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THE CONTEXT OF RISK IN SEX WORK

Sex does not always unfold in the context of love or desire; individuals may trade sex for money, goods such as drugs or food, or for housing. Because "sex work" or "prostitution" is illegal in most states and stigmatized, counselors and sex workers may bring assumptions and fears about discussing this context of sexual activity during HIV counseling. This issue of PERSPECTIVES *seeks to identify these assumptions, their basis—or lack of basis—in the research literature, and the ways in which counselors can remain focused on how the context of trading sex for money or goods might increase an individual client's risk for HIV.*

Research Update

The term "sex work" is used to indicate the exchange of sex for money or other goods such as drugs. In the early days of the epidemic, the sexual nature of transmission led researchers and public policy makers to conclude that sex work was and would be a key route of transmission.[1-3] Prostitution was, and often still is, seen as a vocational choice, and some felt that if sex workers' behavior could be "controlled," then so could the epidemic.[2,4]

While recent research on sex work and HIV in the United States is sparse, it is clear that the predicted explosion of HIV in sex work populations has not occurred.[1] Further, many sex workers, far from spreading HIV, have actively worked to prevent transmission, both to themselves and to others.[1,5] Nonetheless, individual sex workers may face HIV-related risks in the same way that any sexually active person might. HIV counseling can help identify these risks and reduce them.

As with other risk categories with which HIV counselors work, the term "sex worker" represents a range of behaviors and people.[6] Some advocates suggest that the term "sex worker" camouflages the violent and coercive nature that is endemic to all forms of this activity.[7] Although the term is controversial, given the derogatory associations with other terms such as "prostitute," many people working in the HIV field use the term "sex worker."

Since sex work is illegal everywhere except some counties in Nevada, it is difficult to gauge the number of sex workers in the United States. Some sources estimate that more than one million people in the United States have ever worked as "prostitutes."[8] It is also difficult to determine the HIV status of sex workers not only because sex work itself is illegal and underground but because in several states, including California, a person who knows he or she is HIV-positive and engages in sex work is, under specific circumstances, committing a felony (prostitution is normally a misdemeanor).[9] These conditions may inhibit sex workers from testing for HIV, accessing HIV prevention, or participating in studies of any aspect of their work.

The Diversity of Sex Workers

Researchers have organized sex workers into various subgroups in order to understand the influence of demographic factors on the likelihood of HIV transmission. Among these factors are: gender, including transgender people (usually male-to-female transgender people); race and ethnicity; venue, for example, working on the streets versus work-

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ing as an escort or in commercial establishments such as massage parlors, or working as a model or a sex film actor; sexual orientation and whether or not the gender of sex work customers is consistent with the gender of the sex worker's intimate or chosen partners; motivation for sex work, including people who engage in sex work episodically to get food, a place to stay, or drugs versus those for whom sex work is an ongoing profession.

Research suggests that sex workers exercise varying degrees of control over the choice to engage in sex work, influenced by factors such as stigma, poverty, homelessness, drug use, and mental health issues. Each of these factors may create a context for increased HIV transmission risk. Further, studies suggest that between 76 percent and 88 percent of sex workers express the desire to leave prostitution.[6,10]

While not all of these factors are addressed in great detail in this article, all of them may influence the likelihood that sex workers will acquire or transmit HIV, implement HIV prevention, or discuss their activities with counselors. The combination of these factors makes it clear that a static and one-dimensional image of sex work is a false foundation for counseling. The following is a brief review of the research into some of the areas mentioned above.

Gender and Sexual Orientation. The percentages of male and female sex workers vary from city to city, as does the proportion of sex workers of various ethnicities.[8,11] Sex workers may be women, men, or transgender. According to police records, 70 percent of prostitution arrests are of female sex workers and 20 percent male sex workers (the remaining 10 percent of arrestees are clients).[8] A Houston study of 1,494 street-recruited respondents over the age of 18 found that those respondents—both male and female—who reported sex exchange as their primary source of income were more likely than others to identify as bisexual or homosexual.[11]

Race and Ethnicity. Although arrest records suggest that a high proportion of sex workers are people of color, other statistics do not. For example, the Houston study found more White people than Latino or African American people were involved in sex exchange.[11] Another ethnic factor, derived from government estimates, suggests that between 14,500 and 17,500 people are trafficked annually into the United States, many of whom are women and children at risk of being forced into commercial sex.[12] These people are likely to have even fewer choices, resources, and rights than native-born sex workers.

