TRAINER'S GUIDE

Training in Basic Counseling Methods for Family Case Managers

A short course in the fundamentals of home-based counseling for those who provide care to children and families living with and affected by HIV

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Foreword

According to the recent estimates by India's National AIDS Control Organization (NACO), of the 2.3 million people in India who are living with HIV, 94,000 are children[1]. UNICEF estimates that there could be about 4 million children affected by HIV in India, located mostly in the high HIV-burden states of south and northeast India[2]. UNICEF also reports that without treatment, newborn children in India stand an estimated 30% chance of becoming infected with HIV[3]. These children face countless challenges, which become more daunting in the presence of poor socio-economic conditions, stigma and discrimination.

Balasahyoga meaning "active support to the child" is the name of one of FHI 360's flagship programs in India. This five-year collaborative initiative, which began in April 2007, has successfully addressed the comprehensive care, support and treatment needs and vulnerabilities of many children and their families who are affected by HIV. Balasahyoga has yielded significant lessons for FHI 360 and our consortium partners – the William J. Clinton Foundation and CARE International. In particular, it has added to our understanding of the wide-ranging and complex psychosocial issues involved in helping children and their families in community and facility settings. When capacity building and technical resources emerged as critical needs to facilitate child-focused counseling in both settings, Balasahyoga responded by offering a series of trainings on these issues.

This manual compiles over four years of experience in home-based counseling of families and others who provide care for children affected by HIV and AIDS. The manual will be useful for trainers to orient outreach workers, facility staff and the staff of non-governmental organizations on the conceptual and practical dimensions of counseling children and their caregivers on issues related to HIV. The manual also provides guidance on quality control mechanisms and documentation processes that users should follow to counsel children more effectively.

I hope this manual enhances the ability of frontline workers in the larger health and development sector to support the children and families that they serve.

Bitra George

Country Director
FHI 360/India

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[1]UNGASS Country Progress Report 2008, India

[2]India Failing Children Orphaned by AIDS The Lancet, Volume 375, Issue 9712, Pages 363 - 364, 30 January 2010

[3]UNICEF INDIA HIVV/AIDS - FAST FACTS http://www.unicef.org/india/hiv_aids.html

Preface

Our experience since 2007 of working with children and families under the auspices of the Balasahyoga program highlights the profound need for psychosocial interventions – particularly child-focused counseling. Our experience also shows that the quality of counseling that family case managers, community volunteers and other outreach workers are able to provide is important. Effective counseling enables households to cope with members who are HIV-positive: to plan for the future, support adherence to treatment regimens and sustain the well-being of those who are living with HIV.

Children from families affected by HIV are marginalized by stigma and discrimination and, often, by poverty. A comprehensive care, support and treatment program should include counseling to address these vulnerabilities. To meet the psychosocial needs of children and families affected by HIV, outreach staff require training in child-focused counseling.

All these lessons have driven us to develop and publish this counseling manual. We designed it to enable the outreach staff of any HIV care and support program to provide the best possible counseling services for children and their families.

The manual contains the comprehensive modules that we used to train the Balasahyoga family case managers and community volunteers in the fundamentals of HIV counseling, care and support. We prepared it in consultation with Balasahyoga program partners, outreach workers, and experts on counseling and on the special needs of children and adults affected by and living with HIV and AIDS.

I sincerely hope that this important resource benefits other development organizations that are managing programs for children and their caregivers.

K. N. Pradeep

Strategic Director
Balasahyoga

Introduction

FHI 360, Clinton Health Access Initive (CHAI) Foundation and CARE India have been implementing the *Balasahyoga* program in 11 districts of Andhra Pradesh since 2007. Balasahyoga is a Hindi word that means "active support to the child." The program takes a family-focused approach to help children who are living with and affected by HIV. Balasahyoga assigns each family a case manager, who ensures that needs are addressed comprehensively, enabling all to lead better lives.

Balasahyoga developed this curriculum to train its case managers to provide effective psychosocial support to their assigned families through counseling. More than 300 Balasahyoga family case managers, 600 community volunteers, and 67 staff members have been trained, and the modules have evolved in response to their feedback.

The curriculum offered here orients users to the principles of basic counseling and to the process of counseling children and adults on HIV-related issues. It also explains how to ensure a high quality of counseling services through supervision and documentation. It will enable the outreach staff, and especially family case managers, in any HIV care and support program to provide the best possible home-based counseling services to children and their families.

The curriculum is interactive and participatory. Its modules consist of discrete, numbered sessions. Each session has the following sequence:

- learning objectives
- time needed
- session overview
- presentation of the activity, with instructions for the trainer on the preparation, material and training methods that will be needed

A supplement to this manual contains handouts for participants and tools for trainers – case studies, answer keys, and information needed for a particular game or activity.

Participants who complete this training should be able to

- conduct an effective counseling session with clients during a home visit
- communicate effectively with children at different stages of development who are affected by HIV
- conduct documentation and supervision to ensure counseling of high quality
- manage the stress and burnout that can arise in HIV counseling

Notes for Trainers

Using This Manual

This manual is designed to train outreach workers, whose experience and degree of literacy can vary greatly. As the trainer, you must be aware of this and adapt the curriculum as needed. You can change activities that require writing or reading, for example, to require drawing or speaking, instead. Where the manual calls for a participant to read a case study aloud to the group, you can read it to them. Instead of writing words on a flip chart, you (or the participants) can draw pictures.

The manual allows participants to build their knowledge and skills from session to session. Any gaps in a participant's understanding of the material in one session should emerge so you can address them in a later session. This manual is also flexible. Sessions can be put together for a shorter course that responds to the needs of a particular setting. Well before a training begins, you should gather the materials for all of the sessions to be presented and make them available to participants in the training venue.

Training Philosophy

This curriculum is based on adult learning principles and intended to be participatory. Students come with experiences and ideas that you should build on during training. Training techniques that are practical and fun encourage people to share their thoughts and ideas freely. Keep students focused on learning by doing.

Training Methodology

This training uses a variety of teaching methods. Some may be new to you. The curriculum offers guidelines for using these methods. Detailed instructions accompany each activity.

Do's and Don'ts for Trainers

Keep the following do's and don'ts in mind during every session:

Do:

- Come to the training prepared to conduct an interesting and lively presentation.
- Speak to the group, not at them.
- Speak clearly, simply and audibly.
- Maintain eye contact with participants.
- Pay attention to the participants' body language and respond appropriately.
- Gesture and move around the room as a way to hold the participants' interest.

- Use visual aids, placed where everyone can see them.
- Write (or draw) clearly and simply, making marks that are big and bold enough to be legible.
- Prompt the participants to apply what they are learning to their own experiences.
- Encourage questions and other forms of participation.
- Ask questions to make sure the participants understand the material you are presenting.
- Summarize key points frequently, and always at the end of a session.
- Explain how each topic connects logically to the next.
- Keep the group on schedule and on task.
- Be alert to distractions in the room and handle them promptly.
- Give and request feedback on how the sessions are going.
- Be patient.

Don't:

- Talk to the flip chart.
- Block the participants' view of the visual aids.
- Stand in one spot.
- Ignore the participants' feedback, whether verbal or nonverbal.
- Assume that everyone has the same reading ability.
- Read endlessly from the module without explaining and elaborating in your own words.
- Shout at the participants.

Learning Methods Used

Trainer presentation

Although every trainer has his or her own style, observing the do's and don'ts listed above will help to keep participants engaged.

No matter how dynamic a trainer's style, lecturing keeps the participants in a passive role. To promote active learning, you should try to do as little of the talking as possible in favor of more participatory teaching methods. Examples of these methods follow.

Large- and small-group discussions

For large-group discussions to be successful, you should control the conversation and lead it in a structured, purposeful way to achieve clear aims.

When participants break out into small groups to discuss a topic informally, you will be equally responsible for establishing expected outcomes and ensuring that each group makes the most of its time to achieve those outcomes.

If you expect the small groups to present their findings, you should let them know in advance, make sure that each group has writing material for note-taking, and allow enough time for the groups to talk among themselves and then to make their presentations. (Bear in mind that discussion requires a lot of time to be effective.) The groups may be more efficient if you ask for volunteers or assign people to lead the group, take notes, and present the group's conclusions.

Group work

Assigning specific tasks for small groups to accomplish independently can save time, teach group members to make decisions collectively, and reinforce a spirit of teamwork. This strategy can be used to address several topics or issues at once or to elicit multiple points of view on a single topic.

Support the groups by explaining their assignments and objectives clearly before they begin and by giving them enough time to finish. Stay alert to group dynamics and be prepared to help a group cope with a member who is dominating or argumentative.

Demonstrations and return demonstrations

This reciprocal learning method is especially useful to teach skills. It entails the following activities:

- Post a list, in correct sequence, of the steps you will take to demonstrate the skill.
- Make sure that all participants can see and hear you.
- Explain what you will demonstrate.
- Explain each step as you perform it.
- Summarize what you have done.
- Ask one or more participants to conduct the same demonstration that is, a "return demonstration."
- As participants practice the skill, observe and guide them, as needed.

Role-playing

Role-playing is a way for people to acquire and practice skills and adopt new attitudes. Role-playing allows for supervised skill practice when a real learning situation is not possible. It is a particularly good method for participants to practice counseling or teaching skills.

You can either assign roles or ask participants to volunteer. A role-playing exercise should not exceed 20 minutes. Role-playing, like other learning methods, requires clearly defined objectives. Prompt the actors by describing the characters they will play.

You should be ready with questions for discussion after the exercise. What happens after a role-playing exercise is as valuable as the exercise itself. Encourage the participants who observe to give the actors constructive feedback, focusing first on what the actors did well and then suggesting areas for improvement. Instruct the observers to confine their comments to the actors' performance and not their personal characteristics. For example, if an actor's body language was not welcoming, an observer should say something like, "You asked the right questions. Next time it would be better if you make eye contact with the client and avoid taking notes while the client is talking."

Case studies

A case study presents either a true situation or a believable one to participants as an opportunity for them to recognize, analyze and solve problems. Case studies are an excellent way for participants to build on their knowledge and give it practical application.

You should introduce a case study with a clear learning objective in mind, offering such relevant information as descriptions of the setting and the people involved, the events that occurred, and any socioeconomic factors. Next, identify the problem to be solved, pose three or four questions for participants to discuss, and call on the participants to reach consensus on one solution.

Brainstorming

Brainstorming is an excellent technique when you have limited time and want the participants to explore many possible answers. Brainstorming can be done in large or small groups.

Begin by asking an open-ended question and inviting participants to suggest as many answers as they can. The idea is for participants to explore them all, thinking openly about an issue without feeling pressed to come to agreement. The suggestions should be recorded as they are proposed, in a place where everyone can see them. Near the end of the session, review the list with the group, identifying answers that seem most appropriate. By asking participants why a particular answer may not be the best, you will have a chance to correct misinformation.

Questions and answers

This method allows a trainer to evaluate the participants' knowledge about a subject. It can be a good way to review material that you have presented and expect the participants to know. There are two types of questions: memory questions, which ask participants to recall information, and thought questions, which ask participants to apply what they have learned. Questions should elicit reasoning

rather than simple statements of fact, be clearly worded, and contain one idea.

Keep the following precepts in mind:

- Address the whole class but direct each question to a specific person.
- Give the respondent enough time to answer.
- If a question needs to be repeated, find another way of stating it that may be clearer.
- Give credit for correct answers.
- Encourage participants to ask questions.
- Encourage participants to disagree with someone's answer, so long as they debate it with reason and logic.

Games

Games introduce competition and can provide a break from standard training exercises. Some games require the trainees to move around the room, renewing their energy and alertness.

Sample Training Schedule

Day 1		
Time	**Topic**	**Duration**
09:30 – 10:30	Session 1: Registration, introduction and ground rules	1 hour
10:30 – 10:45	Tea break	15 minutes
10:45 – 12:15	Session 2: Introduction to counseling	1½ hours
12:15 – 1:15	Session 3: Counseling skills	1 hour and 40 minutes
1:15 – 2:00	Lunch	45 minutes
2:00 – 2:40	Session 3 (continued): Counseling skills	
2:40 – 3:00	Energizing activity	20 minutes
3:00 – 4:20	Session 4: Phases of the counseling process	1 hour and 20 minutes
4:20 – 4:30	Tea break	10 minutes
4:30 – 5:30	Session 5: Ethics in counseling	1 hour
5:30	Adjourn	
Day 2		
9:00 – 9:30	Recap	30 minutes
9:30 – 10:30	Session 6: Aligning counseling with a child's developmental stage	1 hour
10:30 – 11:30	Session 7: Using interactive communication strategies with children	2 hours
11:30 – 11:45	Tea break	15 minutes
11:45 – 12:45	Session 7 (continued): Using interactive communication strategies with children	

Day 2		
Time	**Topic**	**Duration**
12:45 – 1:15	Session 8: Addressing the special counseling needs of children	3 hours
1:15 – 2:00	Lunch break	45 minutes
2:00 – 4:30	Session 8 (continued): Addressing the special counseling needs of children	
4:30 – 4 :45	Tea break	15 minutes
4:45 – 5:45	Session 9: Developing a memory book	1 hour
5:45	Adjourn	
Day 3		
9:00 – 11:00	Session 10: Addressing the special counseling needs of adults	2 hours
11:00 – 11:15	Tea break	15 minutes
11:15 – 12:15	Session 11: Documenting the counseling process	1 hour
12:15 – 1:15	Lunch break	45 minutes
1:15 – 1:30	Energizing activity	15 minutes
1:30 – 2:30	Session 12: Supervising the counselor	1 hour
2:30 – 3:30	Session 13: Managing stress and burnout	1 hour
3:30 – 3:45	Tea break	15 minutes
3:45 – 4:15	Preparation for Session 14: Learning by doing	30 minutes
4:15	Adjourn	

Day 4		
Time	**Topic**	**Duration**
9:00 – 11:00	Session 14: Learning by doing	5 hours
11:00 – 11:15	Tea break	15 minutes
11:15 – 1:15	Session 14 (continued): Learning by doing	
1:15 – 2:00	Lunch break	45 minutes
2:00 – 3:00	Session 14 (continued): Learning by doing	
3:00 – 3:15	Tea break	15 minutes
3:15 – 4:15	Session 15: Closing the training program	1 hour
4:15	Adjourn	

Pretest/Post-test

Read the following questions and circle the correct answer.

Purpose:

- To help the facilitator and participants identify strengths and areas for learning
- To measure changes in the level of knowledge and skill gained as a result of the training.

Instructions:

- Distribute course assessment.
- Each participant need to complete the test individually.
- Collect the tests Make sure that each person has recorded their name clearly. (Some trainers may prefer to assign numbers).
- The trainer may assist the participants with low level of literacy by reading out the questions to them.

1.	Counseling is exploring options with clients and enabling them to make their own decisions.	Yes	No
2.	Child development is a gradual process from birth to adolescence and does not have different stages.	Yes	No
3.	Children need adults to solve their problems and do not have the capacity to resolve problems on their own.	Yes	No
4.	Active listening is a basic skill of a counselor.	Yes	No
5.	A counselor need not make any preparations before beginning a counseling session.	Yes	No
6.	A counselor must avoid moralistic judgment or preaching.	Yes	No
7.	Drawing is an interactive strategy for communicating with children.	Yes	No
8.	A child needs no preparation for antiretroviral therapy. Preparing the child's parent or caregiver is sufficient.	Yes	No
9.	Children who have been prepared for the death of a parent generally cope better, because they understand what is happening.	Yes	No
10.	Counselors should not encourage children who are teased to avoid their teasers and walk away when confronted.	Yes	No

11.	A counselor can encourage a client to disclose his or her HIV status.	Yes	No
12.	A memory book helps to open channels of communication between parents and their children and improve the relationship.	Yes	No
13.	Children commonly experience loss of appetite when they begin antiretroviral therapy, but gradually their appetites return.	Yes	No
14.	Silence is not an effective tool for counseling a client when it is about sharing the results of an HIV test.	Yes	No
15.	A counselor should schedule at least two counseling sessions before a client begins antiretroviral therapy.	Yes	No
16.	If a client on antiretroviral therapy does not mention side effects, the counselor should initiate discussion.	Yes	No
17.	Bereavement counseling is for a client who is sick and may be dying and not for that person's family members.	Yes	No
18.	The point of supervising counselors is to find fault with them.	Yes	No
19.	Stress leads to burnout.	Yes	No
20.	Counseling involves making decisions on a client's behalf .	Yes	No

Session 1:
Registration, introduction and ground rules

Learning Objectives

During this session participants will

- become familiar with the training's goals
- get acquainted with one another
- decide how the group will govern itself
- test the knowledge they bring to the training through pre course assessment.

Time Needed: 1 hour 

Session Overview

Activity		Time
Activity 1:	Welcome participants, present an overview of the training, and discuss expectations for the training	10 minutes
Activity 2:	Introduce facilitators and participants	20 minutes
Activity 3:	Set ground rules for the group's behavior and process	10 minutes
Activity 4:	Entrust key responsibilities to participants by choosing a moderator, evaluator and reporter	10 minutes
Activity 5:	Conduct the pretest	10 minutes

Activity 1: Welcome, overview and expectations

Welcome participants, solicit their expectations of the training, and provide an overview of the training's objectives. The activity is as follows:

- Post a flip-chart page titled “Expectations” on the wall.

