

YOUTH-CENTERED COUNSELING

FOR HIV/STI PREVENTION AND PROMOTION OF SEXUAL AND REPRODUCTIVE HEALTH

A Guide for Front-line Providers

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PAHO HQ Library Cataloguing-in-Publication

Pan American Health Organization/World Health Organization.

Youth centered counseling for HIV/STI prevention and promotion of sexual and reproductive health: a guide for front-line providers.

Washington, D.C.: PAHO, © 2005.

184 p.

ISBN 92 75 12615 1

Vega, Alex, P.

I. Title II. Mazin, Rafael

III. Maddaleno, Matilde

1. HIV infections - prevention & control
2. SEX EDUCATION
3. ACQUIRED IMMUNODEFICIENCY SYNDROME - prevention & control
4. SEXUAL BEHAVIOR
5. SEXUAL HEALTH COUNSELING
6. SEXUAL HEALTH PROMOTION
7. SEXUALLY TRANSMITTED DISEASES
8. TEEN HEALTH
9. YOUTH COUNSELLING

NLM WC 503.5

Youth-Centered Counseling for HIV/STI Prevention and Promotion of Sexual and Reproductive Health:

A Guide for Front-line Providers

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Design: Francis Rubín/ULTRAdesigns / Editor: Margaret L. Singleton

Photo credits of CD: Armando Waak, PAHO and Photos.com

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Preface



No young person can grow up in the Americas at the beginning of the 21st Century without being affected, directly or indirectly, by HIV/AIDS. The epidemic has changed the way sexuality and sexual practices are viewed and discussed by society at large. The negative impact of HIV on public health and human development is undeniable, as AIDS is responsible for reduced life expectancy in some countries of the Region, a resurgence of common co-infections like tuberculosis, and an increasing number of orphans.

Youth are frequently cited as a vulnerable group for HIV infection due to both vulnerabilities including propensity to engage in high-risk behavior and a lack of control over resources and their environments. While health systems recognize the precarious position of youth, commensurate safety nets are rarely provided. To the credit of national public health systems, most young people in the Region know the basic facts about HIV and have some idea of how it can be prevented. Nonetheless, services related to prevention of HIV and sexual health, and those most likely to interface with the daily world of youth, often do not address the real-life needs of young people's sexual identities and sexual lives.

Front-line providers have a unique opportunity to reach youth and promote HIV prevention and healthy sexuality. Their position as professionals and health experts lends them credibility in communities and provides the opportunity for them to openly address taboo subjects surrounding sexual health. Nurses, doctors, community health workers, social workers, counselors, and teachers all come into contact with young people on a regular basis and have many opportunities to make a positive impact. HIV prevention cannot be left to one agency, organization, or AIDS clinic. Ample evidence shows that collaboration between stakeholders leads to improved results.

This guide for youth-centered counseling is a tool developed by the Child and Adolescent Health and HIV/AIDS Units, Family and Community Health Area, PAHO/WHO to assist front-line providers in reaching young people and effectively promoting sexual health. It contains detailed and theory-based actions and methods to improve the quality of services for young people. Youth-centered counseling, to be effective, must respond to young people's individual sexual behavior, context, and developmental stage. This guide aims to help providers engage in counseling that best fits the needs and wants of youth, providing the young person with the opportunity to learn essential skills for sexual and reproductive health development.

While the book includes guidelines, strategies, and the theoretical underpinnings guiding the practice of counseling, the accompanying CD provides an additional practical tool. Based on experience from youth-centered counseling workshops, the CD serves both for self learning and as an instrument for teaching the material in a group setting.

HIV prevention among youth is an essential part of efforts within the Region to halt and reverse the spread of HIV/AIDS in accordance with Goal 6 of the UN Millennium Declaration. Promoting sexual health among youth also contributes to the achievement of Goal 3, to promote gender equality and empower women, and Goal 4, to reduce child mortality. All countries in the Region of the Americas have committed to reaching these goals by 2015. In order to successfully halt the spread of HIV, long-term strategic planning for comprehensive HIV prevention and collaboration between sectors and agencies are essential. As outlined in PAHO's Regional HIV/STI Plan for the Health Sector, 2006-2015, prevention interventions targeted toward young people and youth-friendly services will be key strategies for reducing new infections in the long term. This counseling guide encourages the prioritization of sexual health promotion among youth in a context of intersectoral and interdisciplinary coordination. It is through attention to vulnerable groups and a comprehensive approach that countries in the Americas will successfully intensify prevention and see the benefits through a reduction of HIV in years to come.

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The Challenges



Each year, millions of adolescents die prematurely or needlessly suffer from illness that could be prevented or treated with simple health interventions (WHO, 2003). Nearly one third of the people who have contracted HIV/AIDS worldwide are young persons ages 15 to 24 (UNAIDS, 2002). Furthermore, a study of youths in Mexico, South Africa and Thailand found that sexually experienced and inexperienced youth alike believed themselves to be at the same level of risk for contracting HIV/AIDS, thus indicating a need for appropriate interventions (Stewart, McCauley, Baker et al., 2001).

Sexual and reproductive health problems that young people face today are varied and complex. Such problems are well documented and include risky sexual behavior, unplanned pregnancy and the development of sexually transmitted infections (STIs), including HIV. Counseling is not a panacea for these problems, but it is one of the very important multi-disciplinary interventions that can be delivered by front-line health or human services providers at various levels who can be mobilized to address these complex problems. Counseling is one response that focuses on the psychosocial and “psychosexual” aspects of youth, including the intense feelings and emotions related to sexuality that often interfere with young people’s ability to make healthy sexual decisions and consequently practice healthy behaviors. At the same time, counseling provides the young person with a safe space to understand themselves more intimately, for example, understanding what exactly puts them at risks for contacting a serious STI, or how they cope with their normal life problems and stressors and what they do when experiencing moments of fear, doubt, loneliness, and anxiety. Counseling also provides the opportunity to learn essential life skills (often ignored in families and schools) for developing healthy sexuality and improving sexual health.

However, while counseling provides the opportunity for a young person to talk with another caring and professional individual about his or her life's situation, experience, choices, challenges and opportunities, it does not exist in a vacuum. Counseling practice is found in the dynamic web of social interactions, and these unfortunately include social barriers such as racism, sexism, gender inequality, homophobia, heterosexism, ableism, ageism, and poverty that constrain and oppress the sexual and reproductive health choices and options of youth. Young people are also confronted with structural barriers such as oppressive and discriminatory policies and laws, laws limiting the reproductive choices of women and the lack of physical infrastructures providing safe and open spaces for positive youth development including sexual development. Counseling then is limited in that while it deals with helping the young person reflect on his or her personal behavior and make decisions for achieving sexual and reproductive health, it does not directly address these social and structural barriers that often undermine the choices young people make and the services that can support them.

It is important to acknowledge that both counselor and the young client face the difficulties of working and living within prescribed social and cultural norms. Both experience environments that may facilitate or impede the development of sexual and reproductive health. Culturally, the age of adolescents often plays an important role in the perception of society about who they are and what they need, want and desire. Gender differentiation, socio-economic status, poverty, lack of employment, lack of educational opportunities, the sex trade, and other barriers that young people encounter all play equally important roles in the development of coping mechanisms which are often difficult to change. In addition, Duncan and Cribb (1996) explain that encouraging health behavior change among those who have the least capacity and resources to do so may add psychological harm and distress to their lives.

Additionally, we recognize that front-line health care providers and human services practitioners are too often overstretched in their own jobs and need to scale up basic counseling skills and health promotion operations to make a real difference in addressing the HIV epidemic. Perhaps asking already case-loaded front-line providers to take on the added burden of engaging in "youth-centered counseling" and thus provide a comprehensive package to their young clients may be asking for too much.

The Opportunities



Most health programs for young persons have tended to concentrate on antenatal care, family planning and sexually transmitted infections, neglecting preventive measures (WHO, 2003). However, many opportunities exist for the delivery of HIV/STI prevention and sexual health promotion through behavioral counseling at the individual level by front-line providers such as nurses, physicians, social workers, teachers, high school counselors, community counselors, youth workers, health providers and psychologists. These front-line health and human services providers have enormous potential to influence young clients' knowledge, skills, attitudes and behaviors because they have access to adolescents in private sessions during their medical or human services interventions and are often trusted as people with precise knowledge in the area of health care.

Unfortunately, front-line human services and health providers have for the most part been unable to realize their potential to engage in effective science-based HIV prevention and promotion of sexual health among adolescents. Coleman (2000) explains that while there is more openness in talking about sexual issues in Western culture today, many health care professionals are still uncomfortable talking about sexuality. When contrasted to cigarette smoking behavior, where health providers have played a recognized role in public health prevention efforts in countries such as the United States, counseling and education about HIV prevention is offered in less

■ The purpose of this document is to guide front-line health and human services providers, such as the professionals noted above, on how to make counseling more responsive, friendly or accessible to young people in the Americas (particularly Latin America and the Caribbean) through “Youth-Centered Counseling” while engaging in a theory-based approach to reduce HIV/STI infection and promote sexual and reproductive health

than one percent of patient visits to their primary care physician (Garofalo, 2003). For smaller countries in Latin America and the Caribbean, the opportunity for front-line providers to discuss HIV prevention and sexuality issues may even be fewer when considering the social, cultural, political and psychological issues surrounding youth's sexuality and AIDS.

Because a cure or vaccine for HIV is unlikely in the near future, anti-retroviral therapy continues to be scarce in Latin America and the Caribbean, and living with HIV is no easy task, efforts to curb the HIV epidemic must focus on effective HIV prevention as a primary goal. It is essential for front-line providers to recognize that HIV prevention counseling does not require sophisticated counseling knowledge and skills, in-depth psychological interventions or extensive prolonged treatment. HIV prevention and sexual health promotion counseling can be a part of routine health visits, social work assessments and interventions, high school counseling or health education sessions. Assessing personal risks, understanding situational and contextual issues surrounding sexual behavior and opening up a safe space for a young client self-disclosure in an individualized, sensitive and empathetic manner can greatly enhance the opportunity to modify high-risk behaviors among young people.

However, in order to integrate sexual health services into regular health checkups and social service interventions in the community, there is a need to build capacity in terms of behavioral science theory, prevention counseling skills, and prevention research (Glasgow et al., 1999 and Knox et al., 1999). Furthermore, these professionals need to learn how to shape interventions so that they are relevant, sensitive and responsive to the needs and wants of the adolescent and youth populations considering their gender, culture, sexual orientation, age, and the developmental stage of the young person.

Youth-centered counseling strategies are aimed at making counseling more palatable to young clients who are initially unenthusiastic about participating in a prevention counseling endeavor. Youth-centered counseling, proposed by the Child and Adolescent Health and HIV/AIDS Units of the Pan American Health Organization (PAHO/WHO), is a theory-based counseling model that emphasizes HIV/STI prevention and the promotion of sexual and reproductive health in youth. This conceptual model draws from already established theoretical frameworks:

- Client Centered Counseling (Carl Rogers, 1951)
- The Transtheoretical Model (TTM) also known as the Stages of Change (SOC) Model and Staged Behavioral Counseling (SBC) (Prochaska & Diclemente, 1983)
- Goal Setting Theory (Bandura, 1977; 1997)
- Motivational Interviewing (Miller & Rollnick, 2002) and
- The Strengths-based Perspective (Saleebey, 1996; 1997)

This guide explains the essential components of each theory and how they are applied to sexual and reproductive health counseling. When used together these theoretical approaches provide a framework for youth-centered counseling. Before the health care or human services provider uses this guide, an important task is to clarify their own ideas of what counseling constitutes and theoretical orientations that they have used to inform their counseling practice. What personal counseling approach do you prefer? How can you integrate this conceptual framework to your style in a way that makes it meaningful?