Venue. In larger cities, street prostitution may account for only 10 percent to 20 percent of the total sex work; in smaller cities with limited or strictly policed indoor venues, street prostitution may account for as much as 50 percent of the sex work in the area.[8] Some research has found that workers who solicit on the streets are at greater risk for HIV than masseuses, escorts, and others who work in commercial establishments;[6] at the very least, they may face different issues, since street workers may be more likely to have substance dependencies and may have less control over the sexual and commercial transaction.[13] Some studies show that condom use is higher off the street than on the street and that other risks related to prostitution are lower off the street.[1] However, other researchers dispute this claim and maintain that violence and lack of control over sexual transactions persist across all forms of prostitution.[7]

Debunking the Elevated Transmission Myth

Since the beginning of the epidemic, sex work has been framed as a key route of HIV transmission. The theory is that sex workers are likely to contract HIV through their work and then transmit HIV to their customers. The theory continues that these customers then spread HIV to "unsuspecting" and "innocent" sex partners, or, in the case of those gay- or bisexually identified male sex workers who sell sex to heterosexually identified male customers, from the gay community to the heterosexual community.[3-5] Several studies have tested this theory.

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There is very little evidence to support the idea that sex work in richer countries, where protection is available, is a key route of HIV transmission. Studies, particularly from Great Britain, Australia, and New Zealand, as well as evidence from a large study in Nevada, have found low HIV prevalence rates among sex workers.[14] For example, a London study found that of 162 sex workers who took more than one HIV test over a nine-year period, only one contracted HIV.[3]

In the 1990s, researchers who reviewed 20,000 HIV test samples over the course of five years from female sex workers practicing legally in Nevada, where prostitutes must undergo monthly HIV tests, found no HIV-positive results for women who were already employed.[15] Of course, a well-regulated sex work

industry with required monthly HIV testing does not represent the likelihood of transmission between sex workers and clients in other contexts. It does suggest, however, that sex workers may operate in a way that protects both themselves and their customers.

Many studies have found that sex workers often intend to take protective measures against HIV and that many of them do take these measures when they can.[2,3] For example, a qualitative study of 46 male escorts who advertised over the internet found that more than half of these men insisted on using condoms and turned down jobs when clients refused to comply.[5] It is significant that the participants often described themselves as health educators as well as escorts. Similarly, in a study of 1,445 injection drug users in California, women who engaged in sex work were more likely than women who had steady partners to report that they used condoms for every sexual act.[16]

Sex workers, like others, tend to use HIV prevention methods more when they are having sex with people they do not know well—that is, customers—and less when they are having sex with people with whom they are emotionally intimate.[1,13] For example, in the London study of 162 sex workers, the yearly percentage of sex workers who used condoms with clients 100 percent of the time ranged from 67 percent to 95 percent; the same workers used condoms with non-commercial partners at rates ranging from 5 percent to 16 percent.[3] A study of 199 African American male and female sex workers in Washington, D.C. found that the more times a participant had sex with the same partner, the less likely the sex worker was to use a condom with that partner.[17] Similarly, a study of 332 transgender sex workers—about one-third each African American, Asian Pacific Islander, and Latina—found that participants were much more likely to use condoms with paying than with non-paying partners.[18]

