The Naz Foundation (India) Trust

GUIDE TO
COMMUNICATION AND
COUNSELING

A Training Manual for Trainers
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Introduction
Counseling and sexual health

Work in sexual health and HIV/AIDS may involve gathering information on sexual behavior that is highly personal to the individual, often taboo and difficult to talk about. These behaviors are seen in society as immoral, dirty and unnatural. It also necessitates learning and working with groups that are often marginalised, neglected and seen as “deviant”. Access to facilities which meet the sexual health needs of these groups are invariably not available, which increases vulnerability to sexually transmitted infections including HIV/AIDS.

Individuals and counselors working in this field need to be aware of their personal biases, prejudices, values and attitudes towards behaviors, groups and issues related to sexuality and HIV/AIDS such as confidentiality, informed choice and consent, compulsory testing. They also need to identify and explore the feelings around the issues. It is not always easy as counselors to be non-judgmental for they are too members of a society that nurses these attitudes. It involves working on sensitive issues such as sex and drug abuse. Understanding and internalizing the principles of counseling helps facilitate a helping process.

It involves providing accurate information in ways that it can be easily understood, facilitating a process of looking at alternatives.

Finally, it is important to acknowledge ones’ limitations as a counselor, burn out and to be aware of the ethical dilemma the counselor often faces in his/her work.
Introduction to the manual

This manual is for trainers. It aims to introduce the participants to different concepts in counseling. It provides several exercises to help understand and internalize various principles, concepts, tools and limitations in counseling.

Each section can be completed in one full morning, afternoon or evening sessions. Thus the whole workshop takes two, long, intensive days or four, more-relaxed days. Nonetheless many workshops may not allow for even the time allotted. If this is the case, carefully select exercises that best meet the objectives of your training and the needs of your audience.

Remember to allow sufficient time for discussion and reflection. You may want to add unstructured time into the workshop for this purpose. Throughout this manual we have provided notes and practical information to help the trainer facilitate each of the sessions. This will help you to be aware of participant’s feelings, reactions, blocks and progress in learning.

The manual is an orientation to different concepts and provides some input in skill building. As is true of any other issue in HIV, counseling skills too develop with practice, with discussions on situations that may arise, and with sharing ideas with other counselors.
How to use the manual

The manual is divided into five sections:

Section I  -  The principles of counseling
Section II -  Communication and counseling skills
Section III -  Application of concepts, tools and principles
Section IV -  Limitations of a counselor
Section IV -  Special Issues
Activities in This Guide

Section I: The principles of counseling

This section focuses on principles of counseling. It looks at the differences between advice, counseling and providing information. The section addresses the importance of confidentiality and informed choice and the implications for behavior change.

Section 1 has four sub-sections:

i) Advice
ii) Informed Choice
iii) Confidentiality
iv) Values and Attitudes

1. Advice

(a) Exercise
Role-play which give the participants a chance to understand the implications of advice and counseling.

Time: 30 to 45 minutes

(b) A guided discussion
A discussion that enables participants to differentiate between providing of information, advice and counseling.

Time: 45 minutes to 1 hour

2. Informed choice

(a) Condom exercise
A guided discussion that aims to familiarize the participants with the concept of informed choice.

Time: 30 to 45 minutes

3. Values and attitudes

(a) The Empathy exercise
A group activity that helps the participants to understand the role our values and judgments play in effective counseling.

Time: 45 minutes
(b) **Statement exercise**
A guided discussion that tries to explore, identify and uncover the attitudes and values we have towards marginalised groups, people living with HIV/AIDS, behaviors related to sex, sexuality and injecting drug use.

Time: 1 1/2 to 2 hours

### 4. Confidentiality

(a) **Meditation exercise**
This is an experiential exercise that enables the participants to internalize issues around confidentiality in HIV/AIDS counseling.

Time: 25 to 30 minutes

(b) **Confidentiality Exercise**
This group discussion aims to familiarize the participants with ethical issues around confidentiality.

Time: 30 to 45 minutes
Section II: Communication and counseling skills

This section aims to examine the importance of communication and counseling skills that includes verbal and non-verbal communication. Appropriate application of tools and exercises also encourages the participants to internalize these concepts.

Section 2 has two sub-sections

1. Non-verbal communication

   A lecturette that familiarizes the participants with the tools used in non-verbal communication. It emphasizes on techniques that help bring out levels of discomfort in the client.
   
   Time: 30 to 45 minutes

2. Verbal communication

   (a) Open ended questions
   This lecturette familiarizes the participants with the concept of verbal communication.
   Time: 15 to 20 minutes

   (b) Paraphrasing
   An experiential exercise that helps in understanding the skills required for paraphrasing.
   Time: 45 minutes

   (c) Reflection of feeling
   This consists of two activities, a lecturette followed by a role-play that helps to bring out levels of comfort and discomfort associated with identifying and reflecting feelings.
   Time: 1 hour

   (d) Asking effective questions
   This is a lecturette that familiarizes the participants with the concept.
   Time: 15 to 20 minutes

   (e) Focusing
   This lecturette demonstrates the importance of focusing in counseling.
   Time: 10 to 15 minutes

   (f) Appropriate use of silence
   This role-play brings out the importance of silence in counseling as well as the levels of discomfort associated with it.
   Time: 30 to 45 minutes

   (g) Confronting
   This lecturette tries to bring out the advantages of confronting in counseling.
   Time: 10 to 15 minutes
Section III: Application of concepts, tools and principles

In this section, the participants are encouraged to internalize the concepts described in sections II and I and apply them to practical situations. Each tool can be used in combination with one another. Application of the concepts also brings out the traps and fears that a counselor might face.

Section III has 3 sub-sections:

1. Traps in counseling

   This lecturette aims to make the participants aware of some of the pitfalls in counseling.
   Time: 30 minutes

2. Application

   (a) Risk assessment exercise - a guided discussion that helps familiarize the participants with the information needed in HIV/AIDS counseling. It also examines the feelings associated with being asked personal questions.
   Time: 30 minutes

   (b) Informed choice - a role-play that explores the use of informed choice in behavior-change counseling.
   Time: 30 to 45 minutes

3. Counselors fears

   This group activity explores fears associated with disclosing a positive result to a client.
   Time: 30 to 45 minutes
Section IV: Limitations in counseling

This section aims to uncover the traps, barriers and limitations of counseling. It also deals with burn out and mechanisms to help cope with it.

Section IV has 2 activities.

1. Limitations exercise
   A guided discussion that explores the ethical dilemmas that may arise in a counseling situation with the help of a case study.
   Time: 30 to 45 minutes

2. Burn out
   This group activity gives the participants a chance to discuss the limitation counselors’ experience and ways to cope with them.
   Time: 30 minutes

Session V: Special issues

This session aims to sensitize the participants about issues related with marginalized groups.

This Section discusses two such groups

- Men who have sex with men
- Street Children

Marginalized groups
A guided discussion that aims to understand some of the problems encountered by the marginalized groups which would enable the participants to effectively facilitate the counseling process.

Time: 11/2 hrs.
Section I: Principles of Counseling

Aim: To understand the principles of counseling, and the differences between information, advice and counseling.

1. Advice

(a) Exercise  

Time: 30 to 45 minutes

Objective:

To understand the helping process and some of the traps we often fall into for example, giving advice.

Methodology:

Ask the group to respond to the following

1. What do we do when a younger brother / sister, son / daughter does something that we do not want them to do? Say for example, one of them smokes or drinks heavily.

2. What are the effects of your action? Does it always have the desired effect? Do you think we have an inherent tendency to advice?

3. What does a patient expect when he / she visits the doctor with a problem? Does a person with a problem who comes to a counselor for help have the same kind of expectations?

Facilitator’s Guidelines

Note some of the important responses of the group and facilitate a discussion by highlighting the following issues:

- There is always a tendency to seek advice, ask for solutions whenever we face a problem. This tendency is stronger when we seek professional help, be it a doctor or a counselor.
- There is also a tendency of doctors or counselors to give advice and try to provide solutions to problems. But would this be effective in bringing about behavior change?
- There is also a power imbalance between doctors/counselors and their patients/clients. The patient/client comes with a problem seeking help. For instance when a patient comes to the Doctor, he prescribes some medication and some do’s and don’ts. Often the person who comes with a problem expects the same kind of solution from the counselor.
(b) A guided discussion  

Time: 45 minutes to 1 hour

Objectives:

- To understand the implications of advice versus counseling in the context of behavior change in counseling for HIV/AIDS.
- To understand the relationship between providing information and counseling.

Methodology:

Divide the group into pairs, make one person take the role of the counselor and the other the client. Give one role-play to each pair. If there are more people than the number of role-play given, the situations may be repeated, or better still, create new situations.

