

HIV COUNSELOR PERSPECTIVES

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USING INFORMATION IN THE SESSION

Delivering and collecting accurate HIV risk-related information is a key part of test counseling. At the same time, doing client-centered HIV counseling involves more than sharing the facts about HIV risks with clients or completing data collection forms. This issue of PERSPECTIVES discusses the role of factual information in the counseling session, as well as the importance of moving beyond a “just the facts” approach to a broader discussion of the context of the client’s risk. It also explores some of the common errors in thinking that can cause counselors to misunderstand the nature of their clients’ risk, and suggests ways to avoid these errors.

Research Update

The volume of HIV-related information available today is staggering—more than any person could keep up with. At the same time, HIV test counselors are challenged to gather and share a great deal of information with clients in a brief period, without interrogating the client or delivering a lecture. Good counseling strikes a balance between sharing information and understanding what that information means for the client. It also strikes a balance between talking and listening.

How we use information can determine whether we achieve the goals of the counseling session. These goals include helping clients understand their personal risks for HIV and helping clients decide how they would like to change their behavior to reduce their risk of acquiring or transmitting HIV. Throughout the article, the term “information” refers to facts that the counselor shares with clients about

HIV and other topics, and to facts that the client shares with the counselor. “Counseling” refers to more than simply giving or receiving these kinds of facts. Instead, it involves exploring the broader context of the client’s behavior. This includes exploring how and why the client engages in behaviors that can transmit HIV. It also involves understanding the client’s motivations and options for change.

This Research Update explores some of the information-related challenges counselors face. These challenges include striking the right balance between presenting or discussing fact-based information. It also discusses the use of other counseling tools (such as open-ended questioning), and describes ways to decide when it is important to focus on fact-based information.

More Than Education

As counselors know, the ability to deliver accurate information about

HIV transmission and prevention is a critical skill at the heart of HIV test counseling. The test counseling session is often the best opportunity clients have to spend time talking about their risk for HIV and their personal plans for prevention.

Some of the traditional models of patient-provider interaction in health care settings can result in patients either not receiving enough information, not understanding what their medical provider said, or receiving an overwhelming amount of information.¹ Having correct information about HIV risk and HIV prevention strategies is important, but it

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is not enough by itself to produce behavior change. Client-centered counseling is a more effective way of promoting HIV-related behavior change than education alone. The leading study on this topic, Project RESPECT, found that people who received client-centered counseling used condoms more consistently and experienced fewer incidents of sexually transmitted diseases (STDs).^{2,3,4}

Counselors using client-centered counseling understand that clients have a range of choices that may be correct for them, and that information is a tool to be used carefully; it is not the main instrument of change. Although counselors strive to be client-centered, there are a variety of challenges that may pull counselors toward substituting information for counseling. These challenges include the need to document the session and to effectively assess risk.

The Challenge of Documentation

Counselors must deliver, collect, and document a tremendous amount of information during a brief counseling session. Some of this information is critical in order for the client to understand and consent to the testing process, some is important to guide the discussion of the client's HIV risk and possible risk reduction steps, and some is important to help planners and funders notice trends in the HIV epidemic and decide how to allocate resources. It is also important to know how and which services were delivered in the session in order to help improve the quality of services over time.

One of the most information-heavy parts of the counseling session is the process of gathering and documenting required data. Because

documentation is so important, it can be easy to let the session become “form-driven.” This means that the counselor's focus in the session is on filling out the data collection form, rather than counseling the client. In contrast, a client-centered session would explore the client's behavior

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and help the client develop a risk reduction goal.

A 1999 study that examined the interaction between clients and counselors at voluntary test counseling sites found that counselors often structured their sessions with the client according to the checklist on the data collection form, resulting in interviews that were impersonal and bureaucratic.⁵ This is one example of how the need for information can overwhelm the purpose of the session, which is helping clients to reduce their HIV-related risks.