In contrast, a study of almost 400 male sex workers in Houston found that those who identified as heterosexual were more likely to use condoms for anal sex with casual male partners than for sex with paying male partners.[19] In addition, research has shown that male sex workers may "mix" or "bridge" between ethnicities, genders, age groups, and geographic locations. This can be important if a sex worker works in a group or area with a low rate of HIV as well as one with a high rate of HIV. For example, researchers studying 42 male sex workers in Houston found that almost half of the participants had traded sex in another city before they traded sex in Houston. Those who had traded in more than one city were more likely than those who had not to identify as homosexual and as HIV-positive, to have been in jail, to have injected drugs more frequently, and to have had more male sexual partners.[20]

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Key Correlates of HIV-Related Risk

Other factors undermine the assumption that sex work by its nature leads to a heightened risk of HIV transmission. For example, several studies indicate that the higher HIV risk for sex workers is actually related not to sex work, itself, but to injection drug use.[1,3,13] The study of Houston male sex workers found that about one-third of the men injected drugs at least weekly and sometimes daily. Of these injectors, almost 40 percent shared needles. Of the HIV-positive injectors, 52 percent shared needles.[19] The California study of 1,445 drug injectors found that 7 percent engaged in sex work.[16]

Homelessness and other economic factors also contribute to HIV risk.[13,21] In a study of 485 homeless and housed female sex workers in Miami, homeless sex workers were significantly more at risk for HIV.[21] Homeless sex workers reported engaging in more vaginal and oral sex, more unprotected vaginal and oral sex, and more sex acts while using substances than did housed sex workers. Compared to housed sex workers, homeless sex workers also reported that more of their customers had refused to use a condom.[21] Several studies have found that customers will often offer more money for unprotected sex, although anecdotal evidence suggests that this may not always be the case today.[2,22,23] In addition, some customers refuse the transaction if a sex worker insists on using condoms.[5,24] Facing economic pressures, sex workers may feel they need to take the higher fee.

Violence, especially rape, raises the risk of HIV infection among sex workers. Whether or not a sex worker intends to use condoms or practice other HIV prevention techniques, rape eliminates that option,[24] and it is perpetrated, in particular, against female and transgender sex workers.[6] A Washington, D.C. study of 100 male, female, and transgender sex workers found that 44 percent reported being raped. Of these, almost 74 percent were women, 35

percent were transgender, and 12 percent were men. For women and transgendered people, the majority of rapes were perpetrated by customers; for men, however, the majority of rapes were perpetrated by non-customers.[6]

On an international level, the World Health Organization called for violence prevention as part of any HIV prevention program.[4,25] As one researcher points out, "The power status of an individual affects the negotiation of condom use," and often it is the customer who has the power in these sexual transactions.[1,2] If sex workers are afraid to insist on condoms, they may gamble with HIV risk to avoid more immediate physical harm. According to the Washington, D.C. study, 61 percent of the participants had been assaulted since they entered prostitution. When broken down by gender, almost 86 percent of the women, 65 percent of the transgender participants, and 28 percent of the men reported being physically assaulted, predominantly by customers.[6] Exposure to violence can lead to depression and other psychiatric problems such as post-traumatic stress disorder (PTSD).[6,10] Studies have documented that many sex workers come from childhood homes where they experienced physical and sexual violence, and this trauma is compounded by violence they experience working in prostitution.

A study of 130 sex workers in San Francisco found that 68 percent met the diagnostic criteria for a diagnosis of PTSD.[10] Sixteen percent of all the participants reported that they had experienced one type of four categories of violence (childhood sexual assault, childhood physical assault, rape in adult prostitution, and physical threat or assault in adult prostitution); 30 percent reported two different types; 33 percent reported three different types; and 15 percent reported all four types of violence. The researchers found that the severity of participants' PTSD was related to childhood physical abuse and to the occurrence and number of times raped in prostitution.

The high incidence of PTSD in sex workers can complicate prevention efforts. Symptoms of PTSD include denial, dissociation, irritability, despair, and avoidance, which may impede a person's ability to listen to and internalize prevention messages.[6,10]

Prevention Behavior

Sex workers and their advocates have come up with creative and practical ways to minimize the most serious risks sex workers face: HIV and violence. For example, to reduce the risk of violence, sex workers may stay sober and aware of what the client is doing, avoid carrying weapons, wear clothing that is easy to run in and which does not get caught in car doors, and avoid clothing and accessories with straps that can be used by a client to tie or choke.[26] They can also have a buddy who will keep tabs on where they are going—or even pretend they have a buddy and wave goodbye when getting in a car so the client thinks someone else is watching.