Ask the counselors to say whatever they feel is appropriate in the role-play to reduce the risk of HIV infection. Give the participants 5 minutes to complete the role-play.

Ask the participants then to reverse roles, i.e. the client becomes the counselor and the counselor the client. The same situation can be enacted.

The participants can then get back to the larger group and share their experiences.

Role plays:

1. Kanta is a commercial sex worker. She sees about 5-7 clients in a day. Her clients often insist on sex without using a condom. Kanta has seen posters on HIV. She knows it has to do with sex. She wants to approach the social worker visiting the red-light area and ask about the problem. But she is scared of the Madam, Namdhari, the social worker, has been visiting the area for sometime now. He has noticed that Kanta wants to speak to him in private. He decides to speak to her.

2. Ram is an injecting drug user. He shares needles with a group of friends, all of whom inject. He has been using drugs for 3 years now. He began with oral drugs but has moved on to injecting as that is the only way he can get high. He has heard of HIV, knows it has to do with sex and drugs, but is unclear on what exactly the relationship is. He goes to a counselor, nervous that he may be infected.

3. Radhika has been married for 7 years now. She has conceived after a long wait. Three months into her pregnancy, she fears she is HIV positive and wants to know the risk of the baby getting infected. She decides to visit this NGO which provides counseling services.

4. A fourteen-year-old boy, Rehman, has been living on the streets since he was seven. He has been having sex with boys and girls for some time now. It is also a means of livelihood for him. Rehman has heard of HIV and is anxious that he may be infected. He goes to a counselor for help.

5. Kritika has recently got engaged to an engineer, Prateek. Prateek has heard of HIV and is aware that the only way to know of persons’ HIV status is through a test. Since it is an arranged marriage, Prateek is insistent that his fiancée go for an HIV test. Kritika is angry
and confused but cannot discuss this with her family. She approaches a counselor to ask what she should do.

Let the participants discuss the situation amongst themselves for 5 minutes. Get the group together and facilitate a discussion on the issues that came up in their role-play.

Facilitate a discussion with participants who were counselors in the role-play with the following questions:

- What was your response to the situation?
- What did you feel you should do?
- Do you think your intervention had the desired impact?
- Did you perceive some limitations / barriers to your intervention?
- Did you try to explore the circumstances under which these behaviors are practiced?
- Did you have the required information?

Facilitate a discussion with the participants who were clients in the role-play with the following questions:

- What was the response/ intervention of your partner?
- Was the intervention applicable to you? Will it help you in bringing about behavior change?
- Did he / she has an understanding of the circumstances under which you were practicing these behaviors?

Questions to the larger group:

- Where do you feel the counselors provided advice to their clients?
- What were the advantages or disadvantages of providing this advice?
- What is the difference between advice and counseling?
- Did you feel a tendency to advice from the counselors?
- Do you feel it is easy to follow the advice provided?
- Did the advice come from an understanding of the circumstances under which the behavior is practiced?
- What do you think are the implications or effect of advice?
- Does providing advice or solutions have the desired impact in change of behaviors related to sex and drugs?
- Do you feel that an individual has the capacity to decide what is safe and what is unsafe if he/ she is provided the information in a language and manner which is understood by him/her?
- Does the understanding of whether the behavior is safe or unsafe necessarily bring about behavior change?

Facilitator’s notes: -
These might be the possible responses of participants who played the counselor role:

- Tell him/her not to sell sex.
- Tell him/her to reduce number of partners.
• Tell him/her not to share syringes and needles.
• Tell him/her about HIV/AIDS condom use and safer needle use.
• Provide him/her with condoms, new syringes and needles.
• Try to know his/her level of information about STDs/HIV
• Does he/she perceive HIV/AIDS as a risk.
• To understand some of the feelings associated with the fact that he/she practices these behaviors.
• Try to find out the pressures from the peer group against or for practicing such behaviors.

Providing information

Information on prevention and treatment of STDs and HIV can be technical. It is crucial to provide complete and accurate information, as providing inaccurate or incomplete information could be risky and dangerous. Information provided should help in identifying alternatives, anticipating consequences, implications of certain actions/behavior and planning. However the presence of technical information alone cannot bring about adoption of safer behavior.

A Note on Advice

Whenever we face a problem we seek advice from peers, adults, parents, teachers, doctors etc. If advice is defined, as providing ready-made solutions, it is likely to defeat the objective of counseling that strives for responsible self-sufficiency. Advice giving fosters dependency and blocks the individuals’ ability to make decisions. The responsibility for success or failure of their action rests with the counselor. In addition to the above, advice is associated with individual values, attitudes and moral judgments that vary among individuals and groups. (In a later section we will discuss in greater detail about values, attitudes, judgments and their connections to counseling.)

Advice stems from what is good or applicable for the counselor rather than the client. What is applicable or good for the counselor may not be applicable for the client.

A Note on Counseling

In counseling, two people, who are in no way related to each other, meet to resolve a crisis or problem and together find ways to overcome them. It is a special form of interpersonal communication where feelings, thoughts, experiences and attitudes are explored, expressed and clarified. The counseling relationship is a space for building the confidence and self esteem to enable a person to make lifestyle changes. In a supportive atmosphere, the person can define the nature of the problem and then make realistic decisions about what they can do to reduce the impact of these problems on themselves and on their families, partners and friends. Counseling is about helping people to help themselves which can only be done with the counselor’s absolute emotional detachment while working closely with the client. Finding a balance between detachment and closeness is important in promoting the well being and problem solving skills of the client.

Technical knowledge about HIV infection is essential while counseling on testing. However it can be applied best along with the counselor’s knowledge of principles, skills, values and referral resources. Counselors have to learn where their weaknesses, prejudices, and values lie before being able to work with other people. This is particularly applicable when working with individuals who come from marginalised sections of society, about whom one may have many preconceived notions or ideas.
A Note on role play

The role play is a useful tool in counseling training as it helps simulate a real life situation and provides an opportunity to enact and feel it. There are also some limitations, as it is often played under the scrutiny of others - a person may be nervous as he/she is watched. To overcome some of these limitations we can use the names “counselor” or “client” when providing feedback, rather than using names of participants. It also helps to tell the participants that it is not a test of their acting prowess or personal faultfinding mission, but an exercise where we try to learn from the process. Feedback is also addressed to the facilitator and not to the persons who enacted the role-play. When giving feedback always try to first stress on the strengths of the counselor.
2. **Informed Choice**  

*Time: 30 to 40 minutes*

**Objective:**

- To understand the concept of informed choice in counseling.

**Methodology:**

There is an exercise wherein participants are split into pairs and are given a situation to role-play. Of the pair, one is a client and the other the counselor. E.g. a pregnant woman, worried that she may be positive visits a counselor. She is not sure whether she should go ahead and have her baby or not. (Groups could also be divided into sub-groups and different sub-groups can be given different situations.)

**Possible suggestions that the groups could bring up:**

She should go through an abortion since the child might also have been infected. She should keep the child because there is only 30% chance that the child would be infected. Explore the possibilities and leave it to the client to decide.

Facilitate a discussion with the following questions: -

- Which suggestion do you feel will have maximum compliance or is likely to work best?
- Why?
- Do you think people are able to decide on what is good and what is harmful for them if they are provided with accurate information?
- Do you think that by providing accurate information behavior change is more probable?
- If your client is practicing high-risk behavior and also declines the test, what would you do in a situation like that?

**Facilitator’s guidelines**

The facilitator can now discuss the advantages and the disadvantages of informed consent with the group: One advantage could be that you are giving your client both sides of the picture, i.e. what could be the benefit of testing and what could be the disadvantages in testing.

At this point the idea of informed consent can be briefly introduced by making the participants consider the following: -

- The individual is in a capacity to make decisions.
- The individual has received necessary information.
- The individual has arrived at the decision without coercion, inducement, or intimidation.

What is the kind of information that facilitates informed choice?
• The information should be conveyed in a language the client will understand.
• The risks, benefits and alternatives are all laid out clearly before the client.
• The client has to be reassured that whatever decision he or she makes the counselor will not disrespect or belittle.
• Assurance of confidentiality regarding the test result and the individuals’ identity has to be conveyed, reiterated and maintained.
3. Values and Attitudes

(a) Empathy exercise

Objective:

The purpose of this activity is to understand how our values and judgments become barriers to effective counseling.

Methodology:

Read the following story to the group:

Anil and Aruna have been married for 7 years. They met in secondary school and married soon after that. They have three children aged 5, 3, and a newborn. They love each other very much and have a good marriage. Anil and Aruna were very excited about the birth of their third child. Anil works in a textile factory and is quite successful at work. He has had some extra-marital affairs. Although Anil knows condoms prevent AIDS, he didn’t think he needed to worry since the women he had been with were “nice”, “clean” women. Besides, he did not see them more than a few times each. Since the birth of their newborn Aruna has been sick and so has the newborn child. She was tested for HIV and the results are positive.

