

‘But You Looked Smart’: Participant Observations of HIV Testing and Counseling for Young Adults

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Abstract: In recent years, a consistent increase of new HIV infections in young adult populations has been reported. One argument is that this population does not receive adequate information or support to promote healthy behavior choices. The current study provides direct evaluation of services and communication about prevention provided to young adults by trained counselors to identify critical issues that could illuminate ongoing barriers. Six clinic sites surrounding a large Midwest university were evaluated. Through participant observations and interviews, this analysis demonstrates that while the rapid HIV test has increased the opportunity for counseling to take place, numerous areas of concern still exist including access to testing, the use of judgmental language, as well as the presence of both halo and horn effect.

Keywords: *barriers to testing, HIV counseling, heterosexual risk, low risk, young adults.*

Currently the Center for Disease Control (CDC) reports young people, aged 13–29, accounting for 39% of all new HIV infections in 2011; an increase from 14% just two years prior (CDC, 2009). Yet, of an even larger concern is that of these new infections 75% were between the ages of 20–24, not to mention that it is estimated that close to half of those living with HIV do not

know their status (CDC, 2011). While researchers and health practitioners may agree that HIV is 100% preventable, and recommendations have been made by the CDC for all young adults to be given the option to test for HIV (CDC, 2006) many young adults remain unaware of their status. As a means of seeking to understand barriers that prevent young adults

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from knowing their status the present research offers an analysis of the HIV counseling and testing (HIV-CT) process. By identifying and addressing factors many young adults may be facing this study offers insight to current barriers those working in the field need to correct.

HIV Counseling and Testing

Arguably the largest and most costly HIV prevention efforts in the United States (Weinhardt, Carey, Johnson & Bickham, 1999) HIV Counseling and Testing (HIV-CT) services provide an opportunity for persons to learn their HIV status and, if infected, to obtain referrals for medical and psychosocial care (Weinhardt et al., 1999). HIV-CT also serves as a vital opportunity for clients to learn about how to protect themselves. Thus, counseling provided by clinics does more for clients than simply providing knowledge of one's status; it offers the education about how to change behavior to avoid infection or if already infected, to avoid transmitting the virus to others (Keane, Hammond, Keane, & Hewitt, 2005).

The counseling obtained during an HIV test has sparsely been evaluated either quantitatively or qualitatively, with most of the previous work focusing on conventional testing (Keane, 2005). As a result, the counseling sessions in those studies, which were reliant on the client returning for results, become a mutable point given testing advancements. Today, the creation and use of rapid tests has greatly transformed testing by reducing the wait time from two weeks to twenty minutes.

While the time between pre and post testing counseling has been greatly reduced, so has the amount of funding for HIV prevention. As a result, given the high costs related to HIV-CT and continued restrictions in funding many HIV and STD (sexually transmitted disease) clinics are choosing to limit who they target for testing as well as who they offer tests to. With limited time and funds many clinics have chosen to focus on populations known for being 'high risk', including intravenous drug users, young African American men, and the MSM (men who have sex with men) populations. Leaving young adults, specifically college students, off the radar.

With this limited view, young adults not only remain untested, they also remain uneducated in terms of STD and HIV prevention. As a result, young adults continue to receive inadequate information or support about healthy behavior choices that prevent infection, reinfection, or infection of a partner (Wallace, et al., 2011). This lack of proper HIV education may explain why studies continue to show little to no relationship between college students' knowledge and personal concern about contracting HIV/AIDS (Ferrer et al., 2007). Ferrer's study argues that despite high levels of knowledge of risk, college students are not personally concerned about contracting the virus. While studies continue to show that young adults are engaging in unprotected sex, they are often overlooked in HIV screening (Bradley-Springer, Stevens, Webb, 2010) due to being thought of as a 'low risk'.

Young Adults as ‘Low Risk’

75 to 95 percent of all college students report being sexually active (Fulton, Marcus, & Paynea, 2010) with the average reporting more than two partners per year (Holman & Sillars, 2011). According to the latest STD trends put forth by the CDC (2013), one of every two college students, by the time they are 25, will have contracted some form of STD. According to a national survey of 34 colleges and universities, including nearly 24,000 students, over 43% had engaged in oral sex, over 46% had vaginal intercourse, and a little over 4% had taken part in anal sex (American College Health Association, 2007). Of those who had oral sex, fewer than 4% used a condom during the last episode, for those engaging in vaginal intercourse 54% used a condom during the last act, and among those reporting anal sex, roughly 26% used a condom during the last occurrence. Students who are experienced in anal sex were also more likely to engage in risky vaginal sex without the use of condoms (Baldwin & Baldwin, 2000). However, according to the perception of many clinics young adults are of little to no risk of HIV.

