When John and Susan married eighteen years ago, they thought his hemophilia would be their greatest health challenge. Having learned to live with its unpredictability and treatment needs, they went on to have two children, at which point they decided that their family was complete. John had a vasectomy, and they threw away Susan’s diaphragm. About twelve years ago, though, they started hearing concerns about AIDS being transmitted through the blood supply. John was told that he might be at risk for contracting the AIDS virus but that the blood supply was thought to be pretty safe by then and that, anyway, not treating his hemophilia with the blood product factor concentrate would most certainly have negative consequences, as compared to the small possibility that he would get AIDS.

In 1986 John was tested and learned he was infected with HIV. Susan was tested as well, and she was not infected. Thus, they learned they were a “serodiscordant couple,” and they were advised to practice safer sex by using condoms. They had many reactions: shock, disbelief, and fear about his diagnosis; different coping styles that sometimes clashed; fear of John’s dying; fear of giving or getting the virus; anger at the doctors and the government; confusion, distrust, resentment, and discomfort about having to use condoms, when they had no experience using them and had no
need for birth control. This was not a simple safer-sex crisis. A multitude of emotional, psychological, and social reactions to the infection and the threat of disease all combined with the need to change their sexual behavior, draining them of their coping abilities.

John heard from other men with hemophilia that HIV was rarely transmitted in heterosexual couples. Susan was told by her physician that if they avoided anal intercourse, they would have nothing to worry about. They tried to use condoms occasionally but felt that it interrupted the spontaneity of lovemaking and served as a reminder of his illness, robbing them of romance. They didn’t always have condoms when they needed them and would usually just skip them entirely if they had had anything to drink. After a while, they found they were having sex less often and feeling less emotional intimacy, as well. Neither one could talk about his or her fears, out of concern of upsetting the other. Their families and friends did not know about John’s HIV infection, so there was no one else with whom to talk. Susan became depressed; John became angry and estranged. The children had no idea what was happening but knew that there was a great deal of tension and unhappiness in the home. They worried that their parents might divorce.

I first met John and Susan at the hemophilia treatment center where I had been hired as a psychologist focusing on risk-reduction counseling. They arrived for their first appointment, a part of John’s annual evaluation for his hemophilia, with many questions, much anxiety, and considerable embarrassment about addressing such a personal area. My role was to provide a secondary prevention intervention, but clearly this would be a complex task.

As a risk-reduction counselor and psychologist, I need to be concerned with all aspects of the patient’s and the partner’s functioning — physical, emotional, and social — and acutely aware of the interplay of each of these with relationship dynamics and sexual behavior. This vignette portrays some of the array of issues that may be present in people who are facing the potential for transmitting HIV from one partner to the other and the demands placed upon the counseling task.

**Background Reading**

If public health efforts for reducing the risk of transmission of HIV were to be concentrated where they would have the most potential for positive effect, it would make sense to start with those people currently in a
position to directly affect transmission: the people with HIV themselves and their sexual partners (Wenger, Kusseling, Beck, & Shapiro, 1994). HIV infection does not preclude sexuality and sexual behavior. Many HIV-positive people continue to have sex, and those uninvolved may seek romantic relationships, although their attitudes about relationships and condoms may vary (Norman, Parish, & Kennedy, 1995). It is not known how often HIV-infected people put someone else at risk, although studies have indicated that up to 40 percent might have unprotected sex after notification of their positive HIV serostatus (Parish, Mandel, Thomas, & Gomperts, 1989; Wenger et al., 1994; Wiley, Hannan, Barrett, & Evatt, 1994). In men with hemophilia, a heterosexual population with a high rate of HIV infection, approximately 10.6 percent of the female sexual partners are known to be HIV-infected as well (Wiley, Hannan, Barrett, & Evatt, 1994).