Ask the group:

• To think about the position of both husband and wife and the situation they are facing.
• To decide whether they have more sympathy for Anil or Aruna in this situation.
• To write down some their thoughts and feelings for the person they have chosen.
• Ask all who empathize with Anil to move to one side of the room and those with Aruna to move to the other side. Now ask the participants to find a partner from across the room and find a comfortable place to sit down. If there are an unequal number of people on each side of the room, some groups can have three people.
• Instruct the pairs (or groups of three) that they are now to reverse their feelings and imagine that they empathize with the other person. So if they originally felt for Anil now they should feel empathy for Aruna.
• Give the participants 5 to 10 minutes to each share a discussion with their partners about why they empathize with that person.
• Next, ask participants to step out of the discussion and think again of the person for whom they originally had greater empathy. Using the thoughts and feelings they had written about at the beginning of the experience, ask each group or pair to discuss what they had written and why they had more empathy for one person rather than the other. Give the groups 5 minutes for this discussion. Return to the large group and discuss their exercise.

- Was it easy for you to change sides?
- What did you learn by changing sides?
- How did reversing your empathy influence your feelings about the other person in the story?
- If you had more empathy for one person, would you be able to counsel both persons?
- How can you help develop empathy for a client, when he/she triggers a negative feeling in you because of your own personal experience?

Facilitator’s Guidelines
Empathy is the ability to be able to understand and relate to another person’s feelings and experiences. This involves being sensitive and responsive to her/him without making assumptions about the feelings that she/he might be having. Empathy is different from sympathy as it does not involve feeling sorry for the person but rather demonstrates a support towards the person. (E.g. “I do understand that you are having to go through this pain”). It involves attentiveness and being equally aware of what the client is not saying as she/he expresses in other non-verbal ways. Sometimes a gentle silence is enough to convey empathy.

To a certain degree, counselors must be aware of their own emotional responses and feelings to be able to sensitively work with the client. It may not be the case that a counselor will have experienced what the client has gone through. Nevertheless, a counselor who knows his/her own emotions can use their own responses as clues to understanding the client. To ‘put oneself in another person’s shoes’ requires emotion, warmth, concern and acceptance, without losing the ability to remain objective and somewhat detached. This is the skill of empathizing.
b) Statement Exercise

**Time: 1.1/2 to 2 hours**

**Objective**

- To explore and identify one’s own values and attitudes towards specific groups or people such as people living with HIV/AIDS, commercial sex workers etc.
- To get a different perspective on the issues of marginalised groups.
- To develop patience to listen to viewpoints and ideas which you may disagree with.

**Methodology**

The facilitator will read out the following statements (page 21), and the participants can say whether they agree or disagree with those statements. Have them explain why they agree or disagree.
Statements

- Women with HIV infection should not have children.
- People with AIDS should not be allowed to continue work.
- AIDS is mainly a problem of people with immoral behavior.
- Men who have sex with men indulge in abnormal sexual behavior.
- People with HIV infection should be isolated to prevent further transmission.
- It is collective responsibility to care for people with HIV infection.
- I would feel uncomfortable inviting someone with HIV infection into my house.
- Surgeons should screen all patients for HIV infection before surgery.
- I would feel uncomfortable discussing sexuality with a person of the opposite sex.
- Intravenous drug users should compulsorily be tested for HIV.
- It is all right for men to have sex before marriage.
- School children should not be educated about safer sex, condoms.
- Women should never have extra-marital sexual relations.
- All professional blood donors should be jailed.
- It is difficult for male counselors to talk to women clients about condom use.
- Homosexuals spread AIDS.
- Foreigners are responsible for the spread of AIDS.
- All foreigners entering the country should be tested for HIV.
- AIDS is a problem of western nations and it is not a problem in India.
- Talking to women about condoms makes no sense, as the decision is not in their hands.
- Commercial sex workers are responsible for the spread of AIDS.
- Needle exchange programs will promote needle use.
- People who get infected have got only themselves to blame.
- Only dirty persons talk about sex.
- All patients with STDs should be screened for HIV/AIDS as they are at a high risk of HIV/AIDS infection.

Discuss the following points with the group:
- Did you feel comfortable discussing your views with the other participants?
- Were you surprised when other participants in your group disagreed with you?
- Did you change any of your views after listening to your colleagues?
- Have you heard of such statements being made by people? Which ones are most frequently used?

**Facilitator’s Guidelines**

Since this exercise often generates disagreements amongst the group, the facilitator should stress on the following guidelines before commencing the exercise:

- Everyone should be given an opportunity to speak
- There are no absolute right or wrong answers.
- We need not come to a consensus as we are trying to get different viewpoints.
- Only one person is allowed to speak at a time.
- All responses are to be addressed to the facilitator and not to the person with whom you disagree.
- From all the above statements, the facilitator can choose the ones that she/he feels will be relevant to the group.

To go further into the realm of exploring our attitudes we can look at the following situations and have a discussion or a role-play. Explain to the group that these are the types of situations that they are likely to come across when working in the field of sexual health counseling.

- A 12-year-old child living on the streets is having sex with both men and women.
- An 18-year-old man from a Muslim family is having sex with his stepmother who is 24 years old.
- An HIV positive sex worker who continues to sell sex.

**Points for discussion:**

Do you have strong feelings for or against the behaviors practiced?
Will your feelings towards that behavior affect you as a counselor?

**Facilitator’s guidelines**

It is very easy to say counselors should be non-judgmental. However counselors also happen to be members of the society which sees these behaviors or groups as abnormal. Hence counseling involves working on personal values and attitudes towards behaviors, groups and issues related to sexuality and HIV /AIDS such as confidentiality, informed choice and consent, compulsory testing. It also involves working on sensitive issues such as sex and drug abuse.

Through these exercises, participants will have an opportunity to freely express their questions, opinions and any prejudices that they have towards certain behaviors or members of specific groups. The process of discussion and debate will enable the participants to identify and explore their feelings.
**Objective:**

This activity gives an opportunity to the participants to explore and clarify their own attitudes towards HIV and AIDS.

**Methodology:**

Divide the trainees into smaller discussion groups of 3-5 members. Each group member will need a copy of the statements on page 21. Allow 10 minutes to read through the statements. Ask each group to choose a leader who can record the group’s ideas and get the trainees to share and discuss their responses. After 10 minutes ask everyone to rejoin the main group.

It is important that the trainer allows for a free expression of views and does not seek to correct or criticize at this stage. The trainer then discusses the following issues with the group: (allow 20 minutes).

Points of discussion:

- Why are these called ‘controversial’ statements?
- Have you heard of such statements being made by people? Which ones are most frequently used?
- Did you feel comfortable discussing your views with your partners?
- Were you surprised when your partner disagreed with you?
- Did you change any of your views after listening to your colleagues?
4. Confidentiality

(a) Meditation exercise  

Time: 20 to 30 minutes

Objective:

To understand and internalize the importance of confidentiality in HIV/AIDS counseling.

Methodology:

Ask the participants to close their eyes. Get them to imagine that they have taken an HIV/AIDS test. Ask everyone to take a deep breath.

Explain the following scenario:
“Blood has been drawn from you, and you have to wait for seven days to get the results. After the seventh day, the report is released to you. Your report indicates that antibodies to HIV/AIDS have been found in your body indicating that you are HIV positive.”

Questions asked to the group:

- What were your feelings when you had to go for a test and your blood was drawn?
- What were your feelings when you had to wait for the result for seven days and when you went to collect your report?
- What was the feeling you had when you were told that your result was positive?
- Do you want your result to be disclosed to anyone else without your permission?
- How would you feel if your result were disclosed to some other person?
- Do you think that things would have been better if you had a pretest counseling session?

Facilitator’s Guidelines:

This exercise could also be used to understand the importance of pre-test counseling.
(b) Confidentiality exercise

**Time: 30 to 45 minutes**

**Objective:**

To familiarize participants with the meaning and implications of confidentiality.

**Methodology:**

Read out the following scenario to the group: -

One of the clients that you are counseling is HIV positive and is going to have an arranged marriage. Neither the fiancée nor her family knows about the HIV status of the person. Your client does not want his status disclosed to any one.

**Ask the group**

- What do you feel about the situation?
- How would you respond to it?
- What would you do as a counselor? Will you disclose the HIV status of the person to the spouse?

**Likely responses from the group**

- Yes, I will disclose the result to the partner or another family member, because saving a human life is very important.
- I will try to convince or counsel the client so that he discloses it to the partner.
- I will not disclose, as confidentiality is important.

