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| Training Guidelines for Peer Counsellors |
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1. Guidelines for Peer-Counsellors
   1. The counselling steps are as following:
      1. Opening the session
      2. Pre-test counselling
      3. Testing
      4. Post-test counselling
      5. Closing the session
   2. Objectives of peer counselling
      1. Opening the session

Our aim is to help the client relax and reduce his anxiety and/or embarrassment.

* + 1. Pre-test counselling

Our **affective objectives** during this phase are the following:

* + - 1. To form an ad hoc alliance with the client by promoting a spirit of common ground and a sense of ‘we-ness’
      2. To help reduce the client’s possible sex-related shame (which may be due to his homosexuality or to sex negativity in general), as well as his sense of embarrassment
      3. To help him feel at ease and encourage him to talk openly about his sexual practices, so that we may be able to assess the potential risks
      4. To help him calm down if he’s terribly anxious
      5. To make him feel comfortable enough to experience his test in a positive way, so that he may be more willing to repeat it in the future
      6. To create a safe space, in which we can adequately support him if he tests positive

Our **cognitive objectives** during this phase are as follows:

* + - 1. To help the client understand what the testing procedure is all about
      2. To give him an idea of what we are aiming at
      3. To do a proper risk assessment of his various sexual practices
      4. To help him understand how the test is conducted
      5. To explain the difference between a negative and a positive result
      6. To help him process the test result, be it negative or positive
      7. To get the client’s informed consent
    1. Testing
       1. To carry out the test in a correct manner
       2. To alleviate the client’s possible anxiety/stress about the test result by focusing on other topics
       3. To fill in the client form
       4. To educate him about risk reduction
* by providing information about protection and HIV exposure risk reduction
* by discussing correct condom use
* by providing information about other sexually transmitted infections and protection
* by ensuring that the information we provide is at a level that the client is capable of comprehending and processing
  + 1. Post-test counselling
       1. **In case of a negative result**

The **affective objectives** are as follows:

-To make room for the client’s expression of relief (tears or laughter).

-To pay attention that his relief does not translate into unrealistic future expectations.

-To acknowledge his relief, but also reposition it within a firmly realistic context

-To reinforce a sense of we-ness

Our **cognitive objectives** are as follows:

- To make sure the client understands the concept of ‘window period’

- To make sure the client understands the concept of ‘PEP’

-To extensively discuss the implications of not using condoms in a relationship with a steady partner

-To discuss issues of false confidence in sexual partners and certain sexual practices

-To make sure he does not use the test as a prevention measure or an alibi for risky sexual behaviour

-To inform him about our appointment reminder service

* + - 1. **In case of a positive result**

Our **affective objectives** during this phase are as following:

* To give the client time to react, before we start talking
* To listen closely to what he has to say. If he has no obvious reaction, he is most likely in shock (the time required to process traumatic information / experiences)
* To accommodate his emotional reactions, encourage them and create a safe space where he can express them freely
* To help him vent those emotions – up to an extent – because if he doesn’t, he won’t be able to mentally process information (which will lead to a failure of our cognitive objectives). If he finds this difficult, we can ask him how he is feeling or suggest some feelings he may be experiencing
* To manage his possible emotional overreaction:
  + if he panics, gets angry, or distraught, we should calm him down, but only after we allow him to vent those emotions for a short while
  + if he starts over-rationalising or resorts to excessive humorous banter (which means he is downplaying the situation at hand), we should help him come into contact with his emotions
* If he is in denial, we should take it into account but hold our ground If he remains in denial, we should at least make sure he takes the confirmatory test
* To ask him about the support network available to him: whom he can turn to as soon as he leaves the facility and also more generally
* To ask him what he’s going to do over the next few hours and days
* To help him manage feelings of anger / shame / anxiety about how he will share this piece of information with his sexual partners
* To enhance our alliance and the sense of ‘we-ness’, so as to convince him that from now on he has someone by his side, for support and information

Our **cognitive objectives** during this phase are the following:

-To convince him to take the confirmatory test

-To help him understand what an HIV-positive status entails for his health and his life: lifelong disease, treatment options

-To explain some fundamental concepts (CD4, viral load)

-To provide information about his infectiousness

-To talk about his sexual partners, both steady and casual

-To discuss the issue of ‘status disclosure’

* + 1. Closing the session
       1. Our aim is to help the client regain his composure
       - In case of a positive result, we make sure that he intends to take a confirmatory test. We inform him that he has the option of being accompanied to the hospital. We also let him know he may ask for further information, if we estimate that he is in need of it. We refer him to a counsellor for further support
       - In case of a negative result, we make sure he has been fully informed about the evaluation procedure of Ath Checkpoint
  1. What we should keep in mind about ourselves during the session
     1. We will probably be nervous – especially during our first sessions. Being nervous about our performance and whether we will accomplish our goals is useful, because it keeps us alert. However, we shouldn’t be so nervous that we focus more on ourselves, what we do and how we come across rather than on our work itself.
     2. The client feels more nervous and embarrassed than we do. He is not here to evaluate us or grade us. We have the upper hand in this situation; we have nothing to prove.
     3. Our aim is to focus on him, not us. It is likely that we will not be able to manage some situations as well as we would have liked. That’s okay. The harm we may do is relatively small. Our less successful efforts will serve as learning experiences that will help us improve and hone our skills.
     4. We should respect the client and his choices. We must always keep in mind that the client’s life and choices are none of our business. It is not up to us to decide how he chooses to lead his life. Our aim is to provide information and support, so that he can make informed decisions, not impose rules on him, even if we strongly disagree with his lifestyle choices. Besides, even if we do attempt to impose rules on him, it is highly unlikely we will succeed anything. We shouldn’t try to change his way of thinking, but rather help him evaluate his own actions and be aware of both his choices and their consequences. We should keep in mind that, gay though as we both may be, we may come from totally different sociocultural backgrounds.