HIV prevention techniques include using plenty of lubricant so condoms do not break, avoiding bodily fluids on hands with open sores or in the mouth, and, when having oral sex, swallowing ejaculate instead of spitting it out, since the risk from swallowing is less than the risk of contact with inflamed gums and open oral sores.[26] In addition, with clients who will not use condoms, some sex workers have been successful surreptitiously slipping on and removing condoms with mouth or hands when these clients are not watching, while ostensibly stroking or sucking a client's penis. Sex workers can redirect clients' hands to parts of the sex worker's body (for example, nipples), so the client does not touch himself and find the condom.

Conclusion

Although the dire prediction of sex workers spreading HIV to "innocent victims" has not been borne out by reality, sex remains the key risk for HIV transmission, and sex workers are likely to participate in activities that can transmit HIV.

But the factor that may increase the risk of HIV infection for sex workers may not, in fact, be their sex work. Likewise, while much effort has been put into educating sex workers about HIV transmission and using condoms, advocates point out that factors beyond choice influence the risk reduction activities of sex workers. Among the factors that increase risk and reduce the capacity to prevent HIV are threats of violence from customers, pimps, and managers, substance use, and high rates of PTSD and its effects on the motivation to prevent HIV and ability to participate in HIV treatment. Others suggest that many sex workers have more pressing concerns that eclipse protecting themselves against HIV, for example, finding food, shelter, or drugs, or tending to more immediate health issues.[2,3,6]

It is crucial for counselors to be aware of this universe of influences. Further, counselors must remain cognizant of the diversity of sex workers in terms of gender, race, sexual orientation, economic status and conditions of sex work, and the variation in HIV-related risk that comes with this diversity. The fact that a client is a sex worker does not imply specific activities, attitudes, or HIV-related risk. Finally, people who exchange sex for money or for drugs may not disclose these activities because of fears of the effects of stigma or fears of law enforcement. For all these reasons, counselors should be careful to ask questions to develop a sense of each individual and his or her specific risks and concerns.

Implications for Counseling

Not all people who trade sex for money or goods are at significant risk of contracting or transmitting HIV. While counselors should not discourage individual sex workers from testing, counseling should focus on serving those sex workers who are most vulnerable to contracting HIV.

Research suggests that sex workers who experience the most HIV risk have also experienced sexual violence and trauma, homelessness, and chaotic drug use. To best meet these clients "where they are," counselors should understand how these contextual factors increase a sex worker's risk for HIV and know how to explore these areas in order to support realistic behavior change.

Behaviors, Not Risk Group

Since "sex work" encompasses so many different types of people and practices, HIV counseling should focus on the context of a client's behavior and not his or her membership in a "risk group." Labeling a client a "sex worker" may also be presumptuous, because not all sex workers trade sex all the time and not all people who participate in sex work think of themselves as "sex workers." In fact, those who do use "sex worker" as a term of empowerment may be at less risk for contracting HIV than those who feel they have less choice about their work.

A Counselor's Perspective

"I am so aware of how the trust of clients who do sex work has been violated: through abuse or violence or society's judgment. I know they have real reason to wonder if they can trust me."

In addition, counselors who assume that sex is the primary avenue of HIV transmission for sex workers may overlook other factors that contribute to HIV risk and impede HIV prevention. For example, breaches of trust from emotional and physical trauma can make a sex worker less receptive to HIV prevention messages. Sex workers may also withhold information about their sex work and needle sharing practices to protect themselves from a counselor's judgment or from legal sanction from society. For these reasons, culturally competent counseling with sex workers means developing sensitivity to the context in which an individual trades sex as well as understanding that individual's barriers to reducing his or her HIV risk.