- Explain that we all have hopes, ideas and expectations about this workshop. Ask each participant to share the expectation they consider most important.
- Record each expectation on the flip chart.
- When the list is complete, go over each expectation and let the participants know if it is within the training's scope or not.
- Finish by reviewing with the group the training objectives listed on Slide 1.

Activity 2: Participants and facilitators introduce themselves

Ask the participants to sit in a circle. Bring out a ball and throw it to one of them. Ask that person to stand and answer the following questions:

- What is your name?
- What do you think is your best characteristic? The characteristic can be physical (for example, beautiful eyes), social (for example, a caring or friendly disposition) or an ability (for example, singing or playing a musical instrument).

Upon answering, the participant will sit down, throw the ball to another person, and repeat the questions. Continue until all have introduced themselves.

Activity 3: Set ground rules and build consensus

Tell the participants that for any training to go smoothly, some basic rules must be established and followed. Post a flip-chart page titled “Ground Rules” on the wall, ask the group to suggest some ground rules, and appoint one of the participants to list them.

Here are some examples of helpful ground rules that you might try to prompt the group to voice:

- Listen to ideas without putting them down.
- Do not interrupt a person who is talking.
- Give everyone a chance to speak about every issue presented for discussion.
- Do not use questions to attack people. Frame questions to invite clarification.
- Speak to people directly, using their first names. Do not refer to people indirectly, using the pronouns "he" or "she."
- Speak for yourself only.
- If something is not working for you, speak up.
- Switch off cell phones or silence them.

- Speak in the language that you are most comfortable using. Do not feel pressured to speak in English.

Activity 4: Entrust key responsibilities to participants by forming a team consisting of a moderator, evaluator and reporter

Tell participants that they need to select three representatives: a moderator to handle negotiations between participants and facilitators, an evaluator to assess the training process, and a reporter to document what happens and what is said during the training.

Begin by defining these roles in more detail:

- Moderator: Makes sure the group follows the ground rules
- Evaluator: Asks participants for informal feedback about their perceptions on training process (e.g. training methods, content, facilitators and logistics) and reports issues to the moderator, who is responsible for handling them
- Reporter: Records the key content and outcomes of the sessions

This information should appear on a flip-chart page that you have prepared in advance. When the team is chosen, add their names to the list and stick the page on the wall.

Activity 5: Conduct the pretest

The pretest tool appears on page 10 of this manual. You will administer the same test to participants at the end of the training, to measure the degree to which their knowledge and attitudes have changed.

Basics of Counseling

Session 2:
Introduction to counseling

Learning Objectives

During this session participants will

- understand what counseling means
- learn the characteristics of an effective counselor

Time Needed: 1½ hours 

Session Overview

Activity	Time
Activity 1: Understand the counseling process	30 minutes
Activity 2: Explore the basic characteristics of a counselor	30 minutes
Activity 3: Engage in a trust-building exercise	30 minutes

Activity 1: Understand the counseling process

Start the session by asking, "What are the key problems that people face who are HIV-positive or who are affected by HIV?" List the participants' responses on a flip-chart page and categorize them in five broad areas: financial, social, health, nutritional, educational and psychosocial.

Next ask, "As family case managers and community volunteers, do we have solutions for these problems? In what ways do we support our clients?" Again, list the participants' responses. This time, categorize them in three broad areas: referral, counseling and other.

Now ask participants to elaborate on the dimensions of their role as counselors. You are looking for statements such as these:

- Provide accurate information.
- Listen attentively to the client.

- Identify problems.
- Develop a client's problem-solving and coping skills.
- Help clients make correct decisions.
- Build trust.
- Share the client's feelings.

Explain that this session and the three to follow will focus on the basic counseling process and that the group will spend some time talking about this. Ask the participants to look at the answers on the flip-chart page and say how they would define counseling.

Record the participants' responses on the flip chart. When they finish, show Slide 2 and point out that the same material appears on Handout 2.1. Emphasize that counseling is many things, but that above all it is a relationship.

Activity 2: Basic characteristics of a counselor

Ask the participants to say what they think is needed for a counselor to establish a good relationship with a client.

Then show Slide 3, and point out that the same material appears on Handout 2.2.

Explain briefly the importance of each characteristic of counseling. Then divide the participants into two groups. Ask one to develop and present a skit demonstrating effective counseling and the other to develop and present a skit demonstrating ineffective counseling.

Activity 3: Building trust

This exercise is called a trust walk.

Ask the participants to stand and find a partner. Make sure that all are in pairs; If the number is uneven, this may require the facilitator to be someone's partner.

Give one blindfold to each pair. One member of the pair will put on the blindfold. The other will make sure that his or her partner cannot see anything.

Ask the partner who can see to guide the other around the room. Allow about five minutes and then have the partners switch roles.

At the end of the exercise, call the group together for feedback.

Use these prompts to help the participants interpret their experience of the trust walk:

- What was it like to be blindfolded?
- What did your guide do to make you more comfortable? Did that help?
- What was it like to be the guide?
- How did you make your blindfolded partner more comfortable?
- Which role was easier for you, leader or follower?

These questions will guide the participants to consider the connections between the trust walk and the training:

- How is a client's role similar to the role of the blindfolded person? How is it different?
- How is the counselor's role similar to the role of the guide? How is it different?
- Why did we do this exercise? Suggest these answer if the participants do not: develop empathy for our clients; identify and experience ways to create a trusting environment.
- How does this exercise relate to counseling?

Session 3: Counseling skills

Learning Objectives

During this session participants will

- explore in depth and practice the skills required of an effective counselor
- learn the difference between sympathy and empathy
- practice techniques to develop empathy

Time Needed: 1 hour 40 minutes

Session Overview

Activity	Time
Activity 1: Listing core skills of a counselor	10 minutes
Activity 2: Defining the skills of counselors (skill card exercise)	10 minutes
Activity 3: Developing empathy	10 minutes
Activity 4: Practicing active listening	10 minutes
Activity 5: Asking questions	20 minutes
Activity 6: Identifying feelings	30 minutes
Activity 7: Affirming and accepting	10 minutes

Activity 1: Listing the core skills of a counselor

Divide the participants into five teams and ask each team to form a line. The first person in line on each team will go to the flip-chart page designated for his or her team and list as many core counseling skills as possible. Then the second person in each line will do the same, without repeating skills already listed.

After everyone has had a turn, applaud the team that has listed the most skills without duplication. Then ask the group as a whole to compare the list on Handout 3.1 to the flip-chart pages and point out any skills the teams might have missed.

Activity 2: Defining the skills of a counselor (skill card exercise)

Give each team a card on which one of the following counseling skills has been entered:

- empathy
- active listening
- asking questions
- identifying feelings
- affirming and accepting

Allow each team 10 minutes to define the skill they have been given and to recall two experiences they have had as counselors in using the skill.

Each team will then have five minutes to present to the group as a whole their definition of the skill and to describe one counseling experience using the skill.

The activities that follow correspond to each of the five skills on the cards. After each team has made its presentation on a given skill, have the group as a whole participate in the activity that supports it.

Activity 3: Developing empathy

This activity consists of two exercises.

1. Have the group to divide into pairs and instruct them to take off their shoes. Ask each pair to exchange shoes, stand up, and walk around. Give them a minute to do this. Then ask the following questions to help them process the experience:

- What is it like to wear someone else's shoes?
- Do they feel the same as your shoes?
- Do they fit? Are they comfortable?
- Do you like wearing your partner's shoes?

Notes to help you conduct the exercise

Empathy is trying to understand a situation from another person's point of view and showing that you care. Empathy is like trying to walk in the shoes of your client and imagine what his or her life and problems are like.

One point of this part of the exercise is that each person's perspective and experience are as unique to them as the way their shoes have molded to their feet.

Some participants will resist switching shoes; others may not mind. Use the participants' various reactions to illustrate the range and depth of feelings people have when they come to counseling. Some may not be at all comfortable in counseling.

This part of the exercise will help you lead the participants to understand the concept of empathy and how the skill comes into play with clients.

2. Ask participants to explain the difference between empathy and sympathy two words that are often used together.

Notes to help you conduct the exercise

Sympathy is feeling sad about what another person is going through. For instance, one might feel sorry for parents who have lost a child.

Empathy is putting oneself in another's place and trying to see the world through their eyes. Empathy does not mean that you feel exactly what the other person is feeling or that you have been through everything they have been through.

Activity 4: Practicing active listening

Ask the participants to stay with their partners. Instruct one member of each pair to talk and the other member to pay no attention. Then ask one member of each pair to talk and the other member to listen but not to speak.

Ask the group the following questions:

- How did those of you who talked feel when you were ignored?
- How did those of you who ignored your partners feel?
- How did those of you who talked feel when your partner listened silently?

Use the information in Handout 3.2 to discuss listening skills.

Activity 5: Asking questions

Tell participants that asking questions is an important part of counseling. Explain that as counselors they must be careful about the way they phrase their questions.

Ask those in the group who are familiar with open-ended and closed questions to explain what they are. Then ask participants to offer examples of these two forms of questions. Follow up by asking participants for their ideas about effective and ineffective ways for counselors to ask questions: What sorts of questions should counselors ask and what should they avoid?

Review with the group the forms of questions discussed in Handout 3.3.

Next have the participants retrieve their copies of Handout 3.4. Following the instructions on the handout, ask the participants to identify the questions that are closed and those that are open-ended. Then ask them to convert the closed questions into open-ended questions.

Activity 6: Identifying feelings

This activity focuses on two skills reflecting a client's feelings and paraphrasing a client's expression of his or her feelings.

1. Reflecting feelings

Explain what this means (referring to Handout 3.1). Offer some examples and invite the participants to share their experiences.

Then ask the participants how they would reflect the feelings of a client in response to the following statement: "Since I came in for my daughter's HIV test last week, I haven't been able to sleep waiting for the test results."

Notes to help you teach this skill

Reflecting feelings means expressing the emotions that seem to be embedded in a client's words. The counselor's focus is on those emotions, not content.

Example:

> *Client*: "I'm the only one working in my family. My mother, my sister and her two children stay with me and my three kids. My sister just came a month ago and she can't find any work. I can't afford the school fees for my own children so I don't know what to do about schooling for my sister's kids."

Counselor: "You sound tired and overwhelmed."

Tips for reflecting a client's feelings:

- Listen for and reflect both verbal and nonverbal communication of feelings.
- Read body language and reflect what you see if feelings are not expressed verbally.

2. Restating, rephrasing or paraphrasing

Explain the skill involved in restating, rephrasing or paraphrasing what a client says (referring to Handout 3.1). Offer some examples and invite the participants to share their experiences.

Then ask the participants how they would paraphrase the following statement in order to identify the client's feelings: "I don't want to discuss about sex matters with my husband."

Notes to help you teach this skill

Restating, rephrasing or paraphrasing what a client says allows a counselor to confirm the message, signal to the client that the counselor is listening and wants to understand, and draw the client to a deeper level of self-knowledge. Using this tool, a counselor will repeat the content and feelings of the client's message using different words.

Example:

Client: "I'm so angry with my husband. I just want to get rid of him; he makes me so mad."

Counselor: "It sounds like your irritation and frustration with your husband have increased and are reaching a climax."

Tips for restating what a client says:

- Use your own words to communicate your understanding of what the client is saying.
- Use different words that have the same meaning; do not repeat verbatim what the client said.
- Rephrase both content and feelings.
- Be tentative and respectful, using such phrases as "I hear you saying ... ," or "It sounds like ."

Activity 7: Affirming and accepting

Begin this activity by explaining what affirmation means. Offer some examples and invite the participants to share their experiences. Then ask the participants how they would affirm this statement by a client: "I have supported my husband to develop doable plans to stop drinking. He said he will try." You will be looking for such suggestions as "Well done!" and "You have done your best."

The activity should proceed as follows:

- Ask the participants to pair up with the person sitting next to them.
- Then say: "Each of you should think of something about your partner that you can affirm. It can be something you've noticed that your partner does well or a positive characteristic that your partner has, such as leadership, patience or optimism."
- Invite each set of partners to express their affirmations to each other. Ask them to pay attention to body language, tone of voice and facial expression.
- Tell them they have a couple of minutes for this.

Notes to help you teach this skill

Affirmation acknowledges and encourages the client. A counselor can affirm a client's choices, knowledge or behavior.

This skill is similar to the way a teacher affirms or verbally rewards a learner, or the way a parent might encourage a child. A counselor's first affirmation of a client might be to congratulate the client for seeking counseling.

The key purpose of affirmation in counseling is to encourage the client to affirm himself or herself to develop a habit of appropriate self-affirmation rather than looking to the counselor and others for approval. For instance, instead of saying, "I am so proud of you for going back to get your test results," the counselor should say, "You should be proud of yourself for returning for your results."

Take-home messages

Wrap up the session by showing Slide 4, which presents the session's key messages.

Session 4:
Phases of the counseling process

Learning Objectives

During this session participants will

- identify and discuss the four phases of a counseling session
- experience the counseling process through a role-playing exercise

Time Needed: 1 hour 20 minutes 

Session Overview

Activity	Time
Activity 1: Phases of counseling	30 minutes
Activity 2: Relay role-playing exercise	30 minutes
Activity 3: What counselors should avoid	20 minutes

Activity 1: Phases of counseling

Show Slides 5 to 9, which explain the five phases of counseling. Refer the participants to Handout 4.1, which also covers this information. Discuss each phase with the participants.

Activity 2: Relay role-playing exercise

Ask the participants to suggest a common and challenging situation that they have confronted as counselors. Or present the following scenario to them: A married woman goes to a voluntary counseling and testing center and is found to be HIV-positive. She refuses to disclose her status to her husband.

Ask for a participant to volunteer for the role of the client on a visit to the center. Then recruit volunteers for the role of counselor. These volunteers will take a turn role-playing one of the counseling phases, in sequence. As each phase is acted out, ask the remaining participants for feedback. Keep their discussion focused on the phases of counseling and the counseling skills covered in Session 3.

Activity 3: What counselors should avoid

Ask the participants to read Handout 4.2 and discuss it with them.

Session 5:
Ethics in counseling

Learning Objectives

During this session participants will

- define ethics, boundaries and confidentiality
- explore the implications of these concepts in a counseling setting
- discuss case studies that have ethical implications

Time Needed: 1 hour

Session Overview

Activity	Time
Activity 1: Define ethics, boundaries and confidentiality	15 minutes
Activity 2: Counseling scenarios involving ethics	45 minutes

Activity 1: Defining ethics, boundaries and confidentiality

Ask participants for definitions of ethics and wait for them to respond. They may suggest standards of conduct, acceptance of responsibility or moral rules or principles for a particular profession.

Say that this session will focus on two aspects of ethics that relate to counseling.

Boundaries are limits imposed on the counseling relationship.

- Ask the participants if they think there should be any limits on whom a counselor can counsel? For instance, is it ethical to counsel one's sister or good friend? If not, why not?
- Let participants discuss these questions briefly in small groups before the group as a whole tackles them.
- Explain that boundaries in a counseling relationship protect the client. For instance, a counselor's relationship with a client should not extend beyond counseling. A counselor and

client should not have a sexual relationship, a dating relationship, a business relationship or be close family members.

Confidentiality and privacy ethics assure clients that they can participate in counseling without fear that others will know about their visits and what takes place.

Ask the participants what they understand by the term "counseling confidentiality." Explain that even the fact that someone is in counseling is confidential, with some exceptions:

- The counselor may share information with his or her supervisor as a quality control measure. However, when reporting to a supervisor, the counselor should avoid mentioning the client's name or identifying personal characteristics.

- If the client is at risk of causing harm to himself or herself or to someone else, the counselor may break confidentiality. For example, if a client is suicidal and will not develop a safety plan, the counselor will call the police.

Invite participants to suggest other exceptions for example, situations related to child abuse and domestic violence.

Activity 2: Counseling scenarios involving ethics

Divide the group into four teams. Give each team a counseling scenario that poses an ethical question.

Scenarios:

1. An HIV-positive man continues to have unprotected sex with his partner. He refuses to disclose his status to the partner.
2. At a counseling session, you realize that a client is suicidal.
3. When you introduce yourself to your new client, you find that he is your former boyfriend.
4. Your sister has started dating a man and is in love with him. When you meet this man you realize that you counseled him six months previously in his household.

Ask the teams to discuss their assigned scenarios and complete the following tasks:

- Identify the ethical issue.
- Outline at least two different plans of action or approaches to the situation.
- Recommend the best plan of action.
- Present the scenario and their findings to the group as a whole.

Note: After each presentation lead a short large-group discussion about the ethical issue. Expect differences of opinion to emerge about the best plan of action in each of these scenarios.