Although many practitioners argue young adults are ‘low risk’, health communication scholars continue to find that due to the typical behavior of college students and the over all lack of concern for HIV this population are in fact putting themselves at greater than average risk for HIV infection (Apostolopoulos, Svanmez, & Yu, 2002, Belgrave, 2009, Caldeira, Singer, O’Grady, Vincent & Arria 2012, Downing-Matibag, & Geisinger, 2009). While young adults may not be

exhibiting as high numbers as MSM and IDU (injection drug users); they are indeed engaging in behaviors putting them at risk for HIV and should be receiving the same testing and counseling as other groups.

Testing the Young Adult Populations

Many free/community clinics argue that doctors and health care providers, knowing the recommendations put forth by the CDC, are testing the young adult population. Yet studies continue to find that doctors remain either unaware of these recommendations (Minnear, Gilmore, Anrold, Flynn, Knapp, & Guar, 2009) or are choosing against offering because they either do not feel their patients are at risk, or they feel uncomfortable asking the patient about risk factors (Jain, Wyatt, Burke, Sepkowitz & Begler, 2009). Another common assumption is that patients who are at risk will disclose this information to their doctors or will ask for the test themselves (Qaseem, Snow, Shekelle, Hopkins, & Owens, 2009). Yet what is known is that many young adults are found to be far less likely than older adults to disclose risk factors to physicians (Branson, Handsfield, Lampe, et al., 2006). Therefore, when young adults remain uncomfortable disclosing their risk for HIV with doctors they often choose to seek out local free clinics.

Within community STD and HIV clinics young adults are not only tested but are also able to gain vital education about prevention. Education, doctors are less likely to provide given other recommendations from the CDC stating counseling is not needed

(CDC, 2006). However, While many find solace in ignoring this population given the low representation in terms of epidemiological numbers, one question the current study raised is could the lack of representation be a result of young people simply not receiving routine HIV testing due to continued known barriers?

Barriers to Testing for the ‘Low Risk’ Populations

Regardless of level of risk, it's asserted that knowing one's status should be guaranteed for anyone who is sexually active. College students in particular should have this knowledge given that every college student has access to HIV testing through their college or university's health clinic. However, over 50% of those infected do not know their own status let alone the status of their partner. Therefore, access cannot be the only factor inhibiting an individual from receiving an HIV test.

Vermund and Wilson (2002) categorized major impediments to HIV testing as: fear of adverse consequences (stigma from peers for even thinking you would need a test), lack of expectation of benefit (it would be better not to know you are going to die), lack of perception of HIV risk, cultural norms, lack of local availability of testing, lack of privacy in counseling and/or testing, lack of guarantees of confidentiality, cost, inconvenience (lack of immediate test result), and the lack of provision and support for testing couples. To overcome these barriers, Vermund and Wilson, as well as Inungu (2002), suggested offering HIV antibody screens as a

standard medical intervention, making them inexpensive, and convenient. Interventions would then also need to use methods of testing promotion in ways that make such tests socially acceptable as well as increasing awareness of HIV risk and the personal and community benefits of knowing one's status. Clinics offering the tests would then need to ensure privacy of testing and confidentiality, while also making it convenient and affordable, if not free. Finally, clinics would need to confirm that counselors are providing information to clients in a manner that would educate as well and encourage them to continue with future routine tests, if they are going to continue engaging in risky behaviors.

Method

To fully understand the barriers college age students may be facing, ethnographic methods were employed. Through both participant observations and interviews, the researcher gained an in-depth understanding about a particular social reality (Morse, 1993). After obtaining approval from the university's Institutional Review Board (IRB # 10.248), the first of two phases commenced by contacting a variety of clinics, surrounding the university, to schedule appointments for an HIV. The following lays out the criterion used in selecting clinics, the procedures employed during the observations, as well as the protocol used when interviewing each clinic's prevention managers.

Clinic Selection

Testing sites were located through criterion sampling using a web search (CDC's HIVtest.org). Four criteria were developed, with the first concern being the location of the clinic. Many young adults live either on or near to the various universities and colleges located in Milwaukee, Wisconsin; therefore a ten-mile radius from campus was set, resulting in 21 possible clinics. This distance also ensured that students without personal transportation would have access to clinics via walking or the local transit. Another criterion was that these clinics would need to offer free testing. College students are often working to pay for school, or are restricted by tight budgets, and may be more amenable to taking a free test if offered. Nine clinics were removed from the list of possible locations because of a lack of free testing. An additional requirement was that the clinic had to offer one of the current forms of rapid testing (either a finger stick test or oral swab). This form of testing inherently leads to immediate counseling given the short processing time of the test. This criterion removed an additional four clinics from the list. The final criterion, offering confidential or anonymous testing, was not a limiting factor. Six clinics met the necessary criterion for observation. To allow for clinic anonymity, each were labeled as A, B, C, D, E, F.