Ask the group to respond to the questions: -

- What happens when you disclose a client’s HIV/AIDS status to his/her partner?
- What are some of the likely repercussions of breaching confidentiality?

**Likely responses**

You save a person's life.
You stop the spread of the infection.
You breach confidentiality and break trust in the counselor/client relationship.
The person might get married to another person and infect that person.
The client may face psychological problems, depression, suicidal tendencies, and/or anger that may be directed towards the counselor or towards society.
Other persons who are likely to get tested for example friends or partner of the infected person may be discouraged from taking a test.

**Facilitator’s Guidelines**
Further points for discussion:
The counselor’s dilemma
In such situations how feasible is condom promotion
What do we have to offer to people who are infected and want to be married?

The Ethics of Confidentiality

People have a right to confidentiality. To divulge information, which is highly personal, could be detrimental not only for the individual but also people around them such as partners and family members. The requirement of confidentiality forbids any reference to, or discussion about, a client except within a professional relationship, and only with the consent of the client.

An often-difficult situation for the counselor is to keep the status of the client from the family. The conflict or the dilemma occurs in taking the larger public interest into consideration. For instance what happens if the positive person continues to put people around him at risk of getting the infection.
Professional ethics requires the counselors maintain strict confidentiality concerning all personal information obtained from clients.

Time management

Providing the client with time is important. Counseling is often a lengthy process and acknowledging this as a counselor and as a client is necessary from the start. Working around the issue of AIDS cannot be rushed and helping the client to absorb all of the information itself takes time. With some clients the rapport building process may take considerable time before that person can open up and trust the counselor. If the counselor is hasty to give out information or get on with problem solving without waiting for the client to be ready, the relationship will not last long. Going at the pace of the client is essential to trust building. On the other hand the counselor must be aware of managing her time with the client. It is easy to give unlimited time and to be available for the client at any time of the night or day. This will encourage dependency in the client and foster burn out for the counselor!
Section II - Communication and counseling skills

**Aim:** To examine the importance of communication and counseling skills in our work.

**Note:**

Good communication depends on careful observation, accurate listening and correct interpretation of a client’s feelings. Proper utilization of communication and counseling skills helps in meeting the objectives of counseling.

By helping the client examine possible options we can facilitate the client’s exploration of solutions and their consequences. It can help the client in making decisions and carrying out the decided solutions.

Communication is at two levels, verbal and non-verbal.
1. Non-verbal communication

Objectives:
To understand the types of non-verbal communication used in counseling.

Methodology:
Interactive discussion in which the participants are asked to list and explain their ideas of non-verbal communication.

Facilitator’s Guidelines
Encourage the participants to share their field experiences.
Non-verbal communication is an important element in letting clients know that they are being attended to, heard and understood, instead of being judged. Counselors convey this to the client by:
- Leaning forward or pulling the chair slightly closer to the client to convey interest.
- Appropriate eye contact (no intense staring).
- Nodding.
- Mirroring client’s energy or emotional level through tone of voice, facial expression and gestures.
- Maintaining a suitable conversational distance, (neither too far nor too near).
- Not fidgeting and maintaining a calm body posture.
2. Verbal Communication

(a) Asking Effective Questions  
*Time: 15 to 20 minutes*

**Objectives:**  
To emphasize the importance in counseling of asking effective and relevant questions.

**Methodology:**  
Interactive discussion in which the participants can be asked to list and explain their ideas.

**Facilitators Guidelines**

Effective questions are used to encourage exploration and clarification of thoughts, feelings, and attitudes, obtain specific information and to help the client focus his/her thoughts. Questions provide information about the client her lifestyle and surroundings. The information relates to his/her personality, his/her interactions with the surroundings, his/her cultural beliefs and role, his/her interaction patterns since childhood. If any of this information is missing a picture of the client is incomplete. A client is very often unable to see a clear picture of ones’ self. The client needs help to clearly perceive heir own resources and inherent strengths. Appropriate questioning can help the client gain a complete understanding of the situation and strengthen them to make a decision.
(b) Asking open-ended questions

Objectives:
To familiarize the participant with the concepts which enables them to understand its importance in counseling.

Methodology:
Interactive discussions in which the participants can be asked to list down their ideas. In the end explain the concept.

Facilitator’s Guidelines

Open-ended questions require more than a yes/no response encourages exploration, communication and clarification of thought feelings and attitudes. Through open-ended questions the client and the counselor both travel through the clients feelings and imagination. Close-ended questions by contrast, limit the exploration process. Closed questions solicit ‘yes’/‘no’ and are more prone to satisfy the counselor than help the client.

Examples of open ended questions:
“Would you tell me more about what happened?”
“Could you tell me more about your feelings?”
“What was that like for you?”
“What must happen, before you talk with your partner about it?”

Examples of closed questions:
“Did you feel upset?”
“How many times did you have sex?”
(c) Paraphrasing  

**Objective:**

To understand and learn the skill of paraphrasing

**Methodology:**

Briefly explain to participants the meaning of the concept.

Each participant should find a partner and choose a subject on which they apparently disagree. E.g. one might agree on sex education in schools and the other might not, or one might believe in having children is important and the other might disagree and so on...

One of the participants can begin by making 2-3 statements on the subject. The other has to paraphrase the statements made, without making any judgment or interpretation of his own.

The former can then provide feedback to their partner as to whether he was paraphrased accurately.

Reverse roles, and have the person who earlier paraphrased make his/her comments on the subject and get the other participant to paraphrase this time.

Following this exercise initiate a discussion on the following points:

- Was it easy to paraphrase a statement with which you apparently disagree?
- How did you feel having to restrain yourself from speaking about how you feel about the issue?
- As a listener, how accurate was your understanding of the speaker’s statement?
- Were you able to get a better understanding of your partner after you paraphrased his/her statement?
- How did you feel at the end of the conversation? How does this feeling compare to your usual emotional state after discussing controversial issues?
- How did you feel when your statement was paraphrased?

**Facilitator’s Guidelines**

Paraphrasing is repeating what the client has said in order to let the client know that he/she has been heard correctly. E.g. if a client says “My family is going to get rid of me if they get to know that I am positive and then I am going to be left in the lurch”. This could be paraphrased as, “You are saying that you are afraid your family is going to be angry and not going to take care of you when they know your status.”

Counselors can paraphrase both content and underlying feelings. This can also help the counselor clarify for oneself what the client has expressed. When employing this skill, the counselor attempts to tell the client the essence or content of what the client has just said. Paraphrasing also encourages the client to open up and express more as he/she feels that they are being understood. The counselor can use paraphrasing as a tool to prevent himself/herself from imposing his/her values and attitudes on the client. The counselor tries to reflect the verbal and emotional component of what the client has said rather than give his/her own comments on the matter.
(d) Reflection of feelings  

**Objective:**

To learn and practice the skill of reflecting feelings

**Methodology:**

Interactive discussions in which the participants are asked to list down their ideas.

**Facilitators Guidelines**

Reflection of feeling indicates that the counselor understands correctly the client’s feelings or emotions. Counselors can help clients identify and clarify their feelings and reactions by listening to what is being described, and then reflecting them back to the client. When properly done, it enables clients to think of their feelings as part of themselves rather than external to or apart from them.

**Why is reflection of feelings so important?**

A client often doesn’t fully understand his/her feelings towards a specific situation. Feelings and emotions are often unspoken, rarely part of the whole situation and never looked at in isolation. As a counselor, you can help the client to give the expression to feelings. Only when you are able to convey to a client that feelings are as important as information, can the counselor make that client fully understand his/her situation.

Reflection techniques serve to bring the client’s feelings and attitudes to the surface and highlight problems without making the client feel that the counselor is pushing them. Reflection gives the counselor the opportunity to interpret, and then compare with the client, what the latter has expressed in terms of his/her emotional state.

The intent is to mirror the client’s attitudes so that they can be clarified and understood. It is a means of self-confrontation.

It may be used immediately after a feeling has been expressed, or summarized at a later point. In the later instance, the counselor tries to tie together in one statement several feelings expressed by the client. For example,

“I got the impression that you are angry with your mother for not providing you with the correct information. Is that true?”

Feelings can also be multi-dimensional thus it is important to realize that many feelings can be present at the same time. A client can be sad, angry, upset and scared simultaneously.

**Traps in reflection**

- The counselor may reflect his own reaction to the clients situation rather than the client’s own feelings.
- The counselor’s reflections may be a result of her own prejudices and biases.
- It is equally dangerous for counselors to recognize that pretending to understand when they actually do not is dangerous as it leads to eventual confusion and distrust.