To support themselves in this role, counselors should be aware of how their own values and judgments impact counseling. While counselors may know that sex workers are no longer considered "HIV vectors," sex work can raise prurient responses in many people. This intrusive sexual interest can lead a counselor to co-opt a sex worker as a "cultural experience."[27] Counselors should be on heightened alert about this dynamic, since such eroticiza tion may mask itself as an appropriate interest in the client's life. The best explorations begin with genuine curiosity ("Who is this unique person in front of me?"), rather than the eroticization of the client ("That's so interesting. I want to know more—for my own reasons.")[27]

Understanding context is not only useful for sustaining rapport and defining risk, it is essential for developing realistic, incremental behavior change. Contextual knowledge prepares a counselor to ask genuine, culturally sensitive questions to uncover both a client's risks and his or her innate capacity to reduce risk. Four areas are particularly relevant: relationships, violence and trauma, substance use, and mental health.

Intimate Relationships

For many sex workers, intimate sexual and needle sharing partners pose more of an HIV risk than their customers. Given the magnitude of sexual and physical violence sex workers tend to have experienced—both in childhood and adulthood—and given the psychological effects of these traumas, unprotected sex may feel less dangerous than initiating condom use. The threat of sexual violence or of the loss of love, trust, commitment, or permanency may stop a traumatized person from taking risk reduction steps. However, counselors must also keep in mind that unprotected sex with an intimate partner can be part of a conscious, negotiated agreement. For example, the partner may have no other partners and the sex-working client may always use protection with customers and routinely test to ensure that he or she remains HIV-negative.

Even so, shying away from asking exploratory questions about unprotected sex would be a disservice to the client. Acknowledge that—from the client's perspective—he or she may be in the maintenance stage, and problem solve. Ask, "What happens if a condom breaks while you're working?" or "That's a clear agreement. How did you come to it?" or "You negotiate your prices well. How do you negotiate protecting yourself with your husband?"

Work-Related Violence

Exploring a client's history of sexual and physical violence is essential, since many sex workers are at greater risk of contracting HIV from rape than from other aspects of sex work. In the case of violence, harm reduction may not be about motivating the client to use protection, particularly if insisting on condoms pits HIV prevention against the risk of immediate physical harm.

A counselor may focus, instead, on protection against rape or violence by assessing its presence in the client's work and home life. For example "How is your job going?" or "What's the best part and what's the worst part

of your job?"[27] If these questions do not reveal safety concerns, counselors may need to be more direct. For example, use third-personing by observing, "I've heard people say that being yelled at or hit is the worst part of the job. What's the worst part for you?"

Since marginalized sex workers may not feel empowered by their profession or their intimate relationships, an appropriate intervention may be to simply say, "No one has the right to hurt you." Counselors should then be prepared to refer the client to additional sex worker-friendly violence and rape crisis services.

Mental Health and Substance Use

Many sex workers meet the criteria for post-traumatic stress disorder and may have other psychiatric daignoses such as depression that interfere with planning, integrating, or trusting the messages of HIV prevention. When working with trauma, in particular, counselors may encounter wariness as they explore the context of a client's last HIV risk—particularly if that sexual act was not consensual.

Counselors may have to address issues related to basic psychological and physical survival before a client will consider more specific HIV risk reduction. Avoidance—one of the key symptoms of PTSD—requires sensitivity in order to facilitate interventions that enhance a client's self-perception of risk and his or her ability to reduce that risk. As always, counselors must take their cue from the client, by focusing on the client's immediate needs. Likewise, brainstorming harm reduction strategies in partnership with a client may be more helpful than trying to get a traumatized client to think on his or her own about risk reduction.