This guide also offers practical guidelines for front-line providers to adapt. Practical strategies, suggestions and examples are embedded throughout the guide in order to help the reader understand the model and implement it in their practice settings. Health care and human services professionals are free to decide which part or parts of the model are applicable to their individual work situation.

Note to Users of this Guide

This guide is intended for professionals in the human services and health field who are front-line providers working with youth in Latin America and the Caribbean. These professionals include social workers, nurses, teachers, high school counselors, physicians, psychologists, mental health specialists, youth workers and HIV prevention workers, and are in unique positions to engage young people in counseling with the aim of preventing HIV/STI infection, and preventing unwanted pregnancy. While it is not expected that all providers have formal training in counseling, it is preferable that providers have some basic training in counseling skills, experience or competencies in counseling, applied psychology or social work with young people.

This guide is not intended to be an introduction to counseling skills; it offers a conceptual model and approach to engaging in counseling aimed at promoting sexual and reproductive health, including reducing HIV/STIs. Thus, this guide is for practitioners who desire to learn more about doing effective HIV prevention work and desire a theoretical framework supported by empirical literature to guide their work. In this regard, these professionals can further their existing knowledge, attitudes and skills (competencies) in providing sensitive and responsive care to young people in Latin America and the Caribbean.

This guide is divided into three major sections. Part 1 helps define youth-centered counseling. Part 2 presents practical guidelines that can help front-line providers implement a youth-centered counseling approach. Some of the guidelines are derived directly from the theoretical frameworks while others are more generally used in the area of counseling.

Part 3 provides an in-depth review of the literature supporting the essential theoretical frameworks. This literature review is presented to help the provider understand the empirical findings of the theoretical components of the model. In addition, the literature discussion reinforces the major ideas and principles of the theoretical approaches discussed in Section 2.

This guide is not a “cookbook” for HIV prevention or sexual and reproductive health counseling. It does not take the place of formal education or training, supervision or professional consultation. Readers are encouraged to use the guide as a resource in their counseling work. Its main intention is to offer providers a conceptual and science-based model to promote sexual and reproductive health and prevent HIV/STI through individual counseling.

Using the Boxes and Tables

Throughout this guide readers will find boxes and tables summarizing major points after a discussion, offering practical applications and principles from a theoretical approach. Providers are encouraged to flip through the document to review the materials in the boxes to get a gist of the preceding discussions. More importantly, the boxes and tables provide strategies and ideas providers can use in their counseling with young people.

Notes on Language

The use of the pronoun “he” and “she” and their possessive forms appears randomly throughout this guide to emphasize that male and female young clients and providers deal with sexual, contraceptive and HIV/STI counseling issues. One of the two pronouns is used singularly instead of “he/she” and “his/her” to facilitate reading. Where this occurs, the authors of this guide do not imply that those examples relate only to that gender.

In this guide, the term “counselor” does not mean that the people doing HIV and sexual and reproductive health counseling are all professionally trained counselors. It refers to any “helping” person or front-line provider when engaged in the counseling process, helping relationship, or taking a counselor/ helper role. Youth-centered counseling can be done in a physician’s office, over the telephone, in a high school counseling office or in a community organization/agency. The terms counselor, provider, practitioner, front-line worker and youth-centered counselor are used interchangeably.

The term “client” is used rather than “patient” to emphasize that counseling from this framework addresses issues of normal development. More is elaborated in defining counseling as distinguished from psychotherapy.

Young persons constitute all those persons between the ages of 10-24. Although there are distinctive needs, wants and factors affecting the vulnerability and opportunities of pre-adolescents, early adolescents, middle adolescents, late adolescents, and youth, for the purpose of making the reading of this guide easier, the terms adolescents, young persons, young clients and youth will be used interchangeably. The provider is urged to take a developmental, gender and cultural perspective in understanding young persons in their counseling session as each sub-group has different needs and wants requiring the counselor to be sensitive to these important differences.

A Theory-Based Counseling Approach

HIV counselors and prevention workers are often so immersed in their HIV-related work that they get accustomed to making counseling decisions in their daily practice using intuition, personal experience, past professional experience or some generic counseling skill they learned in school or in their latest workshop. While these strategies may work, providers sometimes are baffled when asked to justify what they do. Often they cannot provide a rationale for engaging in some counseling or HIV prevention action during the counseling encounter such as the strong foundation that comes from an evidenced-based approach.¹

■ Our intention in proposing a theory-based counseling process for engaging in HIV/STI prevention and the promotion of sexual health is simply to help providers learn from past practice, and a theory does just that as it presents lessons learned in a coherent and systematic framework

In developing a counseling model for working with youth in HIV prevention and sexual and reproductive health, the HIV/AIDS and the Child/Adolescent Health Unit wanted to offer a theory-based guide that has empirical support and provides counselors with a science-based rationale for doing the things they will be asked to do. In this regard, on the application of these theories, providers will understand 1) how people change their behavior and 2) how to facilitate change in their young clients. Furthermore, they will be able to understand the benefits of the different counseling methods and interventions and when best to use them.

In choosing the theoretical approaches for this model, the authors were guided by a theory and approach that have been studied extensively and are:

- ⊕ Congruent with PAHO's view and treatment of youth (positive youth development; empowerment-oriented).
- ⊕ Open to the use of other theories and counseling approaches/strategies.

¹ This refers to making counseling decisions based on the best external evidence combined with the counselor's expertise and the client's desires. The approach requires understanding conflicting results and assessing the quality and strength of evidence.

- Simple, easily understood, and easily taught to a cadre of health and social service professionals in Latin America and the Caribbean.
- Applicable to the situations and diversity of youth in Latin America and the Caribbean (age, sex, gender identity, sexual orientation, sexual identity, culture, developmental phase)

Finally, the HIV/AIDS and Child/Adolescent Health Unit wanted to put together a stage-based counseling behavioral model (matching the client's stage of readiness for change to a counseling intervention) so that young clients can set realistic goals and can be easily assessed and measured by counselors, peers and the clients themselves.

A Note about Theory

Theory helps to explain what happens in a counseling relationship and assists the counselor in predicting, evaluating and improving counseling results (Brammer and Shostrom, 1977). Theories help providers understand the change process in their clients and derive techniques that are most useful and effective in achieving the counseling objectives. By no means are our two Units presenting this theory-based framework as “The way” or as a “Constitution” of how we should all do counseling in HIV/STI prevention and promotion of sexual and reproductive health. Our intention is not for providers to adopt this theoretical approach as the “TRUTH” and reject other meaningful approaches. Therefore, to adopt this guide without critical reflection of counselors' own local counseling practice and situation would be a disadvantage.



Section One

About Youth-Centered Counseling

Youth Defined

This guide focuses on youth of Latin America and the Caribbean. Adults and young people are different in their behaviors, thinking, and development. Counseling young persons is very different from counseling adults. Adults, unlike children and adolescents, for the most part have developed sophisticated coping and adaptation skills to deal with internal and external stresses and problems of life. For example, adults may automatically make a series of associations when they hear the words “HIV positive.” They might think of physical changes in the body (loss of body weight), regular medical check-ups, changes in diet, medical expenses, losing control, getting ill, dealing with sadness, family support, and perhaps premature death.

In contrast, adolescents, especially younger ones, may not have developed such capabilities for abstract thinking but may be very concrete and present-oriented (Spain, 1988). Consequently, younger adolescents may not readily understand the concepts and causal interrelated relationships involved in engaging in unprotected sex and contracting HIV disease. Thus, adult-oriented approaches to counseling often are not appropriate for young people (Sommers-Flanagan, 1997; Spain, 1988). PAHO’s Child and Adolescent Health and HIV/AIDS Units posit that if counselors can learn about, understand and appreciate youth-centered counseling principles as applied to adolescent development, culture, and gender then they will interact in a more effective manner with young clients.

Youth vary in their age and developmental stage, social and geographical environments, economic circumstances, culture and sub-culture, race and ethnicity, gender, sex, sexual orientation, disabilities and marital status. Although these factors affecting each sub-group are beyond the scope of this guide, counselors are encouraged to take each of these factors into account in their counseling interactions, assessments and design of personalized interventions.

■ Counseling provides young persons with a safe and confidential space in which to express their emotions, become aware of and deal with their feelings, develop deeper and new understanding of themselves, their choices and behaviors.

■ Counseling is defined as a process through which one provider and a young client work together to explore and define the young client’s problem, situation or challenge, set realistic goals for the counseling relationship and develop approaches to attain those goals

Youth-Centered Counseling Defined

Counseling has been defined as “an interactive process involving a trained professional counselor and a client, with the aim of enhancing the client's level of functioning” (Faiver, Eisengart and Colonna, 2000). The counselor and the client work together as allies, helping the client grow and change by setting realistic and achievable goals, developing new ways of interpreting and managing problematic situations, and learning to use internal and external resources more effectively (ibid).

In the context of sexual and reproductive health issues in young people, counseling is conceptualized as an encounter in which a provider acts as a facilitator and helps the young person to solve a problem in an understanding and nurturing atmosphere that supports self-disclosure. While the objectives of particular counseling relationships and sessions will vary according to the young client's needs and wants, the counseling process is undergirded by a cognitive-behavioral approach where the provider helps the young client to understand his unhealthy behavior and replace them with learning new behaviors in order to solve such issues as preventing HIV/STI infections and unwanted pregnancy. Counseling then focuses on specific behavioral problems or life challenges in normal development, rather than on changing personality and dealing with severe mental illness or psychopathology.

Front-line providers have an important role to play in encouraging and supporting youth through simple but important techniques such as empathetic listening and facilitating self-disclosure while they reflect on and change their thoughts and behaviors. Furthermore, counseling can help a young client cope with a crisis (how to deal with loss, such as death of a family member, unexpected pregnancy, a new HIV diagnosis, relationship break-up, loss of a home) and develop personal insight and knowledge (intimately learn more about themselves – who they are, what they like/dislike, how they communicate, how they deal with anxiety, sadness, anger, loss, ambiguity, how to manage their emotions and conflicting decisions, how to calm and center themselves when under stress and pressure) (British Association for Counseling, 1989).

Through the decision-making process, counseling can help young people alleviate a situational problem or challenge, expand their skills, restore a sense of well-being and correct some self-destructive behavior (Spain, 1988). Counseling deals with problems of everyday living that emerge in the lives of young people. Often young persons need someone with a listening and empathetic ear, one who shows deep respect for them through their own appropriate self-disclosure, has precise and updated information about sexual and reproductive health issues and can provide a respectful, warm, trusting and non-judgmental attitude toward their concerns.