Counseling Children

Session 6: Aligning counseling with a child's developmental stage ..... Time Needed: 1 hour

Session 7: Using interactive communication strategies with children ..... Time Needed: 2 hours

Session 8: Addressing the special counseling needs of ..... Time Needed: 3 hours
children affected by HIV

Session 6: Aligning counseling with a child's developmental stage

Learning Objectives

During this session participants will

- learn the basic principles of child counseling
- learn the stages in a child's development
- learn how to align counseling approaches with these developmental stages

Time Needed: 1 hour

Session Overview

Activity	Time
Activity 1: Principles of child counseling	10 minutes
Activity 2: Aligning counseling with a child's developmental stage	20 minutes
Activity 3: Role-playing exercise on building relationships with children	30 minutes

Activity 1: Principles of child counseling

Tell the participants that counselors of children should subscribe to a set of discrete, basic principles. Refer the participants to Handout 6.1 and discuss these principles.

Invite the participants to brainstorm the differences between adult and child counseling, based on their counseling experience.

Activity 2: Aligning counseling with a child's developmental stage

Ask participants why a counselor should pay attention to a child's stage of development. Refer them to Handout 6.2 and show Slide 10.

Divide the participants into five teams and ask each team to list the key developmental milestones of children in the realms of communication skills, cognitive development and physical growth. They should group the milestones in the following age categories:

- one to three years
- four to six years
- seven to nine years
- 10 to 12 years
- 13 to 18 years

Discuss the implications of development milestones for counseling (Handout 6.3) as the teams present their lists.

Activity 3: Role-playing exercise on building relationships with children

1. Explain that to counsel children it is essential to form a relation with them. To establish a relationship, a counselor must discover the child's interests and then involve the child in an activity or conversation related to one or more of those interests.

2. Divide the participants into three teams.

3. Write each of the age groups of children listed above on a scrap of paper, fold the scraps, and put them in a basket. Ask each team to choose one and not to reveal the age group they have drawn to anyone who is not a team member.

4. Ask each team to demonstrate how they would build rapport with a child in the age they have drawn, using the information in Handout 6.4.

5. Ask the rest of the participants to identify the age category a team has drawn and to explain their reasons.

Session 7: Using interactive communication strategies with children

Learning Objectives

During this session participants will

- learn why children respond to interactive communication strategies
- observe these strategies in actual counseling settings
- explore a variety of strategies

Time Needed: 2 hours

Session Overview

Activity	Time
Activity 1: Benefits of using interactive communication strategies with children	10 minutes
Activity 2: How to use interactive communication strategies	1 hour and 15 minutes

Activity 1: Benefits of using interactive communication strategies with children

Use Handout 7.1 to discuss this topic with the participants.

Activity 2: How to use interactive communication strategies

Ask the participants if they are aware of interactive communication strategies that are effective with children. Give examples of these strategies and discuss them briefly. Show Slide 11.

Next, have the participants break into teams and distribute copies of Handout 7.2. Ask them to choose interactive communication strategies from those listed in the handout:

- drawing
- storytelling
- puppetry
- role-playing and drama
- play

Instruct the teams to create role-playing exercises that demonstrate how these strategies are used to counsel children in different age groups.

End the session by summarizing the advantages of the strategies.

Session 8: Addressing the special counseling needs of children affected by HIV

Learning Objectives

During this session participants will

- understand the counseling needs of children affected by HIV
- learn counseling strategies to meet these children's needs
- practice the strategies

Time Needed: 3 hours

Session Overview

Activity	Time
Activity 1: Problems of children affected by HIV	1 hour
Activity 2: Team presentations and role-playing exercises	2 hours

Activity 1: Problems of children affected by HIV

Tell the participants that when a family member has HIV, the mental well being of the children is affected. Invite the participants to describe problems they have seen in the field. Post a flip-chart page on which you have written the following list:

- getting consent for HIV testing of children
- preparing children and their caregivers for pediatric antiretroviral therapy
- coping with a caregiver's illness
- the stigma of HIV
- the death of a caregiver
- disclosure of a child's positive HIV status
- child abuse

Tell participants that when they counsel a child whose parent or other caregiver has HIV, they must not fail to address the issues on this list. Let them know that the next activity will focus on each of these sources of stress.

Activity 2: Team presentations and role-playing exercises

Divide the participants into seven teams and give them a few minutes to get settled before you move to the next part of the session.

Handouts 8.1 through 8.7 cover the seven stressors listed above. Assign one of these handouts to each team, whose task for the remainder of the activity will be to master and present the information the handout contains.

A team will begin by choosing a leader, who will prepare to present to the group as a whole a summary of the counseling challenges that the team's assigned stressor poses.

The team will also develop a role-playing exercise to dramatize the ways in which a counselor would work with a child in a family setting to address the stressor.

When each team finishes its presentation, ask the other participants if they have any questions. If a team has missed any key information in the handout, call it to the group's attention. Take care, as well, to clarify any doubts or misconceptions.

Counseling Adults

Session 9:
Developing a memory book

Learning Objectives

During this session participants will

- learn what a memory book is
- understand the value of a memory book to children and families who are affected by HIV
- learn how to guide children and adults to create a memory book

Time Needed: 1 hour

Session Overview

Activity	Time
Activity 1: The content and uses of a memory book	1 hour

Activity 1: The content and uses of a memory book

Creating a memory book is a way for parents who are living with HIV to document for their children the family's history and traditions and other important personal information.

Describe the content and purpose of a memory book and the value of such a book to a child and caregiver. Ask the participants how they think a child and a family might use a memory book.

Show Slides 12 and 13 and distribute Handout 9.1. Ask participants to discuss and elaborate.

Notes on guiding counselors to incorporate memory books in their work

Let the participants know that they may be involved in all stages of developing a memory book. Early on, they could ask a caregiver questions to steer the process. They can offer a list of topics to prompt the caregiver's ideas and memories. Later, they could offer an outline of the book's contents, to make it easier for the caregiver to get on with the work at home with their children.

Tell participants that it is not essential for caregivers to be able to read and write. Instead, they can use pictures or seek support from trusted family members or friends to write the book. Caregivers can ask their children for help, too.

Session 10: Addressing the special counseling needs of adults

Learning Objectives

During this session participants will

- understand the counseling needs of adults affected by HIV
- learn counseling strategies to meet the needs of these adults
- practice the strategies

Time Needed: 2 hours

Session Overview

Activity	Time
Activity 1: Introduction to the counseling needs of adults	40 min
Activity 2: Role-playing exercise on adult HIV counseling and feedback	1 hour 20 minutes

Activity 1: Introduction to the counseling needs of adults

Introduce the special counseling needs of adults. Brainstorm with participants about the special needs that are critical and challenging for family case managers to handle.

Activity 2: Role-playing exercise for practice in adult HIV counseling

Divide the participants into four teams. Ask each team to present a skit in which team members play the roles of counselor and client in one of the following situations:

- HIV testing
- disclosure of HIV status
- adhering to an antiretroviral therapy regimen
- end-of-life care

Distribute Handouts 10.1 through 10.4 to each team and give the teams 30 minutes to prepare. Following each presentation, ask participants to provide feedback on the role of the counselor.

Discuss any information in the handouts that the teams do not cover in their presentations.

Ensuring the Quality of Counseling

Session 11: Documenting the counseling process

Learning Objectives

During this session participants will

- learn why it is important to document the counseling process
- learn the steps involved in documentation
- learn the format of a counseling case report

Time Needed: 1 hour

Session Overview

Activity	Time
Activity 1: The importance of documentation in counseling	30 minutes
Activity 2: Sample counseling case report form	30 minutes

Activity 1: The importance of documentation in counseling

Ask the participants to list the reasons to document counseling sessions. Make sure the following reasons are on the list:

- To plan follow-up visits
- To assign priority to the needs of clients
- To keep track of the issues discussed
- To facilitate supervision of the counseling
- To allow the counselor to assess the counseling process
- To share the counseling experiences with their supervisors to seek further support in the process

Ask participants to brainstorm what parts of the counseling process they think are essential to document and why. Discuss the group's suggestions and evaluate the potential usefulness of each one to counselors and supervisors.

Activity 2: Sample counseling case report form

Refer the participants to Handout 11.1. Explain the questions on the form and their utility.

Session 12: Supervising the counselor

Learning Objectives

During this session participants will

- understand how to ensure high-quality counseling
- learn what supervision of counseling means and why it is important
- learn what counseling supervision does and does not entail
- learn the roles and responsibilities of the supervisor and the counselor in the supervision process

Time Needed: 1 hour

Session Overview

Activity	Time
Activity 1: How do we ensure a high standard of counseling	10 minutes
Activity 2: The meaning and goals of counseling supervision	20 minutes
Activity 3: Roles and responsibilities of counselors and their supervisors	30 minutes

Activity 1: How do we ensure a high standard of counseling?

Ask the participants how they ensure the quality of the counseling they do. List the responses on the flip chart. Then lead a discussion on measures to maintain high quality based on the points given below:

- following organizational policy on issues of consent, disclosure and confidentiality
- following protocols for child counseling
- ensuring privacy requirements
- review of the counseling process
- Supportive supervision for ongoing support

Activity 2: The meaning and goals of counseling supervision

Ask each participant to find a partner and write and present a definition of "counseling supervision." Then ask the participants to complete on their own the exercise in Handout 12.1.

Go step-by-step through the participants' responses to each statement. Invite discussion on why they believe each statement is or is not a goal of counseling supervision. Introduce the idea of other forms of supervision, such as administrative supervision, as appropriate.

To reinforce what the group has learned from this activity, show Slide 14 "What supervisors of counselors should not do" and discuss that list. (The information also appears on Handout 12.2.)

Activity 3: Roles and responsibilities of counselors and their supervisors

Break the group into pairs. One partner in each pair will play the role of counselor and the other will play the role of counseling supervisor. Ask the counselors to share with their supervisors what they expect from the process of supervision. Then ask the supervisors in turn to communicate what they expect from the counselors as supervisees. Spend 10 minutes on this exercise (five minutes per role).

After all pairs have expressed their expectations to each other, open the discussion to the group as a whole. Start by asking those in the role of counselor what they said they expected of their counseling supervisors. List all the key roles and responsibilities mentioned on a flip chart.

Then ask those in the role of supervisor what they said they expected of their counselors/supervisees, again listing the responses on a flip chart.

Place the two flip-chart pages side by side and ask the group for additional comments.

End the session by distributing Handout 12.3 and discussing any roles and responsibilities listed there that haven't come up already.

Session 13:
Managing stress and burnout

Learning Objectives

During this session participants will

- learn to recognize signs of stress and burnout
- identify strategies to manage stress and to prevent burnout within the context of HIV counseling
- identify strategies for supervisors to manage their own stress and prevent burnout

Time Needed: 1 hour

Session Overview

Activity	Time
Activity 1: Identification of stress	15 minutes
Activity 2: The difference between stress and burnout	15 minutes
Activity 3: Stress management	30 minutes

Activity 1: Identification of stress

Post a flip-chart page titled, "Signs of Stress in Counselors." Brainstorm with the group about the signs of stress and burnout physical and emotional that they have exhibited themselves or have observed in others. Examples are fatigue, illness, angry outbursts and withdrawal. List the group's responses on the flipchart.

Activity 2: Differences between stress and burnout

Discuss with the group the meanings of stress and burnout and the differences between the two. Confirm that the group is clear about the relationship between the two and understands that stress can lead to burnout among counselors.

Say that part of a counseling supervisor's job is to detect signs of stress and help counselors manage stress before it evolves to burnout. Emphasize that counseling supervisors are also prone to stress and burnout. Therefore, if they are to be effective with their supervisees, they will need to learn how to manage their own stress, both in order to prevent burnout and to model appropriate practices.

Share Slide 15 (Handout 13.1) about the differences between stress and burnout.

Activity 3: Stress management

Show Slides 16, 17 and 18 and distribute Handout 13.2 and lead the group in a discussion of ways to manage stress.

Ask the participants to create a stress management plan for themselves, using the form on Slide 19 and Handout 13.3 as a template. Explain the form in detail. Make sure participants understand that they will not be asked to share their plans.

Session 14: Learning by doing

Learning Objectives

During this session participants will

- practice their skills in actual household settings
- share and learn from their experiences

Time Needed: 5 hours

Session Overview

Activity	Time
Activity 1: Form teams and delegate cases	1 hour
Activity 2: Conduct house visits	3 hours
Activity 3: Share observations	30 minutes
Activity 4: Summarize the teams' findings	30 minutes

Activity 1: Prepare to provide counseling in a household

Divide the participants into teams of six: four community volunteers and two family case managers.

Assign to each group a household that needs counseling related to one of the following issues:

- HIV testing
- disclosure of status
- adherence to an antiretroviral therapy regimen
- gaining consent to test children for HIV
- preparation for pediatric antiretroviral therapy
- the sickness of a parent

- the stigma of HIV
- the death of a parent
- end-of-life care

Activity 2: Conduct a house visit

Ask the teams to make the house visits and counsel the family members using the skills they have learned in the training. Let them know that the purpose of the practicum is to enable them to apply their learning in the field.

Divide each team into three pairs, with roles delegated as follows:

- Pair 1: Conducts the counseling at the house
- Pair 2: Supervises the counseling
- Pair 3: Observes and documents the counseling process, the application of counseling skills, the practice of counseling ethics and the means of addressing the specific issue with which the household is grappling.

Activity 3: Share observations

Question the pairs, as follows.

Pair 1: Counselors

- Were you able to apply your training in the counseling you did?
- What are the specific areas in which you applied what you learned?
- Did you have any difficulties in addressing the household's most pressing need? If yes, what are they?
- How did you feel being supervised?

Pair 2: Supervisors

- How did you feel supervising the counseling?
- What key steps did you follow in your supervision?
- Did you have any difficulties in conducting supervision?
- How do you think counseling supervision ensures the quality of counseling?

Pair 3: Observers

- How did you feel observing the process of counseling and counseling supervision?
- What do you think are your most significant observations?
- Do you have any suggestions for improving the counseling situation you observed?

Activity 5: Summarize and conclude the findings of the field visit

- Reflect on the participants' responses.
- Provide feedback on the field observations.
- Thank the participants for being actively involved in the practicum.

Session 15:
Closing the training program

Learning Objectives

During this session participants will

- explain changes in their knowledge, skills and attitudes as a result of the training
- provide feedback to the facilitator on the effectiveness of the training

Time Needed: 1 hour

Session Overview

Activity	Time
Activity 1: Have the participants take the post-test	20 minutes
Activity 2: Explain the evaluation form, distribute the forms, and have the participants fill them out	30 minutes
Activity 3: Thank the participants and adjourn.	10 minutes

Activities

The post-test is identical to the pretest. Distribute Handout 15.1.

After the participants complete it, pass out the training evaluation forms. Explain that the purpose of evaluation is to measure the effectiveness of the training and collect suggestions for improvements. Assure everyone that the evaluation is not a test and will not be graded. Let them know that they are not expected to sign it.

End the training by thanking all of the participants for their cooperation.

Pretest/Post-test Answer Key

1.	Counseling is exploring options with clients and enabling them to make their own decisions.	**Yes**	No
2.	Child development is a gradual process from birth to adolescence and does not have different stages.	Yes	**No**
3.	Children need adults to solve their problems and do not have the capacity to resolve problems on their own.	Yes	**No**
4.	Active listening is a basic skill of a counselor.	**Yes**	No
5.	A counselor need not prepare for a counseling session.	Yes	**No**
6.	A counselor must avoid moralistic judgement or preaching.	**Yes**	No
7.	Drawing is an interactive strategy for communicating with children.	**Yes**	No
8.	A child needs no preparation for antiretroviral therapy. Preparing the child's parent or care giver is sufficient.	Yes	**No**
9.	Children who have been prepared for the death of a parent generally cope with the death because they understand what has happened.	**Yes**	No
10.	Counselors should not encourage children who are teased to avoid their teasers and walk away when confronted.	Yes	**No**
11.	A counselor can encourage a client to partially disclose his or her HIV status.	Yes	No
12.	A memory book helps to open channels of communication between parents and their children and improve the relationship.	**Yes**	No
13.	Children commonly lose their appetite when they begin antiretroviral therapy but gradually they regain it.	**Yes**	No
14.	Silence is not an effective tool for post-test counseling.	Yes	**No**
15.	A counselor may schedule at least two counseling sessions before a client begins antiretroviral therapy.	**Yes**	No
16.	If a client on antiretroviral therapy does not mention side effects, the counselor must initiate discussion.	**Yes**	No
17.	Bereavement counseling is for a client who is sick and may be dying and not for that person's family members.	Yes	**No**
18.	The point of supervising counselors is to find fault with them.	Yes	**No**
19.	Stress leads to burnout.	**Yes**	No
20.	Counseling involves making decisions on a client's behalf.	Yes	**No**

Energizers

Body Writing

Ask participants to write their names in the air with a part of their body. They may choose to use an elbow, for example, or a leg. Continue in this way, until everyone has written his or her name with several body parts.

Match the Cards

Write well-known phrases on slips of paper and cut the slips in two, in the middle of each phrase. You should have enough halves for each participant to receive one. Fold the pieces of paper and put them in a hat. Each participant takes a piece of paper from the hat and tries to find the member of the group who has the rest of the phrase. For example, a person whose slip of paper bears the word "Happy" must hunt for the person who has the word "Birthday." This game can be used to introduce participants.