Surprisingly, though, most of the literature on HIV risk reduction deals with primary prevention, defined as working with uninfected persons, and sometimes with populations that face only minimal risk, such as college students, but which are more accessible for study. In an extensive review of HIV prevention literature, Choi and Coates (1994) identified very few studies dealing with secondary prevention, defined as working with infected persons, and those studies involved primarily discordant heterosexual couples. By a large margin, primary prevention is emphasized in intervention planning and evaluation, focusing on self-interest as a motivator.

Furthermore, even those writings that deal with the health needs and the medical treatment of people who are infected with HIV pay minimal or no attention to prevention of HIV transmission. If anything about transmission is noted, the focus is on transmission rates and predisposing factors for unsafe sex, rather than on interventions (Sherr, 1993). Risk-reduction programs for secondary prevention belong directly in primary-care clinics caring for HIV-positive patients (Wenger et al., 1994), combining state of the art treatment and behavioral approaches (Francis et al., 1989).

Perhaps there is an assumption that without a self-protective motive it would be difficult to persuade people to change their sexual behavior. Indeed, the motivation in the case of people who already have HIV infection needs to be altruistic: to protect someone else by giving up something valuable (unprotected sex). Probably there exists some doubt that people would be that altruistic, that they would care about their
partners’ safety more than their own basic gratification. Sometimes, the partners themselves might not be cooperative, believing that it is their fate to take the risk and perhaps to die along with their mates, in a Romeo-and-Juliet scenario. Unfortunately, the timing rarely works out that way when a partner becomes infected, and regrets, remorse, guilt, and anger are more likely outcomes.

Some believe that the sex drive is so strong, the sense of altruism so remote, and the behavior change to abstinence or safer sex so complex and difficult that there is no way to stop transmission once one partner in a couple has HIV, and thus there is little point in trying. At least some of the time, perhaps much of the time, people with HIV do care to keep their partners from getting the virus that infects them. It is true that it is difficult to change sexual behavior, because the activity of unsafe sex is highly reinforcing, strongly motivated, and often well established (Kelly, 1991). As with any other behavior change goal, however, people are more likely to practice safer sex when they believe the recommended means to be efficacious (that condoms really do work to prevent HIV transmission) (Centers for Disease Control, 1993; Feldblum, 1991); when they believe that they are self-efficacious and possess the necessary skills (that they are capable of negotiating and using condoms consistently) (Kelly, 1991); and when they believe that there are strong advantages to using condoms (such as making sex safe and removing fear). Couple counseling with serodiscordant couples has been shown to be effective in changing sexual behavior (Kamenga et al., 1990; Padian, O’Brien, Chang, Glass, & Francis, 1993). Simply notifying people of their HIV status, however, is not adequate intervention. After a group of blood donors were notified of their positive serostatus, more than one third still engaged in unsafe sex (Cleary et al., 1991).

In dealing with the epidemic of this disease, secondary prevention is critical. Sexual partners of people with HIV are the most at risk, and they should be the primary targets of risk-reduction efforts, since such interventions are likely to have the most directed impact. Furthermore, secondary prevention with women with HIV or female partners of men with HIV involves intervening to reduce the risk of HIV transmission perinatally to offspring, by means of informed decision making about getting pregnant, carrying a baby to term, accepting medical treatment, and declining to breast-feed (Benson & Shannon, 1995; Kurth, 1995).

Efforts at secondary prevention that are reported in the literature include several populations and approaches. In studying HIV-positive
women and childbearing decisions, Kline and VanLandingham (1994) noted that partner-related factors, such as whether a partner is seronegative, whether the woman has a sense of power in the relationship, and whether there are conflicts between the woman and her partner, were important for HIV-positive women in determining their approach to safer sex and childbearing decision making. Another study found that after HIV testing, those women who were HIV-positive demonstrated a considerable decline in their desire for pregnancy and an increase in their use of condoms, but only to 54 percent (Lai, 1994). The author cited the need for adequate counseling, beyond disclosure of serostatus, to help bring about critical behavior changes.