**Reflection is important for the following reasons:**
• Reflection helps the individual realize that he/she has been understood.

• The reflection technique helps to break the so-called neurotic cycle, expressed in phrases such as, “She won’t understand me and therefore I won’t understand her.”

• Reflection causes the locus of intervention to be focused on the client.

• It gives the feeling to the client that he/she has the option of exercising a choice.

• Reflection clarifies the client’s thinking so that the situation can be seen more objectively.

• It helps communicate the idea that the counselor is not shocked and does not regard the client as ‘odd’ or ‘different’.

• Reflection helps clients to examine their motives.

• It is difficult for counselors to fully understand the attitudes and feelings contained in the client’s statements. If the counselor is uncertain he/she can ask for clarifications. E.g., “I am not quite sure what you mean, but as I understand the essence of what you feel is....”

• It is not enough for counselors to simply identify and understand the clients feeling’s. They must convey their understanding of it to the client.
Role-plays

Objective:

To understand how important it is to reflect feelings in counseling.

Methodology:

Ask participants to complete the Client Statements’ Worksheet # 1. Instruct participants to read each client statement, and write down the feeling or feelings that the client might be experiencing.

The next stage of this exercise is to ask participants to give a possible reason why the client might be feeling this way. Give participants approximately 10 minutes to complete the worksheet.

Counselor’s worksheet #2.

Ask participants to brainstorm other phrases they might use to identify and reflect feelings.

Next, ask each participant to choose a partner. One partner should play the client and the other, the counselor. Explain that participants will practice identifying and reflecting feelings using the client statements in Worksheet 1 and counselor worksheet #2. The client is to read statement # 1 from their worksheet. The counselor should look at his/her own notes on the worksheet 1 and worksheet 2 and use them as well as the feelings the client is now presenting to respond with a phrase that reflects the client’s feeling.

When this is complete the client and counselor switch roles for statement # 2. The pairs are to continue this process until they have completed all 5 statements on the worksheet. Encourage participants to try different phrases each time they play the role of counselor. Ask the pairs to briefly discuss this activity and give feedback to each other. Once completed ask participants to return to the large group.

Ask the following questions to the group and close with a summary of the major points.

Points of discussion:

• How easy and comfortable did you feel identifying and reflecting feelings?
• What made you feel uncomfortable?
• How will identifying and reflecting feelings be useful for the client?

What were the differences in identifying feelings in the Client Statements Worksheet” and during the live role-plays?

Facilitator’s guidelines

Clients give many verbal and non-verbal clues about their feelings without expressing them directly. When the counselor puts the client’s feelings into words and relates the feeling to a real problem or situation, the client becomes more aware of his feelings. This will help the client make effective decisions about his/her future.

Client Statements Worksheet #1:
INSTRUCTIONS: For each statement, write down the feeling/s that you think the client may be experiencing.

1. “I was so sick in bed. My mother was the only person at home. Instead of taking me to the hospital, she went to do business at the marketplace.”
   Feeling/s

2. “Why is my antibody test taking so long? You said it would take 2-3 weeks. It has already been 3 weeks. Do you think that means it is positive?”
   Feeling/s

3. “Why in the past when I visited home, everyone used to greet me. Now, since I have been cured nobody does. Now I know who my true friends are.”
   Feeling/s

4. “I can’t ask my husband to use condoms. He will refuse. He will think I am accusing him of something or that I am unfaithful.”
   Feeling/s

5. “Oh no! How can I have this virus, HIV? I just got promoted. What am I going to do?”
   Feeling/s
Counselors Worksheet #2

Counselors can use these kinds of statements to identify and reflect feelings of the counselor.

“ You seem _______________ because _______________.
    (feeling)                      (reason)

“I wonder if you’re seeming _______________ because _______________.
    (feeling)                      (reason)

“Do you feel _______________ because _______________.
    (feeling)                      (reason)

“It seems you are feeling _______________ because _______________.
    (feeling)                      (reason)
(e) Focusing

Time: 10 to 15 minutes

**Objective:**
To understand the importance of being focused.

**Methodology:**

Interactive discussions in which the participants can be asked to list down their ideas on focusing. Provide examples to clarify the topic.

**Facilitators Guidelines**

It is easy for the client to get side tracked during the counseling session. The counselor may need to help the client focus on the important issues. The aim of focusing is to prioritize. Focusing brings clarity and perspective to counseling. The counselor can also help the client focus on goals that can be achieved with relative ease.
(f) Confronting

**Objective:**

To learn and practice the skill of confronting.

**Methodology:**

Facilitate an interactive discussion in which the participants are asked to about their ideas on confronting. Provide examples to clarify the topic.

**Facilitators Guidelines**

Confrontation is designed to give the client a point of view that is different from his or her own. It helps the client to see herself and her behavior from another point of view. It involves an examination of incongruities or discrepancies in the client’s thinking, feeling and behavior. By pointing out the discrepancies between what the client says and does, it gives attention to the fact that the reality of a given situation is different from the way the client sees it. It calls attention to possible self-deception, denial, resistance and evasion by the client.

Timing and management of confrontation is essential. It is intrusive and it requires practice and skill, therefore it should be delivered in a warm manner. If confrontation is done too early in the process or done in a rude manner when the client is not prepared for such, it may degenerate into hostility, defensiveness, or resistance to change.

**Uses of confrontation**

- The purpose of using confrontation is to tear down defenses.
- It can be used to reveal assets, defects, strengths, as well as weaknesses.
- It is useful when the client does not know that their behavior is inappropriate and is either unaware of its consequences or unwilling to look at the consequences.
- When using this tool, the discrepancies and incongruities in the client’s statements are noted and should be brought up in a non-threatening manner.
Section III - Application of concepts, tools and principles

**Aim:** To internalize and apply the concepts learnt in the previous sessions and the traps the counselor can fall into.

1. **Traps in counseling**

   **Time:** 30 minutes

   **Objective:**
   - To understand the traps in counseling.
   - To develop skills to overcome them.

   **Methodology:**

   Facilitate an interactive discussion in which the participants can be asked the pitfalls of counseling.

   **Facilitator’s Guidelines**

   Encourage the participants to share their field experiences.

   Some traps in counseling are-
   - Unwarranted reassurance: It could create false expectations in the client. For example, telling an HIV positive person “Do not worry you will be okay”. Such statements could be counter-productive. Reassurance is often the way a counselor tries to build rapport with their clients.
   - Encouraging dependency: When a counselor tries to provide a solution or advice to the client for his problem, there is likelihood that it will create dependency.
   - Premature interpretations: It imposes the counselor’s thoughts or feeling on to the client. The client may, therefore, not get the space to express himself fully.
   - Showing a over-willingness to help: It could make the client suspicious of the counselor’s motives, create dependency or false expectations.
   - Not allowing for expression of feelings: Statements such as “Do not be angry it is okay” or “Do not feel sad, it is a small thing” can act as barriers in exploring the client’s feelings or thoughts.
   - Rigidity with principles and concepts: The principles and concepts in counseling are not absolute. Strictly adhering to it might act as a barrier in the counseling process. There should be a little space for flexibility.
   - Excessive curiosity: Asking questions that are not necessary but those that satisfies the counselors curiosity should be avoided. For example, while providing pre test counseling for HIV/AIDS, asking questions such as “Where did you have sex with your girlfriend?”
2. Applications

In the preceding sections we have made an attempt to understand the principles, concepts, tools and techniques used in the counseling process. These tools and principles are used in combination with one another. In this section, we will see how to utilize and apply all the counseling skills that have been covered.

(a) Risk assessment exercise

**Objective:**
The purpose of this activity is to become familiar with the information that needs to be gathered in HIV/AIDS risk assessment, and to understand the client’s experience and judge the risk of exposure to HIV.

**Methodology:**
This is an exercise where the participants will be given out a list each for them to gauge the risk of exposure.
Ask the participants to answer questions that will assess their risk for HIV exposures. Explain that this risk assessment will remain with them and they will not be asked to share their responses with anybody else.
This is only a guideline regarding the kind of information to be gathered in the session and not a recommended tool for using with clients.
Taking history is used as a means to build a helpful relationship. Questions should be directly related to client’s concerns and at the same time geared towards the clients needs and their ability to use available resources to address those needs.
### Sexual history

In the past one-year have you had sexual intercourse (anal, vaginal or oral) with: -

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Do not know</th>
</tr>
</thead>
<tbody>
<tr>
<td>An HIV positive person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With an IDU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With someone who has had blood transfusions or has had an organ transplant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A man who had/has sex with other men</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A person who has had many sexual partners before you</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Which sexual activity did you most frequently engage in?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Do not know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal intercourse without a condom.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal intercourse with a condom.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral intercourse with a barrier.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anal intercourse without a condom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anal intercourse with a condom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masturbation, body rubbing, kissing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you use a condom for vaginal, anal or oral intercourse, did you use it:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>every time / sometimes / once in a while</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

With how many sexual partners have you practiced unsafe sex, in:

- The past 5 years
- The past three years
- The past year

Are you?
- A homosexual
- A heterosexual
- A bisexual

Have you ever used drugs intravenously?  
If yes, have you ever shared needles or syringes?  
Have you ever shared unsterilised needles for other purposes?  
Such as medication, tattoos acupuncture?  
Do you use non-IV drugs?  
Do you drink alcohol?  
If yes, when using drugs or alcohol have you ever had difficulty remembering what happened?
Pre-test counseling

Informed Choice  

Time: 30 to 45 minutes

Objective:

To understand the use of informed choice in behavior change counseling or pretest counseling.