Observational Procedures

Participant observations of the clinics allowed the researcher to assess the procedures and counseling that took

place. Similar attire was worn to ensure her appearance would not be a factor during counseling sessions. The same story for why she felt the need for testing was also used: the researcher had just ended a long-term relationship, which had produced some doubt on the faithfulness of the previous partner. She believed that it had been about six or seven years since her last STD test, in which she thinks they did an HIV test. At times when the researcher was asked to complete an inventory of behavior, the same items were selected. Specifically, with regard to condom use, the researcher marked using condoms less than 50% of the time, to prompt a discussion about protection. No drug use, intravenous or otherwise, was marked, and the total number of partners was reported as approximately eight.

Given that the researcher sought to uncover the barriers one might have at a clinic, clinics were not made aware of the study until after the test and counseling were complete. This 'secret shopping approach' has been found to not only be useful in other medical fields, (Loden & Frederick, 2008) but also necessary to uncover how those perceived to be low risk would be counseled. At the completion of the test and counseling, the counselor and tester (if a different person) were informed of the true nature of the test and the project. All parties were given the opportunity to opt out and asked to sign a consent waiver, given a copy, and asked a few informal questions about the observation. It should be noted that all clinics selected did agree to be included in the study. Unless expressed disinterest, clinics were also provided the researchers field notes

for review prior to final analysis. In doing so two clinics also requested the researcher return and share findings with counselors while providing a short training.

Interviewing Prevention Managers

At the completion of the participant observation stage, the researcher also returned to each of the clinics to interview prevention managers, using a semi-structured interview plan. Interviews focused on the clinic's history, methods of funding, target population of the clinic, as well as the training and perceived role a counselor plays in the testing and counseling process. Interviews were recorded lasting 30-45 minutes. Digital recordings were transcribed and coded by the researcher.

Data Analysis

After transcribing the digital recordings, transcripts were verified with original recordings. To analyze the data collected from the participant observations and interviews, an open coding scheme using a constant comparative conceptualization process rooted in the grounded theory method of Glaser and Strauss (1967) and further developed by Strauss and Corbin (1990). This process entailed an initial line-by-line open coding of the data, allowing for the identification of a phenomenon to emerge from the data rather than applying a specific model to find a particular theme. Throughout this process initial impressions were noted about the barriers that prevented

testing as well as barriers to receiving adequate information. As a means of offering reliability, an additional researcher was asked to review field notes and transcripts. Impressions and initial codes of each researcher were compared to ensure consistent interpretations were being drawn. At the completion of this initial reading, themes with similar properties were identified and categories were created. Once categories were formed, and axial coding was implemented the researcher reviewed findings with her research colleague as well as with clinics. This stage allowed the clinics to offer any last impressions of the findings and interpretations of the testing and counseling process. Finally, the larger themes were applied to the transcripts as a means of defining and explaining categories in greater detail. Quotations that were representative of the categories were selected from the transcripts. As a result, the insights from this analysis process were used to inform the following iteration of data collection and development of connections between the data and the previous literature.

Six Clinics, Six Observations, and What Should Have Been Six Sore Fingers

Atkinson and Hammersley (1994) argue that participant observation includes an emphasis on exploring the nature of particular social phenomena, rather than setting out to test hypotheses about them. Thus, the first phase of the present study sought to offer a first-hand account of the testing and counseling experience.

Ultimately, these experiences, as well as the interviews that followed, created a clearer and richer portrayal of what occurs in the clinics. The following section presents the experiences and barriers identified through this initial phase of study.

Being on Campus Does Not Equal Access

With nearly every college campus offering health services through an on-site clinic it was assumed that many college students would first seek onsite testing. However, upon review the campus clinic not only charged for testing and could not offer rapid testing they also made information about testing difficult to locate. When observing the campus grounds, website, and on sight clinic nothing was found mentioning HIV testing. Additionally, the campus clinic's lobby provided no information about HIV or STD testing. As it was, the only way for an individual to procure information about the tests offered was by calling a campus doctor directly or through the website. Based on a call to the clinic, numerous questions about rationale for the test were presented. Specially, the woman questioned the researcher numerous times about why she thought she would need to be tested. Finally, after a several minutes of explaining the situation in elaborate detail (cheating ex-boyfriend) the nurse agreed that maybe it would be a good idea. While a test was achieved, given the lack of access, information, and cost (\$20 for students), students on this campus may feel forced to seek alternative methods for testing.

Off Campus Testing

Although each of the six clinics met the criteria, testing was only completed at five. While the website for clinic C stated that testing is offered to anyone, and that it offers 'HIV prevention services for individuals at greatest risk for HIV including gay men, injection drug users, youth and women,' this was not the case. When calling clinic C to make an appointment, prior to being allowed to schedule the appointment, three questions are asked. These include: 'have you recently been in contact with someone HIV in a manner that has put you at risk,' 'have you recently used or shared a form of injection drugs,' and 'have you engaged in sexual behaviors with someone who is an MSM or may be HIV positive?' Answering 'no' to these questions, the clinic informed the researcher that she seemed to be at low risk for contracting the virus and did not meet the qualifications to test at that clinic. The person on the phone then stated, 'If you really think you need a test, I would call your doctor. I am sure they can provide a test for you.'

