either partner’s sexual behaviour is bound to affect the other partner.

• When couples work together in partnership and support they are bound to succeed better in what they want to do than if one partner is in the dark.

• Disclosing HIV test results to the other partner, which is usually a difficulty for most couples, is better handled if both agree to be seen as a couple.
• Couples are better able to cope with such decisions as whether or not to get pregnant, terminate a pregnancy, breastfeed the baby if they are seen and supported together.

Guidelines for working with couples

• Create a conducive and trusting relationship with the couple.
• Contract with both of them.
• Let them know that there will be equal air space for both of them.
• Let them know that everyone’s opinion is important.
• Let the dominant-looking partner start, especially if it is the husband, as this may influence how their action is implemented once they get home.
• Pay much attention to both their verbal and their non-verbal communication.
• If asked whether you are married, say the truth; if you are not married, add that you are trained to work with couples.
• Try politely to draw out the silent partner of the couple, to share their feelings and opinions.
• Do not judge or take sides.
• Keep your values, prejudices and beliefs aside and work with those of the couple.
Map of counseling territory

Counseling is a relationship within which a range of skills is used to initiate a process of positive change, from
- dissatisfaction to satisfaction
- pain to comfort
- low esteem to high esteem
- poor social skills to good social skills

Exploration stage

Aim—to establish a safe, trusting relationship
- Client’s role
  - Tell their story
  - Break through blind spots
  - Choose the problems or opportunities to work with
- Counselor’s role
  - Stay with the client’s agenda
  - Use appropriate counseling skills
  - Help client focus on core concerns

Understanding stage

Aim—to help client reach a greater depth of understanding
- Client’s role
  - Identify preferred scenario
  - Clarify what they need and want in place of what they have
- Counselor’s role
  - Use appropriate skills of support and challenge
Key components of a counseling session

- Counseling environment
- Welcoming of the client
- Contract
- Confidentiality

Counseling relationship

Counseling is a helping relationship. Its core conditions are—
- unconditional positive regard
- genuineness
- empathy

Action

Aim—decide on change, implement change, transfer learning
- Client’s role
  - Explore how to get what is wanted, needed
  - Choose course of action, implement and evaluate it
- Counselor’s role
  - Help client plan a course of action, refine and implement it
Module 4 — Unit 3

PROCESS OF COUNSELING

Basic counseling skills

◆ Non-verbal
  – listening, attending and observing
◆ SOLER
  – S - sit facing client
  – O - adopt open posture
  – L - lean forward to listen
  – E - maintain eye contact
  – R - stay relaxed
◆ Verbal
  – paraphrasing
  – reflecting feeling
  – questioning
  – clarifying
  – summarizing
  – supporting

Active listening

◆ Understanding the verbal message
◆ Observing non-verbal behaviour
◆ Listening to the context
◆ Listening to sour notes

Paraphrasing

◆ How to paraphrase
  – repeat meaning of what client says
  – but use different words
◆ How it helps
  – shows understanding
  – provides a mirror
**Reflecting feelings**

- Pick up on client’s feeling
- Feel with client the flow of emotions
- Communicate back
- Respond to client’s ‘music’

4-3-10

**Working with couples—guidelines**

- Create a trusting relationship.
- Contract with both.
- Assure equal air space.
- Everyone’s opinion is important.
- Let dominant one start.
- Observe both verbal and non-verbal communication.
- Tell the truth about your own marital status.
- Encourage the silent one of a couple to share feelings.
- Do not judge.
- Keep your own values and prejudices aside.

4-3-11
Unit 4

Voluntary counseling and testing for HIV

prepared by
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Voluntary counseling and testing for HIV

Voluntary testing is the anonymous or confidential testing initiated by either the client, the health provider or other persons and performed with the client's informed consent. It is useful for:

⇒ those who wish to know their HIV status
⇒ women in antenatal clinics who would like to know whether they are infected before making decisions about childbearing or breastfeeding
⇒ help in making a diagnosis of HIV infection when it is suggested by clinical signs and symptoms

Counseling for VCT

Voluntary counseling and testing

Antibody testing should be offered only when it can be accompanied by counseling before and after the test. This guarantees informed consent, confidentiality, clear information about the test and its implications, and—most importantly—emotional support.