Methodology:

This game style activity is done with role-plays
Divide the group into pairs. Let one person take the role of a client and the other of the counselor. The situations can either be given to the group or the participants can decide on their own situations.
After providing sufficient time to the pairs to enact the role-play let them reassemble into a larger group.

Situations

1. A 26-year-old injecting drug user who has been sharing needles with a group of friends for the past two years wants to know if he is at risk for HIV/AIDS. He feels he will get some benefits from the NGO if he tests positive.
2. A 23-year-old boy says that he is scared that he may be infected because he had sex with his girl friend (it is not specified what kind of sex he had). He wants to be tested for HIV/AIDS.
3. A 26-year old married woman who is two months pregnant fears that she might be infected as her husband has had many sexual partners. She wants to know if she should get the baby aborted as she has heard that the child can also be infected with the virus.

You can leave these role-plays open by telling the participants who take the role of clients that they can imagine a situation where they have gone to the counselor requesting a test.

Ask participants who were the counselors:
• What did it feel like to be in such a situation?
• What was your reaction? How did you respond?
• Do you think you were able to clarify some of the doubts of the client?
• Did you get stuck anywhere? If so where was it that you got stuck?
• Did the client decide to go for the test?
• Were you able to use informed choice?

To the client: -
• How did you feel about having to go for such assistance?
• Was the counselor able to clarify some of your doubts?
• Did you want to go for the test?
• If yes, what were the reasons for wanting to go for the test?
• Did you get adequate information about the test?
• Did you decide to go for the test on your own?

Discussion with the larger group
Facilitators Guidelines

Behavior change is the main objective of HIV/AIDS counseling irrespective of whether the result is positive or negative. However, it is something that cannot be imposed. All that the counselor can do is facilitate the process by providing accurate information, making the conditions more conducive to behavior change, clarifying doubts, identifying fears, and finding ways of dealing with the same.

Informed choice is essentially providing all the options through the facilitation process and allowing the client to make their own decisions. It is, therefore, imperative to accept other’s behaviors and allow the client to decide a course of action for himself/herself.

Some possible questions that can arise:

- What is the objective of HIV/AIDS counseling?
- What do we tell a person if he/she is positive?
- What do we say when a person is negative?

Guidelines for Pre-test Counseling

- Start with forming a rapport with the client. Make the client feel at ease. You can offer a glass of water. However it is important to ensure that as a counselor one should not overdo anything.
- Explain the concept of confidentiality to the client.
- Ask the person what made him come for the test or how he feels the test will help him.
- Assess the level of information the client has i.e. what he/she knows about HIV? Fill in the gaps. Try to make it interactive and not lecture-oriented.

Information about the test

- What the test looks for: antibodies or the virus
- The window period should be clearly explained
- The three major routes of transmission and how to reduce the risks associated with these routes. If there is a shortage of time, the discussion could be focused on the route that is of concern to the client.
- Differentiate between being HIV positive and having AIDS: Outline the progression of the virus.
- Positive living and lifestyle, touching topics such as re-infection, timely treatment for minor infections should be discussed.

Understanding the implications of a negative result
• A negative result does not mean that the person is immune to the infection. A person who has had unprotected sex a number of times but discovers that he is negative may think that he is immune to the virus. Make sure that the client knows and understands this.
• Ensure that the client is not in the window period i.e. whether the exposure was in the last 3 months.
• If the person has been infected in the last three months, the chances of the antibodies not being detected in the test is very high.

Implications of a positive result

• What does it mean medically; it means that antibodies to HIV could be present in the blood.
• It could be a false result. The ELISA test looks for antibodies to HIV, but the test does not look for antibodies specific to HIV. Often it detects other antibodies like those to thyroid and hence produces false positive results.
• After a positive result one more ELISA using a different company kit are recommended to rule out the possibility of false positives.
• If both results are positive the person is said to be HIV positive.
• This indicates that the person has antibodies to HIV in the body.
• The progression of the virus can be re-emphasized.
• Ask the person for the immediate and future implications at a personal level (what changes would it mean in terms of personal behavior), at the family level and at the societal level.
• Try to get the client to think of all possibilities for himself.
• Discuss if the client would you like to share the result if it is confirmed positive. Who would he/she like to share it with?
• Once the client is aware of the implications of a positive and negative result, let the client decide if he/she wants to go for a test. At this point there is a possibility that the client asks the counselor to take this decision for him/her.

Traps

• A counselor may feel that a person from a high-risk group needs to get tested.
• Build a bridge for a post-test counseling. Emphasize the need for post-test counseling and that the result will be disclosed only to the client and nobody else.

Steps in Pre-test Counseling:

• Rapport formation with the client
• Assurance of confidentiality
• Risk Assessment
• Determine the level of information on HIV/AIDS
• Review the test procedure
• Implications of a possible positive or negative result
• Assessment of persons’ ability to cope with a positive result
• Implications of a negative result
• Establish a relationship to help post-test counseling
• provide adequate preventive counseling

Post-test counseling
(a) Appropriate use of silence  

Objective:

To illustrate the importance of silence in counseling situations and to address the discomfort a counselor may have with silence.

Methodology:

Divide the group into pairs and ask one of them to take the role of a counselor and the other to take the role of a client. The participants who play the role of the counselor are told to disclose a positive result to the client. Participants who play the role of clients are told they have taken an HIV/AIDS test. Allow five minutes to each pair to role-play.

After the group has finished the role play, the following questions are asked of the Counselors:

- Was it easy to disclose the result?
- What was your immediate feeling before you disclosed the result?
- Did you feel the need to prepare the client before disclosing the result?
- How did you feel after disclosing the result?
- Did you feel that you had to say something to make the person feel better?

The following questions are asked of the clients:

- What were your feelings when you went to the counselor?
- Did you want to listen to what the counselor was saying?
- What did you want to know?
- After the result was disclosed to you, were you willing to listen to what the counselor was saying?
  Were you able to register what the counselor was saying?

Facilitator’s Guidelines

Silence is a technique that is difficult to comply with for many counselors. It is considered synonymous with failure and there is a great deal of discomfort with it. Because silence in social situations tends to be looked on as rejection, defiance, or disapproval, this feeling can be transferred to a counseling relationship. When pauses occur the counselor may be tempted to break the silence rather than tolerate it.

Sometimes when silence is maintained, there are possible reasons as to why it happens:
During initial contact, clients may get apprehensive of the impression they created. They may be worried about what the counselor may think of them and become silent. The counselor may use appropriate rapport building techniques in this case.

There could be a pause because the counselor is thinking over what the client has just revealed. Interrupting the silence at this point is inadvisable.

Silence may occur because either the counselor or client or both have reached the end of an idea or line of thought and do not know what to say next.

A pause may mean that the client is experiencing painful emotions and is unable to express it.

A pause sometimes may occur because the client wants some assurance, support or confirmation from the counselor.

There may be silence after a client expresses deep emotions. The counselor’s quiet acceptance of this pause is appropriate.

Silence may be useful to place responsibility on the client to face up to and talk about the problems. It may also be used to slow the pace if the counselor or client is moving too fast. Following a flood of emotional expression, silence often enables the individual to gain insight or achieve integration of feeling.

Silence also gives an opportunity to reflect, on an idea and absorb new information for both the counselor and the client. Counselors may find the silence awkward and interrupt it because of their own discomfort. It is not necessary for the counselor or the client to be speaking all the time.
(b) Counselor’s fears

**Objective:**

To overcome counselors’ fears about “breaking the news” about test results. Telling a client that he/she is infected with HIV may be a difficult and uncomfortable task.

**Materials**

Large paper, 3 X 5 cards or small sheets of paper, pencils.

**Methodology:**

Ask participants to write on a card or small piece of paper two things that worry them most when they have to break the news. Collect the cards. Shuffle the cards and give one to each participant.