Group Statues

Ask the group to move around the room, loosely swinging their arms and relaxing their necks. After a short while, shout out a word. The participants must pose as statues that describe or express the word. For example, if you shout "peace," the participants must instantly adopt, without talking, poses that show what peace means to them. Repeat the exercise several times with different words.

Move to the Spot

Ask everyone to choose a spot in the room and stand there. Next, instruct the participants to move around the room and carry out a particular action: for example, hopping, saying hello to everyone wearing blue, or walking backwards. When you say "Stop," everyone must run to his or her original spot. The person who gets their first is the next leader and can instruct the group to do what they wish.

Fruit Salad

Divide the group into subgroups with an equal number of members. Assign each subgroup the name of a fruit. Participants then abandon their subgroups to sit at random on chairs in a circle. One person must stand in the center of the circle. When you shout the name of one of the fruits oranges, for example all of the oranges must change places with one another. The person who is standing in the middle tries to take one of the empty seats before another can claim it. The one left without a

seat moves to the middle of the circle, shouts the name of another fruit, and the game continues. If the person in the middle calls “fruit salad,” everyone must rush to find a new seat.

Tide's In, Tide's Out

Draw a line representing the seashore and ask participants to stand behind the line. When you shout “Tide's out,” everyone jumps over the line. When you shout “Tide's in,” everyone jumps back. If you shout “Tide's out” twice in a row, anyone who moves the second time has to drop out of the game.

Mime a Lie

Everyone stands in a circle. You start by miming an action. When the person on your right says your name and asks what you are doing, you must lie. For example, if you had been miming a swimmer, you might say, “I'm washing my hair.” The person on your right then has to mime what you said you were doing (washing your hair). Go around the circle in this way until everyone has had a turn.

Balls under Chins

Take a medium size soft ball. Allow the participants to split into teams and each team forms a line. The people in each line pass the ball under their chins, from one to the next. If the ball drops, the team must start over. The game continues until a team successfully passes the ball down the line.

Reflecting on the Day

To help people to reflect on the activities of the day, make a ball out of paper and ask group members to throw the ball to each other. Whoever has the ball can say one thought about the day.

Writing on Backs

At the end of the training, give the participants sheets of paper to tape to their backs. The participants then roam from one of their fellow trainees to another, writing a compliment on each person's sheet of paper. When everyone has finished writing, the participants can take their sheets of papers home with them and read the good things people have said about them.

Sample Training Evaluation Form

Location:

Training dates:

Instructions

- Thank you for participating in the training.
- Please respond to all questions below to help us improve the curriculum.
- Your responses will be anonymous and consolidated with others.
- Please return the form to the trainer when you have completed it.

Which days did you attend the training?

Day 1_____Day 2_____Day 3 _____Day 4 _____

1. Please rate the trainer's expertise, clarity, facilitation skills, time management, and responsiveness to your training needs by circling the appropriate numbers. Provide any additional feedback in the comments section.

Rating scale: 1 = Low 2 = Medium 3 = High

Session name	Expertise			Clarity			Facilitation skills			Time management		
Session 1: Registration, introduction and ground rules	1	2	3	1	2	3	1	2	3	1	2	3
Session 2: Introduction to counseling	1	2	3	1	2	3	1	2	3	1	2	3
Session 3: Counseling skills	1	2	3	1	2	3	1	2	3	1	2	3
Session 4: Phases of counseling	1	2	3	1	2	3	1	2	3	1	2	3
Session 5: Ethics in counseling	1	2	3	1	2	3	1	2	3	1	2	3
Session 6: Aligning counseling with a child's developmental stage	1	2	3	1	2	3	1	2	3	1	2	3
Session 7: Interactive communication strategies for children	1	2	3	1	2	3	1	2	3	1	2	3
Session 8: Addressing special counseling needs for children	1	2	3	1	2	3	1	2	3	1	2	3
Session 9: Developing a memory book	1	2	3	1	2	3	1	2	3	1	2	3
Session 10: Addressing special counseling needs of adults	1	2	3	1	2	3	1	2	3	1	2	3
Session 11: Counseling documentation	1	2	3	1	2	3	1	2	3	1	2	3
Session 12: Counseling supervision	1	2	3	1	2	3	1	2	3	1	2	3
Session 13: Managing stress and burnout in HIV counseling	1	2	3	1	2	3	1	2	3	1	2	3
Session 14: Learning by Doing	1	2	3	1	2	3	1	2	3	1	2	3

Please take a moment to answer the following questions.

What three ideas or lessons that you learned during this training will you take back to your work?

What do you think were this training's strengths?

What do you think were this training's limitations?

How we can improve this training program?

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Handouts for Trainers and Participants

Session 2: Introduction to counseling

Handout 2.1: What is counseling?[1]

Definition of counseling: Counseling is a process based on a relationship grounded in empathy, acceptance and trust. Within this relationship, the counselor focuses on the client's feelings, thoughts and actions, and then empowers clients to:

- cope with their circumstances
- explore options
- make their own decisions
- take responsibility for those decisions

This process helps people to:

- feel less anxious
- feel confident to make decisions
- take action
- grow and change

People solve their own problems. Counselors do not give advice. Instead they help people to face their problems, understand their feelings, examine their options and choose the ones they feel are best.

Counselors create settings in which clients can become better acquainted with their own thoughts and feelings, by hearing themselves talk about their thoughts and feelings.

[1] This text appears, in somewhat different form, in Community Counselor Training Toolkit Basic Counseling Skills: Facilitator Manual, published by Family Health International/Namibia in May 2006. It is used here courtesy of FHI 360.

Handout 2.2: Focuses of effective counseling

Feelings	NOT	Facts
People	NOT	Problems
People	NOT	Principles
Exploring	NOT	Advising or analyzing
Accepting people	NOT	Judging people
Listening	NOT	Lecturing
Empathy	NOT	Sympathy
Mirroring	NOT	Reflecting
Showing respect	NOT	Being patronizing or dictatorial
Empowerment	NOT	Dependence
Genuineness	NOT	Playing a role (pretending)
Openness	NOT	Manipulation
Facing pain and reality	NOT	Promoting avoidance or a quick fix

Session 3: Counseling skills

Handout 3.1: Counseling skills[2]

Practicing active listening

- Pay attention to your client's verbal and nonverbal messages.
- Use verbal and nonverbal cues to show that you are listening.
- Express genuine concern for your client.
- Make eye contact.
- Assume a relaxed posture to help your client relax, as well.
- Respond appropriately to what your client is saying.
- Acknowledge your client's feelings, to help the client feel safe to speak freely and move to a deeper level of understanding.

Reflecting feelings

- Summarize your client's words – clarifying them and reflecting your intuition of the client's feelings.
- Be sensitive to your client's feelings and let your client know you want to understand them.
- Listen to the nuances of what your client says he or she is thinking in order to suggest what your client may be feeling.

  For example, your client might say, "I really wanted to go to the antiretroviral therapy center yesterday but I couldn't because I had too much housework." Your response might be, "It seems to me that you felt sad, because you couldn't go to the center."

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[1]This text appears, in somewhat different form, in Counseling Basics: Follow-up Counseling Toolkit Training Facilitators Manual, published in December 2008 by the International Training and Education Center on Health (ITECH), Tambaram Sanatorium, Government Hospital of Thoracic Medicine (India), Unit 1. It is used here courtesy of ITECH.

Paraphrasing

- Paraphrasing means rewording what your client says.
- When you paraphrase, you should use the client's words only sparingly.
- Try to stay close to the kind of language your client has used.

  For example, if your client says, "I told him to go to hell," you might say (paraphrasing), "You were mad at him." If your client says, "I've got the blues," you could paraphrase by saying, "You feel low."

- Use words like these to help you paraphrase:

  "You seem to be saying ... ."

  "In other words ... ."

  "You feel ... because ... ."

  "What I hear you saying is ...."

Questioning

Ask questions to understand your client's problems or worries clearly and to draw your client to a deeper awareness or insight. Pose questions to clarify your client's concerns, not simply to satisfy your curiosity.

You can frame questions in three ways.

- Closed questions

  A closed question limits your client to a yes-or-no answer. Examples are, "Do you practice safe sex?" and "Do you know how to use a condom?" Closed questions do not invite the client to think about the answer's implications.

- Open questions

  An open-ended question requires a more complex answer. Examples are, "What difficulties do you experience when you practice safe sex?," "How do you feel about your relationship?" and "When do you think would be the right time to talk to your spouse about your HIV status?"

An open-ended question invites the client to continue talking and to decide in what direction they want to take the conversation.

- Leading questions

  A leading question suggests the answer you expect the client to give. Examples are, "You practice safe sex, don't you?," "Do you agree that you should always use a condom?," and "Do you think your wife would be devastated if she learns about your other relationship?"

Leading questions are usually judgmental; try not to use them.

Silence

Use silence to

- give your client time to think about what to say
- create space for your client to experience feelings
- allow your client to proceed at his or her own pace
- provide time for your client to resolve ambivalence about sharing
- give your client freedom to choose whether or not to continue

Nonverbal behavior

How we say things is important, because most communication is nonverbal. When body language is incongruent with the words that are spoken, a subtext is created that can be revealing or confusing. As a counselor, you should be extremely sensitive to your client's nonverbal communication and your own.

Here are some examples:

- Body language

  gestures
  facial expressions
  posture
  body orientation
  the distance between you and your client
  eye contact
  reflecting expressions
  restlessness
  tapping fingers

- Paralinguistic communication

  sighs

  grunts

  groans

  changes in the voice's pitch

  changes in the voice's volume

  fluency (ranging from mumbling to unusually careful enunciation)

  nervous giggles

  coughs

Empathy

Empathy is the act of putting yourself in another's shoes. For counselors, it is the ability to enter a client's world and see things from the client's perspective.

To accomplish this, you must step away from your own point of view and biases and set your personal experiences aside. You can learn to do this by listening to your client intently and allowing yourself to share your client's feelings.

When you show empathy, your client may be more open to explore and accept aspects of the self that have been cloaked in denial. Sensing empathy, a client is likely to feel able to speak without inhibition. Your understanding of your client should grow in equal measure.

Handout 3.2: How to listen

Listening involves more than the sense of hearing. It also involves observing. It can involve touch, as well.

As a counselor, the way you handle yourself physically conveys a message. To show that you are engaged, sit facing your client squarely. Adopt an **o**pen, non-defensive posture, leaning slightly forward. Make eye contact with your client and show that you are relaxed and comfortable.

You can also indicate that you are listening with minimal verbal responses, such as "hmm...hmm," "uh-huh" or "yes." These minimal responses let the client know that you are paying attention and encourage the client to continue talking.

When you practice empathetic or active listening, you will communicate what you have heard and understood. You will participate in your client's world and allow yourself to enter into his or her experience.

Active listening means hearing not just what your client is saying but also how your client is speaking; the tone of voice your client is using; the words your client is choosing to describe an experience; and the body language, facial expressions and gestures your client is using. You will notice the flow of words and the hesitations. You will listen to the silences – to what your client is not saying.

A combination of empathy and listening is a basic requirement for all counseling behavior and in itself is often therapeutic for the client. There is healing power in being able to talk to someone and be heard.

You are not listening to me when you

- do not care about me
- say you understand before you know me well
- have an answer for my problem before I have finished telling you what my problem is
- cut me off before I've finished speaking
- finish my sentence for me
- find me boring and do not tell me
- feel critical of my vocabulary, grammar or accent
- are dying to tell me something
- tell me about your experience, making mine seem unimportant

- are communicating with someone else in the room
- refuse my thanks by saying you have not really done anything for me

You are listening to me when you

- come quietly into my private world and let me be me
- really try to understand me, even if I am not making much sense
- grasp my point of view, even it is contrary to your own convictions
- grant me the dignity to make my own decisions, although you think they might be wrong
- do not take my problem from me, but allow me to deal with it in my own way
- hold back your desire to give me good advice
- do not offer me religious solace when you sense I am not ready for it.
- give me enough room to discover for myself what is really going on.
- accept my gift of gratitude by telling me how good it makes you feel to know you have been helpful.

Handout 3.3: Types of questions

As a counselor, you can phrase questions in a variety of ways, depending on your objectives. Examples of helpful and unhelpful types of questions follow.

Helpful questions

Open questions: These cannot be answered with one word, such as "yes" or "no." Their purpose is to explore the client's thoughts, feelings and experiences. Be careful that the question is not so open that it is vague and unclear.

Examples:

- Can you tell me more about what that was like for you?
- How have you been doing since you started caring for your mother?
- What happened after your husband came home drunk?

Closed questions: Sometimes called yes or no questions, these can be answered with one word. Closed questions can be useful when you're gathering basic information.

Examples:

- Do you want to be tested?
- Do you know how to use a condom?
- How old are you?
- What is your name?

Probing questions: These start with words such as how, who, when or where. Their purpose is to glean concrete information or to clarify.

Examples:

- How did you react to your test result?
- To whom have you disclosed your HIV status?
- When were you first tested?

Hypothetical questions: These rest on possibilities rather than facts. Their purpose is to help the client visualize possible outcomes of behavior and to imagine behaving differently.

Examples:

- If you were to disclose your status to your husband, how do you think he would react?
- If your children found out from your neighbors that you're HIV positive, what do you think would happen?

Checking questions: These allow a counselor to identify how much a client has understood and what topics need further information or explanation.

Examples:

- How will you remember when to take medication?
- What actions have we agreed upon today?

Unhelpful questions

Some forms of questions are unproductive or even destructive. Here are some examples.

Questions that begin with words such as "why" or "how come." Phrased this way, a question can sound judgmental.

Examples:

- How come you aren't getting a test for HIV?
- Why didn't you use a condom?

Closed questions: This form also appears on the list of helpful questions above, because you will need to resort to closed questions occasionally, for clarification. However, this form is useless for exploration.

Multiple questions: Asking more than one question at a time can be confusing. It can also make the client feel interrogated. Ask one question at a time, and let the client answer before asking another one.

Example:

- Have you revealed your status to your wife, children and other family members? Do you have any fears about disclosure? If you do, how do you manage them?

Leading questions: These imply or communicate a desired or expected answer. Questions framed as either/or propositions are invariably leading. Clients will respond in a way they think will be acceptable to you. This does not allow space to explore the truth. Be careful, because your nonverbal signals can communicate a leading question, as well.

Examples:

- In the future, will you have unprotected sex or will you use condoms?
- I know you're going to the antiretroviral therapy center regularly, so you're also adhering to your therapy regimen, aren't you?

Handout 3.4: Worksheet on open and closed questions

Read each question and determine whether it is open or closed. Then convert the closed questions into open questions.

Open	Closed	Questions
		1. Where did you grow up?
		2. What brings you here today?
		3. Are you willing to come back for a follow-up visit?
		4. Have you solved problems in your life before?
		5. Do you want to stay in this relationship?
		6. Have you ever thought about walking as a simple form of exercise?
		7. Is it not important for you to have safe sex and use a condom?
		8. Are you willing to try this for one week?
		9. In the past, how have you overcome problems in your life?
		10. Do you care about your health?
		11. What date did you start taking the medication?
		12. What are your reasons for wanting to be tested?
		13. Do you have any children?
		14. What keeps you in this relationship?
		15. What do you want to do about your smoking: stop smoking, smoke less, or keep smoking?

Session 4: Phases of the counseling process

Handout 4.1: Phases of the counseling session

1. Prepare yourself

The more prepared you are for a counseling session, the more likely it will go well. Because your clients will be looking for help in dealing with the most important issues in their lives, you should treat the sessions with seriousness and respect.

What you can do to prepare yourself for a counseling session:

- Know how much time you have for the session before you arrive at the client's home.
- Know when you are available for your next appointment before you begin. Have a list of dates ready to propose to your client.
- Do not bring your personal problems into the counseling session. Clients and their families need your strength. If you need help with a problem, seek support from other counselors or support groups, not from your client.
- Look and feel presentable. Do not go to a counseling session if you are feeling ill or unable to present yourself to your client in a positive way.
- Read your notes from previous sessions to remember where you left off and important issues to follow up.
- Bring to the session any information or relevant materials your client has requested previously.
- Bring a pen and paper for taking notes.

2. Prepare the counseling environment

The counseling environment sets the stage for the session. Before you begin, you should try to create an environment that will help your client to relax.

What you can do to prepare the counseling environment:

- Remove any items such as radios, telephones and cell phones that can create distractions.
- Arrange chairs, stools or mats at angles a comfortable distance apart so that seating is relaxed and informal. Do not place seats directly facing one another.
- Do not sit with any barriers such as a desk or table between you and your client.
- Do everything possible to ensure privacy during the session. For example, place a "do not disturb" sign on the door or simply ask family members not to interrupt you.
- Have objects you will need during the counseling session – information booklets, drinking water, tissues, and condoms – within reach.

3. Begin the counseling session

At the beginning you should set the tone for the conduct of the session. This is the time for you and your client to work out a set of ground rules for counseling.

How to begin a counseling session effectively:

- Greet your client. Ask how he or she is feeling and if there are any issues he or she would like to discuss in the session.
- Reach agreement with the client on how long the session will last.