A collaborative study between the University of California San Francisco and the San Francisco Department of Public Health suggests that one way to address the

problem of too much data collection and not enough counseling is to allow clients to enter their required risk assessment data into a small personal computer (called a PalmIT) just prior to beginning the counseling session. The study's authors state that because clients have already entered their risk assessment data, they are more ready to discuss their HIV-related risk behaviors in the session.⁶

A study of 1,350 HIV-negative STD clinic patients in Baltimore supports the conclusion that clients may be more comfortable reporting some sensitive behaviors using a computer than they are talking with a person. Published in 2005, this study found that participants assigned to report behaviors via computer were significantly more likely to report anal sex and paid sex, having had at least one new sexual partner in the last six months, and sex without use of a condom in the past 24 hours.⁷

Some test sites in California are currently piloting the use of the PalmIT to gather risk assessment data. While this technology is not available everywhere, counselors can still take steps to prevent data collection from being a barrier to client-centered counseling. It is helpful when counselors are familiar enough with the data collection forms that they use to maintain a conversation with the client while asking the questions they need to ask. This creates a stronger connection in the session than simply “going through a checklist,” which can feel impersonal.

A Conversation, Not a Lecture

Relying solely on the data collection form to guide the counseling session is just one way counselors

can “misuse” information, or use information ineffectively. Like other health care providers, test counselors may sometimes be tempted to share more information than the client is ready to hear. All people have limits on how much fact-based information they can process at once. In addition, behavior is usually motivated by a variety of factors that may have little to do with the “facts.” Further, the limits of the counseling session mean that it is important to concentrate on the most important HIV-related issues for each client. This means that while some key facts are crucial, reviewing all of the facts related to a particular issue is both impossible and not the best use of the session time.

The goal of HIV test counseling is for clients to leave the session armed not only with information (though information is still crucial) but also with an understanding of how they can reduce their own personal risk factors for HIV. Counselors use open-ended questions (questions that require more than a “yes” or “no” or other one-word answer) to understand the broader context of clients’ risks. For example, a counselor might ask, “Tell me more about what happens when your partners say they don’t want to use condoms,” or “What role do drugs and alcohol play in your life—before, during, and after sex?”

Understanding this context allows counselors to then frame their counseling in terms that fit a client’s life experience. This means that the client is more likely to take in the information and find it useful.

Even in a short period of time, by staying focused, counselors can help create an atmosphere that encourages clients to talk about the context of their risk. In the client-centered

counseling model, the session is more of a conversation than a lecture, and ideally, the counselor talks less than the client. Counselors follow their client’s lead, using active listening skills and open-ended questions to facilitate a discussion that focuses on the client’s individual situation.⁸ Following this

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model—and consciously treating each client as an individual—can help counselors avoid some of the most common errors that can throw sessions off track.

Avoiding Errors in Thinking

Each of us constantly screens information, sorting what is valuable from what is not. Our minds look for patterns based on our experience, so that when we encounter a new situation, we can use what we have learned in the past to respond to it. This process is normal, unavoidable, and often unconscious. While this process of comparing current experiences to past experiences is what learning is all about, it can also create errors in thinking that can blind us to what is going on with our clients right now.

Physician, author, and AIDS pio-

neer Jerome Groopman has written about four different types of “errors in thinking” that doctors experience.⁹ HIV test counselors may also experience these in their work. Each of these errors (which are discussed below) has to do with the ways that people pay attention to and process information. Each error is also related to jumping to a conclusion about a client and his or her HIV risk, rather than fully exploring the risk and context of risk for that particular client.

Attribution Error: A client seems to fit a negative stereotype in the mind of the provider. The provider then makes assumptions about the client based on that stereotype. For example, a counselor presumes that a client who does sex work is most at risk for HIV from her customers. Blinded by this assumption, the counselor misses key facts: the client regularly uses condoms with her clients, but has unprotected anal intercourse with her long-term boyfriend, who does not know his HIV status.