‘Informed’ means that in the pretest discussion, the client has been made aware of all the ramifications of HIV testing, including the risks and benefits, as well as of alternatives to such testing, in a language that the client can understand.

‘Consent’ means giving express agreement to HIV testing in a situation free of coercion, in which the client should feel equally free to grant or to withhold consent.

The disadvantage of having the test voluntary is that not everyone will be aware or convinced that they are at risk and therefore may not be reached. Even those who know they are at risk may not choose testing when it is voluntary. However, testing people without their informed consent is coercive and has no advantage over testing with informed consent. Such mandatory testing has no place in HIV prevention and care programmes. Most people who do not want to test are concerned about confidentiality, and others are afraid that if the results are positive, they will be unable to cope with the situation. These are valid fears, and counseling and support can help clients overcome them.
In counseling patients about having an HIV antibody test, it is important to discuss current personal advantages and disadvantages in having the test. This helps patients make informed decisions. Following are examples:

What are the advantages and disadvantages of HIV testing?

<table>
<thead>
<tr>
<th>Disadvantages</th>
<th>Advantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress and uncertainty may increase</td>
<td>Knowledge of the result can reduce stress</td>
</tr>
<tr>
<td>Restrictions are placed on mortgage and life insurance and for job opportunities</td>
<td>Decisions about the future might be made more easily</td>
</tr>
<tr>
<td>Social stigma is attached to a positive HIV antibody test result</td>
<td>Motivation to protect sexual partners is increased</td>
</tr>
<tr>
<td>Maintaining a secret causes stress</td>
<td>Symptoms can be identified and treated promptly</td>
</tr>
<tr>
<td>Making and maintaining relationships is difficult</td>
<td>Prophylactic treatment can be given</td>
</tr>
</tbody>
</table>

For whom is VCT?

People who are considering being tested must be given the information they need to be able to make a well-informed decision. The information must be up to date and cover the technical aspects of testing as well as the medical and social implications.

Counseling helps discuss

Counselors should be able to discuss with their clients the misconceptions and anxieties that the clients may have about HIV antibody testing. Counselors should ensure that their clients understand what the test implies, and what a positive or a negative result means. Many people believe that a positive antibody test means that they have AIDS, and this will likely cause them distress.
The counselor should stress that the available tests detect the presence of HIV antibodies in the blood and should add that current evidence suggests that all those infected will eventually develop AIDS. The counselor should emphasize that one can live a useful life for long after being diagnosed if they receive proper counseling.

Counseling for people who test HIV antibody negative should begin immediately as people who test negative may feel relieved and believe that they can continue to live in the same way as before. They should be told about the window period, which is the period of 3 months or longer after the last exposure to possible infection, during which the test results may be negative or equivocal. They should be told what they should do to prevent acquiring or passing on the infection during this time. They should be urged to return for follow-up counseling and for a repeat test after 3 months.

All donated blood and organs should be tested for HIV antibody. Potential donors should be informed about this beforehand and offered post-test counseling if they want to know their results. Confidentiality must be ensured throughout testing.

Stages of counseling in VCT

The three stages of HIV counseling in VCT are pretest, post-test, and ongoing or follow-up post-test.

Pretest counseling

Pretest counseling is the dialogue between a client and a caregiver aimed at discussing the HIV test and the possible implications of knowing one’s HIV serostatus, which leads the client to an informed decision whether or not to take the test.