With this advice, a total of five medical clinics were contacted, including three general practitioners affiliated with different larger medical complexes, as well as two gynecological offices. In each instance, the response of the nurse who answered the phone followed suit. The nurse on the line asked if there had been a situation leading the 'patient' to think she needed a test, followed by explaining that this was a voluntary test and could cost up to fifty dollars, which may or may not be covered by insurance. Two of the nurses

specifically recommended clinic C as a means of obtaining a free test, while the other nurses simply suggested looking for free clinics online. Additionally it should be noted that three of the five medical clinics contacted directly noted that unless one was using intravenous drugs or engaging in sexual activities with a positive person, he or she did not think a patient would need to be tested.

Although the first clinic contacted, as well as numerous doctors' offices, seemed to share the belief that an average college student was not at risk, none of the remaining clinics shared this sentiment. In fact, the process of making appointments required nothing more than providing a time and date the client could come in and a name or number that would be used to schedule the appointment.

Twenty Minutes for Being Ignored, Being Judged or Finally Being Counseled

The prevailing belief is that counseling sessions should be offered during every HIV test. Silver, D'Angelo and Mischka (1998) note that the communication occurring during the test greatly affects the likelihood of a person returning for results. However, with the rapid tests now being widely offered, the communication occurring during the counseling process should positively impact the likelihood of a client making testing a part of his or her annual routine, as recommended by the CDC.

During the observations and testing process it was clear that some clinics tended to cater to certain groups. From posters that might visually assault

a more conservative client, to the location, to a dominant language (e.g., Spanish), it was very clear that almost all clinics were tailored to a targeted group. For some, this targeting seemed to affect the communication between the counselor and the client, thus ultimately influencing the potential knowledge gleaned from the experience. In two particular cases this focus on a certain type of client ended up greatly influencing the treatment of the researcher during the observations.

Twenty Minutes of Being Ignored

Upon arriving to Clinic A, it seemed clear that the researcher might not be a 'typical' client, given a clear focus on the Latino population. This thought was then confirmed within the researchers field notes:

The woman conducting my test proceeds to look me over and finally states that she can give me the test. Given that this was the second time I had been given a looking over (the first being by the nurse who told me the room that did the testing) I began to think to myself, 'I am in black pants and a short sleeve blouse am I over dressed?' (Clinic A)

As the test continued, the woman, a middle aged woman of Latino descent, proceeded to answer a phone call (in Spanish), checked her e-mail, and did anything but engage in conversation with the researcher about her knowledge or behaviors. At the completion of the test, she simply showed the test and told the researcher she was negative.

During the interview following the test (and unveiling of researchers

intent), the counselor remarked that she thought the researcher ‘looked smart, and therefore would probably already know about HIV and protection.’ However, at this particular clinic, no information about risk behaviors were collected, thus the assessment was purely based on physical appearance alone. When the counselor was asked what she meant by ‘looking smart,’ she replied, ‘Well, you were dressed nice, and had glasses. You had a confidence and calmness about you. It just didn’t seem like you were worried.’ Similar statements were also reported from other counselors during the posttest interview. Regardless of the attempts to ask simple questions or mention common misperceptions such as ‘I did share a glass with a person who said they had AIDS’, or ‘So, if I have antibodies, that means my body ate the HIV. Right?’.

By not fitting the profile the counselor was expecting the researcher was assumed to be ‘low risk’ and in this case ‘smart enough’ and in no need of prevention education. Simply ‘looking smart,’ described as being female, Caucasian, wearing glasses, and dressing semiprofessionally, was equated to already having knowledge about HIV prevention. This assumption can be costly, given that the opportunity is then lost to ask what knowledge the client has or to correct any misconceptions to which the client may be ascribing.

Twenty Minutes of Judgment

While one clinic took an overly positive view of the researchers, another took a completely opposite approach. In

the case of Clinic D, not only was the research not smart, she was assumed to be a drug using liar. The researcher recalls that the woman conducting the test at Clinic D seemed to be of early to mid-fifties and had shared that she had been conducting HIV tests for many years. When it came time for the counseling session to begin, the woman sternly stated, ‘I am going to ask you a series of questions about your behavior. I need you to be completely honest with me so that I can best assess your risk. Again, please be honest.’ This tone continued through the series of questions. When it came to the section of questions regarding drug use the following dialogue was noted:

Counselor - How often do you use marijuana?

Researcher - I have never done that.

Counselor - Never?

Researcher - Nope.

Counselor - (Gives a disbelieving look)

Researcher - I have really poor lungs; heck, I have never even tried a cigarette.

Counselor - OK, well how about cocaine, meth, or heroin?