Basic Principles of Youth-Centered Counseling

◆ **Youth-centered counseling is centered on the youth's needs and wants** and is responsive to the young person's sexual identity (natal sex, gender identity, sexual orientation and sex role) and developmental stage (pre-adolescence, early adolescence, mid-adolescence, late adolescence, youth). Young persons are conceptualized from a developmental perspective seeing adolescence and youth as a normal developmental stage in life with its problems, opportunities and possibilities. Counselors get to know the young person coming to see them in a more personalized and individualized manner in order to develop trust and rapport. Many young people avoid coming to health clinics for health care services simply because they are often seen as just reproductive "cases" or numbers. Young people will not disclose information if they are not respected, if they do not feel that they will truly be heard.

◆ **Health is universally acknowledged as a fundamental human right**, and sexual and reproductive health is an integral component of overall health. Adolescent sexuality and sexual well-being are integral components of adolescent health and development. Sexual development is an essential part of adolescence and the majority of adolescents engage in sexual behaviors as part of their overall development. Effective youth-centered counselors acknowledge that young people are sexual beings and that

because they will have sexual experiences they need to have precise and updated knowledge, clear values, healthy attitudes, and skills to be *sexually literate*.

◆ **Providers practicing youth-centered counseling respect and accept young people for who they are,** not for what they do. Through their language and nonverbal communication, providers express their unconditional positive regard for the young person. This means that providers are non judgmental about young persons, even if they do not agree with everything the young person is doing or saying. Providing unconditional positive regard means being respectful, authentic, honest, caring, interested, and acknowledges that young persons have human dignity, and worth.

◆ **Youth-centered counseling uses a non-directive style.** Providers understand and appreciate that behavior change is facilitated when the young client participates in the selection of possible options to solve their own problems, decision-making, and exerting their own human agency (making their own choices). Providers do not underestimate the youth's knowledge and capacity for self-understanding and making informed decisions. Jourard explains that when counselors provide clients to “be;” to express themselves freely without fear, to disclose their troubles, to trust another human being with their problems and concerns in an atmosphere of trust and rapport between the client and helper, their sense of well-being is enhanced (Jourard, 1971). Just the mere experience of facilitating self-disclosure can be healing; can move clients towards well-being and health.

◆ **Youth-centered counselors acknowledge and use the young client's strengths, internal and external resources, skills and coping strategies** to solve challenges and problematic situations. The youth-centered counselor asks pertinent questions that reveal the internal and external strengths and resilient qualities of the young person. The youth-centered counselor's assessment takes into account client's needs, goals, dreams, wants, desires, strengths, inner resources, familial support, *barriers and resistance to change* and assesses how the young person has solved problems in the past. Using the knowledge collected, the youth-centered counselor builds on those strengths to co-develop an action plan in conjunction with the young client. Work

with youth has often focused on addressing pathologies and “fixing” dysfunctions. Counseling needs to acknowledge the “whole” human being. Counselors must tap into what is currently working, functional, and good in the young client’s life.

◆ **Youth-centered counselors focus on the young person’s subjective reasons for doing things and are interested in exploring the meaning the youth ascribes to the situation.** One often common error that HIV prevention workers do is to treat all young people as the same. They ask the same sexual risks-taking questions; they give the same HIV prevention messages and prescriptions, and do not acknowledge that the sexual behavior of people carry different personal and intimate meanings. Youth-centered counselors ask open-ended questions in order to explore the intricate meanings behind the sexual behavior. While some youth may engage in sexual intercourse for feeling “love,” others may do it for money, pleasure, fun, stress-relief, leisure, companionship, impulsivity, anxiety, or meet a compulsive need. We need to understand the whys of sexual behavior, the ascribed meaning, and the context of the sexual behavior in order to intervene sensitively and sensibly.

◆ **Youth-centered counselors pay attention to the young client’s unique story and perspective of the situation.** While problems and opportunities for change may be similar from one young client to another, the youth-centered counselor appreciates the uniqueness and individual perspective and meaning of each young person in counseling. What counts is what is “real” for the young person. Youth-centered counselors pay keen attention not only to what can be tangibly seen but to the internal “experience” of the young person.

◆ **Youth-centered counselors set specific and realistic goals that are appropriate to the gender and age of the young person.** The counseling relationship is bounded by setting achievable goals, is time-limited and makes use of brief interventions that motivate change. While it is not always possible to match the counselor’s gender with that of the young client, checking with the young person to assess how they feel with working with a person of the opposite gender reflects sensitivity and respect. If referral is possible to facilitate trust and rapport, providers are encouraged to do so. But providers

should make every effort to understand that their gender can play a role in affecting their counseling relationship especially when talking about sexual health issues.

◆ **Youth centered counselors provide pertinent and precise information about sexuality and sexual and reproductive health issues.** Youth-centered counseling takes on an important role to demystify sexual myths, provide accurate and precise science-based information on sexuality and provide practical strategies for the young person to act on the new information and skills learned.

◆ **Adolescents require a full range of confidential sexual and reproductive health services tailored specifically for them.** Youth-centered counselors have the responsibility to find out the policies regarding medical and counseling sexual and reproductive services to adolescents. Countries in Latin America and the Caribbean have different policies regarding the provision of medical and reproductive health services to adolescents. In the absence of policies, youth-centered counselors can develop strategies to inform all parties involved about the nature of the counseling offered and the different levels of confidentiality and advocate for comprehensive access of sexual and reproductive health for young people.

◆ **Youth-centered counselors work in partnership with the young person and accompany them through the process of change.** They do not work on the youth, but with the youth. Youth-centered counseling does not give direct advice, nor impose counselor's own personal views and voice, and does not make decisions for the young client.

◆ **Youth-centered counselors value the inherent dignity and individual worth of the youth.** Valuing worth and dignity is demonstrated through the respectful interaction between counselor and client.

◆ **The youth-centered counselors is critically aware of the power relationship between the youth and counselor** and tries to minimize that power through concrete actions. For example, he attends youth activities, mixes with young people, is interested in their world, advocates for their concerns, and speaks in favor of legitimizing sexual and

reproductive health services including counseling and HIV prevention interventions for youth. The counselor does not use his privileged position to direct, control, manipulate nor advice but nurtures self-disclosure, openness, and self-determination.

Youth-Centered Counselor Competencies

The PAHO Child and Adolescent Health and HIV/AIDS units recommend the following basic competences to engage in youth-centered counseling for HIV prevention and promotion of sexual and reproductive health:

- ◆ **Knowledge of sexual health, reproductive health and sexuality** in adolescents and young persons.
- ◆ **Communication skills:** Knowledge and comfort in verbal exchanges and talking openly and unashamedly about sexuality and sexual and reproductive health issues in adolescence.
- ◆ **Interviewing skills:** Active listening, listening to the adolescent's needs and wants, expressing empathy, keen observation of non-verbal behavior, prompts for relevant sexual health questions, reflection of young client's personal situation, developing a safe therapeutic relationship or alliance, developing rapport and trust through own appropriate self-disclosure, maintaining confidentiality and using age-appropriate language that young people understand.
- ◆ **Assessment skills:** Make sense of the data collected during the counseling interview. Ability to understand the problems and opportunities for change from the counselor and young client's perspective. Ability to see problems as tentative and ability to share assessment of the situation with the young client so she understands her problem or challenge. Exploration of the internal and external strengths of the young client.

- ◆ **Intervening skills:** Conceptualize the problematic situation or challenge, identify change opportunities, work closely with youth to develop options and realistic age-appropriate goals, motivate and encourage the young person, appropriately and respectfully challenge the youth in his views, role model positive healthy behaviors, show flexibility, use critical and creative thinking in understanding the presenting situation, manage crises when they occur, problem-solve, organize.

- ◆ **Abiding by professional code of ethics:** Knowledge of and practice of ethical principles within the medical and counseling professions. Whenever confronted with ethical dilemmas, consults with supervisors or colleagues while maintaining the confidentiality of the young client.

- ◆ **Self-awareness and self-knowledge:** Develop a keen knowledge and awareness of self in terms of one's own limitations, biases, prejudices, religious and cultural beliefs, internal conflicts. Know when to make an appropriate and comprehensive referral to a caring and sensitive professional who can work effectively with youth.

- ◆ **Self-reflection and evaluation skills:** Providers must be able to ask critical questions of themselves in order to improve their knowledge, skills, attitudes and effectiveness as a youth-centered counselor. Questions such as: "How am I doing? How do I know that what I am doing is working? Where could I improve? Did I ask for help when I needed to? Do I ask for feedback from colleagues or supervisors? Do I include the young person in setting goals for himself? Was I sensitive to the person's gender and sexual orientation? What were my strengths? What were my weaknesses? Did I use non-sexist language? Did I check about the young person's feelings about her situation and her decisions? Did I observe her non-verbal communication?" (See Evaluation Checklists).

What Youth-Centered Counseling is NOT

In contrast to psychotherapy, youth-centered counseling, does not provide the opportunity to resolve deep-seated problems or conflicts, to restructure personality or to change major life situations (other than pregnancy, for example) (Spain, 1988). Instead, it focuses on the need to make a particular sexual and reproductive health decision, such as which contraceptive method to use or when to take an HIV tests and facilitates exploration of feelings and conflicts that accompany such decisions (ibid).

While counseling in sexual and reproductive health issues may include imparting of knowledge and information or engaging in some educational activities (for example, reading a personal story of a woman living with HIV, or watching a video on date rape, reading an HIV/STI brochure; talking with a teen mother about the experience of having a baby to care for), it is different from education. Counseling addresses the affective dimensions (feelings and emotions) and practical concerns that often interfere with young people using and internalizing the facts and information available through education (Spain, 1988). Furthermore, counseling provides an excellent non judgmental space for young people to examine their behavior, its positive and negative consequences, explore alternative healthy behaviors and set realistic goals for long-term change.

There are many modalities of counseling, including individual counseling, where the main interaction is between a provider and a client; group counseling where a group of clients and a group counselor work on issues presented by the group; couple counseling where two partners in a relationship examine their challenges together; and family counseling in which a counselor meets with an entire family or parts of it. Each type of counseling has its own techniques, methods and skill levels. For the purpose of this guide, Youth-centered counseling will focus on individual counseling between a provider and a young client. The following section describes what youth-centered counseling is NOT.

■ Counseling in sexual and reproductive health is not a mysterious and complex activity. It can be done with the acquisition of basic competencies (knowledge, skills and attitudes) in sexual and reproductive health.

◆ **Psychoanalysis:** Youth-centered counseling focuses on changing the young person's maladaptive or unhealthy behaviors or attitudes in order to help him make more informed healthy decisions and choices about his sexual and reproductive health. It does not interpret client's past childhood histories or experiences, and dreams, However, youth-centered counseling utilizes psychodynamic techniques that are commonly used in general counseling

such as timing, establishing adolescent's comfort, opening the session, understanding young client's demeanor, dealing with appropriate silence, relevant questioning, and wrapping up the session.

◆ **Advice-giving:** While youth-centered counselors can help develop or provide suggestions or alternative options for discussion with their young clients, they do not give advice or direct clients to one alternative. Advice entails telling a person what they should do or influencing them to take that specific action without allowing the person to exercise her own problem-solving capacity. The key words for the advice giver are "should" and "ought": "What you should do is..." Advice giving is one of the more common response styles in communication. Youth-centered counseling aims to help young clients to analyze their own situation and solve their own problems. In this way, the counseling process achieves two major goals: it accompanies the young client through a problem-solving process while simultaneously serving as a model of how future problems can be solved.