Content of pretest counseling

- Establish a relationship of trust to help the dialogue and to form a basis for post-test counseling.
• Explore the client’s knowledge about HIV and reasons for taking the test. Provide the needed information.
• Prepare for the test procedure and the wait for the result. Review the test procedure.
• Anticipate the emotional and psychological responses to the result.
• Anticipate the effect on client’s relationship with others.
• Discuss the practical consequences of being tested—personal, medical, social, psychological and legal.
• Discuss avoiding infection or transmission of the virus and the behavioural changes this will possibly require.
• Explain and obtain informed consent.

The client should be told that both false-positive and false-negative results occasionally occur, although subsequent confirmatory tests are reliable. The client should be given information about the window period.

The agenda within the session should be flexible. If the client decides that some of the topics are irrelevant, the counselor should respect this. Sometimes the pretest session may turn out to address the underlying concern, for example, a particular relationship. For this reason, counselors need to be trained to do general counseling as well.

The counselor needs to be neutral and should not guide a client towards a particular outcome, since clients should be left to make their own decisions according to their own circumstances.

Post-test counseling

Steps in post-test counseling

Post-test counseling is a dialogue between a client and a care provider aimed at discussing the HIV test result, providing the appropriate support, information and referral, and encouraging risk-reducing behaviour.
Aims of post-test counseling

Aims

• Help someone understand their test result.
• Assist with the shock or the emotional response to the result.
• Provide information on the need for medical attention for those with positive HIV results.
• Help the client prepare for the kinds of personal support they want from those close to them or from any voluntary organizations.
• Whom to tell—assist client in their conflict of wanting to tell someone to ventilate and ease their heightened emotion and their need to control other people’s knowledge of their status, especially if positive, but sometimes even when negative.
• How to tell significant others—support the client in their decision to tell immediately, planning on how to do it at a time best for them or to have a counselor present as they tell.
• Follow-up appointments—arrange for an appointment after the first post-test session, because the client’s needs change as the emotional shock of the results subsides.

Negative results

• Establish a trusting relationship.
• Disclose the results immediately.
• Discuss the meaning of a negative result.
• Remind client about the window period and ask client to consider returning for a repeat test after 3 to 6 months.
• Discuss how further exposure may be prevented.
• Repeat explanations about positive health behaviour.
• Address issues of the ‘worried well’.

Positive results

• Maintain the trusting relationship.
• Disclose the results immediately.
• Ensure that the person understands what a positive result means.
• Give client opportunity to express how they are feeling.
• Provide support to help the client deal with those feelings.
• Discuss their plans for the immediate future.
• Schedule appointments for medical evaluation and follow-up counseling.
• Schedule appointment for counseling partner(s) if possible.
• Refer client to any available support organizations in the community.

Equivocal or indeterminate test result

An equivocal test result is one that is neither clearly positive nor clearly negative. The counselor should consider the type of test used, retest the sample, and if still equivocal, then retest using another ELISA (a different technique). A second fresh sample as well as the first one should be tested after 3 months. If this is equivocal, then the client is negative.

Prevention and support following an equivocal result is important. The counselor should emphasize the importance of using safer sex during the waiting period. The client should be psychologically supported during this trying time.

Follow-up counseling

Follow-up counseling is regular counseling on short- or long-term contracts for clients living with HIV/AIDS.

Aim
• To help clients who are not coping effectively with their situation
• To assist those who are extremely distressed by their status
• To assist those who are extremely distressed by the responses of other people

Note—counselors working with these clients require competencies of generic counseling (more in-depth, theoretically based counseling training) as well as knowledge of HIV-related issues. This is because some of the client’s issues go beyond HIV-related issues.
Content of follow-up counseling

- Concerns about relationships—sexual and other
- Avoidance of HIV transmission
- Issues related to death and dying
- Disease progression and personal implications
- Coping with own feelings—grief process that includes shock, denial, anger, guilt, loneliness, depression, suicidal thoughts, hopelessness, helplessness
- Practical, financial and employment issues
- Whom to tell and how to tell
- Stigma, fear of isolation and prejudice
- Living a healthy lifestyle
- Need for reassurance about confidentiality
- Implications of HIV antibody test

Who will counsel?