Researcher - Nope, I have never done an illegal drug.

Counselor - Well, do you drink?

Similar to other posttest interviews with the counselors, this portion of the interaction was addressed specifically. This time, however, the counselor recalled

‘Well, you see I have been doing this a long time, and I have learned that often people lie about behaviors at first. So by using words such as ‘how often’ instead

of 'do you' I feel it opens up the discussion and lets them know I already assume they are doing these things.' (Clinic D)

While these assumptions may indeed increase some people's comfort in disclosing risky behaviors, it may also produce feeling of fear and discomfort, resulting in a decrease in disclosure for fear of further interrogation. This confrontational style may also generate feelings of suspicion, increasing nervousness, and as a result making it less likely to disclose other risky behaviors or to return for any form of followup tests, given the discomfort felt during the initial experience.

Twenty Minutes of Kindness

In contrast to the other observations, clinic B stood out as exemplar. Open, warm, and extremely knowledgeable, this clinic not only inquired about behaviors in a manner that made the researcher feel comfortable, but also provided the best counseling of all the clinics. This clinic also ensured privacy of testing and confidentiality by requesting, and more importantly used, the alphanumeric code created by the researcher, something clinic D neglected to do. From the moment the researcher walked in until she left, the smiles and genuine compassion for this new 'client' were noted.

As previously mentioned, one of the ways clinics can combat the barriers to seeking an HIV test is by ensuring counselors provide information in a manner that will educate the client as well as encouraging him or her to continue to get tested in a routine basis. This clinic not only disseminated

information about the virus during the counseling, but also provided insight during the test itself. The clinic offered a history and evolution of testing methods as well as discussing specifically how the test works and what it was looking for. None of the other four clinics were noted to provide any information on how the test worked, nor did any other clinic take the time to ask if the researcher had questions about the test itself.

During the counseling at this clinic, everything in the small room where the counseling took place was calming. The dim lights to the soft mustard color on the walls and even to the tone of the counselor's voice, would make a client feel comfortable. To begin, the counselor started building rapport by engaging in small talk about the Olympics and other current events (another distinct difference from any other clinic). After a few minutes of conversation, the counselor asked the researcher why she had come in for a test (only the second time a clinic had directly asked). The counselor then continued by asking a few questions regarding the questionnaire that was filled out by the researcher upon arrival (only the second form that was requested to be filled out by a clinic even though it is a state required form).

When the time arrived to ask the questions regarding behavior, the counselor took time to explain that no judgment would be passed and that to best help him identify one's level of risk, complete trust and honesty would be needed. He then mentioned that nothing discussed in the counseling session would be discussed outside of the room unless a positive result required the

involvement of additional participants. The conversation continued with a tone of genuine interest in helping identify any behaviors that could be modified to prevent any infection, be it HIV or any other STI. At the mention of the number of partners and condom habits, for the first time it was discussed that while it using condoms 50% of the time was good, to be safest, one should always use protection, even in a long term relationship. The counselor also took the time to ensure the researcher knew all the ways in which woman are commonly put at risk, for example brushing or flossing their teeth before or after performing oral sex.

Discussion of Barriers

Fear of adverse consequences (stigma from peers for even thinking you would need a test). A lack of expectation of benefit (it would be better not to know you are going to die). A lack of perception of HIV risk, cultural norms, lack of local availability of testing. A lack of privacy in counseling and/or testing. A lack of guarantees of confidentiality, cost, inconvenience (lack of immediate test result). And finally a the lack of provision and support for testing couples. Each of these are argued to serve as barriers for those seeking, or considering, HIV testing. While many studies explore these barriers from the perspective of the individual seeking testing the current study took an unconventional approach by seeking what barriers are generating from the clinics end of testing.

Barrier No. 1: Testing Runaround

Wallace, McLellan-Lemal, Harris, Townsend, and Miller (2011) argue that most young adults are scared to know the results of an HIV test and that many preferred not to know and therefore remain untested. However what about those who do seek testing? How many have sought testing only to be told they were not at risk? It can be assumed that the average young adult will not call multiple doctors or clinics, and therefore is far more likely to remain untested. Those with the highest levels of anxiety, and the funds to do so, may seek over counter testing. While these tests are nearly the same as those done in a clinic, they do not provide the human connection and counseling to answer questions. These test also require high attention to temperature, reading time, as well as other directions. Thus, if a user is not careful it is easy to generate false negatives.

Barrier No. 2: Judgment during the test

Those who are able to receive testing are then faced with the next level of barriers, judgment. It is thought that building a sense of rapport and comfort is essential not only to help ease the stress of a client but also creates the foundation needed to foster open and honest discussion. Yet to truly gage one's level of risk numerous sensitive topics must be covered including, partner preferences, sexual behaviors, use of protection, and use of drugs or other substances. Therefore, if a client is feeling guarded and uncomfortable they will be less likely to engage in

open discussion. As was the case for many of the present observations. Questions asked with a judgmental tone not only raised levels of anxiety for the researcher but would also rise defenses of any young adult. This was not the case for Clinics C or E. Both of these clinics took significant steps to build rapport by starting with small conversations and then worked into issues that were more sensitive.