◆ **Treatment for severe mental illness:** When youth-centered counselors believe they are dealing with a young person who might need more specialized care, they can make the appropriate referrals. Youth-centered counseling focuses specifically on normal development issues related to sexual and reproductive health. It does not replace intensive psychological or psychiatric treatment for mental health illness or disorders.

■ Healthy sexual development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love

◆ **Dealing with deep seated or clinical problems /conflicts:** Youth-centered counseling is not the same as sex or sexological therapy where clinicians deal such problems as compulsive sexual behaviors, erectile problems, or the inability to achieve orgasms. For further clarity on roles of youth-centered providers please refer to the discussion of the P-LI-SS-IT model developed by Jack Annon (1976).

Sexual Health Defined

The term sexual health does not merely refer to the absence of sexual dysfunction or disease. Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster personal and social wellness and enrich individual and social life. As such, sexual health implies a sense of control over one's body, a recognition of sexual rights, and the strong influence of an individual's psychological characteristics, such as their self-esteem and emotional and mental well-being (PAHO/WAS, 2000; Rosser, Mazin and Coleman, 2001; WHO, 2002).

Healthy sexual development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness, and love (WAS, 1999). Recognition of sexual rights is inherent to healthy sexuality, where individuals have the right to sexual freedom, privacy, equity, pleasure, and to make free and responsible choices. Through the counseling process, counselors can encourage sexually healthy behaviors and bolster self-esteem as well as model with youth important communication, and sexual negotiation skills that can enhance sexual health throughout life.

The basic premise of youth-centered counseling lies in the acknowledgement of the sexual lives of young people. Young people have a right to sexuality information and contraception. PAHO's Child and Adolescent Health and HIV/AIDS Units believe that denial of adolescent sexuality leads to poor sexual knowledge, which in turn contributes to the spread of sexually transmitted infections and unwanted pregnancy. Front-line providers have a great potential to do basic and effective counseling in sexual and reproductive health and can make a significant contribution to the development of

adolescent sexuality. Additionally, by being in strategic positions in health facilities where most young people in Latin America and the Caribbean seek treatment (public and private, outpatient clinics, health centers and dispensaries, health posts and peripheral facilities at village level), and having access to youth and their families, health and human services workers have a high degree of credibility in their communities. Counseling in sexual and reproductive health in front-line facilities can improve prevention efforts already existing in different countries and can provide an opportunity for adolescents to prevent major sexually transmitted diseases including HIV while improving their sexual and reproductive health. In this way, front-line providers play a crucial role in controlling the spread of HIV/STI in the growing adolescent population while providing an opportunity for treatment and care to those infected with sexually transmitted diseases and HIV. Counseling in this regard is consistent with WHO's Integrated Management of Adolescent/Adult Illness (IMAI) and PAHO's Integrated Management of Adolescent Needs (IMAN) approach, extending the benefits of integrated essential care to often neglected adolescent groups.

Characteristics of Sexually Healthy Adolescents

Youth-centered counselors have a unique opportunity to promote certain characteristics in adolescents. While their major function is to address the needs, concerns and wants of their young client, they are in an ideal position to influence young people into developing healthy habits and perceptions. The following characteristics were adapted from *Guidelines for Comprehensive Sexuality Education*, the National Guidelines Task Force and the *SIECUS Report of the National Commission on Adolescent Sexual Health*. The Child and Adolescent Health and HIV/AIDS Units recommend that counselors recognize the **heterogeneous nature of the young population** and **adapt** the following model to suit **their social and cultural environment**.

Model Characteristics of Sexually Healthy Adolescents

- ✦ Appreciate one's own body
- ✦ Understand pubertal change and view it as normal
- ✦ Seek further information as needed
- ✦ Affirm that human development includes sexual development, that may or may not include reproduction or genital sexual experience
- ✦ Identify and live according to one's values
- ✦ Take responsibility for one's own behavior
- ✦ Communicate effectively with family, peers and partners
- ✦ Understand consequences of actions
- ✦ Distinguish personal desires from that of the peer group
- ✦ Assume one's own sexual identity and orientation and respect that of others
- ✦ View family as a valuable source of support
- ✦ Express love and intimacy in appropriate ways
- ✦ Develop and maintain meaningful relationships
- ✦ Exhibit skills that enhance personal relationships
- ✦ Understand how cultural heritage affects ideas about family, interpersonal relationships, sexuality, and ethics
- ✦ Maintain appropriate balance between family roles and responsibilities and growing need for independence
- ✦ Respect the rights of others
- ✦ Interact with both genders in respectful and appropriate ways
- ✦ Have an adult (in or out of the family) to talk to, ask questions and serve as a role model
- ✦ Know parents' and personal expectations
- ✦ Enjoy and express one's sexuality throughout life
- ✦ Enjoy sexual feelings without necessarily acting on them
- ✦ Discriminate between life-enhancing sexual behaviors and those that are harmful to self and/or others
- ✦ Express one's sexuality while respecting the rights of others
- ✦ Seek new information to enhance one's sexuality
- ✦ Engage in age-appropriate sexual relationships that are consensual, non-exploitative, honest, pleasurable, and protected
- ✦ Prevent sexual abuse and avoid exploitative or manipulative relationships

Model Characteristics of Sexually Healthy Adolescents

Continued from p.23

- ✦ Practice delaying sexual intercourse or use contraceptives effectively to avoid unintended pregnancy and avoid contracting or transmitting a sexually transmitted infection, including HIV
- ✦ Practice health-promoting behaviors, such as regular check-ups, and early identification of potential problems
- ✦ Distinguish between love and sexual attraction
- ✦ Act consistent with one's own values in dealing with an unintended pregnancy and seek early prenatal care
- ✦ Demonstrate respect for people with different sexual values
- ✦ Exercise democratic responsibility to influence legislation dealing with sexual issues
- ✦ Assess the impact of family, cultural, religious, medical and societal messages on one's thoughts, feelings, values and behaviors related to sexuality
- ✦ Promote the rights of all people to access accurate sexuality information
- ✦ Avoid behaviors that exhibit prejudice and intolerance
- ✦ Reject stereotypes about the sexuality of diverse populations
- ✦ Educate others about sexuality
- ✦ Promote equality between men and women

Adapted with permission from the National Guidelines Task Force and the SIECUS Report of the National Commission on Adolescent Sexual Health. *Guidelines for Comprehensive Sexuality Education*.

Counseling for the Prevention of HIV/STIs and Sexual Health Promotion

Lindahl (2001), of the Swedish Association for Sexuality Education (RFSU), states that although we may not think about it, sexuality is of key importance in such areas as identity development, relationships, gender roles, marriage, children, inheritance, control over land and other property. Lindahl goes on to say that knowledge of and ability to have control over one's sexuality is therefore one of the keys to a better life for

■ While educational and medical interventions are essential to meet important needs for youth's decision-making processes, it is not a sufficient response to a young client concerned about sexuality and reproductive health

many people. The challenge arises when young people are inexperienced in dealing with complex issues relating to their development, sexuality and relationships. They sometimes do not understand how to make decisions dealing with these *normal* issues because they involve intense feelings and are experiencing them for the first time (Spain, 1988). Sexuality includes sex, gender, sexual identity, sexual orientation, eroticism, emotional attachment/love, and reproduction. It is experienced or expressed in

thoughts, fantasies, desires, beliefs, attitudes, values, activities, practices, roles and relationships and is constructed through the interaction between the individual and social structures. While educational (a lecture on menstrual cycles, transmission of HIV, contraceptive use, using condom and lubricants) and medical interventions (receiving a Pap smear, STI screening, a HIV test or receiving spermicidal foam) are essential to meet important needs for youth's decision making processes, it is not a sufficient response to a young client concerned about sexuality and reproductive health (ibid).

Counseling is an integral part of helping young persons in schools, health and mental health settings, community settings, and other programs, because it provides an opportunity to clarify feelings and values relating to all aspects of sexuality as part of the process of making decisions (Spain, 1988). Through a decision-making process, counseling can help young people alleviate a situational problem, challenge, expand on skills, restore a sense of well-being and correct self-destructive behavior (ibid).

Counseling for the prevention of HIV/STI and the promotion of sexual and reproductive health provides a medium for adolescents and youth to understand their rights and options regarding contraception, to choose when and with whom to have sexual intercourse, to set boundaries with others, to choose to delay sexual activity or engage in safer sex, and to be linked to the system of health care and resources in case of pregnancy, childbirth and illness.

Besides needing educational services or programs that provide updated and comprehensive factual information in order to fully understand the options they have, young persons need medical and counseling interventions as well. Medical interventions offer the resources for pelvic and breast examinations, laboratory tests, medical treatment and any necessary prescriptions. Counseling, on the other hand, responds to the feelings, values, attitudes, fantasies, desires, ideals, interpersonal relationships and internal conflicts and practical concerns relating to their sexuality, thus enabling a decision-making process and behavioral change to occur that move them toward achieving optimal sexual and reproductive health.

Furthermore, counseling is not only for problem-solving but also provides the opportunity to nurture what is already working and to encourage positive behaviors (coping skills, life skills such as assertive communication and sexual negotiation skills, healthy relationships, family and community support). These are often called “protective factors” or “buffers” that promote sexual and reproductive health while reducing opportunities for HIV/STI infection and unwanted pregnancy. Health and human services providers are in unique positions in their jobs to encourage and promote the positive qualities of youth. Encouragements and praise are sometimes needed to uplift the spirit of adolescents and tap into young client’s strengths. Sometimes these simple and concrete things can make all the difference in promoting healthy habits.

Youth-Centered Counseling

General Outcome and Process Goals

General outcome goals are what we are striving for (Long, 1996) or the desired end of our counseling/helping activities. General outcome goals cut across a diversity of clients and client issues and are recognized prior to meeting with the client (ibid). We have identified **three major general outcome goals** for Youth-centered counseling:

- ⊕ **Goal 1.** Prevention of HIV/STIs infection and unwanted pregnancy among adolescents and youth in Latin America and the Caribbean.
- ⊕ **Goal 2.** Promotion of sexual and reproductive health among young people.
- ⊕ **Goal 3.** Provision of comprehensive and precise science-based information and counseling on sexuality and sexual and reproductive health issues with the adolescent and youth population.

Process goals are a means, an action or an activity (Long, 1996). Process goals may be purely a means – talking about sexuality for the pleasure of talking and discussing, or a means to an end – talking about sexuality in order for the young client to understand her sexual identity. Youth-centered counseling **process goals** include:

- ⊕ **Goal 1.** Facilitating behavioral change with young people through exploration of their sexual risk behaviors and consequences to their health, exploration of their attitudes, beliefs and feelings and re-learning maladaptive behaviors, replacing them with more health promoting behaviors (or maintaining those positive healthy behaviors).
- ⊕ **Goal 2.** Working in collaboration with young clients to make informed decisions regarding their sexual and reproductive health issues including contraceptive decisions, HIV/STI testing, seeking medical and psychosocial treatment, further counseling, education or intensive therapy depending on their test results or desired goals.
- ⊕ **Goal 3.** Facilitating the process, integration and internalization of sexuality and sexual and reproductive

■ Through a decision-making process, counseling can help young people alleviate a situational problem, challenge, expand on skills, restore a sense of well-being and correct self-destructive behavior

health information through a personalized and relevant manner that is responsive to gender, sexual identity and adolescent developmental stages.