We don’t need to express our views about his lifestyle choices, much like we wouldn’t feel comfortable with someone else disapproving our own choices. Be aware that disapproval, blame and lack of acceptance on our part will come across to the client even when we don’t explicitly express them in so many words.

* + 1. If we come across any issue that we cannot deal with, we should discuss it with supervisors. If we experience strong emotions (e.g. anger) as a result of some of the client’s choices (e.g. because he consistently refuses to put on a condom, even though he is aware of the dangers involved in this practice), we should discuss the issue with our supervisors; otherwise we will not be able to carry out our work in an efficient manner.
  1. What we should keep in mind about the client during the session
     1. It’s better to focus not on ‘what he does’, but on ‘how he can do whatever he does it in a better way’
     2. We should believe that what the client says is true for him, but not necessarily the truth
     3. We should not judge him
     4. We should not blame him
     5. We should not feel sorry for him
     6. We should not pretend to be a know-it-all
     7. We should not provide information without also listening to what he has to say
  2. What type of language we should employ during the counselling process

We use simple, everyday language. We shouldn’t take for granted that certain terms are common knowledge. We ought to try to adjust ourselves to the *idiolect* (the personal style of language) of every given client. If he employs the word ‘gay, we use the same term. If he prefers ‘homosexual’’, we follow suit. We use the word ‘cock’ rather than ‘penis’ or ‘willy’. We use the word ‘head of the cock’ rather than ‘penis glans’. We use the terms ‘arse’ and ‘arsehole’, if the client uses them first, otherwise we opt for ‘anus’ and ‘hole’. We can use both ‘blowjob’ and ‘oral sex’. Our criterion is to avoid using medical terms that may not be fully comprehensible and also give off a vibe that is too formal and medical.

* 1. How do we refer to sexual roles?
     1. We do not presuppose the client’s sexual role based on his appearance and behaviour. In other words, we should not jump to early conclusions as to whether he is a top or a bottom, promiscuous, prudish etc.
     2. We do not express our disapproval, explicitly or implicitly, of any sexual role or practice.
     3. We are aware of the lower social status and shame generally associated with the passive sexual role and we are sensitive to this fact.
     4. We use the terms ‘active’, ‘passive’, ‘active/passive’, or ‘top’, ‘bottom’, and ‘versatile’, in accordance to the client’s personal language style. In order to make sure he understands us, we generally opt for Greek terms. Not everyone is aware of the equivalent English terms ‘top’, ‘bottom’ or ‘vers’.
     5. When we refer to sexual practices, we use expressions such as ‘the one who receives’, ‘the one penetrating’, etc.

1. Opening the session
   1. What is our objective during the opening phase of an appointment?

We help the client relax, calm down and feel less anxious or embarrassed.

* 1. What feelings will the client most likely have during this phase?

He will most likely be nervous, anxious or scared, for various reasons, including some of the following:

* + 1. because of the test itself
    2. because he has to talk to a stranger about his sex life
    3. because of the test result
    4. because he fears that people from his social environment may find out about his visit to the facility.
  1. How do we go about our goals?
     1. We introduce ourselves by our first name
     2. We open the conversation by talking about something trivial, daily, prosaic and irrelevant to the subject at hand
     3. We ask him how he found out about the service
     4. We talk about the service itself
     5. We bring up the confidentiality of the procedure
  2. Opening examples:
     1. Hi, I’m George.
     2. Did you have a hard time finding it? I hope the rain didn’t get you. So hot today, huh? Were the website/phone instructions of any help?
     3. How did you find out about Checkpoint? We are interested in knowing that because we are looking for new ways of advertising our service.
     4. Checkpoint has been operating for several years now in various cities abroad, including Barcelona, Paris, and Copenhagen. In Athens, it’s been running for the past 2 years. Checkpoint is an HIV prevention and testing promotion centre that operates outside health care facilities and caters mainly to men who have sex with men. This doesn’t mean we don’t provide services to other people. The reason Checkpoints were set up, both here and abroad, is because it’s easier to have HIV tests done by other men who have sex with men in a setting that doesn’t feel like a hospital. Checkpoint is an initiative of the NGO ‘Positive Voice’ in conjunction with the medical supervision of HCDCP (Hellenic Centre for Disease Control and Prevention), ‘Prometheus’, the Greek Liver Patient Association and the Municipality of Athens. All employees here have been trained and certified by HCDCP for this particular job.
     5. I’d like to stress that whatever is mentioned in here will remain confidential. All employees have signed a confidentiality agreement. There is no way we will ever disclose your visit here. One of the reasons we chose this building is because it’s located in a spot where no one can see who goes in and out.
  3. What we should refrain from doing during the opening phase
     1. Ask for the client’s name
     2. Shake his hand – unless he shakes ours first
     3. Wait for him to sit down. We take a seat before he does
     4. Get too comfortable in our chair
     5. Fiddle with our pen or clothes
     6. Resort to too much light banter
     7. Bring up clothes / hair / jewellery / bags etc.
  4. What we should keep in mind when we introduce ourselves

We introduce ourselves by our first name: “I’m Kostas”. We don’t ask for the client’s name. If he feels like it, he will introduce himself. If he introduces himself by his full name and surname, we clarify that we do not need his surname and that the test is completely anonymous.