Barrier No. 3: Halos and Horns

For years, psychologists have studied a phenomenon known to as the halo and horn effect. The halo referring to one being positively influenced by a person's perceived strengths, weaknesses, physical appearance, behavior, or any other single factor (Nisbett & Wilson, 1977). The halo effect is most often apparent in situations where one person is responsible for evaluating or assessing another in some way. For example when a counselor generates positive assumptions with little to no information being shared. Simply 'looking smart,' as described by the woman at clinic A was simply the fact that the researcher was female, Caucasian, wearing glasses, and dressing semiprofessionally. Assumptions such as this can be costly, given that the opportunity is then lost to ask what knowledge the client has or to correct any misconceptions to which the client may be ascribing. Moreover, enacting a halo effect with a client could be just as problematic as an individual thinking that just because his or her partner 'looks healthy,' she or he could not possibly have HIV.

On the other end of the spectrum, Nisbett (1977) argues that a person

responsible for assessing behaviors could also attribute negative characteristics to a person based on personal qualities. While only occurring once during the counseling session at Clinic D, when the counselor was convinced that the researcher would be lying about behaviors, the impact on a client could be permanent. It should go without saying that these types of assumptions often produce feelings of fear and discomfort, resulting in a decrease in disclosure for fear of further interrogation. While halo and horn effect are thought to be two sides of the same coin, the impact they have on testing becomes vital, with both functioning as barriers for testing given the impact they have on those receiving the test.

Implications and Guidance

Overwhelmingly, studies have shown that college students do not perceive themselves at risk for HIV, even when they do possess basic knowledge of the virus (Opt & Loffredo, 2004). Extent research has also found that even in cases of high risk populations basic education remains a vital part of the counseling process, given the number questions clients continue to ask about prevention (Kalichman, Cain, Knecht & Hill, 2008). Therefore, it becomes vital when a young adult does seek out testing that barriers are removed and that counseling is always provided. This conversation may be the only education the individual receives about HIV or STIs given the more conservative approach to health education provided in schools. Clinic prevention managers identified

that schools were not giving enough information: ‘We almost need to scare them. Or you know pull out a dildo and show them how to put on a condom. No one else is teaching them’ (Clinic C). Yet, the counselors need to avoid assuming that those who ‘look smart’ know the truth about HIV. All it would take is a few questions resulting in not only the counselor seeing what the client knows, but also entering into a dialogue about the other risk factors that a client might not have known about or have been comfortable disclosing.

A Feeling of Ease

Once clinics and public health professionals break down the disconnect of who is at risk versus their own perceptions of who is at risk, it is the counselor’s obligation to ensure that the client does not feel judged or uncomfortable. It is normal for a client to feel a sense of unease; however, this study identified that at least for one clinic, it is possible to talk about uncomfortable topics in an open and comfortable way,

Counseling provides the information people need to know before testing. It also explains what they should expect and they are the people who can address the client’s concerns. Counselors are also the people who need to make sure the client is ready for the results and if the test is positive then they are there to help the person get the other needs. Counselors also need to make the person feel comfortable. (Clinic A)

All of the clinics expressed a feeling

that counseling was important. Specifically, all the clinics made mention in some way that providing information was vital as a means of prevention. Even those that provided little to no information about prevention during the observation stage claimed that counseling was ‘extremely important.’ Yet, few (only clinics A and B) made any mention of the need for the counselors to comfort or make the client feel at ease.

Training of Prevention Educators

Silver, D’Angelo, and Mischka (1998) stated that the communication occurring during the test greatly affects the likelihood of a person returning for results as well as the posttest counseling, which may be why in the past twelve years we have developed the rapid tests. However, regardless of the removal of the extended waiting period, these conversations still play a vital role in the education of those receiving the test. Providing training that focuses on these aspects is critical. In other words, training must arm counselors not only with information about HIV but also with the tools and skills to encourage behavior change. Moreover, regardless of age, or how smart a client may look, the time one waits for a rapid test to be processed is indeed an opportune time for the dissemination of knowledge. Without this knowledge, the client cannot be expected to change their behaviors.

Beyond this dissemination, however, the counselor serves as a role model for the conversation that needs to take place. If the counselor implies that he or she is already assuming the client will lie or is engaging in a behavior,

then there is strong potential that the client will not return for another test in the future for fear of judgment. On the other hand, if the counselor seems open, outgoing, and confident, the client may also feed off this energy and in less time be open about discussing behaviors.

A Larger Issue

With funding continuing to be a major concern clinics are forced to target only high risk populations. In doing so this not only creates barriers for those who seek testing, but also contributes to the perception that young adults are not at risk. It is this perception combined with the overall lack of sexual health knowledge that leads to populations becoming high risk for STDs and HIV.