Ask each person to read what is on the card. The trainer should list all the concerns on a chalkboard or large sheet of paper, eliminating duplications.

Explain that the counselor’s fears and concerns can result from lack of knowledge and lack of skills or the counselor’s emotions, attitudes personal issues. It is important for the participants to understand the basis of their fears or concerns. Some of this can be avoided if counselor acquires more knowledge and learns or practices new skills. When the counselor’s concerns result from his/her own situations or from personal feelings and attitudes, it is often best to discuss this with other HIV/AIDS counselors or with senior counselors.

On a large piece of paper write the following as three separate headings:

- Knowledge
- Skills
- Personal issues

Re-examine the group’s list and decide (with trainee inputs) whether increasing knowledge, improving skills or acknowledging the issues that may arise for the counselor can lessen each fear or concern. The trainer should then rewrite the fear or concern being discussed under the appropriate heading. Some fears could be best addressed in more than one category and should be listed in each relevant category. Discuss how these fears or concerns affect the counseling session, and how counselors can best respond to their fears.

**Facilitators Guidelines**

**Possible Responses**

- The client may find it difficult to take a positive result.
- The client will commit suicide.
- The client will walk out of the counseling session.
- The client will not return for follow-up counseling or medical care.
- The client will be angry at who infected him/her and will try to hurt that person.
- The client will knowingly try to infect others.
• The client will get angry with the counselor.
• The client will not know how to respond to extreme reactions, such as anger, depression, uncontrollable crime or hopelessness.

Breaking the news is a difficult and uncomfortable task for all of us. Sometimes it is difficult because it is so unfamiliar and the counselor does not have enough knowledge or skill to carry out the tasks. Other times, breaking the news is difficult because the counselor gets personally involved with the client or because the counselor feels that he/she cannot really help the client. Frequently, counselor’s fears lessen after they have had a chance to practice breaking the news. They gain confidence with experience and begin to develop a wide range of response to clients.

There are reasons why revealing a person’s test result might be difficult:

• The counselor is inexperienced and not sure what to do or say.
• The counselor doesn’t understand the progression of HIV and cannot explain clearly what a positive result means.
• The counselor always feels uncomfortable when a client expresses anger openly.
• The counselor doesn’t know where to send the client for medical care or legal help.
• The counselor has not dealt with his/her own feelings around being associated with an HIV positive person.

**Checklist for post test counseling**

• Give the result
• Check what the patient understands by the result
• If it is negative, suggest re-test after three months, if appropriate
• Reinforce strategies for prevention
• If positive, identify immediate concerns
• Discuss who the client would like to disclose his result to
• Discuss what the client might tell others
• Discuss how the client would say this to the others
• Discuss how the client would like to spend the next few hours and days
• Identify what problems the client foresees and how he might deal with them
• Help the client decide who else he might look to for support
• Encourage the client to ask questions
• Discuss health maintaining behaviors such as safer sex, good diet, sleep and exercise
• Assure the patient that the reaction of shock, anger, or disbelief is common.
Section IV - Limitations in counseling

1. Limitations of counseling  

Objectives:
To explore the ethical dilemmas that may arise in a counseling situation.

Methodology:
Read out the following case study.

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A 32-year-old IDU who is HIV positive informs the counselor that he usually lives in the streets and is a heavy drinker. He says that when he is drunk he doesn’t wear condoms while having sex.

In one session, the client informs the counselor that he is getting married. The marriage is to be an arranged match. In the course of the counseling sessions, the counselor realizes that the client is fully aware of the possibility of infecting his partner. The counselor is concerned that the client might infect his partner and shows his concerns to the client. During the process of counseling the client postpones his marriage. The counselor realizes that the client very much wanted to get married as he had TB infection and felt that he needed someone to take care of him when he is sick.

Ask the group:  
- What would you have done if you were in the counselor’s shoes?  
- Was the counselor right in influencing the client’s decision to get married?  
- Will getting married prevent him from having unprotected sex with casual partners?

Facilitator’s Guidelines

Points of discussion:  
- Feasibility of condom promotion - Is condom use practical under different circumstances?
2. Burn outs

Time: 30 minutes

Objective:
To discuss the limitations of counseling, and discuss ways to cope with these limitations.

Methodology:
Ask participants to think of a real or imagined counseling situation where in they were aware of their limitations as a counselor or when they felt their personal lives came into contact with their counseling.

Ask each person to write answers to the following questions:

- Describe the situation.
- In what ways did you feel limited?
- What did you do or say?
- How did you feel about yourself and your counseling skills?
- Could you have handled the situation any better? What might you have done differently?

Divide the group into small groups of 4 to 5 people. Ask people to share what they have written with their small group. Ask each group to discuss the common ideas and situations in the stories of the group members.

Based on discussions, each group is to write on a large sheet of paper “10 ways to cope with personal limitations.” When each group is finished, their sheet of paper should be taped on the wall. Invite participants to walk around the room and read each group’s list. Return to the large group and discuss the ideas. To make one large list can be useful.

Facilitator’s Guidelines

It is important to acknowledge that HIV / AIDS counseling is very demanding and that as counselors, we all have personal limitations. Since our first obligation is to our client, we must identify our limitations and find ways to help ourselves and each other cope with these limitations so that they do not interfere with counseling.
Section V: Special Issues

Aim: To sensitize the participants about issues related with marginalized groups.

Objectives:

To understand some of the problems encountered by the marginalized groups which would enable the participants to effectively facilitate the counseling process.

Methodology:

Interactive discussion in which the participants can be asked to share their experiences regarding the groups they are working with such as commercial sex workers, injecting drug users, men who have sex with men etc. In the end the facilitator can talk about certain marginalized groups that have not been covered in the course of discussion.

Facilitators Guidelines

Two such marginalised groups have been discussed in the following section to illustrate issues that surface vis-à-vis counseling:

- Men who have sex with men
- Street children
Men Who Have Sex With Men (MSM)

The Naz Foundation (India) Trust has been working with groups of MSM for some time; this was one of our first intervention programmes. In this section we have recounted information from our experience.

Exploring, concerns, emotions, and societal pressures linked to the sexual behaviors of MSM:

There is a sense of internalized guilt, often accompanied by self-hate. Statements such as “I am attracted to men and I feel guilty about it”, “Is there a cure or treatment for homosexuality”, are reflective of their self-esteem and their perception of themselves. A lack of societal acceptance about the behaviors practiced appeared to be the main cause of low self-esteem. Some of the MSM want to be married, as they fear of old age; they probably think, “Who will look after me when I get old”. For others it marriage is part of the social pressure: “What will people say if I do not get married”.

Low self-esteem often acts as a barrier to behavior change in the context of HIV. Exploring these feeling thus becomes crucial for effective counseling.

Information on HIV/AIDS:

Some of the men had heard of HIV/AIDS through the media, but did not have complete information about the infection. Only few of the men knew that unprotected anal sex is a high-risk activity as the mainstream messages on HIV/AIDS are directed towards the heterosexual population. Advertisements always show heterosexual relationships, and preventive messages say “avoid multi-partner sex”. Thus many of them felt that you get HIV only if you have sex with a woman. This creates a false sense of security among the men.

Encouraging treatment of STDs by providing accessible services:

STDs are quite prevalent in this group of men. Piles, sores, and other complications are common. Medical treatment is often sought only when it becomes very serious and many of them often go to quacks. To add to this are a number of myths. Beliefs such as “sex with a donkey cures sores in the penis” and practices such as “cutting an anal pile with a blade and putting fresh lime on it” exist among the MSM.

Men usually access private clinics when the problem becomes severe. This entails large expenditures. The men who go to the government hospitals are not satisfied with the quality of services provided. They often complain of harassment in the government hospitals.
Interventions with MSM:

At Naz the following interventions are ongoing with MSM.

Treatment

Due to the lack of health care seeking behaviors in the group and the general lack of affordable diagnostic and treatment facilities, a volunteer medical doctor accompanied Naz Staff on fortnightly outreach. Serious cases were referred to hospitals. STD treatment and medical attention has also been an effective entry point for HIV work.

Informal Discussion Groups

Providing space for informal discussion groups where the men discuss their problems related to sexuality, sexual health, marriage, sex change, sexual practices, police harassment and problems in the family has helped in understanding the various problems faced by the group. As queries on HIV/AIDS often come up in these sessions it has also helped in the promotion of condom use, adopting safer sex behaviors and need for timely and proper treatment of STDs.

Telephonic Counseling

Telephonic counseling is given on sexual health, sexuality and HIV/AIDS. The most frequently addressed issues are marriage, conflicts associated with it, guilt feelings associated with having sex with men, information on safer sex, preventative counseling on HIV and STDs, need for pre test counseling for people who want to get tested.