We do not use polite forms when addressing him, unless he is significantly older. If the client still uses polite forms to address us after the first 3-5 minutes of our conversation, we switch our speech accordingly. When it comes to much younger clients, we always use informal / colloquial speech, regardless of how they choose to address us.

* 1. What we should keep in mind about body posture

The first thing the client will notice, consciously or otherwise, is our body posture. It provides the first clues about the vibe of our discussion.

As we welcome him into the room, we try to make ourselves feel at home. This will effortlessly give off a positive, relaxing vibe. We may not feel all that relaxed in the beginning, but eventually we will.

We take a seat. If he does not sit by himself, we point at his appointed armchair and encourage him to sit down. We do that once. He may choose to remain standing for a short while. He will almost certainly take a seat eventually. If he chooses to remain standing after several seconds, we offer him a seat again.

Our armchairs should be set at a small angle and not facing each other. We sit comfortably in our armchair, but we do not sink into the armchair, as if watching TV. We should sit up straight, with our whole body facing the other person. We should neither sit on the edge of the armchair, nor fiddle with pens, clothes, fingers etc.

We smile and try to be friendly. We should not, however, be excessively cheerful or try to be very chummy with him. We are not friends with him. The client has not come here to make new friends.

* 1. What should we do if we have definitely met the client before?

We shouldn’t pretend that we’ve never met before. We acknowledge the fact and **immediately** bring up the confidentiality clause. If he declines to acknowledge our previous meeting, we **do not insist** on our knowing him: “I must be wrong / I thought you were someone else”. We should not be interested in verifying whether we’ve truly met him before or not. He is most likely not interested in this either. What’s troubling him is whether his social environment will find out about his visit here or the fact that he’s gay. That’s why it’s no concern of ours where and when we first met. We immediately address the crucial issue at hand: confidentiality.

* 1. How do we react in case the client knows us?

Again, we’re not concerned whether we know each other from before. We acknowledge the fact, overlooking the ‘where’, ‘when’ and ‘how’ of our prior meeting and immediately address the issue of confidentiality.

We may acknowledge the fact with a brief comment, such as ‘It’s a small world’, ‘It may come as a surprise to meet me here’, and then take up the confidentiality issue. If we are HIV-positive and the client is not aware of the fact, we deal with the situation according to our stance vis-à-vis this issue (if we are open about it or not), regardless of whether he asks us or not.

2.10. What if we have had sex with the client?

If we have sexual history with the client, again we cannot pretend that this never happened. We acknowledge the fact. We may say something to effect of, ‘It is probably a bit awkward for both of us to be here now’ and then, based on his reactions, move forward accordingly.

In any case, if the client’s fears are not allayed by our declarations of confidentiality or if he feels too insecure or embarrassed to do the test with us, we can offer him the option to carry out the test with another peer counsellor: ‘Would you rather take the test with another counsellor’? We offer this option **only** after we have made sure he cannot overcome his distrust and/or hang-ups, in spite of our efforts to the contrary. If there is an available counsellor, he takes over; otherwise, a new appointment is booked.

* 1. What should we keep in mind about confidentiality?

We make very clear to him that both the test and this session are entirely confidential. We do not keep names or other personal data in our records. We guarantee that whatever we discuss here will remain between us. We acknowledge his worries that his visit here may eventually become known to his social and personal environment, yet we emphasise that will never disclose it to anyone. He is free to tell others of his visit here or even disclose the identity of his to the peer counsellor. However, on our part, we vouch to never disclose his visit.

Judging on his level of fear / anxiety, we may insist on confidentiality, but only up to a certain point. We may never fully convince him.

1. Pre-test counselling
   1. What goals do we wish to accomplish during this phase?

Our **affective objectives** during this phase are:

* + - 1. To form an ad hoc alliance with the client by promoting a spirit of common ground and a sense of ‘we-ness’
      2. To help reduce the client’s possible sex-related shame (which may be due to his homosexuality or to sex negativity in general), as well as his sense of embarrassment
      3. To help him feel at ease and encourage him to talk openly about his sexual practices, so that we may be able to assess the potential risks
      4. To help him calm down if he’s terribly anxious
      5. To make him feel comfortable enough to experience his test in a positive way, so that he may be willing to repeat it in the future
      6. To create a safe space, in which we can adequately support him if he tests positive

Our **cognitive objectives** during this phase as follows:

* + - 1. To help the client understand what the testing procedure is all about
      2. To give him an idea of what we are aiming at
      3. To do a proper risk assessment of his various sexual practices
      4. To help him understand how the test is conducted
      5. To explain the difference between a negative and a positive result
      6. To manage the test result, be it negative or positive
      7. To get the client’s informed consent
  1. How do we go about our objectives?

We go about our **affective objectives** by taking the following steps:

* + 1. We encourage him to speak: ‘What brought you here’? We do not open our questions with ‘why’, because this question poses difficulties for certain people. Neither do we tell him, ‘I imagine you have reasons for coming here’.
    2. We do NOT make assumptions or pass judgment about his reasons for taking the test. Many people are scared of HIV, and everybody has their own reasons for taking the test, some of which they may choose not to disclose. Having said that, we have to evaluate his reasons by the end of the session, but we should at least listen to him first without any preconceptions or bias.
    3. We listen to his story carefully, encouraging him to carry on, asking for clarifications when necessary.
    4. We find out (and also infer) what he already knows about HIV in terms of information, but also in terms of his own emotional attitude vis-à-vis HIV.
    5. We may need to slightly amend / rearrange the above steps, depending on the client.