Considering that many of these clinics were found inadequate, in terms of offering appropriate counseling, the question remains where or how this population will obtain safe sex information they need. Educators have their hands tied by policies against the distribution or education regarding condoms, parents remain unaware of the sexual practices of their children, and doctors assume patients will disclose risky behaviors. Therefore, many young adults remain uninformed about their HIV status as well as overall knowledge about safe sexual practices.

Limitations and Directions for the Future

The most obvious limitation to this study is the number of clinics observed and interviewed. While these five clinics did offer a great deal of insight,

to see the whole picture clearly, more clinics will need to be explored. This study does provide insight into the barriers and issues shared by the clinics in this area; however, the results cannot be generalized to other clinics or cities. To combat this limitation, one area for future exploration would be to expand the location criteria to the clinics surrounding other cities having large population of young adults.

Another limitation is that the present study is that only one researcher was conducting the observation and interviews. Much of what was found may have been a direct result of the perceptions of the clinic staff. Therefore conclusions about how the effectiveness of other counseling sessions cannot be made. However this study does illuminate the barriers young 'low-risk' populations maybe facing.

For a more in-depth study, additional researchers of varying gender, race, and sexual history would need to be included. The inclusion of additional researchers will provide a clearer insight to how effective/ineffective counseling is done at the selected clinics. This expanded study may also elucidate if in fact the problem is not an issue of perception of risk but one of an overall need for additional training for counselors.

At the conclusion of this project, contact was made with the Wisconsin State HIV prevention and planning group. A discussion of findings was presented and questions about risk, training, and future prevention measures was addressed. During this conversation, the state expressed interest in expanding this 'secret shopper' approach to counseling

evaluation. As a result, an additional avenue for research would be to work with the state and conduct a statewide evaluation of counseling. While these evaluations would only focus on state funded clinics, based upon the current findings these may be the clinics in the greatest need of training modification.

Conclusion

Research demonstrates that large portions of young adults are not concerned about becoming infected with HIV (Kaiser, 2009). To modify this perception, young adults need accurate, age-appropriate information about HIV infection and AIDS. This information should include education on how to talk with their parents or other trusted adults about HIV and AIDS, how to reduce or eliminate risk factors, how to talk with a potential partner about risk factors, where to get tested for HIV, and how to use a condom correctly. Yet as seen throughout this study, even with the advances in testing, the dissemination of knowledge is still imprisoned behind a multitude of barriers.

While the obstacle in receiving counseling has been previously evaluated, both quantitatively and qualitatively, this study was the first of

its kind to provide a first-hand account of the testing and counseling process. Moreover, while these counseling sessions are sometimes being offered during an HIV test, this study indicated that young adults are still not receiving adequate information or support to bring about healthy behavior choices.

As stated previously the communication occurring during and HIV test greatly affects the likelihood of a person returning for results as well as the posttest counseling. However, even with the creation of the rapid tests, this communication is still playing an important role to the modification of risk behaviors as well as receiving a future test. Moreover, it is still apparent that behavioral changes of an individual are based on an understanding and an awareness of prevention strategies, namely education. These prevention interventions remain highly limited in their effectiveness if the barriers in testing and counseling are not remedied. Through prevention and awareness of risk, HIV is 100% preventable. However, if the counselors providing the only prevention education some will receive it seems that many of the common barriers to testing will continue and young adults will remain at risk.