Counseling

Individual face to face counseling on the issues of concern to MSM, both in the outreach areas and the office premises.

Pre and post test counseling facilities

Providing facilities for pre and post HIV test counseling for people who want to get tested voluntarily.

Support group for gay men

A support group for gay men was set up. Group meetings are held once a fortnight and serves as a drop in space at the Naz office. Issues related to sexuality and their lives are also discussed.

Humraaz, a helpline for gay men that is staffed by volunteers of the group has also been started. Naz has trained the volunteers of the helpline in the tools and techniques of counseling.
Limitations faced in working with the MSM group:

Inability to identify with or relate to HIV

Most of them do not perceive HIV/AIDS to be an immediate risk, as they have not met an HIV-positive person.

Myths about the infection through anal sex are expressed in the following sentences:

“I clean the anal passage with Dettol after anal sex.”
“I have been having sex with my partner for the last ten years but I still have no infection as I clean my anus every morning...”
“I do not let the person ejaculate inside me.”
“Since the semen will come out of the rectum on its own how can I get infected”.

Marriage

Most of these men are married. If these men become infected with HIV/AIDS then their wives and children are also put at risk. Therefore, the issue of MSM cannot be seen in isolation. However, it is usually difficult to reach out to the families.

Police harassment

Police harassment is very common in the areas where they meet and often just the sight of policemen is enough to scatter them. This happens with a lack of awareness about their rights and inability to assert them even if they do. This probably is linked to their low self-esteem and lack of acceptance in the society. The police not only extort money with threats to expose their identities to members of their family but also have forced sex with them.

Policemen often quote Section 377 of the Indian Penal Code to harass MSM according to which, “Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life.”

Barriers to condom use

Permanent partners: Those that have permanent (steady) partners do not feel the need to use condoms. They say, “I have been living with my partner for the last 3 years; I just come here to socialize”, or “Only those who have sex with many partners get it”. Many also believe that sex with Indians is safer than sex with a foreigner, and may negotiate condom use only when they have sex with the latter.

Carrying condoms: Most MSM find it difficult to carry condoms, either because sexual encounters do not take place in a planned fashion, due to fear of police harassment, or for fear of being caught at home.

Access to water based lubricant
Complaints of condoms tearing while having sex and of burning sensation during condom use due to lack of lubrication are common. The only water-based lubricant available in the market is the 50-gm. tube of K.Y. Jelly that costs Rs.65/- per tube. The chance of HIV infection increases when condoms are used without lubricants, as latex burns results in cuts or abrasions. The use of oil, Vaseline, Vicks, Betnovate C etc. for lubrication is quite common. These substances increase chances of tears in condoms. Condoms that are specifically made for anal sex are not available in the market.

**Male Sex Workers**

Some of the men are full-time sex workers and generally, do not have any other source of income. A majority of the full-time male sex workers are from the lower socio-economic strata. Some that have left other jobs as they find paid sex work more lucrative, earning up-to 6000 rupees per month. Their age ranges from 15 to early 40s. Most of the sex workers take a passive role in the sexual act; they are penetrated when having sex, which puts them at higher risk of infection. Some sex workers report that they have had sex with about 50 sexual partners in a month. However the sex workers do not always have paid sex. While they may have sex with someone because they enjoy doing so, they also say, “We do not refuse money if we are offered”.

Street Children

Naz collaborates with social service agencies that work with street children. The lack of complete knowledge about the high risk behaviors, inability to negotiate safer sex, barriers and apathy to health care, inadequate information about sexual health, and inability to relate to HIV makes them increasingly vulnerable to STDs and HIV.

Experiences with Street Children interventions

Sexual activity for boys begins at a very early age because of the circumstances and the conditions they live in. The number of boys living on the streets are many more than girls. Some of the boys say that the older boys had sex with them when they were young and as they have grown, continue the same abuse. Many of them also say that boys are more accessible for sex. The youngest boys in the group who was 10 years old said that he had sex with both boys and girls. Most of the older boys admitted going to the red light area of Delhi. They also said that they use condoms when they have sex with the sex workers as the latter insist on it, but do not do so when having sex elsewhere.

Their first sexual experiences are often abusive; it may be with a dada, the police or any other older person. It could have taken place by choice or by coercion.

Sexual activity appears to fulfill many emotional needs of these children, such as the need for intimacy and affection. Instances where the elder boys who take care of the younger boys, and have sex with them, are quite common. In an environment that is often hostile, intimacy and touch is a rare occurrence, and sex happens to fulfill some of these needs. A young boy interviewed by Naz said that he had sex with older girls, often at their invitation. Sex is also used in exchange for an ice cream or a ticket to the cinema.

Research suggests that sexual activity is linked to a social identity among a child’s peer group, i.e. a boy is more masculine if he is sexually active. Sex also appears to have several social functions.

Preliminary information in our work suggests that many of the girls living away from their homes are active commercial sex workers. Selling sex is a quick and easy way of earning money. Awareness or condom use is negligible among the girls. In fact, almost nothing is known about the sexual behaviors or sexual health of girls, such as contraceptives used, the number of abortions, where they seek such services, gynecological problems, the prevalence of STDs and health care seeking behavior.

Much of the information currently available is collected from the boys. The boys report that pregnancies are quite common, and the babies are often abandoned. Moralistic messages like, “You should not have sex before marriage”, become a barrier when working with the girls. The boys on the other hand are aware of condoms, but condoms are seldom used. According to a fifteen year old boy, “Sex is easily available around the station and here I do not have to use condoms... I have to use condoms when I have sex at GB Road as the sex workers force us to use them”. While the older boys have access to condoms through the dispensaries and the shops, the younger boys do not. One young boy said, “The shop keepers will not give [condoms] to us, and we can’t get them from the dispensaries”. Moreover, there are no small sized condoms available for the younger, sexually active boys. Consequently STDs are quite common, and more often than not go untreated.
Pornographic films and peer groups are the most common source of information on sex. Most boys watch blue films at local video parlors that arrange special shows. They are exposed to these films at quite an early age. A 7-year-old can watch blue films at one of the video dens for a sum of Rs.5/-. Such media and ignorant peers often perpetuate myths.

**Program interventions**

1. Naz facilitates group discussions with street children to sensitize them to issues around
   - Sexual health and STDs,
   - Linking STDs with HIV/AIDS,
   - Sexual negotiation,
   - Prevention methods and safer sex practices,
   - Human anatomy.

2. Sensitize NGOs, street children educators who work with street children through culture/area/situation specific values and training workshops with exercises on sex, sexuality, gender stereotypes, and commercial sex work.

3. Importance is also given towards training elder boys as they have a major influence on the younger ones. Emphasis is put on group discussions, role-plays, training workshops and developing communication skills.

4. Street plays developed by the boys with guidance by the Naz staff has been powerful in disseminating information about HIV/AIDS. The children are able to relate to them better.

5. Presently Naz is working with Karm Marg, an NGO run solely by children from the street. The elder boys do the teaching, cooking and cleaning without any monetary incentives. They are given the responsibility to look after the younger children, which creates a feeling of ownership and belonging among them. The children are also taught survival skills that serve a dual purpose of income generation and vocational training. Some of these trades are boot polishing and selling peanuts.
Limitations

1. Street children are highly mobile and floating. This is a constraint in developing a long-term link with the children.

2. There are moralistic messages given by some NGO staff, which acts as a barrier as the children do not open up easily. Staffs of some NGOs think that talking about HIV and sex will encourage the children to be sexually active. They also think that providing condoms to children is dangerous and prefer providing messages that only promote abstinence. These messages are impractical when we look at the circumstances under which the children live and what sex means to them. This not only confuses the children but also buttresses their low self-esteem, sense of weakness within society, and fatalism.

3. Most of them are not able to relate to HIV/AIDS as no one has seen anyone who is HIV positive, let alone someone who has AIDS. Further their philosophy is day-to-day survival where they do not concern themselves with long term consequences. As one of the boys said “who cares what happens after 10 years, I do not know if I would live tomorrow!”

4. Small sized condoms are not currently available. The size of the condoms available is too large for small boys and does not ensure a good fit. The boys as young as 10 are sexually active need smaller size condoms, thus talking to them about prevention from HIV/AIDS is not realistic without providing them with practical options.

5. Police Activity against street children maybe a deterrent to working with street children. The children living in the streets are often rounded up by the police under the ‘Juvenile Justice Act’ to be protected and rehabilitated by the state. The conditions in the remand homes are not good. The elder boys called dadas literally run the show. They beat up the younger boys and some times sexually abuse them. Recently the remand home has been handed over to an NGO and the conditions have improved. But many of the boys are sent to the long stay homes where the conditions remain the same.