Affective Error: The client seems to fit a positive stereotype in the mind of the provider. The provider likes the client and may identify with the client. The provider then makes decisions based on not wanting to make the client uncomfortable. For example, a counselor who is working with a client who reminds him of his father. Afraid of offending the client, the counselor doesn’t ask about injection drug use.

Confirmation Bias: The provider leaps to a conclusion about what is happening with the client. Then the provider pays attention to the information that confirms this conclusion, and ignores signals that this conclusion might be wrong. For example, a counselor hears

that the client goes to sex clubs. The counselor then focuses the session on sexual risk at the clubs, without realizing that the client only engages in mutual masturbation with partners there. By focusing the session in this way, the counselor misses the fact that the client has recently begun to use methamphetamine, and that this drug use is affecting the sexual risks he takes with the friends who provide him with speed.

Availability Bias: The provider jumps to a conclusion about the client based on what usually happens at the counselor's work site or what has been happening recently. For example, a counselor who has seen a number of young gay male clients who use methamphetamine assumes that the young gay man she is currently counseling is high on methamphetamine because of his pressured speech, darting movements, and red eyes. In fact, the client is experiencing the manic phase of bipolar disorder.

In each of these cases, a counselor could be misled by paying attention to some (less relevant) information and ignoring other (more relevant) information. Groopman suggests that we can overcome some of these

natural errors in thinking by keeping a few questions in mind. When providers reach a conclusion about what is happening with a client,

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they can ask: “What else could it be?” “Could more than one thing be happening here?” “What information that the client is presenting doesn't fit my conclusion?” In this way, counselors can stay open to new information that may lead to a more helpful counseling session.⁹

Conclusion

One of the key challenges of providing good client-centered counseling is striking a balance, for example, between giving information to clients and asking for and receiving information from clients. The counseling session must also move beyond a focus on fact-based information to a discussion of the context of the client's risk behaviors and the client's motivation to reduce those risk behaviors.

While counselors know that staying “client-centered” is important for effective counseling, there are a number of concerns, such as the need for adequate documentation, that can pull counselors into substituting information for counseling. Common errors in thinking can also prompt counselors to misinterpret information about clients and jump to conclusions about their HIV risk.

The next section reviews some of the other reasons that counselors may be pulled out of their client-centered stance, including counselors' anxiety, their need to feel that they are “HIV experts,” and the difficulty of explaining complex or ambiguous risk information. It will also explore some techniques for keeping the conversation—and the “client-centeredness” of the session—on track.

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Implications for Counseling

Effective HIV test counseling requires more than knowing the facts about HIV. It is a way of being with clients that uses information about HIV thoughtfully and strategically. This means that the counselor knows what to follow up on and what to let go of in order to stay within the constraints of the session's goals, time limits, and the limited counseling role.

How Do We Get Off Track?

There are a number of reasons why counselors and clients may find themselves focusing on information in a way that does not help the client reduce his or her HIV risk. While it is important to have a sense of the relative risk of a behavior in order to make a wise decision about whether or not to engage in it, sometimes clients want to talk about exact numbers and statistics because it is hard to focus on their own risk. Anxiety is often one of the experiences that leads people to take an HIV test, and sometimes focusing on something besides their own risk for exposure to HIV lessens that anxiety.

Counselors may themselves be uncomfortable or anxious talking with clients about certain risk behaviors. Sometimes they “take on” the anxiety

the client feels. At other times, the client is seeking an absolute answer that research has not yet conclusively provided (or that the counselor does not know), which can lead the counselor to feel frustrated, irritated, or inadequate.¹⁰

One reason for these feelings is that it is natural for counselors to want to feel knowledgeable and that they are helpful to clients. While this is a valid concern, many counselors carry this a step further, believing that they should be “experts.” This belief makes it difficult for some counselors, both new and experienced, to admit that they don't know the answers to some of the questions clients ask.