If this is the first session:

- Reach agreement on the language the two of you will speak.
- Explain that everything said within the session will remain confidential unless your client wants to involve specific friends or family members. If the client chooses "shared confidentiality," he or she must give consent to the information to be conveyed and stipulate who may receive it. When this protocol is adopted, you may be able to broaden the scope of your work to engage in couples, family or group counseling as a tool to resolve issues.
- Explain your role as a counselor.
- Ask your client's permission to take notes (but never take notes while your client is speaking).
- Establish agreement with your client on what the two of you can expect from one another during the counseling.

4. Conduct the session

Regardless of the tasks and objectives you have in mind, you should conduct the session in a spirit of respect and collaboration.

Ways to approach your work with the client:

Assess: "What would you like to talk about today?"

Ask about your client's health or concerns. Check your client's knowledge, beliefs or behaviors.

Advise: "I have some information. Would you like to hear it?"

Using nonjudgmental language, give correct information about your client's illness, the risks the client might be taking, the benefits of treatments, positive living (that is, habits a person who is HIV-positive can adopt to stay healthy), and so forth. Provide options.

Agree: "Given the options we've discussed, what would you like to do?"

Help the client decide by discussing the possible advantages and disadvantages of each option. Help the client select from the options discussed. Make sure that the client's decisions are clear, measurable and limited in number. The goals must be within the client's direct control.

Assist: "What problems might arise when you follow this plan?"

Help your client anticipate barriers to his or her plans and overcome them. You can do this by providing written information or adherence equipment (such as pillboxes or calendars) and by directing your client to resources such as peer support or group education sessions.

Arrange: "I would like to see you again [suggesting a specific date, if possible] to find out how you're doing."

Arrange follow-up appointments and access to support. Give your client a written list of upcoming appointments. Record what happened during the visit.

5. End the counseling session

Ending the counseling session is an important opportunity for you to help your client feel positive and empowered to work on the problems discussed. Take the following steps to end the session:

- Summarize what the two of you have discussed and review your client's action plan.
- Ask the client how he or she feels about the session and what could make it better next time.
- Ask the client if he or she has any questions.
- Acknowledge the client's contribution to the session. Congratulate him or her for making progress toward solving problems or for discussing a sensitive issue openly and honestly.
- Set a date for the next home visit.
- Make referrals or direct your client to information resources that may have been discussed in the session.
- Accompany your client to the door while engaging in positive, social talk.

Handout 4.2: What to avoid in counseling

Below is a list of what to avoid when interacting with others generally, and especially in a counseling relationship.

- Exclamations of surprise

  Client: "I slept with my boyfriend last night and we didn't use a condom."
  Wrong: *"Oh, my goodness. Have you told him your HIV status?"*
  Right: *"Tell me more about that."*

- Appearing overly concerned

  Client: "I often feel like I don't want to go on living."
  Wrong: *"How horrible for you! Please tell me that you are not going to try to commit suicide!"*
  Right: *"When do you feel this way? Can you tell me more about these feelings?"*

- Moralizing or preaching

  Client: "I feel really bad. I have multiple partners and I transmitted my infection to my husband."
  Wrong: *"You should feel bad. The Bible says that you are only to have sex with your husband."*
  Right: *"You said you feel really bad. Can you describe that a little more?"*

- Punishing

  Client: "I did it again. I missed my antiretroviral pills."
  Wrong: *"I don't know if I can continue to counsel with you if you don't stick to your decisions."*
  Right: *"Tell me more about what happened and how."*

- Criticizing

  Client: "I'm HIV-positive and my wife doesn't want to be tested. But things are going on as usual. I feel pretty good about it."
  Wrong: *"How can you feel good about it? You must change your behavior so she doesn't get infected!"*
  Right: *"I'm not sure I understand. Can you tell me more about what you are thinking and feeling?"*

- Making false promises

  Client: "My wife will break down if she knows I have HIV."

Wrong: *"She'll definitely understand and accept you."*
Right: *"What makes her feel so miserable?"*

- Threats

  Client: "It's becoming difficult. I feel I can't continue taking anti retroviral."
  Wrong: *"If you don't continue you're going to die soon."*
  Right: *"How are you feeling about that?"*

- Burdening others with your own difficulties

  Client: "I don't have enough money to pay the rent next month."
  Wrong: *"I hear you. I don't have enough to pay for electricity. I don't know what I'm going to do."*
  Right: *"Sounds like you have some real financial concerns. Let's talk more about that."*

- Displays of impatience with a client

  Client: "I miss my husband so much and can't seem to stop crying."
  Wrong: *"It's been six months since your husband passed away. It's time you moved on."*
  Right: *"It's painful to miss someone."*

- Expressing your political or religious beliefs or values

  Client: "The church I attend says it's wrong to have sex before marriage. What do you think?"
  Wrong: *"The church is absolutely right. Premarital sex is why HIV has spread so fast."*
  Right: *"Tell me more about what you think and feel about it."*

- Arguing

  Client: "I'm so stupid. I can't believe I failed the exam."
  Wrong: *"You aren't stupid."*
  Right: *"How does failing the exam make you stupid?"*

- Ridiculing

  Client: "I've only had sex with my husband, so I won't get HIV."
  Wrong: *"That's such a naïve way to think. Are you stupid?"*
  Right: *"It sounds like you're a very trusting person."*

- Belittling

  Client: "I stayed out really late last night at the bar and was too tired to get up this morning

and go to work."
Wrong: *"You're behaving like a teenager or a child. It's time you grew up and behaved like an adult."*
Right: *"What are the results of the decision you made to stay out late last night?"*

- Blaming your client

  Client: "It's my husband's fault. He makes me so mad and then I do things I regret."
  Wrong: *"If you hadn't gotten mad, you wouldn't have behaved irresponsibly."*
  Right: *"What are you in control of? What are other possible reactions to your husband?"*

- Rejecting your client

  Client: "I got mad at my supervisor and quit my job yesterday."
  Wrong: *"How could you be so stupid? How will you support yourself now?"*
  Right: *"You must have been very upset to quit your job. Tell me more about the situation."*

- Displays of intolerance

  Client: "I went out to the bar last Friday and ended up sleeping with someone I met there."
  Wrong: *"Oh no, there you go again, increasing your risk of being infected with HIV."*
  Right: *"Can you tell me more about what happened?" or "How are you feeling about it now?"*

- Dogmatic or blanket statements

  Client: "I'm gaining too much weight."
  Wrong: *"Nonsense, fat people are happier than thin ones."*
  Right: *"Do you feel you should be thinner?"*

- Offering deep interpretations of a client's problems

  Client: "I've told you what's bothering me. Why do you think that is?"
  Wrong: *"I think you have an inferiority complex and can't form positive relationships."*
  Right: *"We should look at this together. Why do you think you may be bothered by these things?"*

- Probing difficult or emotional material when the client resists

  Client: "I just don't want to talk about my mother right now!"
  Wrong: *"You must if you want to see some positive changes."*
  Right: *"It's hard for you to talk about her."*

- Unnecessary reassurance

  Client: "What am I going to do now that my husband is gone?"
  Wrong: *"It will be OK. Everything will work out just fine."*
  Right: *"Let's explore your concerns further. Then maybe we can look at some of your options."*

- Advising

  Client: "My boyfriend has been drinking a lot lately and last night he got mad when I told him not to drink all of my money away. He hit me."
  Wrong: *"How could he do that? You need to leave him."*
  Right: *"How are you feeling today?"*

- Labeling
  Client: "My boyfriend doesn't want to use a condom."
  Wrong: *"Men! They're always like that!"*
  Right: *"How do you respond to him when he says that?"*

Session 6: Aligning counseling with a child's developmental stage

Handout 6.1: Principles of child counseling

- Address the child and the child's family, because everyone is affected by the results of an HIV test, whether positive or negative.
- The cognitive and emotional developmental stage of the child is central. The counseling process should be responsive to the child's age. Harmonize what you say and how you say it with the child's age and stage of development.
- Holistic approach to counseling and care, addressing not just a child's issues involving HIV and AIDS but all aspects of the child's life.

Handout 6.2: Aligning counseling with a child's developmental stage

Part of your task in assessing a child for treatment is assessing the child's developmental stage. Research has shown that some children who are HIV-positive exhibit growth problems, developmental delays and developmental regression when evaluated according to a standard scale or through neuropsychological tests.

A child's stage of development has the following implications for you as a counselor:

- Growth and development are important indicators of a child's health.
- HIV treatment options are dictated by a child's stage of growth.
- Measures of a child's development reveal nutritional needs that you can address.
- A child's developmental stage determines the content, skills and tools needed for effective counseling on such matters as disclosure of HIV status, preparedness for treatment and adherence to treatment.

Handout 6.3: Developmental milestones key to counseling children

Individual children develop at different rates, but across cohorts, the following patterns are discernible.

One to three years

Communication skills: The child can imitate speech and use words in short sentences.

Cognitive development: The child can name pictures of common objects, point to body parts, state first and last names, and recognize and label colors appropriately. An infant from birth to six months has a strong attachment to the primary caregiver (the term we will use here to refer to a parent or someone else with responsibility for the child). The child is not significantly fearful of strangers. Encourage the caregiver to be especially responsive to the infant's vocal expressions, because these are the beginnings of language development. Between the ages of six months and three years, the child becomes aware of strangers. She or he may cling to the parent or caregiver while at the same time developing a sense of independence from the caregiver.

Physical growth: The child becomes able to run, walk upstairs and down and feed herself or himself.

Three to six years

Communication skills: The child begins to recognize written words and can read short sentences.

Cognitive development: The child understands such concepts as size, shape, direction and time and enjoys rhymes and other word play. During this preschool period the child's language skills and capacity for fantasy play increase. The child's understanding is directed by a phenomenon that psychologists term "magical thinking" – confounding fantasy and reality.

Physical growth: The child enjoys doing most things without help.

Six to nine years

Communication skills: The child understands and is able to follow sequential directions, begins to read, and becomes more skilful in verbal communication.

Cognitive development: The child develops a sense of belonging to the family, begins to recognize peers, understands cause and effect, and acquires the capacity for concrete thinking.

Physical growth: The child develops curiosity about genitals and an interest in comparing his or hers with those of others.

Nine to 12 years

Communication skills: The child understands and is able to follow sequential directions. Reading and verbal communication skills are well developed.

Cognitive development: Peer recognition becomes important. The child enjoys talking about family, friends and school and their interests are easily determined. Children in this age group can generalize and understand the causes of illness.

Physical growth: Boys and girls develop armpit and pubic hair. Girls develop breasts and begin menarche.

Thirteen to 18 years

Communication skills: During adolescence, the capacity for reading, writing and speaking reaches full fruition. Teenagers may be less willing to share thoughts and feelings with people in positions of control.

Cognitive development: This is the age of identity, characterized by an increasing ability to think abstractly, make plans, and set long-term goals. Teenagers tend to develop an interest in philosophy, politics and social issues. They also tend to compare themselves with their peers. They are able to understand the general principles of illness and recovery.

Physical growth: Children reach nearly their full height during these years. Also reaching maturation are their secondary sex characteristics. Their internal and external genitalia develop, genital secretions begin, and the sebaceous glands become active. The hips of girls broaden. Boys experience increased muscle mass, their shoulders broaden and their voices deepen.

As adolescents begin to struggle for independence and control, they can challenge their caregivers in new ways:

- asserting their independence from their caregivers
- submitting to the influence of their peers and placing a high value on acceptance by their peers
- experiencing sexual attraction
- falling in love
- entering into long-term, committed relationships

As a counselor, you can help a caregiver to support an adolescent's social development in the following ways:

- Encourage the adolescent to take on new challenges.
- Talk with the adolescent about resisting peer pressure.
- Encourage the adolescent to talk to a trusted adult about problems or concerns, even if that person is not the caregiver.
- Discuss ways to manage and handle stress.
- Provide consistent, loving discipline with limits, restrictions and rewards.
- Find ways to spend time together.

Handout 6.4: Building rapport with children

The following tips, keyed to a child's age as measured by developmental milestones, can help you counsel more effectively.

Development stage of five years and younger

- Physically, get down on the child's level. If the child is sitting on the floor, you should, too.
- Comment positively on the child's appearance.
- Show the child several interesting toys or objects.
- Find a simple game for the two of you to play.

Development stage between the ages of six and 12

- Physically, get down on the child's level.
- Find out what activities or sports the child likes to play.
- Find out the child's hobbies or other interests.
- Look through an interesting magazine together.
- Because children in this age group like to show adults what they can do, ask the child if she or he can do mildly challenging tasks, such as balancing on one foot, hopping and touching his or her nose.

Development stage between the ages of 13 and 18

- Comment positively on your client's appearance.
- Share an object of interest, such as a beautiful rock, and discuss it.
- Look through a magazine or newspaper together.
- Discuss your client's opinions about fashion or ask which film actor or sports figure she or he would like to be.

Session 7: Using interactive communication strategies with children

Handout 7.1: Benefits of using interactive communication strategies with children

Very young children have trouble expressing themselves, because they cannot use words to describe their emotions or thoughts. Thus, counselors need less abstract ways to communicate with children and help them express their feelings.

Interactive tools such as drawing, storytelling and skits can help children to express themselves, explore sensitive issues and identify solutions. Because these are forms of play, they help children to feel safe in the counseling setting. Using many such tools is an effective way to adjust to children's short attention spans.

Interactive counseling strategies are effective

- for shy, introverted or aggressive children
- for children who have trouble expressing themselves
- when conventional verbal communication has failed
- when a child is in crisis
- in helping the child, caregiver and counselor to develop rapport

Interactive communication strategies convey the counselor's respect for the child's identity and emotions, building the child's self-esteem. They are in line with these fundamental principles of child-centered counseling:

- Children are capable of solving problems on their own.
- The child's needs are paramount.
- Counseling is tailored to the child's physical and psychological development.
- The goal of counseling is to promote the child's potential and abilities.

Handout 7.2: Interactive communication strategies for use with children

Drawing

Drawing can be a powerful activity, enabling children to communicate their emotions without words. In this way children open secret drawers that the counselor can explore with them.

Most children enjoy drawing, and it is a useful and practical counseling tool effective for children of all ages and for groups as well as individuals.

Drawing can help children to

- express themselves more freely and thoroughly than they can in words
- feel more comfortable in the counseling setting
- feel successful, because they have made the drawing
- take pride in explaining the drawing from their own perspective

Process

- Give the child drawing material: for example, paper, colored pencils and pens.
- Ask the child to draw on a theme that you want to pursue, such as the family in happy moments or what makes the child angry.
- Stay in active listening mode as the child draws. Ask open questions to lead the child to talk about the drawing and explain the images. (The child may reveal worries about his or her illness or treatment, or some that have nothing to do with HIV.)
- Let the child narrate the sequence of events in the context in which they have drawn.

Prompts

- a normal day in the child's life
- a routine day for the child's caregiver
- what makes the child happy, sad or angry
- how and when the child takes medicine
- the child's family
- a day at school

Storytelling

Stories are useful problem-solving tools. When children, regardless of age, find painful issues difficult to talk about, listening to a story about someone in a similar position can be comforting. Stories can help children see that they are not alone. They can also give children the sense of being understood.

Process

- Storytelling can be done in an individual or group counseling setting.
- Sometimes more effective than telling an entire story yourself is to make it a collaborative effort. You could suggest a topic to prompt a story, outline a story and ask the child or group to bring it to life, or present half of a story and ask the child or group to finish it.
- Avoid using real names or events.
- You can tell a familiar story, fable or folk tale to convey a message to the child that sheds light on a problem.
- You can substitute animals for human beings to create interest and make the story impersonal.
- At the end of the story, encourage the child to talk about the characters and explain their behavior.
- Encourage the child to talk about what happened in the story. Ask if the story has a message or lesson, to find out if the child has understood the story's relevance.

Prompts

Giving a child a topic for a story is a good way to develop problem-solving skills. Encourage the child to make up a story about how the characters find their way to a happy ending. The topics listed below could also be prompts for puppet theater:

- Two children live with their mother and father, who are constantly sick … .
- A five-year-old boy lives in a village with his grandmother. She is old and finds it difficult to take care of the house and the boy … .
- A little girl was very sad. …
- Once upon a time there was a man who got sick … .

Puppetry

This technique works best with older children, in groups. There are many different kinds of puppets for example, string, finger, hand, and shadow. Puppetry can be an extension of storytelling.

Process

- Give the children a topic or an outline for a story, or ask them to develop and perform their own story.
- Suggest to the children that they can select the puppets and decide how the story goes.
- After the performance, discuss the roles of the puppets and what the characters thought, felt and did.
- Relate the discussion to a situation the children face.

Role-playing and drama

Children often mimic the actions of others perhaps especially their parents and peers. Because role-playing and drama simulate a child's actual environment, they give a child space in which to reflect on problems and analyze them.

Role-playing exercises are informal dramas that do not require extensive planning. Most effective for groups of older children, these exercises are a way to act out responses to an issue. Children who do not have roles observe and provide feedback, and in that way continue the process of exploration.

Process

- Give the children a topic for role-play.
- Ask the children to think about the roles and behave and respond in the same manner as the person they are pretending to be.
- After the exercise, invite the children to discuss the roles they played the thoughts, emotions and behaviors the roles allowed them to express.
- Relate the discussion to a real-life situation.