HIV antibody testing in antenatal clinics

Ask the participants to read the material below as an exercise. The information here will be vital for the role-plays on pre- and post-test counseling.

Reasons for offering HIV antibody test to pregnant mothers and perhaps to the fathers

- Transmission of HIV can be prevented:
  - from mother to child
  - from one sexual partner to another
  - to health care staff who come into contact with patient’s blood and where invasive procedures have been performed

- Decisions have to be made as to whether or not an infected mother should use antiretroviral drugs.
• Decisions have to be made as to whether or not an infected mother will breastfeed her baby. Need to explore pros and cons of breast milk and breast-milk substitutes for the mother and the baby.

• Decisions have to be made as to whether or not the sexual partner or father will be informed and encouraged to be tested.

• Follow-up care and surveillance for a known HIV-antibody-positive mother and her family will need to be provided—medical care, living conditions, child-care arrangements, social support.

• Pregnant women with HIV infection need intensive counseling on family planning options for the future.

Specific issues in antibody testing in antenatal clinics

• Infection control—universal precautions must be adhered to and staff reassured of their occupational safety.

• Busy clinic—introducing HIV counseling in antenatal clinics will increase the workload. Specialist counselors can be called upon but staff in the clinics will need to develop strategies for coping with the busy clinics.

• Timing of the HIV antibody test—ideally is before pregnancy. During pregnancy it is advisable to test as early as possible so that consideration can be given to antiretroviral therapy. This may mean booking women earlier than usual. Because of the window period women may need to be retested 3 months later in the course of pregnancy if exposure has been very recent. Also the options of interventions for both mother and obstetrician are fewer if the HIV test is done at a late stage in pregnancy.

• Management of the HIV-positive mother:
  ⇒ Counsel client to help her make informed decisions.
  ⇒ Explore views about using antiretroviral drugs and avoiding breastfeeding.
  ⇒ ‘Dreaded issues’ need to be raised with mothers who choose not to breastfeed.
  ⇒ Emphasize taking precautions during sexual intercourse.
  ⇒ Consider whether the father will be informed and tested.
  ⇒ Have a physician monitor the mother from the HIV point of view.
  ⇒ Provide a paediatrician to be on the scene at an early stage.
• Management of the antibody-positive father:
  ⇒ If the mother is HIV positive, chances that the father is also positive are very high.
  ⇒ Discuss with the mother the need to counsel and test the father.
  ⇒ In cases where the father is positive and the mother negative, the mother should be tested 3 months after the first test. This is because seroconversion of the mother may take place during the course of pregnancy, which will carry an increased risk of transmission to the baby.

What to include in the counseling session

• Greetings, introduction and establishment of rapport: ‘Good morning, Mrs Otieno. Welcome to our clinic. Please take a seat. My name is Jane. I am a counselor. How may I help you today?’

• Introduction to HIV antibody testing: ‘Mrs Otieno, as you know, in our clinic we offer the HIV antibody test as a routine to all expectant mothers. What do you understand about why we offer this test?’

• Knowledge about AIDS and transmission of HIV.
  ⇒ ‘How might someone in your position come to be infected with HIV?’
  ⇒ ‘What do you know about AIDS?’
  ⇒ ‘What do you understand about the risk to the unborn child if the mother has HIV?’
  ⇒ ‘If the father is positive, what do you know about the risk to the mother and the unborn child?’

• Knowledge about HIV antibody test: ‘What do you know about the HIV test?’

• Assessing the risk for HIV: Explore issues relating to past sexual practices, drug use, blood transfusion and artificial insemination by donor. Assess whether there has been rape or sexual abuse in the past.
  ⇒ ‘Have you had any sexual contacts outside of this relationship in the past?’
  ⇒ ‘Do you think your husband or partner has been at risk in any way?’
• Talking about having the HIV antibody test

⇒ ‘Do you agree to have the HIV test?’