- ✦ **Goal 4.** Providing safe spaces for self-disclosure and transparency and permission for youth to discuss any doubts, fears, anxieties and questions about their sexuality with the aim to facilitate enjoyment of their sexuality and enhancement of a positive sexual development.

Role as a Youth-Centered Counselor

Youth-centered counselors work with young clients by realistically resolving sexual and reproductive health concerns through the introduction of problem-solving and communication techniques, as well as by providing accurate and precise information. Youth centered counseling for sexual and reproductive health is generally short term and client centered, focusing on the immediate concern or problem.

Jack Annon (1976) developed a very useful model which we have adapted to guide the parameters of youth-centered counseling. The P-LI-SS-IT model for sexual counseling defines very specific roles for front-line providers who are trained to **perform the first three steps (P-LI-SS)**, while specialized sex therapists or mental health specialists who have specialized in sex therapy/sexology can provide all four (P-LI-SS-IT).

The P-LI-SS-IT Model for Youth-Centered Counseling

The P-LI-SS-IT Model (Permission, Limited Information, Specific Suggestions and Intensive Therapy) simplifies our role in counseling and helps us to do the following:

- ✦ Define our role as youth-centered counselors.
- ✦ Define the specific tasks in counseling.
- ✦ Distinguish when we should educate (provide accurate and precise information) and when we should help develop specific suggestions

and alternative options for the resolution of problems or challenges with the young client.

- ⊕ Determine when we should refer the young person to a specialist.
- ⊕ Develop individualized interventions for youth.

The first role in sexual and reproductive health counseling according to Annon is to give **Permission (P)**. Many sexual and reproductive health problems exist because people are often conflicted and confused with what is accepted and what is not accepted or normal and abnormal in the realm of sexual behaviors. Because of religious and cultural values, people often believe that their sexual feelings, thoughts or behaviors may be wrong or immoral. The youth-centered counselor can help resolve many of these conflicts by simply providing a space for the expression of these concerns (thus legitimizing them) and giving permission for experiencing issues of normal development.

■ Youth-centered counselors work with simple sexual and reproductive health concerns of youth (as contrasted with complex and severe problems) and do not provide comprehensive and intensive psychotherapy over an extended period of time.

■ Young people are often taught that sexual feelings, thoughts or behaviors may be wrong or immoral. The youth-centered counselor helps to resolve many of these conflicts by providing a space for the expression of these concerns and giving permission for experiencing issues of normal development.

Case Example: Giving Permission

An 11-year-old student arrived feeling very sad and wanted to see a counselor. When the counselor asked him what was bothering him, he told the counselor that his friends were laughing at him at school because he was too small and thin and his friends were bigger, taller, and more muscular than he was.

The counselor listened attentively to the young client and responded to his sadness saying: "It must be very difficult to be surrounded by bigger boys who laugh at you at school. It is not amusing that others laugh at you because of your size." The counselor then asked how he felt when they laughed at him. The young student had an opportunity to share his feelings in a safe and comfortable space which allowed for rapport building. After tuning in to the young student, the counselor began to normalize his experiences saying: "Do

Case Example: Giving Permission

Continued from p.29

you know that at your age it is normal to be your size? I have noticed that many boys your age are no bigger than you and that those bigger boys in your class are actually older than you. But it sounds to me that it makes you very sad when they tease you about your height and size. It must feel awful.” By giving the young boy permission to have his feelings and to share his experiences in a safe space, and to talk about his physical development, the counselor normalized his experience. The boy began to feel “normal” and was relieved to know that there were others like him and that he was going to continue to grow and develop. An important ingredient in this counseling process is to give permission to clients to have their feelings, to express any doubts, fears and anxieties in a non-judgmental and accepting atmosphere, and to normalize their emotions and experience. ■

The second role providers play in the field of sexual and reproductive health is to give **Limited Information (LI)**. Many problems in sexual and reproductive health can be resolved with basic and precise information. Knowledge can empower young people. This is where the counselor’s role is like a sexuality educator or sexual health teacher, addressing specific sexual and reproductive concerns and attempting to correct myths and misinformation. The counselor asks some key relevant questions to assess the level of knowledge of the young client and determines whether the client needs precise and science-based information. It is very important to recognize that young clients may not process the information as quickly or as thoroughly as adults. Youth-centered counselors therefore are encouraged to ask pertinent questions to assess how much the youth has understood and internalized. Youth-centered counselors can ask their young clients to provide examples of what they have just spoken about or to tell them what they understood from their conversation.

■ The purpose of assessment is to identify needs and priorities that lead to recommendations that will improve young clients’ lives and assist with the decision-making process

For example, if the counselor notices that the young person nodded in agreement or showed disapproval or doubt with a facial gesture the counselor asks the young client what he felt when he said that, again, in a very non judgmental tone. Providers must be aware that giving information or educating a client

on new behaviors or teaching about consequences of risky sexual behavior does not instantly translate into application and behavioral change, as emotions and feelings can get in the way of decision-making. Youth-centered counselors therefore explore the feelings and emotions of the client and “check-in” with the client to discover how he or she is reacting and processing the information. In this manner, providing information is very personalized and relevant to the reality of the young client.

Case Example: Limited Information

Gisella, a first year high school student, asks the counselor if she was at more risk for pregnancy and sexually transmitted infection if she was not using contraceptives during her menstruation. The counselor warmly welcomes her, listens carefully to her concerns and responds to her questions with precise information. The counselor explains that she is at risk for getting pregnant during menstruation and that she can also get infected with sexually transmitted infections. The counselor affirms the importance of using contraceptives especially condoms to prevent a sexually transmitted disease, especially HIV, during sexual intercourse. Further questions posed by the counselor about the student’s daily life help the young client open up and the possibility for the young girl to continue to ask relevant questions relating to contraceptives. Both identify alternative methods of contraceptives and the counselor provides suitable easy to read brochures. ■

The third role Annon (1976) suggests for counselors in sexual and reproductive health issues is to provide **Specific Suggestions (SS)**.

The counselor compiles a sexual history or profile of the young client through what is commonly referred to in counseling as **assessment**. According to Hood and Johnson (1991), assessment is an integral part of the counseling process which consists of problem orientation, problem identification, generation of alternatives, decision-making, and verification. These authors explain that assessment provides information at each step of the counseling process and increases our sensitivity to problems and can also serve to prevent further problems. Vernon (1993) adds that

■ Knowledge can empower young people. This is where the counselor’s role is like a sexuality educator, addressing specific sexual and reproductive concerns and attempting to correct misinformation. It is very important to understand that young clients may not process the information as quickly or as thoroughly as adults

assessment provides information for the client as well as for the professional conducting the assessment. “Assessment procedures also are used to help clarify problems and determine the extent of the concern, as well as identify strengths that can be expanded on to enhance development (ibid). Vernon further explains that the purpose of assessment is to identify needs and priorities that lead to recommendations that will improve young clients' lives and assist with the decision-making process. Applying Annon's P-LI-SS-IT Model, assessment in sexual and reproductive health mainly consists of:

- Defining the issues and concerns of the young client.
- Understanding how the issues have evolved over time.

Case Example: Specific Suggestions

Seventeen-year-old Enrique says he is afraid to have sex, even with a condom, from the moment he found out he was HIV positive. He does not know how to deal with his feelings for his girlfriend and his HIV status.

The counselor listened attentively to Enrique by restating his fears and his assertions. The counselor's reflection allowed Enrique to hear himself out loud for the first time and let him know that the counselor was truly listening and understanding him. Then the counselor asked some open-ended questions in order to encourage him to elaborate on his feelings. The counselor discovered that underneath Enrique's fears there were great feelings of guilt and shame for contracting the disease while desiring to be sexually intimate with his girlfriend. After asking questions such as “Tell me more about you” and “What happened then?” the counselor found out that Enrique was infected when he was born. The counselor also found out that Enrique had never spoken about his HIV status to anyone, except his mother.

After listening with a non judgmental and caring attitude and asking for clarifications of his nonverbal communication, the counselor felt there was a real dialogue between himself and Enrique. This trust provided the opportunity for the counselor to share pertinent and science-based information about how HIV is transmitted and how Enrique can express his sexuality in a variety of healthy ways including using safer sex methods. Enrique learned that he can be physically intimate with his girlfriend and enjoy his sexuality without sexual intercourse. He also learned that when he was ready to have sexual intercourse with his girlfriend, he could use water-based lubricants and condoms. In subsequent sessions Enrique was also taught how to effectively use condoms so to avoid breakage or misuse. ■

- Facilitating the young client's understanding of the central issues and co-developing options and suggestions for resolution.
- Working with the young client in formulating and developing realistic and age-appropriate goals, options, and solution plans.

Intensive Therapy (IT), the fourth role elaborated by Annon, is reserved for a mental health specialist trained in sex therapy. This is where the therapist provides specialized treatment in cases that are complicated by the coexistence of other complex issues which may include psychiatric diagnoses such as depression, anxiety disorders (including obsessive-compulsive disorder), personality disorders or substance abuse, or by interpersonal or intrapersonal conflict.

Youth-centered counselors are trained to identify situations that require intensive therapy and make appropriate referrals to specialists in the field. The youth-centered counselor acknowledges when she is unable to provide such special care to a young person and makes the appropriate referral to a competent and caring professional in the community. Referral goes beyond making a simple telephone call. Referral includes