The sexual practices of persons with hemophilia and HIV were described and the potential for heterosexual transmission was raised as a concern by Lawrence and colleagues (1989), but their recommendation that female partners should be sure to abstain or change their sexual behavior suggests a lack of appreciation for the role played by gender power differences within relationships.

There appears to be an important link between safer sex and communication, which has important bearing on secondary prevention. HIV-positive persons having unprotected sex with partners at risk for HIV transmission often relate discomfort in discussing HIV with others (Wenger et al., 1994). Sexual partners are often unaware of the other person's HIV infection (Marks, Richardson, & Maldonado, 1991; Wenger et al., 1994). Marks and colleagues (1991) state that people who are HIV-positive and who have sex have a social and legal responsibility to disclose their infection to their partners, or else there is increased potential for transmission and infecting others. In one study, HIV-infected women stated that ethical responsibility and concern for partners' health led to disclosure to partners and that a desire for support was the reason for disclosing to family and friends (Simoni et al., 1995). Cultural factors also influence rates of disclosure; the same study found lower rates of disclosure among Spanish-speaking Latinas than among English-speaking Latinas, African Americans, and Anglo Americans. Catania et al. (1992), in a study of 1,229 San Francisco households, found a correlation between sexual communication and condom use across gender and sexual orientation and concluded that condom promotion programs should build sexual communication skills. Discussion of safer sex by an HIV-infected person with a partner was the strongest predictor of consistent condom use in a study of 351 adults with hemophilia, supporting the conclusion that
sexual communication is a key factor in risk reduction (Parish, Mandel, Thomas, & Gomperts, 1989). In one study, repeated counseling was shown to lead to increased disclosure of serostatus to partners of HIV-positive adults, and perceived social support further predicted self-disclosure (Perry et al., 1994). However, one third of the sexually active subjects still did not disclose their HIV infection to any current sex partner after counseling, although very few reported unsafe sex. Thus, self-disclosure and safer sex may be related in some cases, but not necessarily in all.

My Clinical Work

At Huntington Hospital Hemophilia Center in Pasadena, California, my work as a psychologist has involved clinical practice and clinical intervention research in secondary prevention of HIV transmission. The patient population comprises people with hemophilia and related bleeding disorders, most of whom are followed on a lifelong regular basis for comprehensive medical and psychosocial care by hemophilia treatment centers. Hemophilia is a genetic blood-clotting disorder affecting all racial, cultural, and socioeconomic groups and thus creating a community otherwise representative of the general population.

By the mid-1980s it became clear that the agent causing AIDS was linked to blood and that people with hemophilia were infected in large numbers. Approximately 70 percent of people with hemophilia, including 90 percent of severe factor VIII deficiency, the most common type of hemophilia, were infected before the pooled blood product used in their treatment could be produced safely (Gomperts, 1990). In 1986 the U.S. Maternal and Child Health Bureau and the Centers for Disease Control stepped in with programming and funding to provide psychosocial support and risk reduction, spurred on by the potential for a second wave of the epidemic that would involve sexual partners and their newborns. Even before this point, however, hemophilia treatment centers had begun to encourage safer sex practices among their patients (Mason, Olson, & Parish, 1988).

At Huntington Hospital Hemophilia Center, a risk-reduction clinical model was developed that would provide a separate risk-reduction session for patients during their annual comprehensive evaluations, in addition to social work, nursing, and physician meetings, to which partners are invited as well. As part of the risk-reduction services, we offer free confiden-
tial or anonymous testing for partners; free condoms and safer sex literature; counseling for adolescents as a frank and routine part of their medical care; and separate counseling for partners or for parents of adolescents, as requested. The risk-reduction sessions for children are designed to make it comfortable to address any questions about HIV, hemophilia, or sexuality and to promote communication skills and self-esteem as a foundation for later dealing with safer sex.