Dramas are formal and do require a script and planning. Actors must practice and perform and an audience must come to see the play. Dramas also enact issues but need expertise to be compelling. When counselors use plays as an interactive communication strategy, feedback is the audience's responsibility.

Play

Children love games. When children play, much of their activity involves imitation or acting out, and this can help you to understand their emotions. Moreover, children are more likely to accept you if you play games with them.

Play can be directive or nondirective.

Directive play, which conveys information and teaches skills, is best suited to children who are older than six and most effective for groups. One approach is to adapt card games and board games such as Snakes and Ladders with content related to such counseling topics as hygiene and adherence to an HIV treatment regimen.

Nondirective play involves acting out events, feelings or thoughts. It is best suited to children younger than six and most effective in an individual counseling session. Invite the child to choose from a variety of play materials: art supplies such as clay and colored pencils; toys such as human and animal figures, dollhouses and miniature cars; and everyday objects such as boxes, strings and sticks. Let the child develop the play activity, but you can shape it by making suggestions.

One possibility is for you to pretend to be the child and for the child to pretend to be his or her caregiver. Observe the child during this game and ask focused questions. Some situations for this role-playing activity are

- a normal day in the caregiver's life
- what happens at home when it is time to take medicine
- the caregiver's morning routine
- the child goes out to play with friends
- mealtime at home

Another possibility is to ask the child to show you parts of his or her life using the play materials. You might ask, “Show me what you like to do with your family,” or simply observe how the child spontaneously plays with a dollhouse and the figures in it.

Do not take over, but you can prompt communication by making comments or asking questions especially helpful if the child gets stuck and cannot proceed. For example, you might say, “I see the mother doll is so sick she can't get out of bed,” and see if the child agrees. Or you could ask, “What's going to happen next?” or “Tell me about this person” (while pointing to one of the characters).

Session 8: Addressing the special counseling needs of children affected by HIV

Handout 8.1: Obtaining a child's consent for HIV testing

Customarily, parents or legal guardians give consent on behalf of their children for medical procedures, including HIV testing. It is unusual to seek separate informed consent from children younger than 10.

Verbal communication with a parent or guardian is normally adequate for the purpose of obtaining their informed consent on behalf of the minor, when the child is aged less than 10 years. This is because of concerns related to developmental stage, emotional maturity, and legal requirements. However, where there is no parent or legal guardian, obtaining consent for children and infants can be difficult. Orphans, child survivors of rape, abandoned infants and street children are specific examples of situations where a parent or guardian many be unavailable to give consent. In such cases the decision to test should be made by the health care worker, provided it is determined to be in best interests of the child. Consent of one parent (maternal or paternal) should be sent o be sufficient.

In all cases it is important to involve the child in the process of testing. A child has a right to information about his or her health status, commensurate to their developmental age and level of maturity.

A child who is 10 years or older should be involved in the process of discussing HIV testing and obtaining a parent's or guardian's consent for the child to be tested. According to the United Nations Convention on the Rights of the Child, a child has the right to "participate in decisions affecting his or her life." The convention also holds that a child's desires should be "given due weight" in accordance with the child's "maturity."

Parents may forbid testing of their children for any reason, including fear that their own status will be disclosed to the community.

A child may consent to his /her HIV testing from the age of 18 years without the parents/guardian's consent.[3]

[3]Policy requirements for HIV testing and counseling of infants and young children in health facilities. World Health Organization and UNICEF;2010.

Counseling about HIV testing should be delivered to children in a rights-based, nonjudgmental, nondiscriminatory, child-friendly and family-friendly manner. Such counseling requires special skills, training and tools. When informing a child of his or her HIV status, you must be able to correctly assess the child's maturity. You should use age-appropriate language, pictures, and symbols; speak briefly and simply; describe the physical setting of the place where the test will be done; focus on the child's feelings; and address the child's fears, assumptions and misconceptions;

Counseling a child's caregiver

- Be relaxed and open.
- Think about your body language: sit close to the caregiver, lean forward, and keep your expression neutral and friendly.
- Assess the caregiver's knowledge of testing children for HIV.
- If the caregiver is reluctant for the child to be tested, do not insist. Instead, probe to find out why.
- If the caregiver is willing for the child to be tested but says the child is not, explore with the caregiver better means of communicating with the child. Seek the caregiver's permission to counsel the child.
- Provide complete information about the testing procedure for children.

Counseling a child

- Get down on the child's level so that the child can see your eyes and read your intentions.
- Build rapport with the child before you start counseling about testing.
- Speak softly. If the caregiver is present, speak directly to the child. Children respond better when you speak to them rather than about them.
- Ask what the child knows or has heard about HIV testing.
- Determine the child's perception of testing and probe for barriers.
- Use age-appropriate interactive communication strategies (Handout 7.2) to help the child overcome any barriers.
- Allow and respect normal emotions. Crying is okay, and so is anger. Be patient with the child.
- Give the child information and offer choices. Choices provide a sense of control. Allow the child to make the decision.
- Support the child's relationship with his or her caregiver, and help the child discuss his or her opinion with the caregiver.
- Avoid comparing the child with others who have agreed to be tested.
- Do not infantilize an older child with such words as “be a good boy” or “that's a good girl.”
- If the child declines testing, do not insist or end the session abruptly. Engage the child in conversation about things of interest such as school or friends or hobbies.

Handout 8.2: Preparing a child for antiretroviral therapy

Preparing children for antiretroviral therapy is important, because the therapy's success depends on taking the drugs as prescribed by the doctor: at the right time and in the correct dose and manner.

Before treatment begins, explain it to the child and obtain the child's consent as well as the caregiver's.

Preparation for the therapy involves the following activities:

Assess the child's and caregiver's readiness for treatment:

- How much do the child and caregiver know and understand about HIV and AIDS?
- What do the child and caregiver know about treatment and its implications?
- Do the child and caregiver understand and accept the implications of disclosing the child's HIV status?
- Is the existing support system strong enough to ensure adherence?
- What are the potential barriers to adherence?
- How emotionally stable are the child and caregiver?
- What is the family's situation, living conditions, financial status, food habits and daily routines?

Assist in planning for treatment and adherence:

- How will disclosure of the child's HIV status be handled, if that is required?
- What is the plan for treatment and adherence?

Advise the child and caregiver about treatment and adherence:

- Make sure the child and caregiver understand that treatment is not a cure, has side-effects, and must be lifelong.
- Explain the importance of adherence to antiretroviral therapy.
- Explain the importance of regular medical follow-up.
- Counsel the child and caregiver about proper diet, nutrition and hygiene.
- Work with the child and caregiver to manage side effects.

Arrange investigations and referrals:

- Work with experts to ensure that the child has an enabling environment for adherence to treatment.
- Support the relationship between the child and caregiver.
- Develop a pictorial monitoring tool to track the child's drug intake.
- Plan regular follow-up visits.

Agree with the child on a treatment and adherence plan.

- Ensure that the child agrees to the plan.
- Ensure that the child commits to 100-percent adherence to treatment.
- Ensure that the child is willing to accept regular follow-up visits.

Handout 8.3: Helping the child of a sick parent to cope

In a family affected by HIV, children will be faced with problems long before AIDS might develop and death occurs.

A parent who suspects or learns that he or she has HIV may show less interest in their children. The parent may experience dramatic mood swings, because of stress, worry about having the disease, and worry about what will happen to their children. Although the children may not know what is wrong with the parent or why the parent is moody, they will surely notice that something has changed and may react with fear and anxiety.

The real pressure begins for a child when he or she realizes that the parent is often sick. Most children are unhappy when a parent is ill. The normal rhythm and structure of family life changes, because the sick parent cannot do the jobs around the house that he or she normally handles. Other family members have to help. Older children understand that these changes are because the parent is sick, but younger children may be upset. Older children will have to accept more responsibility. Children of all ages may begin to feel neglected and angry. Children who already understand the relationship between disease and death might start to worry that the parent may die. They begin to worry about their own future, as well.

Children of parents infected with HIV have reported that they worry about their sick parents. They say they worry about going to school and finding their parent dead when they come home. Often children are afraid that there will be no one to take care of them.

Family case managers should understand these family dynamics and provide counseling assistance, as follows:

- Express to each child that his or her fears are realistic and you will take them seriously.
- Spend time with the parent discussing how the parent can address the children's reactions. Let the parent know that often, children who are preoccupied by fears for a sick parent cannot concentrate in class. Explain to the parent that it is important to spend time with the child and explain what is happening. If the parent is not able to lead that conversation, ask if you can help.
- If the parent is not terminally ill, explain to the children with the parent present that the parent is sick now but that his or her health will improve with treatment. Say that by doing chores around the house they can help the parent to recover faster.

- If the parent is terminally ill, explain to the children that the parent may not recover and that they will need to take more responsibility at home.
- Explain to the children that the sick parent is not choosing to neglect them and they do not need to feel angry at the parent.
- Discuss alternate sources of care and let the children know that they will not be left without someone to look after them.

Handout 8.4: Preparing for and dealing with the death of a parent

Preparation

Preparing a child for the death of a parent is painful but important. It helps the child and the parent to accept what is going to happen. The death of the parent will still be traumatic, but preparing for it softens the blow a little.

Preparing for death also gives the child and the parent time to say all the things that they need to share. Looking back one day, the child will see the time as precious. It can be the basis for healing.

Children who have been prepared for the death of a parent (either by the parent or by other caregivers) generally cope better with the death, because they understand what has happened.

Parents may prepare for their own deaths by arranging with relatives to take care of their children, by drawing up a will to provide for their children, and by talking to their children about death. Their effort goes a long way toward helping their children accept the loss and endows them with a more secure future. Without such preparation, the death of a parent can be earthshaking for a child. The child may be overwhelmed by the sudden loss and may react with shock and confusion. It will take longer for the child to understand what has happened. This makes the grieving process more complicated and may cause severe nightmares, hyperactivity or outbursts of anger.

Aftermath

Most children have seen dead birds or animals by the side of the road. In households with televisions they probably see death daily on television and they also hear about it on the radio. They hear adults talking about death and see them going to funerals. It is normal for children as they play to refer to people or animals dying.

How a child understands the death of a parent is strongly influenced by the child's age, level of understanding, and view of the parent. A child who is being raised by grandparents may react more calmly to news of a parent's death than a child who has grown up with the parent. Nevertheless, a parent's death is always shocking and traumatizing for a child and leaves a child feeling extremely vulnerable.

Adults move through clear stages when dealing with death, but children grieve differently. They do not grieve constantly; instead their grief seems to come and go.

A child may have phases of severe sadness and depression. During these times the child may cry and alternate between clinging and wanting to be left alone. After a while, the grief seems to fade away and may even be forgotten until something triggers a memory of the deceased parent.

Some children try to avoid dealing with the death of a parent. They do not want to think or talk about their parents and prefer to live in their own fantasy worlds. These children may seem to be numb, feeling nothing.

Other children tell of pictures of the deceased parent suddenly flashing through their minds. They have problems concentrating. They feel helpless and afraid and sometimes succumb to anger, aggression or severe depression.

Because of the social and financial consequences of the death of a parent, many children do not get a chance to mourn. They are too busy telling relatives about the death, making funeral arrangements, and organizing transport to bring the corpse home from the hospital. Often the family's money is used up paying for the funeral and food for the guests.

In many cases, the deceased parent dies without a will and without having made plans for the children. When extended family members suddenly take control without talking to the older children who have been managing the family's affairs, these children feel vulnerable and resentful. Extended family members often divide the parent's savings among themselves without taking the needs of the children into consideration.

Orphaned children are often divided among several family members. The children are thus forced to deal with separation from brothers and sisters, as well. A child may be caught between resenting the substitute caregiver while at the same time being dependent on him or her. The caregiver may expect the child to be grateful. Confused by these conflicting feelings, children sometimes act angrily or aggressively toward the caregiver. Ideally, older children should be asked which relative they would like to stay with. If children have to be separated for financial or practical reasons, it is important to discuss these reasons with older children.

Handout 8.5: Coping with the stigma of HIV

Children are severely affected by the stigma of this disease and experience discrimination from members of their extended families and their communities.

Orphans and children whose parents are HIV-positive generally face teasing by other children. Sometimes the teasing may lead to physical bullying. They may not be allowed to play with other children. Many children may say that they would rather stay at home than go to school. They may rely on teachers and others to protect them from the teasing and to respect their privacy.

In certain communities gossip about people's HIV status by the community members can be common. Many adolescents might feel hurt by the gossip and their sense of self-worth can get affected. Parents who are HIV-positive can feel the same way. It often becomes hard to support their children who are being teased when they are the subjects of gossip, as well.

Some families keep the HIV status of a family member secret. Some children make up stories about their parents and family. Children may start living in this fantasy world in order to cope with what is actually happening at home. Children between the ages of five and eight may not be able to distinguish between their fantasy worlds and reality.

Older children probably make up stories about their parents because they feel ashamed and do not want their friends to see them as different. Some children worry that teachers or other authorities and may find out that something is not "normal" at home and they can get afraid of having to answer questions.

Forced secrecy can be a great burden, because it forces children to control what they say, what they do, and how they express what they feel. The secrecy and stigma still attached to HIV make dealing with the illness and death of parents even more difficult for children. In certain communities people still see children who have been orphaned by AIDS as different from children who have been orphaned by other diseases or by accidents.

Counseling tips

- Children cannot put a stop to stigma. They need committed adults, religious groups and organizations, and institutions to support them and fight for their rights. This will eventually erase the stigma that attaches to HIV and AIDS.

- Children require your utmost support and sensitivity. Explain to them that stigma results from ignorance and that those who tease and bully do not understand the seriousness of their actions.

- Encourage the children you counsel to try to avoid bullies and to walk away when confronted.
- Affirm the child's right to report these events to supportive teachers and seek their protection.
- Educate parents and caregivers to be alert to problems arising from stigma. A child may not volunteer the information, even if directly asked, so parents and caregivers need to ask probing questions about the child's day.
- Observe the child and ask the caregiver if the child has been asking to stay away from school for insignificant reasons.

[4]Schmitt B. School avoidance. In: Parker S, Zuckerman B, Augustyn M. Developmental behavioral pediatrics a handbook for primary care. 2nd ed. New York: Lippincott, Williams & Wilkins; 2004.

Handout 8.6: Disclosing a child's positive HIV status

Disclosing to a child and his or her caregivers that the child has HIV should be undertaken in a manner that is sensitive to the child's age, developmental level, emotional maturity, level of understanding and communication skills. Disclosure can take either of two forms:

- partial , in which rudimentary information is conveyed about the child's health and HIV status ("You have an infection in your blood")
- full, in which complete information is conveyed about the child's HIV status, including the name of the virus, the likely mode of transmission, and the implications for the child's health

Disclosure is usually a process, not a one-time event, and involves both the child and the caregiver. Ideally, the process begins with partial disclosure and proceeds eventually to full disclosure.

Starting with partial disclosure allows children to get used to the concepts. In general, a caregiver should partially disclose the information to a child. This process will help all parties feel more comfortable when you introduce health and treatment education.

Points to consider before beginning the disclosure process

It is imperative for you to identify whether the child and caregiver are aware of the child's HIV status. If the caregiver knows and the child does not, you should explore with the caregiver the following questions:

(a) *Why* should the child's HIV status be disclosed?

(b) *When* should the status be disclosed?

(c) *How much* information should be disclosed?

(d) *How* should the status be disclosed?

(e) *Who else* should know the child's status for example, the school principal and the extended family?

Encourage the caregiver to be the first to speak to the child. The caregiver can practice disclosure with you through role-playing. If the caregiver does not want to convey the information, you may do so with the caregiver's consent and in the caregiver's presence.

Advantages of disclosing children's HIV status to them

As children grow up and mature, they have a right to information about their illness. This knowledge encourages children to participate actively in their own medical care.

- Children who find out about their HIV-positive status from a person other than their caregivers may lose trust in their caregivers.
- Children who learn their HIV status from others tend to suppress their emotions and have trouble accepting the situation and adapting to it.
- Caregivers who have disclosed their children's HIV status to them experience less depression than those who have not.
- When children receive simple, concrete and direct information appropriate to their age and maturity from a person they trust in a supportive environment, their psychological trauma can be reduced and the negative impact of disclosure – for example, fantasies and nightmares – can be minimized.
- Studies suggest that children who know their HIV-positive status have higher self-esteem and are better able to cope with their illness than children who have not been told.

Counseling tips

Barriers	Response
Caregivers want to shield children from bad news and feel that not talking to the child about HIV protects them.	• You can talk to the caregiver alone and explain the advantages of disclosure.
Caregivers feel guilty. They believe that if they talk to their children about HIV, they will be judged and will lose respect.	
Caregivers feel uncomfortable about HIV. They do not know what to say to their children and how to answer their questions.	• You can guide the caregiver, who can then disclose the child's HIV status in your presence.
Caregivers are afraid of the social consequences of disclosure.	• You can also advocate at least partial disclosure.