Referring to Intensive Therapy

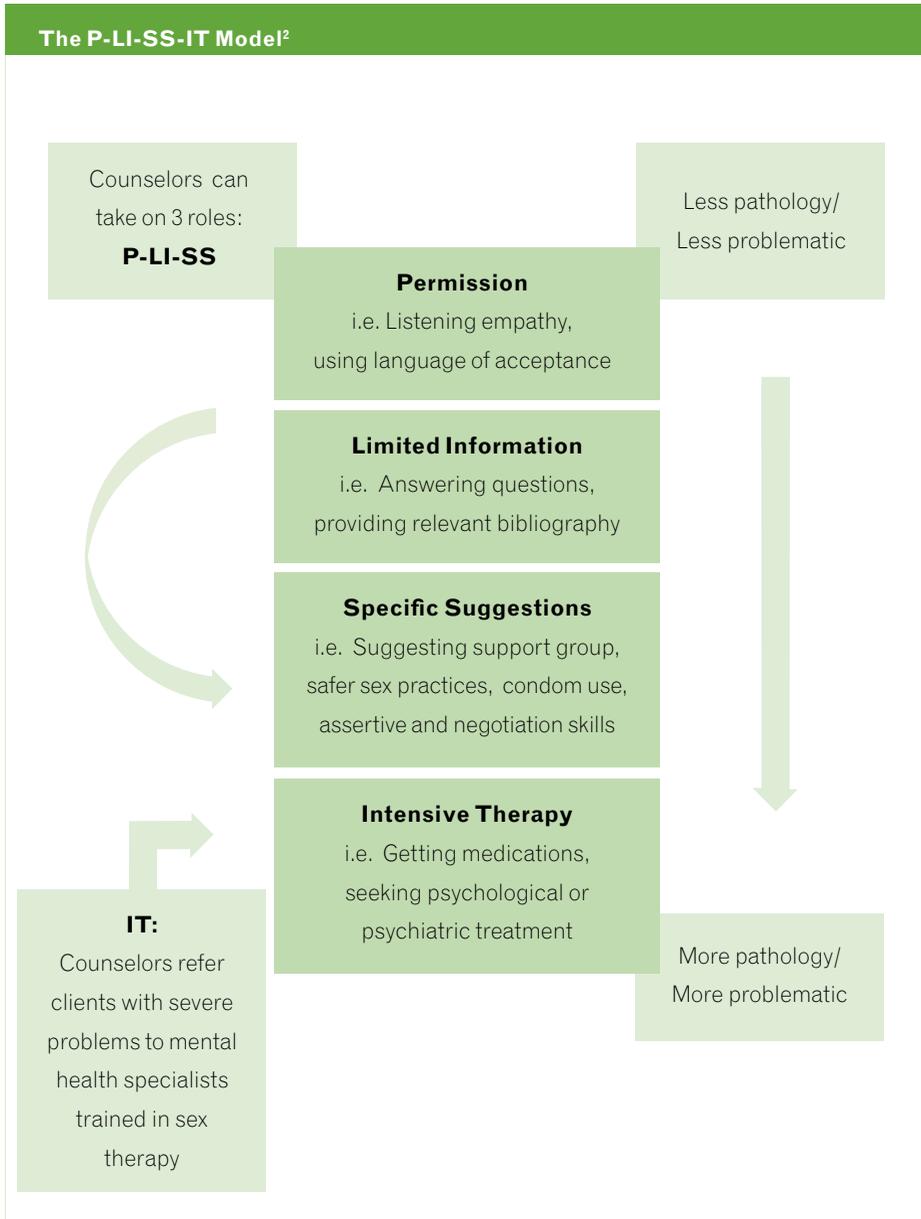
A 14-year-old girl comes to see a nurse in a health clinic. When the young client walks into the clinic office the nurse can not help but notice that she's wearing a long sweater even though it's very hot outside. The young girl is not so talkative at first. In order to develop rapport the nurse "chit chats" about her hobbies, favorite leisure time, school activities, and her likes and dislikes. The young client relaxes by finally sitting comfortably on a chair and unfolds her legs and hands. The nurse notices some bruises and scars on her hands and arms. The nurse asks what brings her here today. The young girl tells the nurse that she does not know what to do with herself because she fears hurting herself. She tells the nurse that she is cutting herself often with razors and shows her scars on her wrists and arm. She begins to cry and shout intensely and begins to beat her hands and her head against the wall.

The nurse quickly calls for some help and a physician administers a tranquilizer. The nurse then calls in the local psychiatric nurse to visit her young client. The nurse makes the appropriate referral by explaining to the psychiatric nurse what happened. ■

identification of the appropriate professional in the community whom the youth-centered counselor believes can work with the client and follows up with the professional or the client to make sure the young person is being cared for.

Referral also comes into play when the youth-centered counselor connects young people who are HIV positive with environmental resources in the community. This includes connecting them to healthcare institutions that have access to anti-retroviral therapy, making referrals to a non judgmental physician that can provide treatment for any possible STIs or other infections, and linking them to any existing psychosocial support group or mental health service relevant to the individual case. We must recognize though that referral is problematic in low-resource communities where there may be no psychologist, psychiatric nurses, trained social workers, or mental health specialists.

These first three roles (P-LI-SS) proposed by Jack Annon can be effectively facilitated by front-line health and human services providers trained in basic counseling skills. Counselors can make a significant contribution to HIV/STI/pregnancy prevention within these first three levels. Finally, counselors refer to specialists for young clients with psychiatric diagnoses, severe mental illnesses or complex life experiences such as rape, sexual abuse and sexual violence. We have built on the Rosser, Mazin & Coleman (2001) adaptation of Annon's model and illustrate the different roles and levels of the P-LI-SS-IT Model with the following diagram:



2 Annon, J.S. (1976). *Behavioral treatment of sexual problems: Brief therapy*. New York: Harper & Row, Harper Collins.



Section Two

Practical Guidelines for Youth-Centered Counseling

Part A: Knowledge, Values, Skills and Climate for Youth-Centered Counseling

- Knowledge base for youth-centered counselors

Part B: Youth-Centered Counseling Process

- Phase 1: Initial encounter and engagement
- Phase 2: Sexual health assessment
- Phase 3: Setting age-appropriate goals
- Phase 4: Creating Plans of Action
- Phase 5: Implementing youth-centered plans
- Phase 6: Monitoring progress and evaluating change

Part A: Knowledge, Skills and Climate for Youth-Centered Counseling



Knowledge Base for Youth-Centered Counseling

Sexual health counselors need to possess a repertoire of skills in order to engage in effective counseling and HIV/STI prevention. PAHO's HIV/AIDS and Child Adolescent Health Units recommend that youth-centered counselors have knowledge of the following major areas. This list of recommendations is neither exclusive, nor exhaustive. Health providers seeking to develop their knowledge, skills, and attitudes in this field should seek further training in sexual health counseling and see their education as a life-long endeavor.

Healthy sexuality of young people within their cultural environments

Counselors need to have a comprehensive understanding of what is considered healthy sexuality for adolescents and young people. This constitutes comprehending the concept of “sexual health” based on current and precise knowledge. There is no universal list of characteristics of “healthy sexuality” for adolescents as health and sexuality take on different meanings depending on cultural and socio-economic contexts and environments. We have used principles of the Sexuality Information and Education Council of the United States (SIECUS) as a starting point for providers to

consider. We encourage providers to examine these characteristics and adapt them to their own local community and country. Providers can also use the list to simply stimulate their thinking in order to develop their own definitions and characteristics. They can develop their list to reflect their cultural diversity and situational context (See Characteristics of Sexually Healthy Adolescents in Section 1).

Sexual health is manifested in the free and responsible expressions of sexuality that foster harmonious personal and social wellness. This integrated approach means that while sexual health encompasses a physical dimension, as in the presence or absence of disease, it also includes non-physical dimensions such as awareness and acceptance of one's sexuality, ability to enjoy sexuality and acceptance of one's body. For sexual health to be attained and maintained it is necessary that the sexual rights of all people be recognized and upheld.

General values and attitudes of young people in their communities

In order to respond effectively and sensitively to youth, youth-centered counselors must understand the cultural and social values of youth in their communities. Youth-centered counselors are encouraged to immerse themselves in the world in which adolescents and young people work, play, learn and live. Youth-centered counselors are interested in discovering youth's beliefs about STIs and HIV and their attitudes toward sex and sexuality. In order to develop a greater understanding of the youth in their community, providers can attend and organize youth conferences, meetings, forums and youth activities. This kind of immersion allows the youth-centered provider an opportunity to develop a deeper and personal knowledge of young people's needs and wants and the socio-economic and cultural factors affecting their sexual health choices.

Counselor's self-awareness of his own body, sexuality, reproductive capacity and sexual health

Working effectively in the counseling field, especially in the area of sexuality and sexual behavior, requires a keen knowledge of self. We have all learned and developed attitudes and biases regarding sexuality. In order to avoid doing harm to young clients, providers must continually assess their beliefs, values and feelings toward their own body and

their sexuality. Providers must strive for continuous self-knowledge and self-evaluation in order to provide ethical and unbiased counseling services.

Sexual health risks of youth

Youth-centered providers need to know which factors play a role in putting young people at risk for HIV/STIs. They need to understand behaviors young people engage in and

■ It is important for youth-centered counselors to consider risky behavior in the context of the youth's community, culture and socio-economic situation in order to be effective providers for young people

how these behaviors may put them at risk for contracting HIV and STIs, particularly unprotected sexual activity, violence and substance use and abuse. Furthermore, youth-centered counselors must also understand the factors that put HIV-positive youth at risk for transmitting the virus to others, developing AIDS and becoming re-infected. Youth-centered counselors also need to know how HIV-positive youth in their community cope with HIV

disease and AIDS. They need to be aware of how youth in their community seek help when in need and access medical and psychosocial interventions. Are there caring and competent professionals working with youth? What informal support systems (i.e., families, neighbors, traditional healers, friends, religious community, and community health workers) exist to work with HIV-positive youth? What specific social and economic factors put HIV positive youth at further risk for developing AIDS (i.e. lack of a nutritious diet, poverty, lack of adequate medical support)? Youth-centered counselors must become deeply aware of existing barriers in their local community that hamper the development of sexual health of young people such as sexual harassment, domestic violence, rape, sexual coercion, incest, commercial sex work, STIs, and HIV stigma and discrimination. With a better grasp of these social and contextual issues, youth-centered counselors increase their opportunity for providing effective and sensitive counseling and act as bridges that connect youth to medical and social services, sensitizing mainstream service organizations to the needs and wants of youth.

A situational analysis of youth

Besides having a comprehensive understanding of adolescent sexual health issues, youth-centered counselors must expand their knowledge of the epidemiology of HIV/AIDS and STIs among the young population in their community and country. “What is going on with youth in my community?” “Do youth face violence, gangs, rape, unemployment and homelessness where I work?” While recognizing these problems is essential, we must not lose sight of the good qualities, strengths and contributions young people bring to the community. Youth-centered counselors can examine the programs that exist in their communities that support positive youth development. It is important to consider the kinds of role models that exist in the community. Who is paying attention to youth? Where do youth hang out – in libraries, in internet cafes, on street corners? What types of positive activities are happening in those circles? These types of ethnographic questions help youth-centered counselors develop a balanced and comprehensive understanding of the positive and negative experiences and social factors affecting youth. Furthermore, youth-centered counselors search for answers to critical questions such as, “Where does my counseling intervention fit in the systems of care or services offered in the community?” “With which types of youth am I most effective?”

Developmental perspective

Adolescence is a normal period of development where “normative crises” frequently occur around “big decisions” to be made in the lives of young people, including their current and future sexual behavior and orientation. Youth-centered counseling can support young people in making healthy decisions about their sexual behavior in order to avoid unplanned pregnancy and sexually transmitted diseases, including HIV/AIDS.

One of the major lessons HIV prevention workers have learned over the past years is that HIV prevention programs must be tailored to the specific and individual needs, interests and desires of the target group. Furthermore, when working with adolescents and youth, counseling must be appropriate to the developmental stages of the adolescent. One of the most important tasks youth-centered counselors must accomplish if they are to be successful in promoting sexual health and preventing HIV is developing a trusting relationship with their young clients. Understanding the different needs and wants of youth from a developmental perspective is invaluable to establishing rapport,

■ Looking at youth from a developmental perspective helps us to understand how their behaviors are often manifestations of their developmental changes and tasks

undertaking assessments and devising alternative solutions in counseling youth.

Often, youth-centered counselors come from a different generation, culture, socio-economic situation and life phase than the young people they serve. How will youth-centered counselors make a strong connection with youth if they are so different from their clients? One approach

is for the youth-centered counselor to conceptualize youth from a developmental perspective and understand how their behaviors are often manifestations of their developmental changes and tasks. By using age-appropriate questions and language, and being interested in exploring the youth's world, youth-centered counselors can learn how to relate and connect with them. Furthermore, taking a developmental approach can assist youth-centered counselors in developing practical interventions that match the assessed situation and readiness for change of the young person (youth-centered counselors must integrate the developmental perspective when using the Transtheoretical Model, Goal Setting Theory and Motivational Interviewing in their counseling practice. See boxes in this Section "Youth-Centered Counseling Process," "Five Dimensions of Risk Behavior for Identifying and Staging Behavioral Change Targets;" Matching Stages of Change with Counseling Strategy for TTM of Change;" "Counseling Strategy: Information Giving;" "Principles for Goal Setting in Health Behavior Change and Maintenance Program for Youth;" "Well Formed Goals;" and Five Principles of Motivational Interviewing").