Our center is also participating as a site for the adult Hemophilia Behavioral Intervention Evaluation Project, in collaboration with the Centers for Disease Control and Prevention and five other national sites. This project involves developing and piloting an individualized intervention to reduce HIV transmission between men with HIV and hemophilia and their female partners. The intervention makes use of a stage-based behavioral approach, developed from the Transtheoretical Model of Behavior Change (Prochaska, DiClemente, & Norcross, 1992), in which sexual behavior change is conceptualized as a process through stages, each approached with different strategies. The intervention that was developed for this project is designed to enhance communication skills and was offered to participants either individually or in group retreat settings. The interventions were very well received by participants, and components of this stage-based, communication skills approach may be valuable in secondary prevention with other populations, as well.

Several tenets emerge as important in HIV transmission prevention counseling for people who are HIV-infected and their sexual partners. First is the belief that people with HIV, like anyone else, need and deserve to have closeness, caring, and connectedness in their lives. It is normal and healthy to seek sexual expression and intimacy. Becoming sexually involved when an individual has HIV does, however, raise some unique issues. These issues include disclosing HIV status to a partner, communicating feelings and concerns about sexuality, and negotiating and making decisions about having safe and healthy sex. Effective HIV safer-sex counseling, then, is best delivered in a trusting relationship, in which information about reducing the risk of transmission is offered thoroughly and sensitively and with respect for the needs, problems, and cultural context of the individual or couple being counseled. Safer-sex counseling is best offered in the context of supporting people in dealing with HIV, and with life in general, in a broad, whole-person perspective. It deals with both sexuality and loss. It requires that the counselor be self-aware of values, beliefs, and feelings elicited by the work, especially about sexuality,
illness, and death, and be willing to deal with these honestly and to get help when needed.

**Barriers to Effective Secondary Prevention**

The barriers to effective secondary prevention of HIV transmission are many but fall into categories: those arising from the HIV-infected persons, from the partners, from the culture/social system, and from the counselor or agency. The case study about John and Susan at the beginning of the chapter demonstrates a few of the barriers.

- One barrier is a sense of unfairness. John and Susan had already been faced with one illness and had managed that one, and they had taken other measures to avoid pregnancy—a vasectomy—and figured that they wouldn't have to deal with birth control (i.e., condoms) again. For others, the problem is that they still wish to have children, and their goals for safety and pregnancy conflict; actually, in the first years of safer-sex recommendations, the birth rate among people with hemophilia increased. These issues involve losses and resentments that, unresolved, stand in the way of making healthy behavioral choices and changes.

- John and Susan had never used condoms before, having relied on birth control pills and the diaphragm, as did most of their contemporaries, so condom use presented a further barrier, the need to learn a new behavior. Their negative feelings about condoms and their failure to keep them always available stood in the way of using them all the time. It is often the case that use of alcohol or drugs reduces the likelihood of condom use, too.

- At first, John's doctor was reluctant to have him tested for HIV, because he felt that it would upset him beyond his coping abilities and because there was no treatment to offer. Years later, this reluctance is less common, but many HIV-infected people say that they began to practice safer sex consistently only after receiving their test results. Thus, any barrier to testing—attitudes, fears, stigma, or practical matters of cost, access, or confidentiality—has the potential to impede safer sex.

- Lack of accurate information, or misinformation, represents another barrier to secondary prevention. John and Susan had both been given inaccurate information from lay and professional peo-
people, giving them a false sense of security about having unprotected sex.

- John and Susan’s decision not to disclose John’s HIV infection to family and friends left them isolated and growing apart from each other. Many people make the decision to keep HIV a secret because they fear rejection and discrimination, having heard of people forced out of school or work or burned out of their house. Not only does secrecy cut people off from receiving the support of others; it impedes a self-acceptance that is a critical part of the process of behavior change and the decision to protect a partner or oneself.