We go about our **cognitive objectives** by taking the following steps:

* + 1. We explain the specifics of the test: namely, that there will be a 15-minute discussion before the test (pre-test counselling), then a saliva test whose results we will have in about 15 minutes, and finally a 15-minute discussion after the test (post-test counselling). We do not use English terms, such as ‘counselling’. Accurate terminology is of no concern to the client; additionally, those terms sound too formal.
    2. We explain to him what our aims as peer counsellors are: ‘I’m not here to tell you what to do and what not to do, but to help you see how you feel about whatever you already do’.
    3. We invite him to assess the risk of his sexual practices: ‘Based on what you do in your sex life, how risky do you think your sexual behaviour is?’ We share our own honest opinion about the estimated risk of his practices based on what he told us. We aim to reach a mutual understanding of the estimated risk.
    4. It is important that the client acknowledges the possible risk, that he asks for the test and that he owns up to the test result. He must feel that he is the active agent and in control of the procedure, rather than a passive recipient.
    5. We explain how the test is done and what we expect from its results.
    6. We investigate how he is likely to respond when faced with a positive or a negative result. We **begin with the negative result**:
       1. We ask him what he thinks his feelings will be if the result is negative and we figure out his reactions.
       2. We ask him what he thinks his feelings will be if the result is positive: ‘If the result is positive, how do you think you’ll feel? What will you do?’ We figure out his reactions and prepare ourselves for possible stress, shame, guilt, or other emotions. We initiate a discussion.
    7. We recommend that he takes the test, asking for his informed consent, without using the word ‘consent’, if possible, because it carries negative connotations. We say something to the effect of, ‘Now we can proceed to the test, if you feel like it. Do you want to take the test?’ If he replies ‘yes’, we proceed. If his response is negative, we have to accept that some people don’t feel ready and it may take them more time to prepare for this.

3.3. What do I do if the client declines to take the test?

* + 1. We do not question his decision by asking him things like, ‘are you sure you don’t want to take it?’
    2. We do not, directly or otherwise, pressure him into taking the test. If he is not ready for it, he won’t be able to use the test result to his own benefit.
    3. We start a discussion regarding his fears and what a positive test result entails health-wise and prognosis-wise.
    4. We emphasise that he is welcome to visit again, whenever he feels ready.

3.4. What should we always keep in mind regarding the client’s consent?

* + 1. Before we carry out the test we are obligated to ask him if he agrees to proceed with the test.
    2. Nobody can impose a test on an individual without the individual’s consent.

1. Testing

4.1. What objectives do we wish to accomplish during the testing phase?  
Our objectives during this phase are the following:

* + - 1. To carry out the test in a correct manner.
      2. To alleviate the client’s possible anxiety/stress about the test result by focusing on other topics.
      3. To fill in the client form.
      4. To educate him about risk reduction
* by providing information about protection and HIV exposure risk reduction
* by discussing correct condom use
* by providing information about other sexually transmitted infections and protection
* by ensuring that the information we provide is at a level that the client is capable of comprehending and processing
  1. How do we go about our objectives?
     1. We follow the test instructions closely.
     2. If the client asks for more information about how the test works, we provide such information without going into too much technical detail.
     3. Together with the client, we fill in the first page of the form. We will fill in the second page after the end of our session; it is best to keep it out of the client’s sight.
     4. During the time required for the test result to come through (20 minutes), we discuss the issue of sexual practices (if it hasn’t been brought up yet). We should have already acquired pertinent information during the first part of the session. If, however, this proved unfeasible, we initiate a discussion about his sexual practices now; first, we ask him about his own sexual practices and then we provide information. If the client doesn’t open up easily or if he is too uncommunicative, we may fall back on our common ground as gay men and talk about our own sexual practices to help him open up.

4.3. What should I bear in mind about the test?

* + 1. We should always keep in mind the 10-12-week period (the so called window period) during which antibodies to HIV may be undetectable.
    2. If the client is currently in such a window period, we should proceed with the test, yet also point out that he should definitely take a new test as soon as the window period is over.
    3. We instruct the client not to eat, drink or chew a gum for a minimum of fifteen minutes prior to the test.
    4. We instruct him not to use any oral care products for at least thirty minutes before taking the test.
    5. Additionally, it is recommended that the client has not smoked for at least fifteen minutes prior to the test, because saliva production is decreased as a result of smoking.
    6. When we open the kit, we make sure that it contains everything required for the test:
       1. A test tube with liquid in which we will put the pad of the test stick after collecting saliva.
       2. The stick pad for collecting saliva.
       3. A holder to support it all.
       4. A small packet which protects the kit from humidity (which we will discard immediately afterwards)

4.4. How do we talk about sexual practices?

One of the main goals of the test is to impart valid, easy-to-grasp information about safer sex and risk reduction.

It has been proved that humans acquire new information more quickly and effectively when they are, to a small extent, emotionally involved, that is, when they feel that the issue at hand concerns them directly.

In light of this, we should not provide information in a vague or general manner, e.g. ‘when one performs oral sex, one should be careful not to have gingivitis’ etc. We should talk at a more personal level, utilising our own experiences to illustrate examples, e.g. ‘when I have mouth ulcers, I avoid blowing guys I am not very familiar with, because there’s more danger of getting infected with HIV if the other guy has pre-cum; mouth ulcers can act as a doorway for the virus to get inside my body. Of course, if I’ve met a real hottie and I just have to blow him, at least I make sure he doesn’t come in my mouth’. Starting from personal experiences, we then move on to a more theoretical discussion.