⇒ ‘You say that you do not want to have the test. What do you fear most about having it?’

⇒ ‘If your partner were here today, would he agree with your decision not to have the test?’

⇒ ‘If your results were positive, what would be your views about antiretroviral drugs and avoidance of breastfeeding? Would your partner agree with this?’

⇒ ‘If the results were negative and you knew there might be some risk, would you agree to have another test in 3 months time?’

⇒ ‘When we give you the results would you like to come on your own or with your partner?’
VCT definition

- anonymous or confidential testing
- initiated by client or
- referred by provider or other persons
- client’s informed consent always

Counseling for VCT

- If HIV testing results are to be given out, counseling should always be provided.
- Counseling for HIV testing is essential for—
  - informed consent
  - confidentiality
  - clear information about test
  - emotional support

For whom is VCT?

- Those who wish to know their status—
  - for marriage
  - for decisions about childbearing
  - for planning life in general
  - as part of risk reduction
  - anxiety about symptoms
- Women giving antenatal care
For whom is VCT? (contd)

- For clinical diagnosis when referred by clinician
- For other purposes
  - insurance
  - immigration
- For post-exposure prophylaxis (PEP)

Counseling helps discuss—

- Misconceptions and anxieties about the test
- What a positive or a negative test means
- Prognosis if one tests positive
- Window period if negative
- Risk reduction for positive and negative

Pretest counseling

The counselor—

- Discusses HIV test with client
- Discusses implications of knowing HIV status
- Helps client make informed decision
Content of pretest counseling

- Establish relationship
- Explore knowledge of HIV and reasons for testing
- Prepare for test
- Anticipate reactions and effect on relationships
- Prepare for practical consequences
- Prevent infection or transmission
- Explain and obtain informed consent

Steps in post-test counseling

- Discuss HIV test results
- Provide support
- Provide referral information
- Encourage taking preventive measures

Aims of post-test counseling

- Help understand results
- Assist with shock and emotional response
- Provide information on medical care
- Help prepare for personal support
- Discuss whom to tell
- Set up follow-up appointments
**Negative results**

- Explain window period
- Consider repeat testing
- Address issues of the worried well
- Discuss preventive measures

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**Positive results**

- Ensure understanding of results
- Allow expression of feelings
- Provide support for feelings
- Discuss immediate plans
- Make appointment for follow-up counseling
- Refer for support

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**Equivocal results**

- Consider type of test and retest with a different test
- Retest after 3 months
- Support in the meantime
- Practise prevention in the meantime
**Definition of follow-up counseling**

Regular counseling on short or long term
- to help cope with client’s situation
- to deal with extreme distress
- to deal with responses from other people

**Content of follow-up counseling**

- Relationships—whom to tell?
- Prevention
- Death and dying
- Disease progression—living a healthy lifestyle
- Own feelings
- Practical financial issues
- Stigma, prejudice and confidentiality

**Who will counsel?**

- All ANC and MCH staff in pilot sites are to receive full training on the MTCT course
- Counselors of care and support organizations will provide ongoing counseling
- Some HIV+ mothers will be trained and employed as peer counselors
Unit 5

Counseling on safer sex

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Counseling on safer sex

Introduction

Introduce the topic with the paragraph below and then ask the participants to discuss sexual behaviour change using the questions following.

Sex is a special topic that evokes much anxiety, pleasure, pain, hope, discussion and silence. Sexual behaviour is part of social norms, and individuals cannot alter these on their own or overnight. People satisfy various individual needs through sex (refer to Maslow’s hierarchy of needs).\(^1\) It helps you as a counselor to examine what need of yours is satisfied by sex. For you to help others explore personal sexual issues, you must first explore and confront your own sexuality. As you advocate behaviour change, ask yourself the following questions about it:

⇒ change to what?
⇒ change for what?
⇒ change for how long?
⇒ change for whose sake?
⇒ change dictated by whose values and needs?
⇒ change with what power and resources for women?