Needs of marginalized, oppressed and poorer youth in local communities

Youth-centered counselors in Latin America and the Caribbean need to recognize that young people are often marginalized, ignored, oppressed and pushed back by mainstream society. Youth-centered counselors must be knowledgeable of how structural barriers in society, such as laws prohibiting the use of contraception, affect the health choices youth make. Youth-centered counselors must know how youth are affected by oppression, whether, at best, they are ignored in their society or, at worst, abused, criticized, ridiculed and their needs trivialized. Although most youth-centered

counselors work individually or in groups with youth, they can appreciate how macro problems such as poverty, racism, prejudice and discrimination are sometimes the causes of young person's problems. Youth-centered counselors pay particular attention to sexual minorities including self-identified gay, lesbian, bisexual and transgender (GLBT) youth, those who are questioning their sexuality and non-identifying youth who have sex with members of the same sex.

Resources for youth in local community

Youth-centered counselors must know the local resources available for youth in her community in order to make appropriate referrals to other counselors or youth-friendly organizations. Youth-centered counselors refer young clients to specialists when dealing with a particular problem that needs more focus than the provider is able to provide (for example, sexual compulsions, rape, substance abuse and schizophrenia). Furthermore, youth-centered counselors provide referrals for health and medical concerns (i.e., sensitive and caring psychosocial support for a young person living with HIV/AIDS; where to refer a young woman who is interested in learning more about her reproductive choices; if the counselor is male, where can he send a young female client who wishes to seek counseling from a female counselor; where to refer a young client who is dealing with job discrimination because of his HIV/AIDS status).

Youth-centered counselors know how to develop strong relationships with other resource persons in the community so as to facilitate a smooth transition of services for youth. Youth-centered counselors apply specific networking skills involving communication, rapport building, trust-building skills and team work when working with organizations and other professionals. However, youth-centered counselors are often confronted with the lack of existing physical and social infrastructure supporting youth in Latin American and Caribbean countries. They are therefore challenged to build formal and informal alliances and support systems with professionals and community activists who believe in and support healthy youth initiatives.

Human and cultural diversity

Young people are different in many cultural aspects including their nationality, ethnicity, race, culture, subculture (gangs, LGBT communities) and social cliques. Young people are different from each other as they may have different needs, interests and wants. They are also different in individual human aspects such as age, stage of development and maturation (pre-teens, early adolescents, middle adolescents, late adolescents and youth), sex (biological male, biological female, intersex), gender identity (see themselves as men or women or other construct in their society), sexual orientation (gay, lesbian, bisexual, non-identifying youth who have sex with members of the same sex and those questioning their sexuality), economic situation, physical and mental abilities and life experiences (victims of sexual abuse, rape, trauma, violence). Youth-centered counselors understand how each youth is different from the other and how their worldviews are influenced by their developmental phase, life experiences and social context. Youth-centered counselors take on an exploratory and open “tentative” stance when making their counseling assessments by remaining receptive to the young client’s social and sexual history in order to better understand the young person’s behavior.

A comprehensive understanding of “How people change”

Health providers engaged in counseling about sexual health must understand how people change their sexual behaviors. Youth-centered counselors need to have a strong conceptual understanding of how people change their behaviors and how they maintain new behaviors. As mentioned earlier in this guide, we propose a conceptual framework to guide counselors in facilitating change with young clients. This framework is based on the Transtheoretical Model of Change, Goal Setting Theory, Client-Centered Counseling, Motivational Interviewing and a Strengths-based approach (for explanation of different components, see the section that follows; for empirical support of the components of this model see section 3: Literature Review).

Youth-centered counselors apply this conceptual framework as a model of change for preventing HIV/STI/pregnancy and for promoting sexual and reproductive health. We realize that nurses, physicians, social workers, psychologists, counselors, educators,

public health workers and other health providers bring a wealth of professional expertise and formal education into the counseling experience. This conceptual framework is presented to enrich that knowledge-base; it is not intended to replace what these providers already know and what already works in their practice setting.

A comprehensive understanding of “How to facilitate change”

The nature of human behavior is very complex. Changing behavior is a difficult undertaking, particularly for youth. Therefore, in order to facilitate changes, a thorough understanding of the change process, specifically the counseling process, is very important for youth-centered counselors. For the purpose of changing attitudes and behaviors relating to sexual behavior, we use principles from Client-Centered Counseling, (thus the concept of Youth-Centered Counseling), the Strengths-Based Perspective, Motivational Interviewing and the Transtheoretical Model – also known as Stages of Change – to facilitate behavior change. These theories are elaborated in the section that follows and reinforced in the literature review. The application of professional values and ethics of human services such as social work, counseling and psychology are integral to working with youth.

Effective HIV Prevention: What Works and What Doesn’t

We must invest in prevention programs that have shown effectiveness. Youth-centered counseling is an integrated approach derived from humanistic and behavioral theories, counseling and direct social work practice that have individually shown effectiveness in facilitating behavioral and attitudinal change with diverse populations. Our aim is for youth-centered counselors to adapt “best practice” methods and models to guide their counseling with youth. This framework and guide is presented to accompany the youth-centered counselor in a flexible manner, using other skills and knowledge that are relevant and appropriate for the local practice setting. From this perspective, youth-centered counselors must remain open to the latest research findings and state of the art innovations in HIV prevention and sexual and reproductive health promotion.

Disease Prevention vs. Sexual Health Promotion

Youth-centered counselors must be knowledgeable of the difference between prevention work (i.e. preventing HIV/STI and adolescent pregnancy) and promoting sexual health (enhancing sexual well-being, enriching sexual communication, promoting sexual assertive and negotiation skills). While these areas often overlap, they constitute different assumptions, methods and activities. A recent social work dictionary (cited by Bloom, 1996) clarifies the differences between prevention and promotion.

Prevention refers to “actions taken by health care providers, social workers and others to minimize and eliminate those social, psychological or other conditions known to cause or contribute to physical or emotional illness and, sometimes, socioeconomic problems. This includes establishing those conditions in society that enhance the opportunities for individuals, families, and communities to achieve positive fulfillment.” (Barker as cited by Bloom, 1996).

Health Promotion is defined as furthering health and well-being through general measures such as education, nutrition, or social services aimed at host populations (Leavell and Clark as cited by Bloom, 1996). While there are overlapping ideas when examining disease prevention and health promotion, prevention emphasizes specific protections and measures applicable to particular diseases to intercept the pathogenic agent before it affects the host population. In contrast, health promotion deals with activities that support people in achieving high-level potentials or making environmental changes for achieving these same ends. Furthermore, health promotion is a process by which individuals and their communities exercise control over the determinants of health, thus improving their state of well-being.

Comprehensive knowledge of what constitutes youth-friendly services

Youth-centered counselors understand the concept of youth-friendly services. They strive to provide youth-centered counseling in this context. The International Planned Parenthood Federation states that “a youth-friendly service is one that attracts young people, meets their sexual and reproductive health needs and is accessible and acceptable to a diversity of young people” (adapted with permission from Advocates for Youth, www.youthshakers.org).

Youth-friendly services should:

- Meet the needs of all young people, whatever their age, sex, sexual orientation, gender, ability (disability), beliefs, religion and sexual lifestyle.
- Encourage young women and men to access services and to become involved in their health.
- Provide an environment free from the obstacles that make young people feel uncomfortable about using the services.
- Support young people in expressing their sexuality in the way they choose.

Youth-centered counselors are aware of barriers to youth-friendly services and work to reduce or eliminate these barriers. Listed below are several barriers to youth-friendly services. They are organized into three categories: facility barriers; program or service-related barriers; and provider's attitudes (adapted with permission from Advocates for Youth).

Facility or logistical barriers

- Facilities are not always located in areas accessible to young people. They may have a difficult time traveling long distances or reaching places that lack public transportation.
- The lack of privacy at facilities, as well as the lack of youth-only designated spaces, can be a barrier.
- Crowded waiting areas deter young people from feeling welcome at facilities.

Service or program-related barriers

- The high cost of services can be a problem as many young people do not have sufficient income.
- The lack of variety of services available requires young people to go to several different facilities to get services and deters them from going at all.
- The lack of variety of services available requires young people to go to several different facilities to get services and deters them from going at all.
- Not linking the education of young people about sexual and reproductive health with other educational, social programs or medical services. Young people will

not seek services if they are unaware of the importance of reproductive health care or do not know where to obtain such care.

Providers' attitudes as barriers

- ❖ Poor and negative attitudes from providers and other adults (such as receptionists, front-desk secretaries) toward youth seeking out sexual and reproductive health services is a huge barrier to youth-friendly services.
- ❖ Providers who fail to take young people's need for services seriously, or who try to dissuade young people from having sexual relations. Providers who are prescriptive to youth and want to offer direct advice without understanding young people and their capacity for informed decision-making.

Basic medical knowledge of STIs and reproductive health concerns

Youth-centered counselors will be sought by adolescents and young people for their specific knowledge and expertise in sexual and reproductive health issues. Youth-centered counselors are encouraged to have in-depth knowledge of reproductive health issues, including medical, educational and psychological needs of the adolescent. They are encouraged to be proficient with factors that influence the vulnerability of adolescents for contracting HIV/STI or having an unplanned pregnancy. Furthermore, youth-centered counselors must be comfortable in imparting this information with a non-judgmental attitude. They must be able to teach and model sexual negotiation, sexual assertiveness skills, sexual self-efficacy and sexual self-esteem and have sufficient communication skills to transmit this knowledge during their counseling session.

Youth-centered counselors have two important contributions to make to the sexual and reproductive health of adolescents.

- ❖ They have the knowledge and skills to develop a strong rapport and connection with adolescents, gaining their trust and respect to establish a working relationship with them (See discussion on Strengths-Based Perspective and Client-Centered Counseling)
- ❖ They have the knowledge and skills to impart updated and precise information, ask key assessment questions to make comprehensive sexual health evaluations and deal with emotional issues that may interfere in decision-making (See

Guidelines for Strengths-Based Assessment and Five Dimensions of Risk Behavior for Identifying and Staging Behavioral Change; Counseling Strategy: Information Giving, and Phase 2 of the Counseling Process: Sexual Health Assessment for youth, particularly Sexual History Questions.

Frequently, young people do not ask their physicians, high school teachers, parents and seniors questions pertaining to sexual health matters because of embarrassment, fear of being judged or lack of trust that their concerns will not be treated with respect and confidentiality. They then turn to their peers, who often provide misinformation on sexuality and sexual and reproductive matters. Youth-centered counselors meet adolescents “where they are” by applying the Transtheoretical Model of Change (Prochaska and DiClemente, 1983) and viewing adolescents from a strengths-based and developmental perspective. In addition to having updated and precise medical knowledge of STIs and sexual and reproductive health issues, providers can bridge the gap that often exists between health services and adolescents.