4.5. How much detail should we provide?

Information about risk reduction in sexual practices should be easily absorbable by others. Thus, we shouldn’t just blurt information out and be done with it. It’s better to provide only a little information that the client can take in easily, rather than flood him with tons of information he may not be able to retain.

4.6. To what extent do we use our own sex life as an example?

We shouldn’t talk about ourselves and what we do or don’t do in bed just for its own sake. Referring to our sex life can be a useful tool **only** when the client has a hard time opening up and talking about his own sex life. If he has already done it by himself or following our encouragement (through questions, encouraging looks, warm reception), there is no reason to talk about our own sex lives. We should make use of our common ground as gay men sparingly, only when we think it’s necessary.

4.7. What should we do in case the client is extremely nervous?

We acknowledge his nervousness (‘You’re really nervous, huh? It’s normal. I would be nervous, too’), without focusing too much on it. We then turn the conversation back to his sexual practices: ‘Are you worried you might be infected? Why do you think it may have happened? What type of sexual activity may have put you at risk? Yes, this activity could lead to infection, but it’s not 100% certain. Since we are waiting for the test result, tell me in which other ways do you think it’s possible to catch it? I used to think for example that you couldn’t get it from …’

Providing information is of no use if it’s impossible to have a proper conversation with him, because he’s too anxious and cannot participate in the conversation. In such cases we should focus on his anxiety. We encourage him to articulate his anxiety: ‘What’s the worst case scenario? What worries you so much? Are you worried you may have it?’

**We should not console him! We should not allay his fears!** We provide valid information based on risk assessment and restore HIV to its real proportions (e.g. it’s a chronic disease; you don’t die from it anymore etc.)

4.8. What if there is still time left?

It is possible that the client is either very well informed or so closed-up that he’s absolutely unable to retain any information we provide. In such cases it may not be required or even possible to provide much information to him.

In the first case (a well-informed individual), we initiate a more general discussion on HIV: ‘Are you acquainted with HIV-positive individuals?’ ‘What do you know about treatments?’ ‘Do you know how the human body is affected by HIV?’

In the second case, we skip the information altogether and instead help the individual manage his emotional burden.

1. Post-test counselling

5.1. In case of a negative result what objectives do we wish to accomplish?

Our **affective objectives** during this phase are the following:

1. To make room for the client’s expression of relief (tears or laughter).
2. To pay attention that his relief does not translate into unrealistic future expectations.
3. To acknowledge his relief, but also reposition it within a firmly realistic context
4. To reinforce a sense of we-ness

Our **cognitive objectives** during this phase are:

1. To make sure the client understands the concept of ‘window period’
2. To make sure the client understands the concept of ‘PEP’
3. To extensively discuss the implications of not using condoms in a relationship with a steady partner
4. To discuss issues of false confidence in sexual partners and certain sexual practices
5. To make sure he does not use the test as a prevention measure or an alibi for risky sexual behaviour
6. To inform him about our appointment reminder service

5.2. How do we go about our objectives?

* + 1. Obviously, relief is the most common reaction. Why should someone feel relieved? For many reasons: because he’s worried about a life-threatening disease, because he escaped the HIV stigma, because he hasn’t infected others.

Often, these fears are so deeply rooted in a person that even he himself hasn’t realised how terrified he was. Now that his fears are gone, it is likely he will feel freer to express his emotions, often by crying, even loudly. It is perfectly normal. **We allow him to cry; in fact, we encourage him to do so**. We don’t console him, or stop him, or hand him tissues. We listen to him and we remain present, keeping in mind how beneficial crying can be for his emotional health.

If he begins to slightly tremble or break into a cold sweat, he is manifesting his fear; this is excellent. We demonstrate, both through our facial expressions and our posture, that we are present and attentive, encouraging his emotional expression with nods and few words: ‘Yes…’, ‘I understand…’, ‘Yes, you were afraid…’ Gradually he will calm down.

* + 1. We should make sure his relief does not translate into unrealistic goals about the future (e.g. I will never again have sex, I will blow men only with a condom on etc.)
    2. We acknowledge his relief, but also reposition it within a firmly realistic context.
    3. We should promote a sense of we-ness, so that he will be able to share certain patterns of sexual behaviour that he didn’t feel relaxed enough to share with us during the pre-testing counselling.
    4. We must always keep in mind the 10-12-week window period during which antibodies to HIV may be undetectable. If he is currently in this period we should proceed with the test, but also point out that he should definitely take a new test as soon as this period is over.
    5. We explain to him the concept of PEP (Post Exposure Prophylaxis). PEP may prevent infection with HIV. Its results are not guaranteed. A potentially exposed individual must go on PEP within a strict maximum of 72 hours (three days) following unprotected sex or if the condom breaks. PEP is provided free of charge in Greece, and consists of a four-week course of antiretroviral drugs; it may have side-effects. We make sure that the client understands that PEP is NOT a cure-all, that is, he cannot carry on having unprotected sex and then ask for PEP. We stress that only a doctor can decide whether PEP is to be administered or not, depending on his/her risk assessment.
    6. We should make sure the client doesn’t use the test as prevention measure and convince him that the test is not a *carte blanche* for risky behaviour. Certain gay men use the HIV test as a means of prevention and/or permission to perpetuate risky behaviours instead of adopting risk reduction in their sexual practices. Their rationale goes as follows, ‘I did something dangerous but I got a negative test result, hence I’m free to do it again’. They may expect from the counsellor to be complicit in their way of thinking: ‘Since you gave me a negative result, I’m good’. In this way, they try to renounce responsibility.