- Sometimes, partners know little or nothing about the risk they face, and not being able to talk with a partner directly is a barrier for the counselor. When the partner is not informed, he or she cannot share the responsibility for safer sex. Other times, a partner knows of the HIV infection but takes the position that “if he goes, I might as well go, too,” something of a Romeo and Juliet theme. Such situations suggest an overuse of denial. At the same time, it is important to note that denial is often encouraged and reinforced among people dealing with chronic disease: Such behavior is seen as brave or stoic. It shouldn’t be surprising that denial is so widely employed, especially by people with lifelong chronic illness, such as hemophilia.

- Some messages about safer sex conflict with some religions, social behavior in some groups, and values held by people of various ages, races, or political beliefs. The relative lack of power held by women in many relationships stands in the way of their asserting their right to refuse unsafe sex or to insist on condoms.

- Sex is considered a highly private, sensitive area of most people’s lives, and reactions to discussions of safer sex may range from being uncomfortable to being insulted to being completely unwilling to discuss the subject with a counselor or any health care provider. Professionals themselves may feel embarrassed, unskilled, or intrusive about opening up sexual issues and may avoid the topic or communicate their wish to end the conversation quickly.

- Illness symptoms can get in the way of secondary prevention. Dementia, fatigue, distorted thinking, reduced capacity to reason or problem-solve, and suspicion can manifest with HIV/AIDS,
and each of these problems makes it difficult for a person to understand, decide, make changes, and trust. People with HIV infection and their partners experience behavioral and physical barriers to using condoms: discomfort, loss of sensation, outright dislike, loss of spontaneity, and allergic sensitivity to latex or lubricants. On a more subtle plane, clients tell us that talking about and practicing safer sex can serve as painful reminders of the disease, thereby taking away a sense of pleasure and intimacy in sex, or lead to negative emotional reactions in one's partner, creating powerful emotional barriers (Parish, Cotton, Huszti, & Parsons, 1993).

Tools for Clinical Practice

The following are important points to consider in risk-reduction counseling:

- *Risk-reduction sessions must be tailored to the client and carefully planned from a menu of topics, and they should include a risk-reduction plan.*

  The following topics are typically covered during a risk-reduction session. Not all topics are relevant for each person, and not all are covered each time. Also, the order of presentation will vary. The counselor can make an attempt to assess which of these are important for the patient and the situation and focus on these topics first.

  — Sexual history. The meaning of sexuality in the person's life is explored, as well as sexual activity in the past year and before. Changes in sexual behavior, interest, and attitudes are assessed. Beyond these basics, it is also important to ask about how illness and disability affect sexuality and sexual self-image for the patient and the partner, keeping in mind that sexual development continues through the lifespan, not only in adolescence.

  — Update of current information about reducing the risk of sexual transmission. Use and efficacy of condoms is reviewed. Condom breakage or other problems are assessed, and suggestions are discussed to address these. Choice of condom type/brands, other contraceptives, female condoms, and allergies or
sensitivities are discussed. Information about other STDs and protection from and treatment for these is presented.

— Deciding on a risk-reduction plan. In this area, the health care provider covers various sexual practices and how to evaluate risks and protect against transmission. The discussion also includes an exploration of communication and negotiation with the sexual partner and elicits issues and concerns or problems in talking about and practicing safer sex with that partner. The counselor can suggest strategies to support behavior change and to avoid "relapse" to unsafe sexual behavior.

— Building and enhancing a safer-sex repertoire. Sexual practices other than penetrative intercourse can be explored, evaluating risk in each case. The idea is to promote thinking about and experiencing sex and intimacy creatively. For those clients who no longer have sex, or who have it less often than they wish, discussion may be opened about any desire to restore sexual activity and to increase intimacy and sexual satisfaction while still protecting one’s partner from transmission.