The truth is that while giving up-to-date HIV-related information is a key part of the counseling process, no one has all the answers. There are still some things that even scientific experts do not know about HIV, and occasionally what we think we know changes over time. If you do not know the answer to a particular question, it's OK to say “I don't know,” and, if you can, to offer to help the client locate a resource where he or she can find the answer. Finding the answer may be particularly important if the question is likely to come up in future counseling sessions. The counselor's limited role requires a clear grasp of the basic facts of HIV disease and its transmission, as well as good counseling skills, but not advanced medical or other scientific knowledge.

Even in cases where you do “know the answer,” it is often important to explore the meaning of what the client is asking or saying before you give an answer. For example, a client may reveal that he or she is sharing injection drug needles. It is important for counselors to understand the philosophy of harm reduction, and to be able to make referrals for the client, such as needle exchange. At the

same time, don't overwhelm the client with harm reduction referrals before you have a chance to explore together what would work for the client. Remember also the errors in thinking that Groopman described, and how easy it is to get off track by focusing on one piece of information about the client without exploring the rest of the client's risk.

Another way that the session can be derailed is for counselors to make assumptions about clients—their risk for HIV, their knowledge level, their capacity for change. Even seasoned counselors with tremendous skill and experience must watch out for this trap, since sometimes greater experience can make counselors feel that they know what is happening in a situation without fully checking it out. Open-ended questions can be helpful. These questions often start with phrases like “Tell me more about...” or “What do you think about...” or “What happens when...” Such questions can provide critical information; they shift the balance of who is talking in the session to the client; and they can be validating. For example, a counselor might ask, “So you've tested 30 times, what has that been like for you?” These types of questions convey openness and invite clients to share their experience, which is the energy and attitude that you want to bring to the session.

Remember that the session's ultimate goal is to help the client identify which, if any, behaviors he or she wants to change in order to avoid acquiring or transmitting HIV and how he or she might go about changing these behaviors. Let that purpose guide the session, rather than moving into the “comfort zone” of simply giving information. It can be easy to slip into a “one size fits all” approach to counseling, unconsciously giving the message: “Here's the information that I have. I'm going to give it to you whether it is relevant to your situation or not.” Being truly

A Counselor's Perspective

“Everything comes back to the context of risk in the client's life. Any other information that doesn't relate to the client's risks, needs, motivations to change—is just unsolicited advice.”

responsive to each client is much more challenging than having a standard way of interacting with all clients, but this individualized interaction is the key to client-centered counseling.

Picking Your Battles

Two other challenges that counselors may face are when clients seem to “have all the answers” (even if some of those answers are incorrect), and when clients seem to want to debate counselors on certain points. In these cases, counselors must decide which information is important to clarify and which is not critical to the goals of the session.

One way to determine which information should be clarified in the session is to ask, “Is this related to this client’s HIV risk?” For example, say that the client has a theory about how HIV began that does not seem to be supported by facts. If this belief stands in the way of the client protecting himself or herself from HIV, it is more important to address the issue than if the client understands accurately how HIV is transmitted and how to avoid it. Without arguing or confronting, correct key information that is related to this client’s HIV risk.

By prioritizing the discussion of factors that are specifically related to the client’s risk, counselors can help clients “pick their battles” as well. One aspect of this is helping clients feel empowered to make decisions with the “best” information, rather than getting stuck in the search for “complete” information. Which sources of HIV-related information (including friends, the internet, and medical sources) do they seek and trust? After learning where clients go for information, the counselor can also ask permission to share some additional sources of accurate, up-to-date information as needed.

In the end, “debating” a client may not be an effective strategy. The client’s worldview and beliefs may not be changeable even with your accurate, fact-

based information. In cases when the client is insistent on information that you know to be incorrect, offer an alternative, and if the client rejects it, continue the discussion to see whether there is a way to work a client-centered approach to risk assessment and risk reduction within the client’s belief system.