In all such cases, it is important to point out that a negative test result does not in any way guarantee that a sexual practice is safe. It is simply a matter of probability. This piece of information may be absorbed by some people but not others, because their behaviour may be motivated by underlying psychopathological causes.

If we see the same person show up repeatedly for testing, always mentioning risky sexual practices, we are entitled to ask him, ‘Do you want to get HIV? Do you come here in the hope of finally getting a positive result?’ and see how he reacts.

We must handle such individuals sternly, in order to protect both ourselves and the services we provide.

* + 1. We should convince the client to repeat the test on an annual or even biannual basis if he has a particularly active sex life. We will say how often is best for each person to repeat the test, based on our risk assessment.
    2. We should inform the client of the appointment reminder service.
  1. What should we keep in mind while announcing a negative result?
     1. We may erroneously believe that a positive result is more important than a negative result. This is not true for a number of reasons. How we will announce the negative result is equally important.
     2. We announce the result by taking into consideration the risk assessment we carried out earlier together with the testee. If the risk assessment was accurate, the announcement will be easier, in the sense that the client has a generally fair idea of the amount of risk involved in his sexual practices.
     3. The client may have invested a tremendous amount of thinking, energy and time in worrying and preparing himself for a positive result. He may be taken aback by a negative result. He may have been certain that he would be happy and absolutely relieved to get a negative result, but this is not always the case. A gay man with a negative test result may feel he has been given a temporary ‘deferral’, but will continue to live in a world where HIV remains a threat. The negative result will not magically cancel the threat of HIV, as he may have vaguely and unwittingly wished for. His relief may not be as great as he had expected; he may experience sadness instead.
     4. Certain individuals may not believe the negative result, particularly if they had convinced and prepared themselves for a positive status, or if they consistently engaged in risky practices in the past.
     5. Certain gay men may have a hard time accepting the negative result because, unwittingly, they feel that their infection is a punishment that is fitting, appropriate, inevitable or righteous. Certain gay men feel they deserve punishment because they are convinced they have no value or that their love life is worthless or contemptible. People belonging to a population group that has always been persecuted often cannot escape feeling that there are good reasons behind their persecution. Consequently, certain gay men may feel they deserve getting HIV.
  2. How can I recognise hypochondriacs?

Hypochondria and HIV often go hand in hand. HIV is one of the usual diseases hypochondriacs imagine having, because the initial symptoms of HIV are extremely general. Hypochondriacs can easily manifest early symptoms of HIV infection; due to their anxiety, they can cause diarrhoea, loss of appetite, chest pains, and rash upon themselves.

If the client answers affirmatively to most of the following questions, we should help him understand that his problem is not HIV or other diseases, but that his issue is clearly psychological in nature and he should consult an expert.

We shouldn’t ask the following questions one after the other as if we are interrogating the client. Rather, we glean answers to our questions from the entire session with the client. Of course, we can always explicitly ask certain questions.

* + 1. Have you ever been told by a doctor that you are not at high risk of getting HIV, but nevertheless you ` carry on thinking you are infected or will get infected?
    2. Are you wary or doubtful of the doctors’ ability to perform an accurate risk assessment based on your sexual practices? Do you doubt their ability to perform the test correctly?
    3. Do you spend several hours searching the Internet or in books about HIV in an effort to find out whether you’ve been infected?
    4. Have you taken HIV tests numerous times in a short period, even though the window period has passed and you’ve already got a negative result?
    5. Do you take HIV tests numerous times before the window period expires, even though you know the results will not be guaranteed?
    6. Do you take expensive HIV tests, for viral load or p24 antigen, even though you know you have a low or virtually non-existent risk of transmission?
    7. Do you have a hard time believing your test results?
    8. Do you constantly or frequently think about the possibility of getting infected with HIV?
    9. Do you link any major or minor physical discomfort or other health issues with HIV?
    10. Have you had what you believe are HIV-related symptoms for several weeks or months in a row?
    11. Do you believe you may have got HIV in a less probable way? (e.g. food, handshake, saliva, blowjob etc.)
    12. Do you believe you belong among the very rare cases of individuals whose test takes more than six months to show an HIV positive result?
  1. How do we handle hypochondriacs?
     1. We carefully listen to their concerns. Even though we can easily tell their concerns are unfounded, we must keep in mind that for them they are valid. We allow them to present things from their point of view – for a little while.
     2. We discourage self-diagnosis. Often, hypochondriacs are well versed in their supposed disease, by having read a lot of information, especially on the Internet.
     3. We advise them to seek the deeper cause of their hypochondria, with the aid of experts.
  2. How do we deal with individuals who have shown up for tests numerous times?

These individuals can be broadly classified into two groups: individuals who suffer from phobias and those who use tests as a method of prevention or permission for unprotected sex. Both cases demonstrate a certain degree of psychopathology. We must realise this and accept the fact that we are of no help to these people. By allowing them to waste our time, they have an adverse effect on us and on other clients. They are drain to our resources, and this can take a toll on our work. More importantly, we cannot really help them.

If we realise that we do, in fact, tolerate their recurring appearances, we should keep in mind that we do it because it makes *us* feel better, not because we genuinely help them out in this way.

**Individuals with phobias**

Individuals who show up numerous times for tests can be tedious and exasperating for counsellors. Individuals who are obsessed with HIV and refuse psychological aid cannot be easily handled in set ups for HIV control and prevention. We cannot really do much to help them, but we can understand their problem and encourage them to seek help elsewhere.

Gay men who are obsessed with taking HIV tests are often tormented by internalised homophobia. Their real issue is a deeply-rooted shame for their sexual orientation and their sexual activities (which they may or may NOT practice) rather than HIV itself. HIV serves merely as a displacement for their true problem.