Safer sex

Behaviour change to safe sexual practices cannot be measured by the amount of information people have been given or the level of awareness of one’s own risk. Some believe that they are OK because their partners are, some believe that they will never get HIV. Some believe that they should share their HIV-positive partner’s fate. Some people will practise safe sex only sometimes, and some all the time. Others will change their behaviour only after their partner is discovered to be HIV positive and others will not change even then.

It is important to let women grow into a safer and more satisfying sexuality from the start by offering everyone information and the means to protect themselves in both the short and the long term.

Common safer sex strategies

Be faithful to one partner

Works as long as . . .

⇒ neither partner has HIV
⇒ neither partner is not at risk from other sources of infection
⇒ partners are faithful to one another all the time

Does not work with . . .

⇒ women whose partners are not faithful to them
⇒ women who already had HIV before the relationship

Note—people wishing to use this strategy should receive VCT and remain mutually faithful to one another.

Say NO to sex

Works well with . . .

⇒ young people who can manage to delay starting sexual relations until they marry; then if they remain faithful to each other, their risk is greatly reduced
⇒ those who want to protect their partners without having to reveal their HIV status or how they became infected; however, the partner may feel totally rejected and suffer psychologically
⇒ those who are separated for short periods from their regular partner, for example, migrant workers not living with spouses

Does not work with . . .

⇒ those who definitely want and choose to have sex
⇒ those women who may be unable to say NO to sex even if it is negative, demeaning or risky because of negative experiences or social or economic dependency
⇒ those whose form of saying no is deserting partners with HIV/AIDS
Losing a partner can be disastrous, and both deserted and deserting men and women can turn to others for sex for various reasons such as, for a poor woman, economic gain.

**Note**—saying NO to sex is the most effective safer sex strategy, but in practice it may be difficult to implement. It or mutual faithfulness are the strategies that religious leaders advocate.

**Use a condom**

This strategy is safer than unprotected sex. The more it is used, the lower the frequency of exposure. Consistent and correct condom use can result in nil rates of HIV transmission. Using a condom with every partner and in every act, however, is not an easy task.

Most people are willing to use condoms only sometimes, during casual sex but not with their spouses or partners. Others are unwilling to question or threaten love or trust. Some women fear violence or desertion if they suggest condom use. Sex workers may be too desperate for money to turn away men who refuse to use condoms.

Those who are HIV positive and have not yet disclosed their condition to their partners may fear being asked if they are HIV positive and continue to have unprotected sex. The fear of rejection in an HIV-positive person may force some to be unfaithful to satisfy their sexual needs with those for whom they do not feel responsibility.

Many people may not know how to acquire, store or use condoms correctly and yet are too shy to admit it. Some people believe that condoms interfere with sexual pleasure.

Some positive points are that some men are able to maintain a longer erection time with condoms and they can also be used as sex toys. Some women find condom use less messy, especially those who dislike the wetness of the seeping semen and the bad vaginal odour that follows sex.

Condoms are a form of contraception and a prophylactic protection.

**Consider alternatives to penetrative sexual intercourse**

Finding safe alternatives to intercourse does not mean stopping sex. It simply means replacing intercourse with other pleasurable practices—all of the time to be very safe, or some of the time to reduce risk.
Some people, for example religious leaders, believe sex to be for procreation. The dominant male-centred point of view is that sexual intercourse is essential for male sexual pleasure.

Alternatives to intercourse are petting, engaging in mutual or self-masturbation, having sexual fantasies, practising oral sex, using non-abrasive sexual aids, fingering, viewing pornography, talking about sex, watching sexual dances. Some people, however, find non-penetrative sex immature, unnatural, perverted, abnormal or dirty.