Barriers	Response
Caregivers are afraid of becoming emotional when disclosing their children's status.	• You can guide the caregiver, who can then disclose the child's HIV status in your presence. • You can also advocate at least partial disclosure. • You can use – or teach the caregiver to use – interactive communication strategies for disclosure, such as storytelling, role-playing, puppetry, and drawing.
Caregivers fear that children might talk about their HIV status to others, thus revealing that the caregivers are HIV-positive, as well. Cultural taboos may prevent the caregiver from talking openly and honestly to the child.	• You can talk to the caregiver alone and explain the advantages of disclosure. • You can also advocate at least partial disclosure. • You should explain to the child that some family matters are not discussed with others, and this is one.
There may be no caregiver available for disclosure for example, if a child has been orphaned and is on his or her own.	• You can ask if the child has siblings who know his or her status and may have disclosed it to the child. • You can work through the caregiver most closely associated with the child in an institution or community.

Handout 8.7: Child abuse

What is physical abuse?

Physical abuse is when the child's body is hurt. This ranges from small bruises to broken bones or even death. The child's body may be hurt by punching, beating, hitting, biting, shaking, burning, throwing, choking or stabbing. Whether or not the person meant to hurt the child is irrelevant. Such injuries are considered abuse, even if the person who hurt the child tells you, "I didn't mean to do it."

What is sexual abuse?

Sexual abuse includes fondling the child's genitals, penetration (inserting the penis into the child's mouth, anus or vagina as well as inserting objects into the child's mouth, anus or vagina), indecent exposure (showing sexual body parts to the child), trading sex with the child for money, and producing pornographic pictures or videos of the child.

What is emotional abuse?

Emotional abuse covers much different behavior, but we can say that any repeated behavior that harms the child's emotional development or the child's sense of self-worth – the child's feeling that he or she is a valuable person who deserves to be loved and to be happy – is abusive. If a child is criticized all the time, repeatedly threatened, or pushed away, you could say that the child is emotionally abused. If a caregiver consistently refuses to be loving and affectionate or to support or guide the child, you could say that the child is emotionally abused. Children have the right to be valued and supported.

Children are safest from abuse and neglect if they are raised in environments that value and support children.

What can caregivers do to prevent abuse?

As a counselor, you can help caregivers to protect their children from abuse with the following guidance:

- Make sure that each child has his or her own place to sleep.
- If a child refuses to stay alone with a certain person, do not force him or her to do so.
- Make time for the child. Show an interest in what the child is doing. Talk with the child about things that happen in his or her life. Ask the child what he or she did at school and after school. Get to know the child's friends and the child's teachers.

- Teach the child that his or her body belongs to him or her alone.

- Teach the child about feelings which ones are okay and which ones are not okay.

- Childhood is an important learning time for children a time when they learn to be confident and assertive. Sometimes children think that because they are "just" children, they do not have rights. Children need to understand that rights are things that they are allowed to do and no one may stop them. One of these is the right to feel safe. Another is the right to say no when someone touches them in a way that makes them feel uncomfortable.

- Most children are trusting. It is important for children to learn the difference between good secrets and bad secrets. Good secrets are okay to keep. Bad secrets need to be told to someone who can help. In the same way, children need to understand the difference between a present given to him or her because they are loved and a present that is given in exchange for something that they must do in return.

Counseling children about abuse

Discuss the issue of "sugar daddies" with children. Gifts and support may be tempting for a child, but you need to talk about the emotional and physical consequences for a child and the reason why men like these offer their help. Children must be made to understand that men like this want to harm children, not help them. Talk about safe places where children can find help and support from people who will not hurt them.

Helping children who have been abused live through such difficult experiences and encouraging their resilience often demands more than ordinary caregivers are able to offer.

If a child tells you that he or she has been abused, listen to what the child has to say and treat the information seriously. Take time to listen to the child [choose a time that suits you both]. Make sure that you stick to this arrangement and that you can listen to the child without any disturbances.

Bear in mind that the child will only reveal as much information as she or he feels that you, the listener, are comfortable hearing. Try to avoid making judgmental or strongly emotional remarks, even though you may find that difficult. The child needs to feel that he or she is safe with you and that you are able to cope with the information that he or she is sharing. It is important for the child to feel accepted and respected in whatever he or she tells you.

Session 9: Developing a memory book

Handout 9.1: The value of a memory book

Creating a memory book is a way for parents who are living with HIV to document the family's history and traditions and other important personal information for their children. The process of making a memory book can be as helpful as the book itself. Here are some examples of the benefits:

- opens channels of communication between parents and children, thus improving the relationship
- helps children understand their families' traditions and beliefs
- gives parents a place to state their hopes and advice for the future
- encourages parents to plan for their children's future
- encourages a parent to set up a will, making the child's inheritance more secure if the parent dies
- increases the child's knowledge of family assets and how to manage them
- helps a parent to realize the importance of naming a guardian for their child and forges a link between the child and the guardian
- puts a child in touch with a "lost" parent and perhaps also that parent's family
- improves the self-image and self-esteem of parents who are HIV- positive
- encourages parents to disclose their HIV status to their children, and possibly to the wider community, as well
- increases the child's knowledge of HIV and how to avoid infection
- helps to raise awareness in the community of HIV and to decrease stigma for people who are living with HIV

The aim of a memory book is to give surviving children a clear sense of identity, including the parent's

- personal history and important life experiences
- family background
- family traditions
- guidance about how to face up to life, on whom to rely, and how to contact relatives
- photographs and other types of pictures

Session 10: Addressing the special counseling needs of adults

Handout 10.1: Counseling adults about HIV testing

A blood test is all that is needed to find out if someone has HIV. Your goals as a counselor are to enable your clients to choose voluntarily to be tested and in turn to encourage their family members to be tested. Clients who learn they are HIV-positive will need your support to deal with their status.

Pretest counseling

Motivate the client and the client's family to be tested. This involves the following tasks:

- Explain that detecting HIV early makes early care and support possible and also is important for preventing mother-to-child transmission of the virus.
- Because information on the importance of testing is rarely sufficient to lead a client to be tested, you should probe for barriers.
- List the major barriers to HIV testing that emerge from the conversation.
- To help the client overcome barriers to testing, review the list with the client and ask open-ended and hypothetical questions about its content: for example, "What would happen if your wife also tests positive for HIV?"

When your client and his or her family agree to be tested, provide moral support by offering to accompany them and to counsel with them after they receive their results.

Post-test counseling

Your role is to help those whose tests are positive and the family as a whole to

understand and accept the result and to cope with HIV.

Make effective use of silence to allow clients to overcome their emotions. When clients are ready, explore their feelings. Ask, "What are your biggest concerns about being HIV-positive?" You may

then address those concerns by counseling clients on any or all of the following topics:

- planning for the future: family planning methods, financial planning and care for children
- multidimensional support for the client and family: emotional, social and spiritual through counseling in individual and peer-group settings and through access to organizational resources
- medical care: treatment and prevention of infections and diseases
- preventing transmission of HIV from mother to child
- positive living through good nutrition, clean water, rest, exercise and household sanitation
- risk reduction: abstinence, being faithful, using condoms, limiting the number of sexual partners and disclosure of status

You are also in a position to help clients who are HIV-positive and their families by conducting community interventions:

- sensitizing the community to the needs of families coping with HIV
- mobilizing community members to help meet those needs
- addressing stigma and promoting empathy

Handout 10.2: Counseling adults about disclosing their status

Disclosure can help clients in the following ways:

- Accept their status and reduce the stress of coping without assistance.
- Access medical services, care and support.
- Protect themselves and others.
- Influence others to avoid infection.

Counseling methods to prepare clients for disclosure

- Let clients think about their barriers to disclosure and the consequences disclosure might have.
- Help clients to identify the advantages and disadvantages of disclosure.
- Brief clients on the advantages of treatment for HIV.
- Identify sources of support for clients.
- When clients decide to disclose their status, help them to identify the people to whom they can disclose it.
- Discuss in detail how clients will go about disclosing their status.
- Prepare clients for reactions of shock and hostility.
- Work out with clients how they will respond to the feelings of people to whom they disclose their status.

Handout 10.3: Counseling adults about adherence to antiretroviral therapy

Adherence is "the extent to which a person's behavior, taking of medication and following a healthy lifestyle including a healthy diet and other activities, correspond with the agreed recommendations of the health care providers."

Adherence counseling entails helping clients who are HIV-positive to comply with their treatment regimen, by working with them to identify and overcome challenges. Adherence is key to maintaining a high quality of life.

Objectives of adherence counseling

- Help clients understand their treatment and its challenges.
- Prepare clients to initiate treatment.
- Help clients set goals for their treatment.
- Help clients develop behavior that promotes adherence.
- Provide ongoing support for clients to adhere to treatment long-term.

Challenges to successful antiretroviral therapy

- The regimen requires lifelong compliance.
- Clients must take the drugs on a fixed schedule.
- Opportunistic infections call for additional drugs.
- Drug side effects make it difficult to adhere ART
- The therapy has psychological, social and economic consequences.

Predictors of faithful adherence

- Clients have disclosed their status.
- They have recourse to emotional and practical support.
- They are able to fit the drug regimen into their daily routine.
- They feel comfortable taking medicine in front of others.
- They believe and have confidence in their providers and in the efficacy of the medicines.
- They show personal determination to adhere to treatment.

- Their symptoms improve with the therapy.
- They have adequate food and regular meals.
- They keep their appointments at the therapy center.

Predictors of poor adherence

- Clients lack a good relationship with the treatment center.
- They have mental illness, such as depression.
- They suffer from alcoholism and use of other unprescribed drugs.
- They have not received adequate education about HIV.
- Their nutritional status is low.
- They lack reliable access to primary health care and education.
- They fear or experience side effects from the therapy.
- They experience domestic violence.
- Their belief systems and cultural practices are at odds with the treatment.

Counseling tips

Your focus as a counselor will shift as a client's treatment progresses.

Before treatment

- Schedule at least two sessions before your client's treatment begins.
- Develop a rapport built on trust.
- Conduct a behavioral and psychosocial assessment of your client.
- Educate your client about HIV treatment, explain the possible side effects, and emphasize the importance of adherence. Give your client information sheets.
- Assess your client's readiness for and commitment to the therapy.
- Encourage disclosure, but remember that the decision must rest with your client.
- Encourage your client to establish relationships with peers who are in treatment and help your client identify people who can support the treatment.
- Develop an individual treatment plan for ART initiation.

When therapy begins

- Re-assess your client's readiness and counsel on all aspects of the therapy.
- Confirm that your client is committed to lifelong therapy and understands why adherence is essential.
- Describe the medicine.
- Review the possible side effects and assure the client that they usually resolve within the first three months of treatment.
- Advise the client about storing the medicine.
- Help your client solve practical problems in the antiretroviral treatment plan.
- Assess financial difficulties and help your client access secondary sources of support.
- Confirm contact details.

When therapy is in progress

- Assess adherence two weeks after the therapy starts and regularly thereafter, by listening to the client's own reports and by counting pills.
- If the client is not taking the correct doses, find out why and work out strategies for adherence.
- Ask about problems taking the medicine.
- Ask about side effects and help the client understand them clearly.
- Check with the client about other prescribed medication and use of alcohol and other unprescribed drugs.
- Work with the client to plan a diet with proper nutrition, an exercise routine and habits for positive living.
- Discuss how treatment has changed areas of the client's life and how to minimize some of the negative effects.
- Review the frequency of clinic visits
- Plan for follow-up counseling
- Review the level of support the client is receiving from the family and community.

Counseling about side effects of antiretroviral therapy

- Discuss the common and possible side effects before and throughout treatment.
- Pay immediate and close attention to any side effects your client complains about.
- Initiate a discussion of side effects if your client does not mention any.
- Ask simple and open-ended questions
- Give advice on how to manage the side effects.
- Inform your client about potentially serious side effects that require immediate medical attention.
- Educate your client about the interactions of antiretroviral drugs with other drugs, being careful to use a level of detail that your client can understand. Answer questions your client raises simply and accurately.

Handout 10.4: End-of-life care

You can help a client at the end of life by practicing active listening and by using other counseling tools for social and emotional support.

Preparing your client for death

- Be present and compassionate with the client.
- Provide physical contact by holding your client's hand with a light touch.
- Encourage communication within the family.
- Make sure that the family and others respect your client's wishes.
- Discuss worrying issues such as custody of children, family support, future school fees, old quarrels and funeral costs.
- Offer practical support to help your client resolve these issues.
- Make sure your client gets help with feelings of guilt or regret.
- Tell your client that they are loved and will be remembered.
- Bring in a spiritual or religious counselor if your client requests one.
- Ask if your client wishes to die with pastoral care or with only family present.
- Talk in more detail about death if your client wishes, but keep in mind cultural taboos that should deter you from broaching the subject if your relationship with the client is not close.
- Be aware of and responsive to the stages of grief: denial, bargaining, anger, depression and acceptance.[5]
- Help your client accept his or her own death.
- Keep communication open. If your client does not want to talk to you, ask: "Would you like to talk later?"

Measures to propose to a caregiver when your client is close to death

- Make sure someone is holding the person's hand, listening and conversing.
- Moisten lips, mouth and eyes (applying drops) frequently.
- Keep the person clean and dry and prepare for bladder and bowel incontinence.
- Manage pain and other symptoms with medicines essential to relieve suffering: for example, antidiarrheal drugs and round-the-clock doses of paracetamol to ease pain and treat fever.

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[5]Kubler-Ross.E; Kessler.D, On Grief and Grieving Finding the meaning of grief through five stages of loss; 2005.

If the person is dying of AIDS, antibiotics and antifungals will be palliative, as well. Make sure pain is under control.

- Do not worry that the person is eating less or prod the person to eat more.
- To avoid bedsores, turn the person at least every two hours.

Signs that death is imminent

- decreased social interaction: the person sleeps more, acts confused, and may slip into a coma
- decreased food and fluid intake: no hunger or thirst
- changes in elimination: reduced urine and bowel movements or incontinence
- respiratory changes: irregular breathing; "death rattle" (the sound someone near death makes because saliva has accumulated in the throat)
- circulatory changes: cold and grayish or purple extremities; decreased heart rate and blood pressure

Signs that death has occurred

- breathing, heartbeat and pulse stop completely
- no response to shaking or calling
- fixed gaze if the eyes are open
- skin tone changes to white or gray

Counseling a bereaved family

- Be aware of and responsive to the stages of grief: denial, disbelief, confusion, shock, sadness, bargaining, yearning, anger, humiliation, despair, guilt and acceptance.
- Help the family accept the death of the loved one.
- Share the family's sorrow; encourage them to talk about their feelings and memories.
- Do not offer false comfort; speak simply and take time to listen.
- Try to find a friend or neighbor to offer practical help such as cooking and running errands.
- Ask the family if they can afford funeral costs and future school fees, and help them find a solution if they can't.
- Encourage patience; it can take a long time to recover from a major loss.
- Say that they will never stop missing their loved one, but the pain will ease and allow them to go on with life.

Session 11: Documenting the counseling process

Handout 11.1: Sample case report form to document counseling sessions

This form, with minor changes, was used in the Balasahyoga program. It can be adapted for use in others. The acronym FCM stands for family case manager.

FCM number/name:
FCM code:
Household ID code:
Date of the session:
Length of the session:
Session number:

Presenting issues	Precipitating factors	Counseling intervention

Outcome of the previous session

Counseling interventions in the previous session

Goals set or decision made by the client about the presenting issues in the previous session

If the client did not make progress toward the goals or implement the decision, state the reasons why.

Plan for the next session

Note on the referral made by the counselor, if any

Counseling difficulties

1. . . . . .
2. . . . . .
3. . . . . .
4. . . . . .
5. . . . . .

Suggestions/interventions to resolve the counselor's difficulties (for completion by the supervisor in consultation with the counselor)

Signature of the counselor _ _ _ _ _ _ _ _ _ _ _ _ _

Signature of the supervisor _ _ _ _ _ _ _ _ _ _ _ _ _

*Signature of the project coordinator*_ _ _ _ _ _ _ _ _

Session 12: Supervising the counseling process

Handout 12.1: Goals for the supervision of counselors

Read the following statements and place checks next to those you believe are appropriate goals for the supervision of counselors. You have five minutes for this exercise.

1.	Protect the interests of the client.	
2.	Update counselors and improve their knowledge and skills.	
3.	Ensure that counselors report to their immediate supervisors.	
4.	Explore how counselors' personal issues may affect their work.	
5.	Provide counselors with job descriptions.	
6.	Develop counselors' self-awareness and insight.	
7.	Check that counselors arrive at work and leave work on time.	
8.	Support and guide newly trained counselors.	
9.	Encourage counselors to adopt effective stress- management strategies.	
10.	Provide psychotherapy and other forms of counseling to counselors.	
11.	Facilitate the transfer and integration of counseling skills.	
12.	Identify and prevent counselor burnout.	
13.	Provide counselors with emotional support.	
14.	Provide counselors with a positive role model.	
15.	Monitor the quality of counseling practices and uphold the professional standards of supervisors of counselors.	

Handout 12.2: What supervisors of counselors should not do

- Counsel the counselor.
- Impose on the counselor.
- Use negative criticism (this is different from constructive feedback).
- Disempower.
- Make friends with the counselor.
- Find fault.
- Supervise with the intention to promote, demote or terminate a counselor, regardless of job performance.
- Punish.
- Pay attention only to new counselors.
- Serve only the organization, to the detriment of a counselor's clients.