All gay men invariably have internalised homophobia. The only difference is to what extent we carry homophobia within and how much of it we have been able to shed. We have all been raised in environments which have conditioned us to feel shame, guilt, fear, or embarrassment for liking men and wanting to have sex with them. Our guilt and shame are further aggravated if we are gay men who have the ‘nerve’ to have unprotected sex.

According to research individuals who take tests too often usually have issues with coming out. They may be completely in the closet, without any friends or with few people who are aware of their homosexuality. HIV test is not really about HIV itself but rather symbolises the difficulty they have in accepting their homosexuality and preference for gay sex. Their desire for sex is inhibited / forbidden / guilt-ridden, and they camouflage this inhibition and guilt through an excessive anxiety about getting HIV.

HIV and AIDS serve as a perfect vehicle for displacing much of this sexual frustration. Besides, numerous people – gay and straight alike – experience sex-related anxiety and guilt, regardless of HIV. Some people have a hard time discerning sexuality-related anxiety from health-related anxiety.

If an individual insists that he may have been infected and that the test may be a false negative or otherwise defective, we should assure him of the test’s validity, and repeat pertinent information to him, but only up to an extent. We shouldn’t bother persuading him with reasonable arguments, because his problem is not due to lack of rational thought but to psychological obstacles.

**100% safety and inconsistent practices**

Often people who compulsively take HIV tests ask how they can be 100% safe. We underscore that there can never be 100% safety in life. Furthermore, we point out possible inconsistencies in their sex life, e.g. if a person is frequently terrified of getting HIV from his partners’ precum, but insists on blowing them without a condom on, we point out the inconsistency: ‘You’re afraid of getting HIV and regularly take tests, but you’re obviously not that afraid, since you don’t put on condom when you blow someone. You can’t have it all. If you want 100% safety, don’t have sex. However, you should know that you can significantly reduce the risk of transmission’.

If we conclude that we are dealing with a (homo)phobic person, we have to impose boundaries: he can book a new appointment only once every six months / a year. Of course, given how new our organisation is, we won’t be able to detect these individuals immediately.

* 1. In case of a positive result, which objectives should we go for?

Our **affective objectives** during this phase are as follows:

* + 1. To give the client time to react, before we start talking
    2. To listen closely to what he has to say. If he has no obvious reaction, he is most likely in shock (the time required to process traumatic information / experiences).
    3. To accommodate his emotional reactions, encourage them and create a safe space where he can express them freely
    4. To help him vent those emotions – up to an extent – because if he doesn’t, he won’t be able to mentally process information (which will lead to a failure of our cognitive objectives). If he finds this difficult, we can ask him how he is feeling or suggest some feelings he may be having
    5. To manage his possible emotional overreaction:
       - if he panics, gets angry, or distraught, we should calm him down, but only after we allow him to vent those emotions for a short while
       - if he starts over-rationalising or resorts to excessive humorous banter (which means he is downplaying the situation at hand), we should help him come into contact with his emotions
    6. If he is in denial, we should take it into account but hold our ground. If he remains in denial, we should at least make sure he takes the confirmatory test
    7. To ask him about the support network available to him and whom he can turn to
       - immediately (as soon as he leaves the facility)
       - at a more general level
    8. To ask him what he’s going to do over the next few hours and days
    9. To help him manage feelings of anger / shame / anxiety about how he will share this piece of information with his sexual partners
    10. To enhance our alliance and the sense of ‘we-ness’, so as to convince him that from now on he has someone by his side, for support and information

Our **cognitive objectives** during this phase are as follows:

* + 1. To convince him to take the confirmatory test
    2. To help him understand what an HIV-positive status entails for his health and his life: lifelong disease, treatment options
    3. To explain some fundamental concepts (CD4, viral load)
    4. To provide information about his infectiousness
    5. To talk about his sexual partners, both steady and casual
    6. To discuss the issue of ‘status disclosure’
  1. What should I keep in mind while announcing a positive result?
     1. We announce the result with empathy, rather than pity or sadness. We take into consideration the risk assessment we performed earlier together with the client.
     2. We have to make sure he understands what this test result means and that a confirmatory test is required. We don’t just announce the result, we make sure – as much as possible – that he has grasped its full meaning. We then focus on our affective objectives.
     3. As soon as he is presented with a positive result, the client is confronted with multiple losses:
        + He loses his health (or so he thinks)
        + He loses his future (as he had it in mind or was actively planning it)
        + He loses the normality of his everyday life as he knew it
        + He stops being ‘like everyone else’
        + He loses his sexuality as he knew it

For all these reasons, we need to keep in mind that he may go through a process of grief, with everything this entails.

* 1. Negative result
     1. When a client receives a negative result, it’s the right moment to initiate a discussion on sexuality and other sensitive issues, since most individuals are now calmer and it is easier to build a rapport of intimacy with them.
     2. With those who take tests regularly and are already well informed on most HIV-related issues, a more customised counselling procedure should be implemented.
     3. We should provide information on our Appointment Reminder Service
     4. We should provide information on Checkpoint assessment procedure (see 12. Appointment Reminder Service)
  2. What should we do, if we need more time to effectively carry out the post-test counselling phase and we have a scheduled appointment coming right up?

In this case, another peer counsellor should take care of the next appointment; if nobody is available, then the secretariat will take care of it.

* 1. What should we do if the client requires an extra counselling meeting?

The peer counsellor books a new appointment – the sooner the better.

* 1. What should we do if the client requires psychological support from a professional?