References

- Atkinson & Hammersley, M. (1994) 'Ethnography and Participant Observation', in *Handbook of Qualitative Research*, N. K. Denzin and Y. S. Lincoln (Eds.), Sage, Thousand Oaks, pp. 248-261.
- Apostolopoulos, Y., Svanmez, S., & Yu, C. H. (2002) HIV-risk behaviours of American spring break vacationers: A case of situational disinhibition? *International Journal of STD & AIDS*, 13, 733-743.
- Baldwin, J. I. & Baldwin, J. D. (2000) Heterosexual anal intercourse: an understudied, high-risk sexual behavior. *Arch. Sex Behav.*, 29, 357-373.
- Belgrave, F. Z. (2009) *Sexual Behavior and Consequences African American Girls* (pp. 123-140): Springer New York.
- Branson B. M., Handsfield H. H., Lampe M. A., et al. (2006) Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR Recomm Rep.*; 55(RR-14): 1-17
- Bradley-Springer, L., Stevens, L., Webb, A., (2010) Every Nurse Is an HIV Nurse. *AJN, American Journal of Nursing*, 110 (3), 32 - 39.
- Caldeira, K. M., Singer, B. L., O'Grady, K. E., Vincent, K. V., & Arria, A. M., (2012) HIV Testing in Recent College Students: Prevalence and Correlates. *AIDS Education and Prevention*: 24, 363-376. doi: 10.1521/aeap.2012.24.4.363
- Centers for Disease Control and Prevention (2011), Diagnoses of HIV Infection and AIDS in the United States and Dependent Areas, 2011
- Centers for Disease Control. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. (2006); 55(RR-14):1-17.
- Corbin, J. L., & Strauss, A. C. (2007) *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Thousand Oaks, CA: Sage.
- Downing-Matibag, T. M., & Geisinger, B. (2009) Hooking Up and Sexual Risk Taking Among College Students: A Health Belief Model Perspective. *Qualitative Health Research*, 19, 1196-1209. doi: 10.1177/1049732309344206
- Ferrer, L., Cianelli, R., Guzman, E., Cabieses, B. I., Irrarázabal, L., Bernaldes, M. (2007) Chilean University Students: Knowledge and Concern About HIV/AIDS. *The Journal of the Association of Nurses in AIDS Care : JANAC*, 18(5), 51-56.
- Fulton, J. J., Marcus, D. K., & Payne, K. T. (2010) Psychopathic personality traits and risky sexual behavior in college students. *Personality and Individual Differences*, 49, 29-33.
- Glaser, Barney G, Strauss, Anselm L., 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*, Chicago, Aldine Publishing Company
- Holman, A., & Sillars, A. (2011) Talk About, Hooking Up: The Influence of College Student Social Networks on Nonrelationship Sex. *Health Communication*, 1-12. doi: 10.1080/10410236.2011.575540.
- Inungu J. N. (2002) Potential barriers to seeking human immunodeficiency virus testing among adults in the United States: Data from the 1998 National Health Interview Survey. *AIDS Patient Care STDs*. 16, 293-299.

- Jain, C. L., Wyatt, C. M., Burke, R., Sepkowitz, K., Begler, E. M. (2009). Knowledge of the Centers for Disease Control and Prevention's 2006 routine HIV testing recommendations among New York City internal medicine residents. *AIDS Patient Care STDS*, 23(3), 167–176.
- Kaiser Family Foundation, *Survey of Americans on HIV/AIDS*, Conducted March 24 - April 18 2006.
- Kalichman, S.C., Cain, D., Hill, J., and Knetch, J. (2008) HIV/AIDS Information Needs of Sexually Transmitted Infection Clinic Patients: Content Analysis of Questions Asked During Prevention Counseling. *Sex Education: Sexuality, Society, and Learning*, 8, 11-24.
- Keane, V., Hammond, G., Keane, H., & Hewitt, J. (2005) Quantitative evaluation of counseling associated with HIV testing. *The Southeast Asian Journal Of Tropical Medicine And Public Health*, 36, 228-232.
- Loden, L. C., & Frederick, R. C. (2008) Do Secret Shoppers Have a Place in Medicine? *Medical Association Journal of Ethics*, 10 (5), 288-294.
- Minnear, T. D., Gilmore, B., Arnold, S. R., Flynn, P. M., Knapp, K. M., & Gaur, A. H. (2009) Implementation of and Barriers to Routine HIV Screening for Adolescents. *Pediatrics*, 24 (4), 1076-1084. doi: 10.1542/peds.2009-0237
- Morse, J. M. (1993) *Critical issues in qualitative research methods*. Thousand Oaks, CA: Sage.
- Nisbett, R. E., & Wilson, T.D. (1977) The halo effect: Evidence for unconscious alteration of judgments. *Journal of Personality and Social Psychology*, 35, 250-256.
- Opt, S. & Loffredo, D. (2004) College students and HIV/AIDS: more insights on knowledge, testing, and sexual practices. *Journal of Psychology*, 138, 403.
- Silver, S., D'Angelo, L. J., & Mischka, K. P. (1998) Direct evaluation of adolescent HIV counseling and testing services. *AIDS Patient Care And Stds*, 12(4), 295-301.
- Qaseem, A., Snow, V., Shekelle, P., Hopkins, R., Jr., & Owens, D. K. (2009) Screening for HIV, in health care settings: a guidance statement from the American College of Physicians, and HIV Medicine Association. *Annals of Internal Medicine*, 150(2), 125-131.
- Vermund, S. H., Wilson, C. M., (2002) Barriers to HIV testing – where next? *Lancet*. 360 1186-1187.
- Wallace, S. A., McLellan-Lemal, E., Harris, M. J., Townsend, T. G., & Miller, K. S. (2011) Why Take an HIV Test? Concerns, Benefits, and Strategies to Promote HIV Testing Among Low-Income Heterosexual African American Young Adults. *Health Education & Behavior*. doi: 10.1177/1090198110382501.
- Weinhardt, L. S., Carey, M. P., Johnson, B. T., Bickham, N. L., (1999) Effects of HIV counseling and testing on sexual risk behavior: A meta-analytic review of published research, 1985–1997. *American Journal of Public Health*, 89:1397–1405. [PubMed: 10474559].