Uncertainty and Complexity

Counseling clients about behavior change is challenging enough when the HIV risks being discussed are clear. It becomes even more difficult when counselors and clients discuss behaviors that carry an uncertain level of risk, or when the risks involved are very complex and difficult to explain. In these cases, it is easy for the counseling process to become confusing as counselors attempt to help clients sort through all of the statistics and possibilities related to the risk behavior.¹⁰

Each client’s needs and motivations are different, and it is these needs and the focus and limits of the counseling session that should determine which information is important to communicate. If a client says he or she serosorts, it is not only important to have an understanding of whether serosorting prevents HIV transmission, but also what serosorting means to this client. For example, a counselor might say: “Lots of folks tell me that they serosort, and sometimes they mean different things. What does serosorting mean to you?” Similarly, if a client asks, “Is oral sex risky?” the counselor needs to know what the client really wants to know: “Is oral sex just as likely to expose me to HIV as receptive vaginal sex?” “Should I wear a condom for oral sex?” or “My steady partner is HIV-positive and I have a lot of cuts and sores in my mouth. Is there any chance at all that I could get HIV through going down on my partner?” Knowing what the client is really asking allows the counselor to respond to the question in a way that is useful to the client.

The client is the expert on his or her own motivations and capacity to change HIV risk-related behaviors. The client is also the expert on his or her own “risk tolerance”—the amount of risk that he or she is willing to accept. Often people weigh the risks of activities against the rewards: pleasure; intimacy; or other benefits (such as money, shelter, safety, or avoiding drug withdrawal). Even with regard to complex issues, it still makes sense to bring together what you know about HIV and what clients share with you about the context of their HIV risk to help them think of options that they can use to reduce risk.

Sharing Information Effectively

Just as it is important to gather information during the session in a client-centered way, it is also critical to share information with clients in a way that is clear, helpful, and keeps the conversation flowing in both directions. One way to do this is to use the “Ask, Tell, Ask”¹¹ approach:

Ask. Inquire as to what the client knows about a topic. For example, “Since you have tested before, can you tell me what you remember about the window period?” After the client responds, affirm his or her current level of knowledge and ask for permission to share more information. For example, “It sounds like you have good basic information on how HIV is transmitted. Is it OK if I add a few things?”

Tell. Give the client a small chunk of information. Don’t talk too long without making sure that the client understands and has absorbed what you are saying.

Ask. After you have shared a chunk of information, ask the client what the information means to him or her. For example, “What does that information mean to you?” or “How do you feel about what I just said?”

This kind of process keeps the counseling session from turning into a lecture. It can also help counselors know if the

Case Study

Vic, a new 28-year-old HIV test counselor, begins his session with Derek, a 48-year-old straight-identified man. As they start, Vic asks, “What brings you in for counseling?” Derek replies that he’s recently come out of a relationship and has been having sex with a number of new partners. As Derek gives this answer, Vic becomes distracted by the fact that Derek has track marks up and down his arms. Vic quickly shifts the focus of the session to an exploration of Derek’s drug use, asking which drugs Derek uses and how often.

“I guess it’s been about six years that I’ve been using heroin—maybe twice a day,” Derek replies.

This response seems to confirm Vic’s belief that Derek’s primary HIV risk comes from his injection drug use. Vic recently attended a harm reduction training and, in the back of his mind, he is hoping that he can remember all of the strategies that might be useful to clients like Derek. Vic thinks that maybe the best way to lead into the topic of harm reduction is to get Derek to acknowledge his risk of acquiring HIV from shared needles.

“Can you tell me a little bit about your understanding of how HIV is transmitted?” Vic asks.

Derek responds by listing the five fluids that typically transmit HIV. Vic then follows up by zeroing in on the risk of transmission through blood-to-blood contact. He continues to question Derek about his drug use, asking Derek if he has sex when he is high.

“Well, you know, shooting up twice a day, I’m almost always a little high. So when I have sex, yeah, I’m usually a little loaded.” Derek also notes that sometimes he uses methadone on top of the heroin.

“I’m wondering if the people that you have sex with use heroin as well?” Vic asks.

Derek replies, “Some do, and some don’t,” shifts in his seat, and looks away.