We can refer him to the Counselling Centre, which can receive individuals for a while. As a service we also need two groups of psychologists: those who will work for free and those who require a fee.

1. Closing the session
   1. Which objectives do we wish to accomplish during this phase?

Our objectives are the following:

* + 1. Our aim is to help the client let off steam
    2. In case of a positive result, we make sure that he intends to take a confirmatory test. We inform him that he has the option of being accompanied to the hospital. We also let him know he may ask for further information, if we estimate that he is in need of it. We refer him to a counsellor for further support.
    3. In case of a negative result, we make sure he has been fully informed about the evaluation procedure of Ath Checkpoint
  1. How do we go about our objectives?

Both in the case of a negative result and especially in the case of a positive result, we make sure he does not leave in an emotionally-charged state.

In case of a positive result, we make sure he plans to take the confirmatory test.

In case of a negative result, we hand him the card that mentions the organisation assessment webpage and urge him to provide an assessment.

We stand up and then accompany the client back to the secretariat.

1. Supervision
   1. **What should I know about supervision?**

Supervision is the regular and continuous scientific and psychological support of peer counsellors. Supervision is done both at a group and personal level.

In supervision, we discuss specific incidents, difficulties we face, ways we can improve ourselves, and solutions to problems.

We also bring up any emotions that may rise during work: anxiety, sadness, fear, anger.

We also discuss our cooperation with fellow counsellors and any issues or conflicts that may have come up.

* 1. When should I request supervision?
     1. When I have a work-related question
     2. When I leave work and cannot get out of my mind a certain incident or cannot stop thinking about work
     3. When I have intense emotions for a client or a particular type of person, e.g. anger, sadness, indifference etc.
     4. When I am facing difficulties with colleagues
     5. When I am attracted to a client or a colleague
     6. Any other issue which I think I should discuss with my supervisor
  2. How are supervisions conducted at Ath Checkpoint?
     1. There will be a weekly visit by a HCDCP psychologist to support the counsellors’ work
     2. The entire counsellor team is divided into two groups that will convene separately once a month
     3. Once a month both groups will hold a joint meeting
     4. Personal supervision is offered whenever requested

1. Gay men and HIV-related issues
   1. Where does our personal history figure into all of this? Should we talk about ourselves? How much? When? With what purpose in mind?

One of the biggest advantages of talking with a gay peer counsellor is that clients and counsellors belong to the same community. We are also gay and we may also be HIV-positive; hence we have first-hand experience of what the client may be going through.

However, belonging to the same group does not mean we have exactly the same life experiences or the same way to go about facing life and solving problems.

We may all belong to the same group, but we are also different people and we should bear that in mind. If we overlook our differences, we may be annoyed by clients who react in different ways than we do.

Our personal history carries its own weight in a session. As counsellors, sharing with clients the fact that we have personally lived through all of this, and that not only have we survived but also lead happy lives, is much more than mere theoretical information. It is important that we address clients while speaking from our personal experience.

Let’s be careful though! We share our own experiences and histories sparingly and cautiously. We do not employ our experiences as guidelines for other people’s lives.

* 1. Sexuality

Condemnation and guilt-tripping of sexuality from a very young age can and does tremendously influence gay men’s self-image and their attitude in general vis-à-vis themselves, their bodies, their partners. During counsellor training, there is no time to properly address issues of sexuality, but suffice is to say that internalised homophobia (that is, oppression and guilt-tripping of sexuality) can considerably distort perceptions of selfhood and foster self-hatred.

* 1. Our precious bodily fluids

Human bodily fluids carry numerous – and complicated – significations and connotations, be it blood, menstrual blood, saliva or semen.

Semen is much more than a mere bodily fluid. It carries life-giving connotations, which contrast sharply with HIV. For many gay men, semen is central in sex; ejaculating inside their partner’s body or receiving semen in their own bodies can be an important part of sex. In heterosexual couples, semen represents the possibility of creating new life. In same-sex male couples, even though conception is unfeasible, semen also carries life-giving associations. The fact that semen is now associated with death rather than life is a source of anxiety, sadness and great loss for many gay men.

On a psychological level, the association of semen with HIV is much more problematic than the association of blood with HIV, because blood is already, in our collective unconscious, linked with injuries and pain. By contrast, semen is conceptually linked with sexual ecstasy and pleasure.

‘You can’t imagine how pissed I am for having to have sex with a condom’, a 33-year-old gay man admits. ‘Sex is something very personal. It’s a form of sharing with your partner. Sharing our bodily fluids is an important part of sex. Becoming one, he enters you, you enter him’. For some men, trading bodily fluids carries spiritual connotations; it signifies a sexual as well as psychic union.

Unfortunately, precisely because homosexuality and sex have little or no prestige in society, swapping semen can be a condemnable, furtive, guilt-ridden pleasure. How many gay men can freely, guiltlessly admit they like having their partner come in their mouth or conversely come in the partner’s mouth?

Now that semen is directly linked with HIV, the meaning of semen in the sexual act is further burdened with guilt. As in anything fraught with guilt, this can affect our emotions and promote erratic, impulsive attitudes.

As peer counsellors it is of paramount importance that we fully grasp the complex psychological damage inflicted on HIV-positive men, due to the fact that a personal, intimate, life-giving and significant part of their sexuality is suddenly transformed into something dangerous, a potentially harmful weapon instead of an arousing, pleasure-giving fluid.

It is important that we keep in mind the various connotations of bodily fluids when we talk about safer sex, because it can help us be more understanding towards men who continue giving or receiving semen. Our own understanding, even if left unexpressed, will help reduce their sex-related negativity.