— Casual transmission. Equal in importance to discussion about how HIV is transmitted is discussion about how it is not transmitted. It is important to explore for myths and unsubstantiated concerns that are hampering an individual’s behavior towards others, participation in routine activities, or positive self-image. At the same time, routine household blood safety precautions and feelings and behaviors about these practices are reviewed.

— Relationships with partners. This area includes a broader discussion about needs for intimacy and how to meet them. Single patients may want to talk about their concerns regarding dating, getting involved, and coping with loneliness, and patients with partners may have concerns about relationship satisfaction and maintaining intimacy in a healthy relationship.

— Partner testing. The importance and purpose of repeated HIV testing for partners is presented. It is also important to cover the meaning of test results and any difficulties or barriers to testing, ranging from access to attitudes. Former partners may need to be notified about their possible risk, and patients may need assistance in getting word to them and encouraging them to be tested.
— Communicating with the partner. Here, the patient’s experience in talking with a partner about safer sex and his or her ability to do so is assessed. This kind of communication involves an open sharing of needs, feelings, and problems. Communication skills, including problem-solving and assertiveness skills, can be taught and encouraged. For those people without partners, the most essential communication task is the disclosure of one’s HIV status to a new partner. This disclosure can be discussed, planned, and practiced with a supportive provider.

— Communicating with others. Closely tied to communication with partners are issues about disclosing HIV status to family members and to support systems, along with concerns about discrimination, stigma, and rejection. For those patients with children, there is a unique need to determine if, when, and how to talk with them about a parent’s HIV disease.

— Having children. The desire to have children, the decisions that are facing couples, and the feelings involved are discussed. Risks of transmission to mother and offspring are presented, and options (including donor insemination, adoption, involvement with the children of others, and methods to reduce risk in conceiving) and the pros and cons of each are explored. For those who have put aside plans to have children, support is offered for dealing with feelings about not having one’s own children.

— Coping. The patient’s overall well-being, ability to function emotionally and socially, and ability to cope with hemophilia and HIV within his or her life circumstances are assessed. Coping strategies and mechanisms that work or backfire are explored, and together the patient and health care provider problem-solve for responses to some of the challenges. This area is closely tied to safer sex, as a person’s ability to cope in general with life demands highly influences his or her ability to maintain relationships and safer-sex practices.

— Loss and grieving. The patient with HIV faces multiple losses in functioning, opportunities, dreams, and intentions, as well as in physical health and anticipated life span, and the counselor needs to become aware of and to acknowledge these losses. Assistance is offered in understanding and addressing
the needs of other family members. Support is offered for grieving what is lost in relationships and sexuality, in particular, as an essential step before a person can move on to live fully within the limits imposed by HIV infection.

• To be effective in secondary prevention, the counselor is advised to begin with the client’s agenda.

Although you may want to move into talking about safer sex right away, this may not be where the client’s attention is directed. Since the focus of these interventions is on relationships, it is important to establish one with the client that communicates respect and interest in the client’s needs and issues.

• Keep a broad perspective.

Sex, and safer sex, are integral parts of a person’s life, connected to needs and relationships in more general terms—intimacy and loneliness, physical and emotional well-being, self-image and self-esteem, personal strength, child-bearing, and hope for the future.

• Deal with coping with HIV as well.

HIV and safer sex are fairly inseparable. Each serves as a reminder to the person of the other. Learning to live with HIV helps make safer sex possible. It’s about multiple losses: As more and more aspects, capabilities, and dreams are lost, the sense of loss can be overwhelming, and having to give up freedom in expressing sexuality can feel like the last, impossible straw.

• Deal with grief.

All the multiple losses add up to having one’s usual life die off, one or a few pieces at a time. In sexuality, there is grief over what is no longer safely or physically possible: sex without condoms, sex with health and vigor, sex without fatigue and pain, sex to conceive a child. To resolve these losses, it is necessary to mourn, to feel sorrow and other grieving feelings, before a person can move on and look to live life and experience sexuality or intimacy differently. (See chapter 5.)

• Address fears.