Vic notices that he’s losing his connection with Derek.

He decides to try a different approach. He asks if Derek would mind if Vic shared some information about harm reduction techniques.

Derek agrees to hear the information. Vic describes the needle exchange process, including two sites in the county, their location, and hours of operation. Taking Derek’s nodding as encouragement, Vic goes on to describe how to use bleach to clean works. He finishes by explaining that some people label their needles with their names so that other people won’t use them.

Derek sighs and is silent for a minute. Finally he says, “All that sounds good, but I’ve been in this game a long time and I’m pretty safe.” Derek explains that he always shoots alone in his home, never shares any of his equipment, and buys new needles at the pharmacy when he picks up his blood pressure medication.

Vic says: “That’s great that you are so on top of it. Just wanted to make sure you knew.” The session time is almost up, and Vic asks Derek if he has any other questions.

“Yeah, can we talk about rubbers?” Derek asks. “I’ve kinda started having sex with this guy and I don’t know that much about condoms. My girlfriend is on the Pill.”

Vic realizes that he’s been so focused on Derek’s drug use that he failed to do a complete, client-centered risk assessment. In the 10 minutes that remain in the session, the two explore Derek’s questions about condom use, and which risk reduction steps Derek might be willing to try.

information that they are sharing is relevant and understandable to clients.

“Ask, Tell, Ask” can also ensure that the counselor understands what clients are saying. For example, a counselor might Ask: “It sounds like you have a great understanding of how HIV is transmitted. How do those ways of transmission relate to your HIV risk?” Then, in a little switch on this process the client can do the Telling: “Well, when I have sex with my boy-

friend, we don’t always use condoms, because I am on the Pill.” Then, the counselor might Ask, “So it sounds like the risk from unprotected sex with your boyfriend is one concern about your possible exposure to HIV, is that right?” Making sure that you understand the information that clients want and what they are trying to tell you before jumping into giving information, making suggestions, or offering referrals is critical.

Conclusion

HIV test counseling sessions are only one of many sources of competing HIV and health messages. A real conversation about the context of the client’s HIV risk, however, is one of the unique benefits of the test counseling session. By going beyond just giving and collecting information, effective HIV test counseling helps clients take their next step in changing their HIV-related behaviors.

Test Yourself

Review Questions

1. True or False: The Project RESPECT study found that providing comprehensive information about STDs and how they can be prevented is the most effective way to reduce STD risk.
2. The Implications for Counseling section notes that a counselor might feel pulled toward substituting information for client-centered counseling because: a) information is the key to changing HIV risk behaviors; b) test counselors are experts on HIV disease; c) it is easy to slip into a “one size fits all” approach; d) all of the above.
3. True or False: Some research suggests that people may be more comfortable using a computer to report sensitive sexual information than they are reporting the same information to a person.

4. A client reminds a counselor of his favorite niece, who is very shy. The counselor assumes that the client would not feel comfortable talking about anal sex. This is an example of: a) attribution error; b) affective error; c) confirmation bias; d) availability bias.

5. The data that HIV test counselors collect helps: a) planners and funders to notice trends in the epidemic and decide how to allocate resources; b) evaluators to know how and which services were delivered in the session; c) guide the discussion in the session toward a focus on the client’s specific HIV risk-related needs; d) all of the above.

Discussion Questions

1. What do you think client-centered counseling adds to the HIV test counseling process that education alone does not provide?

How can you tell when a client has reached his or her limit for hearing

and processing information? How do you shift the discussion when this happens?

2. How do you balance the need to document information with the goal of staying client-centered?

3. What open-ended questions do you find useful when you are encouraging clients to talk about the context of their HIV risk behaviors?

4. How do you feel when a client openly challenges the facts you are presenting in the session? How might you respond to the client?

Answers to Review Questions

1. *False. Project RESPECT found that people who received client-centered counseling experienced fewer incidents of sexually transmitted diseases.*

2. *c.*

3. *True.*

4. *b.*

5. *d.*

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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