Counseling role-plays

Preparing for role-plays

Ask the participants to divide themselves into groups of 3 to a group. Each group selects a counselor, a client and an observer. Allocate an equal number of groups to each of the following categories: pretest counseling; post-test counseling of an HIV-positive case, and post-test counseling of an HIV-negative case. Then have each group prepare a counseling case study that they can use for their role-play. Have the participants rehearse their role-plays as if they were preparing to perform a drama. Each role-play should last for 5 minutes. Following each role-play, the group observer kicks off a 5-minute discussion commenting on the skills displayed.

All 3 members of a group should help the person in the counselor role to prepare a good show by referring to the lessons learned in counseling throughout the course. The participants should have at least 30 minutes to prepare their role-play. While preparing, every person in each group should practise the counselor role.

Performing role-plays

Inform the participants that they will perform the role-plays one after another. Estimate the length of this session by multiplying the number of groups by 10 minutes. For example, a group of 30 participants will have 10 groups of 3 each = 100 minutes, or 1 hour and 40 minutes, to perform and discuss the role-plays. Add the 30 minutes for group preparation and 20 minutes for breaks between groups. Thus allow 2 hours and 30 minutes for the whole role-play session.
Before each role-play begins, the person playing the role of the counselor arranges two chairs in the front of the whole group of participants to reflect an ideal counseling room. The discussion following one role-play helps the next role-players to improve their skills, and the role-plays that come later should be much better than the earlier ones.
Safer sex

- Be faithful to one partner
- Say NO to sex
- Use a condom
- Consider alternatives to penetrative sex
Unit 6

Counseling supervision and support

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Counseling supervision and support

Use the following text to introduce the topic of counselor stress and how supportive supervision can help counselors to cope with it.

Challenges counselors face and the need for counselor supervision

The helping relationship requires the counselor’s commitment, and counseling in relation to HIV infection is especially intense and difficult. The counselors must regularly face their own mortality, deal with loss, offer support to people in extremely distressing circumstances, and sometimes accept behavior of which they personally disapprove. Without feeling committed, the counselor will not be able to provide the necessary support.

Counselors can also suffer stress from work overload, lack of or inadequate expertise, and lack of support and appreciation of their work. The counselor can very easily get overwhelmed by all the challenging work involved in working with people living with HIV/AIDS. For this reason, it is important that counselors take care of themselves as well. Counselors can get support from senior and more experienced counselor colleagues or supervisors or by sharing with other counselors. This form of supervision should provide the counselor with an opportunity to share difficult client work, in a confidential way, as well as get help with personal problems or issues that may become barriers to the counselor’s work with clients. The support should be ongoing and regular as long as the counselor is doing client work. Counselors should have enough rest and relaxation, and sleep and eat well.

Staff stress in clinical settings

Having to work with HIV/AIDS people can have considerable adverse impact on the morale and the efficiency of the health care staff.

Ask the participants to brainstorm on the sources of stress, reactions to stress and coping with stress. Use the information below to fill in the gaps.
Sources of stress

Unanticipated or stressful tasks

• Talking to patients about life-threatening illnesses.
• Taking a sex history.
• Caring for a large number of acutely ill people whose condition may lead to death.
• Having to help young people face disfigurement, disability and death.
• Having to give information that is incomplete or that may later prove to be incorrect because of the rapidly increasing knowledge about AIDS and HIV.
• Not being able to reassure patients about their condition.
• Having inadequate or insufficient skills for counseling patients, their relatives and friends.

Management and organizational difficulties

• Pressure at work from insufficient and inadequate resources, such as counseling rooms, telephones and secretarial help.
• Not being consulted by managers when policy decisions are being made.
• Unclear or poorly defined work boundaries between members of staff.
• Pressure at work to do either more research or more clinical work.
• Pressure at work to give lectures and seminars.
• Lack of suitable supervisors or people with whom one can discuss issues in this rapidly growing field.