Research suggests that many sex workers use substances, and their elevated HIV risk is associated not with sex work but with shared drug injection, including—for some transgender sex workers—hormone injection. Counselors can explore how substance use is related to sex work by stating, "Sometimes you share your works and sometimes you don't. What's the difference between these times?" or "It sounds like you're more likely to share when you're in withdrawal. Does that sound true to you?" Since injection is a stigmatized behavior in and of itself, counselors should be prepared to offer culturally sensitive referrals to needle exchange sites and to explore syringe disinfection and injection safety—

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Case Study

Loretta is a 26-year-old woman who identifies as transgender (male-to-female). She has come for an HIV test because she recently found out that her "sister"—a friend who shares her room in a single-room occupancy hotel—is HIV-positive. Loretta and her sister have shared syringes a few times for hormone injection and work together on the streets.

Counseling Intervention

Raul, Loretta's HIV test counselor, responds to the news about Loretta's "sister" by saying, "That's hard news. How are you doing?" Loretta nods her head, and looks out the window and then at her watch. Picking up on Loretta's desire not to linger on the topic, Raul makes a process comment, "We'll just talk about what you'd like to talk about. What's your biggest concern today?"

Given the potential for PTSD—considering Loretta's street work, her likely struggles as a transgender person, and her marginal living situation—Raul backs away from exploring Loretta's feelings until he has built more rapport with her. Instead, Raul chooses to find out where Loretta would like to lead the session.

Loretta says, "I want to know if I have it." She explains that she thinks she might have given the virus to her roommate, since she does not always use protection with all of her clients. Raul responds, "We'll know more soon. What else is on your mind?"

Loretta explains that she started trading sex because it was the best way to make money. Her family dropped her shortly after she came out as transgender and no one wanted to give a "tranny" a "real" job. Sometimes Loretta will agree to have anal sex with men without a condom if these men agree to pay her more money.

Loretta has been trying to save enough money to get out of sex work altogether because, in the past year, three johns had sex with her and beat her up. She figures, the faster she can make some money, the sooner she can stop working, but she says she knows she is risking HIV. "It sounds like you're balancing not getting beaten up over protecting yourself against HIV. But, it also sounds like you don't really want either of these things to happen."

Raul is following Loretta's own logic about how to protect herself. He looks for the strength and reasoning behind her actions without judging her behavior. At the same time, he highlights her concern for her own safety and reinforces the value of protecting her health.

After Raul discloses Loretta's HIV-negative result, he reminds Loretta that she may have to test again to be sure she does not have HIV. In the meantime, Raul asks, "How could you get what you need—more money and more safety—without getting HIV?" They discuss: raising her price altogether, so she can earn money faster; getting paid before sex; using post-exposure prophylaxis, if she has unprotected anal sex again; and leaving the car door ajar, so her clients can't lock her inside.

Of these options, Loretta feels most motivated to consider raising her price. She and Raul discuss how Loretta currently negotiates with customers, whether she has regular customers, and whether and how she has negotiated price increases with regular customers in the past. They also discuss how Loretta might react if a client were to refuse to pay her. In closing, Raul covers what kinds of resources might be available to support her and her friend in the future.

including hepatitis C and overdose prevention—where needle exchange is not available.

Substance use may be related to psychiatric distress. For example, a client may be "self-medicating" depression or PTSD, in which case referrals to mental health agencies may reduce some of the harm of the client's substance use.

Sex Work Harm Reduction

HIV prevention interventions for people who trade sex are as various as the contexts for sex work and the diversity of sex workers. For those clients most at risk for contracting HIV, the most effective risk reduction strategy may result from responding to other dangers, for example, by treating sexual trauma or reducing the likelihood of job-related assault. Counselors can use whatever the client defines as his or her primary concern as a route toward negotiating HIV prevention.

For example, a counselor might say, "It sounds like your biggest worry is not knowing if you'll get hurt by a john. Could we talk about how you can feel safer in your work?" Options may include being aware of exits and the locks on car doors, using mace instead of knives or other weapons that could cause death if used against the sex worker, or avoiding long dresses that can get caught in car doors.

As always when negotiating realistic, incremental change, a preset list of harm reduction practices may not be enough of a resource. This information will be essential, but the bulk of behavior change results from an exploration of how that information can apply specifically to an individual client.