It is important to discuss fears, founded or not. Some people are so afraid of transmitting the virus that they avoid even casual contact with others. Clearly, they need a different message from those who don’t appear to care about unprotected sex. Single
people with HIV infection may fear getting involved and being rejected. Once in a relationship, some individuals fear becoming dependent on a partner or caring so much that dying is made more painful. Fears about getting sick and dying get involved in sexual behavior, along with fear that those events will adversely affect the people for whom they care. In working through a person’s fears, listening with empathy and concern is much more helpful than advice and halfhearted solutions. Counseling can provide a precious opportunity to talk, to be acknowledged, to be listened to, about the most taboo issues in our culture—sex and death.

• **Talk about disclosure of HIV serostatus to partners and others.**

Disclosure of one’s HIV infection can mark the beginning of working together on risk reduction, but it is fraught with risk of rejection. As a relationship grows, disclosure becomes ever more difficult, especially if sex, even protected, has occurred without the partner’s being aware that he or she faces HIV risk. Exploring the options, working on different ways of presenting the information, and practicing with a counselor and feeling supported in taking on a difficult task can help a client sort out the pros and cons of disclosing.

• **Consider facilitating networking or group support.**

It is believed that people who have social support are more likely to maintain safer sex behavior, perhaps mediated by increased self-esteem. HIV is a tremendously isolating disease, and even after committing to practice safer sex, HIV-infected people may need social support to help maintain the new behavior. Support groups and retreats for people with HIV and even newsletters and Internet chats can provide an important sense of connection.

• **Encourage empathy, sexual assertiveness, and communication skills.**

For people with HIV infection, the motive for HIV-transmission prevention has to be altruistic, rather than self-protective or overtly self-beneficial. Exploring questions such as, “How would you feel if someone were carrying an infection that could be devastating to you and didn’t tell you?” and role-playing the role of a partner are possible means of facilitating an altruistic response. For HIV-infected individuals as well as their partners, the ability to say no to unsafe sex and to communicate what they can
feel comfortable with are important communication skills that a counselor can help develop.

- **Individualize the intervention, taking into consideration the person's readiness to change.**

  For people who are not yet ready to make a change to safer sex, raising their consciousness about the importance of protection and exploring with them the pros and cons of safer sex will likely prove helpful. For people who have been using condoms faithfully for months or years but who don't want to risk relapsing, however, these approaches will likely hold little value, compared to evaluating interpersonal and intrapersonal mechanisms to make maintenance of the behavior easier.

- **Welcome further questions; admit what you don't know; develop resources to get answers for clients.**

  It is of no help to clients to give information about which you're unsure, especially when the consequences of misinformation can be so serious. It is a better idea to work hard to learn and keep up with developments and to be honest about what you don't know and then offer to get answers and get back to the client. There are many resources for up-to-date information, including AIDS projects, the National AIDS Clearinghouse, the Centers for Disease Control, newsletters, and researchers, and every counselor can develop the resources needed to get information (see appendix B).

  Many times as a counselor doing secondary prevention work, you can be left feeling that there is much more to cover, more that needs to be imparted, more that needs to be changed. It's far better to create or build on a good working relationship with a client who will be willing to return, however, than to overwhelm or fail to establish adequate rapport with the client and never have another chance to talk. Sometimes, it is possible only to plant a seed, to lay a groundwork for the next step.

To follow these recommendations for secondary prevention, the counselor must work at self-awareness and the processing of feelings, reactions, and values that are regularly churned up in this work. She or he must work to enhance and expand communication, relating, and counseling skills, to reach out creatively to varied people with many needs, and to be nonjudgmental and empathic. Finally, the counselor should consider
the impact she or he can have not only on an individual but on a partner, a couple, a family, a network, a community, as well as on society and on institutional and governmental entities, in facilitating understanding, sensitivity, and changes that create a supportive climate for the prevention of further HIV transmission.

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