Personal and home issues that intrude into the work situation

• Anxiety about being infected with HIV by patients in the clinical setting.
• Anxiety of the spouse, lover or close friends of the professional about being infected and the social stigma that is associated with AIDS.
• Over-identification of health care staff with patient—many professionals are themselves young, sexually active and at some personal risk of being infected with HIV.
• Difficulty in achieving a balance between time spent at home and at work.
Typical reactions to stress

Physiological signs
- eye strain or sore eyes
- trouble sleeping or insomnia
- muscle strain or pain in neck, back, arms, shoulders
- stomach pains or digestive problems
- nausea or dizziness
- tightness or pressure in the chest
- headaches
- indigestion and diarrhoea
- impotence or reduced sex drive

Emotional signs
- depression
- periods of irritability or anger
- feelings of failure, inability to cope, irrational dread of future events
- problems of concentration, daydreaming
- loss of sense of humour and interest in life
- belief that one is not liked or cared for
- feeling of isolation exhibited by withdrawal and problems in communication
- swings in mood
- worry about physical health
- feeling of tiredness

Behavioural signs
- less care about personal appearance
- forgetfulness, clumsiness
- increase in periods of inactivity while at work
- difficulty or unusual slowness in decision-making
⇒ more time taken from work, for example, longer lunch breaks
⇒ accident proneness including car accidents
⇒ increased intake of alcohol or use of other drugs
⇒ over- or undereating
⇒ declining job performance
⇒ increased absence from work
⇒ less time and energy for family, friends and social activities

What can we do about stress?

Change the situation
⇒ add resources
⇒ lighten the task

Improve ability to cope
⇒ undergo training
⇒ get supervision and appraisal

Accept the unsolvable
⇒ avoid the situation
⇒ let go

Change the way we think—attitudes and responses by avoiding
⇒ indulging in negative self-talk
⇒ making everything a catastrophe
⇒ using demand words
⇒ labelling
⇒ blaming upwards or outwards
⇒ expecting imperfections

Maintain a positive lifestyle by having more relaxation and making allowances.

Know your own triggers.
Have clear goals and boundaries, know your role and others’ roles, and take short breaks or pauses to review each task done.

Ensure that you have high support and high challenge in your workplace.

Have access to a counselor in your workplace with whom to share your personal concerns.

It is important to remember that stress can be a motivator for growth, development and adaptation; it is a challenge, it adds variety, and it can be the spice of life.

How to manage stress in a clinical setting

It helps to organize regular meetings for all staff members at all levels to give them the chance to express their concerns.

Consider the following:

- Composition of group—all medical consultants or a mixture of professionals and others in the team or unit?
- Frequency of the meetings—monthly or every 3 months?
- Leadership of the group—have different facilitators from within the unit or outside facilitators or head of the unit?
- Purpose of the group—for discussing practical matters or also for raising personal issues?
- Setting of guidelines—and sticking by them.
- Involvement of head of unit—a necessary feature.
- High support and high challenge—no blaming.
- Respect for everyone’s opinion.

The meeting should provide an opportunity for staff members to share their own grief with the survivors of the patient, staff counselor or someone from outside the clinical setting, especially when overwhelmed by the death of a dear patient.
Summary

In this module, we have learned that being aware of one’s values and prejudices is essential before one can help others. Counseling and counseling skills have been reviewed and their application to HIV has been explored. The three-stage model of counseling consists of Exploration, Understanding and Action, but clients may be at different stages, and it is the role of the counselor to move them along according to their needs.

Voluntary counseling and testing consists of pre- and post-test counseling as well as ongoing counseling. It is an important component of interventions to reduce mother-to-child transmission of HIV, as it allows the mother to learn her HIV status and make appropriate decisions about use of antiretroviral drugs and about the options she has for feeding her baby.

Counseling in MTCT should include couple counseling and safer sex counseling.
Summary

- Self-awareness is important for counselors
- Counseling helps clients cope with HIV worries
- The three-stage model of counseling is exploration, understanding and action
- VCT is vital for reduction of MTCT
- MTCT counseling should include couple and safer-sex counseling