Test Yourself

Review Questions

1. True or False: Seroprevalence among sex workers is significantly higher than among other key subpopulations.

2. Studies have shown that the majority of sex workers: a) want to continue doing sex work; b) want to leave sex work; c) have chosen to go into sex work; d) recognize the value of sex work as a way to express themselves.

3. True or False: HIV risk for sex workers is due more to injection drug use than any other factor.

4. A sex worker may agree to engage in behavior that has a risk of HIV transmission if: a) they are an escort; b) they think the customer looks healthy; c) they need money; d) they have access to regular HIV testing.

5. True or False: Many sex workers have experienced sexual or physical abuse as children.

6. True or False: When a client discloses sex work, a counselor can assume that the client faces a high risk of HIV infection.

7. Violence: a) may remove a sex worker's choices about using condoms; b) is overstated—sex work is safer than it seems; c) is less of an issue for transgender sex workers; d) is transient and does not have a lasting psychological effect.

8. Prevention measures for sex workers may include all of the following except: a) swallowing ejaculate rather than spitting it out; b) wearing flowing clothing so that violent clients grab cloth instead of body parts; c) using extra lubricant with condoms; d) surreptitiously putting a condom on a client.

9. True or False: It is important for a counselor to express as much curiosity as possible about the details of a client's sex work practice.

Discussion Questions

1. How might you approach the range of issues that arise related to violence or post-traumatic stress within the limited context of HIV counseling?

2. How might a sex worker's concerns vary depending on whether the client is male, female, or transgender?

3. How might you approach a person who says he or she uses condoms for sex work but not for their intimate or casual partners?

4. How might you approach a discussion about possible harm reduction techniques with a sex worker?

5. What are the laws in your area regarding prostitution and HIV? How do you think these might affect your interactions with a sex worker in a test situation?

Answers

1. False. Studies of sex workers have shown low rates of infection.

2. b.

3. True.

4. c.

5. True.

6. False. A counselor should explore, as with any client, all the different behaviors that may elevate HIV risk in order to assess an individual sex worker's risk.

7. a.

8. b.

9. False. Counselors should focus on the details that illuminate the particular client and his or her behavioral risk; counselors should avoid expressing what may be perceived as prurient curiosity.

Using PERSPECTIVES

PERSPECTIVES is an educational resource for HIV test counselors and other health professionals.

Each issue explores a single topic. A ***Research Update*** reviews recent research related to the topic. ***Implications for Counseling*** applies the research to the counseling session. Also included are a ***Case Study*** and two sets of questions for review and discussion.

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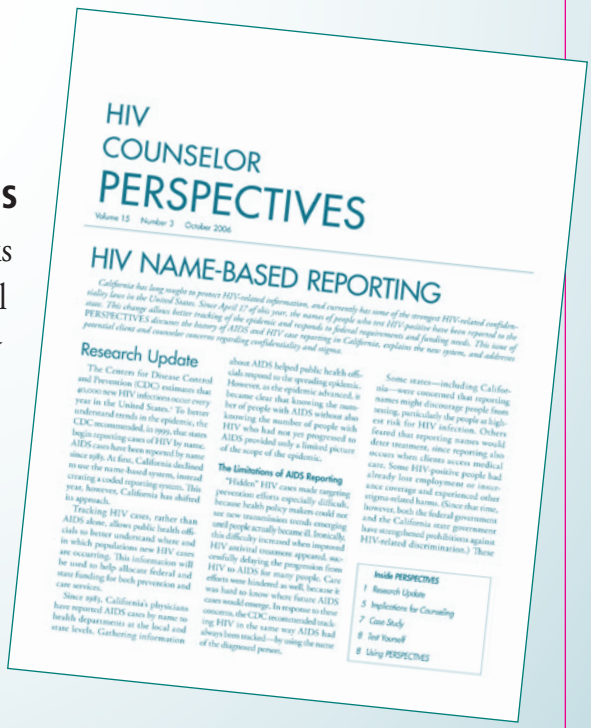
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