Handout 12.3: Responsibilities of the counseling supervisor and the counselor

The supervisor and the counselor have important roles and responsibilities for counseling supervision to be successful. Both must be active participants and willing learners. They must give each other feedback about how the supervision is progressing. As the working relationship develops, the supervisor and counselor should help each other to feel comfortable in their roles, so that their confidence and competence can grow.

Counseling supervisor	Counselor
Capacity builder • Shares work-related knowledge and experiences • Teaches by example • Generates ideas • Provides opportunities for the transfer of knowledge and the practice of new skills	**Active participant** • Presents issues, cases and dilemmas in a variety of formats • Is open to maximizing learning opportunities • Puts new knowledge and skills into practice, as guided by the supervisor
Challenger • Gives open, honest and constructive feedback on performance • Sets performance standards • Challenges negative behaviors or attitudes	**Learner/student** • Accepts and integrates knowledge and skills acquired • Addresses issues related to self-awareness and professional development • Commits to ongoing upgrading of knowledge and skills in counseling practices and understanding of HIV and AIDS

Counseling supervisor	Counselor
Guide/role model • Encourages critical thinking; inspires and models high- professional standards • Promotes and sustains ethical practices • Models all targeted counseling skills • Offers learning options	**Guide** • Guides his or her personal learning agenda • Makes suggestions about learning needs and areas that need to be strengthened • Monitors the supervision process and provides constructive feedback to the supervisor
Supporter • Listens empathetically • Serves as a confidante when necessary • Motivates and empowers the counselor • Promotes self-awareness	**Facilitator** • Fosters conditions that encourage the supervisor to provide a high standard of services
Mediator/facilitator • Mediates conflict between the counselor and management • Facilitates problem-solving	**Reflector** • Reflects openly on practical issues and skills base • Reflects on feelings experienced during counseling sessions
Learner • Requests feedback on his or her performance as a supervisor • Is open to new ideas • Commits to ongoing upgrading of knowledge and skills in counseling practices and understanding of HIV and AIDS	

Session 13: Managing stress and burnout

Handout 13.1: Differences between stress and burnout

Stress	Burnout
Obsession	A defense mechanism characterized by disengagement
Overactive emotions	Blunted emotions
Physical health at risk	Emotional health at risk
Physical exhaustion	Emotional exhaustion inhibiting motivation and drive
Disintegration	Demoralization
Loss of physical energy	Loss of ideals and hope
Urgency and hyperactivity	Helplessness
Produces panic, phobias and anxiety disorders	Produces depersonalization and detachment

Handout 13.2: Strategies for managing stress

Take action

- Talk to someone you trust.
- Laugh.
- Write, gaining perspective by putting your feelings on paper.
- Create distance, by asking yourself how much it will matter a few years from now.
- Do relaxation exercises or meditate.
- Get physical exercise.
- Confront a potential source of stress, by addressing concerns before they escalate.
- Establish a 15-minute worry session, and put aside your worries until then.
- Create diversion, by doing something you enjoy.
- Get enough sleep.
- Eat balanced meals.
- Avoid negative people and places as much as possible.
- Delegate: What can others do to reduce your load?
- Be a team member: Share concerns appropriately with others.

Change your mind

Unhealthy attitudes	Antidotes
Feeling used/taken for granted	Know your rights and needs, and let others know them.
Workaholism	Balance work, family, play and rest.
Negative and self-defeating thoughts	Think positively; smiling releases tension.
Self-punishment	Be as fair to yourself as you are to others.
Disliking yourself	Accept yourself as you are.
Defensiveness	Be yourself; allow yourself to be human.

Change the stressor

- What is in my power to change or influence?
- Can I take action by myself?
- Who might help me?
- If the stressor changes, what will the advantages and disadvantages be to me and others?

Adapt to the stressor

- Can I take it less seriously?
- Can I turn a threat into an opportunity?
- "I will be okay no matter what."
- Be solution-focused, but keep an open mind.
- Do relaxation exercises (physical and mental).
- Be assertive, set boundaries, and learn to say no.

Handout 13.3: Strategies for managing stress

Stress management plan

For each of the key areas below, identify what you need to do to improve your own well-being in order to become an effective counseling supervisor.

Area	Stressors	What I need to do	By when
Physical (for example, health, nutrition, sleep, housing, exercise, recreation)			
Family/relationships			
Work			
Spiritual			
Psychological			
Others			

Session 15: Closing the training program

Handout 15.1: Pretest/post-test

Read the following questions and circle the correct answer.

Purpose:

- To help the facilitator and participants identify strengths and areas for learning
- To measure changes in the level of knowledge and skill gained as a result of the training.

Instructions:

- Distribute course assessment
- Each participant need to complete the test individually
- Collect the tests – Make sure that each person has recorded their name clearly. (Some trainers may prefer to assign numbers).
- The trainer may assist the participants with low level of literacy by reading out the questions to them.

1.	Counseling is exploring options with clients and enabling them to make their own decisions.	Yes	No
2.	Child development is a gradual process from birth to adolescence and does not have different stages.	Yes	No
3.	Children need adults to solve their problems and do not have the capacity to resolve problems on their own.	Yes	No
4.	Active listening is a basic skill of a counselor.	Yes	No
5.	A counselor need not make any preparations before beginning a counseling session.	Yes	No
6.	A counselor must avoid moralistic judgment or preaching.	Yes	No
7.	Drawing is an interactive strategy for communicating with children.	Yes	No

8.	A child needs no preparation for antiretroviral therapy. Preparing the child's parent or caregiver is sufficient.	Yes	No
9.	Children who have been prepared for the death of a parent generally cope better, because they understand what is happening.	Yes	No
10.	Counselors should not encourage children who are teased to avoid their teasers and walk away when confronted.	Yes	No
11.	A counselor can encourage a client to disclose his or her HIV status.	Yes	No
12.	A memory book helps to open channels of communication between parents and their children and improve the relationship.	Yes	No
13.	Children commonly experience loss of appetite when they begin antiretroviral therapy, but gradually their appetites return.	Yes	No
14.	Silence is not an effective tool for counseling a client when it is about sharing the results of an HIV test.	Yes	No
15.	A counselor should schedule at least two counseling sessions before a client begins antiretroviral therapy.	Yes	No
16.	If a client on antiretroviral therapy does not mention side effects, the counselor should initiate discussion.	Yes	No
17.	Bereavement counseling is for a client who is sick and may be dying and not for that person's family members.	Yes	No
18.	The point of supervising counselors is to find fault with them.	Yes	No
19.	Stress leads to burnout.	Yes	No
20.	Counseling involves making decisions on a client's behalf.	Yes	No

Content for Supplementary Power Point Slides

Slide 1: Objectives of the training

The broad objectives of the training are to

- build your skills in basic counseling and enable you to use them in your work with children and families
- improve your knowledge of child communication techniques
- increase your capacity to meet a critical need: counseling children and adults who are dealing with HIV
- teach you how supervisors should support counselors
- enhance your understanding of the ethics of counseling
- enhance your ability to recognize and manage stress and burnout

Slide 2: What is counseling?

Counseling is a process, based on a relationship of empathy, acceptance and trust. Within this relationship, counselors focus on their clients' feelings, thoughts and actions to empower clients to

- cope with their circumstances
- explore options
- make their own decisions
- take responsibility for those decisions

As a result, clients

- feel less anxious
- feel confident to make decisions
- take action
- grow and change

Rather than give advice, counselors help people to face their problems, understand their feelings, examine their options and choose the options that seem best. Counselors create settings in which clients can examine thoughts and feelings.

Slide 3: Focuses of effective counseling

Feelings	NOT	Facts
People	NOT	Problems
People	NOT	Principles
Exploring	NOT	Advising or analyzing
Accepting	NOT	Judging
Listening	NOT	Lecturing
Empathy	NOT	Sympathy
Mirroring	NOT	Leading, agreeing or moralizing
Showing respect	NOT	Being patronizing or dictatorial
Empowerment	NOT	Dependence
Genuineness	NOT	Playing a role (pretending)
Openness	NOT	Manipulation
Facing pain and reality	NOT	Promoting avoidance or a quick fix

Slide 4: The main skills you need for counseling

- Empathy: Putting yourself in your client's place
- Active listening: Paying attention to your client's verbal and nonverbal messages
- Identifying (naming) your client's feelings: To show the client that you are practicing active listening
- Paraphrasing: Rewording (and reframing) what your client says
- Asking good questions: To understand clearly your client's problems or worries
- Affirming: To acknowledge your client's right to his or her opinions and feelings
- Silence: Giving your client time to think about what to say

Slide 5: How to prepare for a counseling session

- Know how much time you have for the session before you arrive at the client's home.
- Know when you are available for your next appointment before you begin. Have a list of dates ready to propose to your client.
- Do not bring your personal problems into the counseling session. Clients and their families need your strength. If you need help with a problem, seek support from other counselors or support groups not from your client.
- Look and feel presentable. Do not go to a counseling session if you are feeling ill or unable to present yourself to your client in a positive way.
- Read your notes from previous sessions to remember where you left off and important issues to follow up.
- Bring to the session any information or relevant materials your client has requested previously.
- Bring a pen and paper for taking notes.

Slide 6: Preparing the counseling environment

- Remove any items such as radios, telephones and cell phones that can create distractions.
- To create a relaxed and informal atmosphere, arrange chairs, stools or mats at angles a comfortable distance apart. Do not place them directly facing one another.
- Do not sit with any barriers such as desks or tables between you and your client.
- Do everything possible to ensure privacy during the session. For example, place a "do not disturb" sign on the door or simply ask family members not to interrupt you.
- Have objects you will need during the counseling session information booklets, drinking water, tissues and condoms within reach.

Slide 7: Effective ways to begin the counseling session

- Greet your client. Ask how your client is feeling and if there are any issues he or she would like to discuss in the session.
- Reach agreement with your client on how long the session will last.

If this is the first session:

- Reach agreement on the language the two of you will speak.
- Explain your role as a counselor.
- Establish agreement with your client on what the two of you can expect from one another during the counseling.
- Explain that everything said within the session will remain confidential, unless your client wants to involve specific friends or family members. If the client chooses "shared confidentiality," he or she must give consent to the information to be conveyed and stipulate who may receive it. When this protocol is adopted, you may be able to broaden the scope of your work to engage in couples, family or group counseling as tools to resolve issues.
- Request your client's permission to take notes (but never take notes while your client is speaking).

Slide 8: Effective ways to conduct the counseling session

Assess: "What would you like to talk about today?"

Ask about the client's health or concerns.

Check the client's knowledge, beliefs or behaviors.

Advise: "I have some information. Would you like to hear it?"

Using nonjudgmental language, give correct information about the client's illness, the risks the client might be taking, the benefits of treatments, positive living (that is, habits a person who is HIV-positive can adopt to stay healthy), and so forth. Provide options.

Agree: "Given the options we've discussed, what would you like to do?"

Help the client decide by discussing the possible advantages and disadvantages of each option. Help the client select from the options discussed. Make sure that the client's decisions are clear, measurable and limited in number. The goals must be within the client's direct control.

Assist: "What problems might arise when you follow this plan?"

Help by providing written information or adherence equipment, such as pillboxes or calendars. Help clients anticipate barriers to their plans. Link the client to resources such as peer support or group education sessions.

Arrange: "I would like to see you again [suggest a specific date if possible] to find out how you're doing."

Arrange follow-up appointments and access to support. Give the client a written list of upcoming meeting dates. Record what happened during the visit.

Slide 9: Ending the counseling session

- Summarize what the two of you discussed and review your client's action plan.
- Ask how your client feels about the session and what could make it better next time.
- Ask the client if he or she has any questions.
- Acknowledge the client's contribution to the session. Congratulate the client for making progress toward solving problems or for discussing a sensitive issue openly and honestly.
- Set a date for the next home visit.
- Make referrals or direct your client to information and other resources that you may have discussed in the session.
- Accompany your client to the door while engaging in positive, social talk.

Slide 10: Importance of aligning counseling with a child's developmental stage

- Growth and development are important indicators of a child's health.
- HIV infection can lead to growth problems, developmental delays and developmental regression.
- HIV treatment options are keyed to a child's stage of growth.
- Measures of a child's development reveal nutritional needs.
- A child's developmental stage determines the content, skills and tools needed for effective counseling.

Slide 11: Benefits of interactive communication strategies

These counseling strategies are effective

- for shy, introverted or aggressive children
- for children who have trouble expressing themselves
- when conventional verbal communication has failed
- when a child is in crisis
- in helping the child, caregiver and counselor to develop rapport

Interactive communication strategies convey the counselor's respect for the child's identity and emotions, building the child's self-esteem.

Slide 12: The value of a memory book

Creating a memory book is a way for parents who are living with HIV to document the family's history and traditions and other important personal information for their children. The process of making a memory book can be as helpful as the book itself. Examples of benefits are:

- opens channels of communication between parents and children, thus improving the relationship
- helps children understand their families' traditions and beliefs
- gives parents a place to state their hopes and advice for the future
- encourages parents to plan for their children's future
- encourages a parent to set up a will, making the child's inheritance more secure if the parent dies
- increases the child's knowledge of family assets and how to manage them
- helps a parent to realize the importance of naming a guardian for their child and forges a link between the child and the guardian
- puts a child in touch with the issues related to a “lost” parent and perhaps also that parent's family
- improves the self-image and self-esteem of parents who are HIV- positive
- encourages parents to disclose their HIV status to their children, and possibly to the wider community, as well
- increases the child's knowledge of HIV and how to avoid infection
- helps to raise awareness in the community of HIV and to decrease stigma for people who are living with HIV

Slide 13: What can go into a memory book

Examples of material that a client might place in a memory book are

- personal history
- memorable incidents
- photographs and drawings
- family background
- family traditions
- advice
- names of people on whom a child can rely
- instructions for contacting relatives
- financial information

Slide 14: What supervisors of counselors should not do

- Counsel the counselor
- Impose on the counselor
- Use negative criticism (this is different from constructive feedback)
- Disempower
- Make friends with the counselor
- Find fault
- Supervise with the intention to promote, demote or terminate a counselor, regardless of job performance
- Punish
- Pay attention only to new counselors
- Serve only the organization, to the detriment of a counselor's clients

Slide 15: Differences between stress and burnout

Stress	Burnout
Obsession	A defense mechanism characterized by disengagement
Overactive emotions	Blunted emotions
Physical health at risk	Emotional health at risk
Physical exhaustion	Emotional exhaustion inhibiting motivation and drive
Disintegration	Demoralization
Loss of physical energy	Loss of ideals and hope
Urgency and hyperactivity	Helplessness
Produces panic, phobias and anxiety disorders	Produces depersonalization and detachment

Slide 16: Stress management strategies

1. Take action
    - Talk to someone you trust.
    - Laugh.
    - Write, gaining perspective by putting your feelings on paper
    - Create distance, by asking yourself how much it will matter a few years from now
    - Do relaxation exercises or meditate.
    - Get physical exercise
    - Confront a potential source of stress, by addressing concerns before they escalate
    - Establish a 15-minute worry session, and put aside your worries until then
    - Create diversion, by doing something you enjoy
    - Get enough sleep
    - Eat balanced meals
    - Avoid negative people and places as much as possible
    - Delegate: What can others do to reduce your load?
    - Be a team member: Share concerns appropriately with others

Slide 17: Stress management strategies

2. Change your mind

Unhealthy attitudes	Antidotes
Feeling used/taken for granted	Know your rights and needs, and let others know them.
Workaholism	Balance work, family, play and rest.
Negative and self-defeating thoughts	Think positively; smiling releases tension.
Self-punishment	Be as fair to yourself as you are to others.
Disliking yourself	Accept yourself as you are.
Defensiveness	Be yourself; allow yourself to be human.

3. Change the stressor

- What is in my power to change or influence?
- Can I take action by myself?
- Who might help me?
- If the stressor changes, what will the advantages and disadvantages be to me and others?

Slide 18: Stress management strategies

4. Adapt to the stressor

- Can I take it less seriously?
- Can I turn a threat into an opportunity?
- "I will be okay no matter what."
- Be solution-focused, but keep an open mind.
- Do relaxation exercises (physical and mental).
- Be assertive, set boundaries, and learn to say no.

Slide 19: Strategies for managing stress

Area of stress	Stressors	What I need to do	By when
Physical (for example, health, nutrition, sleep, housing, exercise, and recreation)			
Family/relationships			
Work			
Spiritual			
Psychological			
Others			

Psychosocial support especially through counseling has an important role in prevention, care and support of people infected and affected by HIV and AIDS. Recognizing the urgent need of trained outreach workers to address counseling needs especially of children affected by HIV/AIDS, FHI 360 under its program Balasahyoga undertook the task of equipping outreach workers with basic counseling skills to enable them to provide more comprehensive and effective care and support to children and their caregivers.

This manual compiles FHI 360's experience in home-based counseling of families and others who provide care for children affected by HIV and AIDS. The guide can be used to orient outreach workers, facility staff and the staff of non-governmental organizations to the conceptual and practical dimensions of counseling children and their caregivers on issues related to HIV. The manual also provides guidance on mechanisms of quality control and documentation that users can follow to put in place a strong counseling process.

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