Finally, youth-centered counselors not only provide counseling or impart information, but also work at providing the means for youth to access contraceptives, condoms, lubricants, emergency contraception (“morning-after” pills) and HIV/ STI tests. Providers must work towards changing laws and policies in Latin America and the Caribbean that prohibit young people from accessing contraceptives or condoms. Other barriers include lacking money to buy them or the need to get prescriptions for some of them. Youth-centered counselors try to make condoms and contraceptives available in places where they work. This provides counselors the opportunity to discuss the importance of using contraception and condoms, as well as the opportunity to demonstrate how they work. Additionally, counselors must know the policies and laws governing the provision of birth control and condom distribution of their agencies and countries.

Summary of Knowledge Base for Youth-Centered Counseling

Culture, Community, Contextual and Environmental Influences— Role of culture and religion on sexuality, how cultural norms shape and influence sexual choices, how lack of resources and education, poverty, racism, sexism, heterosexism, classism, ableism and homophobia affect youth sexual choices and development.

Current Social Issues Affecting Youth Development – Possessing a sound perspective of the situational analysis of youth in their community.

Knowledge of Self – Critical self-awareness, knowledge of one's own motivations for engaging in counseling with young people, awareness of biases and prejudices toward groups of adolescents, openness to growth and supervision, commitment to life learning and development.

Growth and Development Stages in Adolescence – Physical, social, cognitive and emotional development of pre-adolescents, early adolescents, mid-adolescents, late adolescents and youth.

Gender Differences – How boys are different and similar to girls, gender construction, gender identity, gender roles, sex roles and their capacity to change, oppression and marginalization of women and girls.

Effective HIV/STI Prevention Science – Knowledge of how to prevent HIV/STI and teenage pregnancy effectively.

Interviewing and Assessment – Knowing which key questions to ask, and the rationale for asking them. Ability to apply questions to adolescent population in order to make them relevant, youth-friendly and appropriate to developmental stage, age, sexual orientation and gender of youth. Uses critical thinking in developing a “picture” of the situation facing the adolescent.

Making Referrals – How to make referrals, why and to whom. Ethical issues surrounding reasons for referral- example- What do I do if I do not feel comfortable talking about pregnancy options to an adolescent although she is requesting it, but there is no one else in my town who I can refer her to?

Knowledge of Laws and Policies – Surrounding issues of sexual and reproductive health counseling. ■

Skills of Youth-Centered Counselors

Counselors whom young people respect and like, and whom are effective in facilitating behavioral change possess some general counseling skills; attitudes and knowledge that help establish a supportive relationship. We have identified the following skills and qualities that can help counselors work effectively with youth. This is not an exhaustive list as there are many more skills and competencies that can be added.

Communication skills

Engage in active listening (as contrasted with passive listening; this includes being an active responder to the young client); maintain eye contact; understand the adolescent's situation and communicate this understanding to the youth (demonstrate empathy); paraphrase, summarize, relate, articulate and reflect his sharing; carefully consider youth's questions and answers; stay focused on the session; respond to emotional content of the encounter; use humor appropriately and be comfortable talking about sexual and reproductive health issues.

Basic counseling and interviewing skills

Ask for clarification; give meaningful and specific feedback; observe and attend to non-verbal and verbal communication; establish comfort and rapport; be non judgmental; demonstrate positive regard through using language of acceptance; avoid criticism; validate feelings; reflect feelings back; acknowledge difficulties and conflicts; recognize doubts and fears; validate experiences and emotions; demonstrate warmth; respect youth's story; maintain and protect confidentiality; use easy-to-understand language; use prompts to elicit more information; maintain a positive disposition; show respect for youth; be comfortable with youth's range of feelings and issues; focus on the needs and wants of the young client; use appropriate self-disclosure, and be relaxed and comfortable when asking purposeful questions.

Assessment skills

Analyze the situation at hand; conceptualize why it is happening and make sense of the circumstances; use critical thinking; ask important and key questions to elicit information about risks, concerns, problems and internal and external strengths and coping mechanisms; maintain an open-mind when listening to problems; avoid hasty conclusions; be open and interested to young person's behaviors and thoughts; brainstorm to find possibilities for change (think outside the traditional solutions); be flexible in thinking about the situation/problem of the young client and do not rely on only one theoretical orientation; avoid diagnosing and pathologizing normal youth development issues including sexuality. Share the assessment with the young person and check to see if it makes sense for the youth.

Implementation and intervening skills

Develop a trustful and respectful relationship with young clients in order to facilitate behavior change; provide support and encouragement, co-develop strategies and practical suggestions; provide opportunities for young clients to dream and plan for the future; use role modeling and problem-solving skills to provide opportunities for youth to make their own decisions (enhancing *self-determination, autonomy, and choice*); ask for feedback; and follow up on tasks and promises.

Self-awareness, good will and personal growth

Know yourself, explore attitudes and emotions about self; recognize your feelings and values about sexual and reproductive health issues; be aware of biases; assess your own competence, attitudes and knowledge; have a desire to work with young clients in an empowering manner, protecting the autonomy and self-determination of the youth in a way that is ethical and supportive for the development of young people.

Creating a Youth-Centered Counseling Climate

Create a warm and welcoming environment

The counseling process can be an intimidating experience for young people, especially if they have been referred to the counselor by someone else. While most young people have visited a physician or nurse during their childhood, few have ever seen a counselor, psychologist or social worker. Therefore, the first few moments a young person walks into the counseling room or space are critical in setting up a welcoming and safe environment. As counselors of sexual and reproductive health, it is even more important to create a “safe space” in which to discuss sensitive issues. Three approaches (client-centered counseling, strengths-based perspective and motivational interviewing) affirm that one of the most important aspects of counseling is establishing an environment in which the client feels safe and secure and empowered in the decision-making process.

There are several specific techniques that the youth-centered counselor can utilize in order to create a warm and youth-friendly environment. The young client is best served by being interviewed alone. If the young client is accompanied by a parent, the counselor can ask to visit with the young person privately and, when appropriate, invite the parent to sit in on the session. The decision to have the parent present in the counseling session depends on the particular situation that brings the youth into counseling. The counselor

should assess the particular idiosyncrasy of the situation and assess whether the youth is permitting the parent to sit in on the session because he is expected to do so by his family, or is genuinely interested in inviting his parent to the session. The counselor can also request a separate session with the parent to provide general information about the nature of the counseling process, but should not break *confidentiality* without the consent of the youth. Should the parent

Appropriate Counseling Environment

Privacy for interviewing the youth alone
(when appropriate)

Private and attractive location

Avoid external distractions

Avoid physical barriers

Ensure confidentiality

insist on knowing what is going on with the young person, the counselor can provide general information about the counseling session(s) without giving particular details. For example, the counselor can say, “We are dealing with relationship issues or managing school and sports.” Nevertheless, the counselor may break confidentiality and inform the parent if the young person intends to harm himself or others. For that reason, counselors need to make the degrees of confidentiality very clear to their young clients at the onset of the counseling process.

Additionally, the actual location of the counseling interaction should be a private place free of external distractions. The main point about a counseling space is to ensure that privacy is kept. It is also helpful for the counselor to sit at the same level as the youth and avoid physical barriers such as sitting behind a desk. It is essential that the young client feel she is receiving the counselor's undivided attention. If at all possible, phones should be unplugged until after the session, and writing down notes kept to a minimum while the young client is talking.

Physical environment

Counselors can let the young person feel relaxed in the counseling setting by providing a comfortable chair or sofa to sit in. By having the chair or sofa situated in an adjacent position to the counselor instead of directly in front of a desk, an open space for purposeful conversation is created. This open space between the counselor and the young person may reflect that both persons are working together in the counseling process and both can learn from each other.

Friendly staff

In order for youth to come to clinics to receive youth-centered counseling, they must feel valued and welcomed. Having friendly and sensitive staff members at the reception area is key to establishing a youth positive environment. Often, youth are sent to counseling by someone in authority and it takes very little to discourage them. Thus, they turn around, walk out the door and seldom return for counseling. A friendly staff person who is sensitive to the needs of youth, who values them as important members of society, who keeps their visits confidential and who treats them with dignity and respect significantly contributes to the environment of trust in which youth-centered counselors operate.

Providing confidential services

As mentioned previously, *confidentiality* is one of the top priorities for effective youth counseling. Young people must be assured that information exchanged during a counseling session will be kept confidential. Keeping confidentiality with youth is of primary importance to establish a safe place for youth to express their issues and concerns. Counselors should explain that office policy and the counseling profession requires that everything discussed will remain between the counselor and the young client, unless the youth wishes to disclose information to somebody else. It should also be mentioned that counseling records are kept in a locked file which can only be accessed by the counselor or other professional staff directly involved in the youth's care. The young person should know that she has the right to review her counseling record whenever she wishes and can grant others access to the counseling record as desired.

The more difficult question arises when youth-centered counselors must decide to break confidentiality. The primary reasons for breaking confidentiality are when young clients are potentially harmful to themselves or to others. However, when counseling young people, there may be instances depending on the age and the seriousness of a situation of the young person where parents might need to know

■ Research your country's policies regarding the provision of sexual and reproductive health counseling to know the limits of providing care to young people

what is happening. For example, if a 12-year-old girl is involved with substance abuse or dating an older man who is known by others to be harmful, is this a situation in which confidentiality should be broken and parents or guardians made aware? Youth-centered counselors must make it clear to their young clients where exceptions to confidentiality exist.

Parental consent not required

In areas throughout the Americas, parental consent is required in certain circumstances, such as when an adolescent chooses to terminate her pregnancy. Clearly, this represents a major barrier for youth coming to youth-centered services where they can openly discuss issues relating to sexual and reproductive health. It is essential that young people have access to the appropriate freedom and space to receive services

without consent or permission from their parents. On the other hand, youth-centered counselors need to research the local policies of their country regarding the provision of sexual and reproductive health counseling in order to know the limits of providing care to young individuals. Counselors must take the responsibility to understand what the local policies enforce.

Making counseling services accessible

This is accomplished by offering services for free or on a sliding scale. Often youth do not see mental health practitioners or health care providers because of the high costs entailed. Since young people are not yet earning a full wage, they often cannot pay to see counselors in their community and often rely on people who are accessible – their friends, neighbors or family members – for support. While these individuals are very important to the development of young people, they often fall short in providing effective sexual and reproductive health strategies, including HIV prevention interventions. In order for youth-centered counselors to be responsive to youth, they must be as accessible to them as these natural helpers. By providing “free” services or working on a sliding scale, young people can have more access to them.

Having peer counselors promote the counseling services

There is sufficient empirical evidence to show that young people are heavily influenced by their peers. Subsequently, youth-centered counselors take this opportunity to engage young people who are interested in making a difference in their lives and in the lives of their peers. By training young people in basic counseling skills required to counsel other youth, they can make a significant difference through peer counseling. Additionally, peer counselors can refer their peers to trained adult youth-centered counselors to deal with issues which they are not qualified to handle.

Develop a “road map” for youth

An important task for any youth-centered counselor is to help the young person navigate through systems of care in their community. Many times youth do not know where to go for help especially in times of personal crisis, such as getting a positive HIV diagnosis. By having a depth of knowledge of the local resources available to youth in their local

community, youth-centered counselors can connect young people to health care professionals and human service workers who can provide the necessary assistance to the young person. This referral process is not limited to telling the young person where to go for help, but also requires that counselors develop personal relationships with other providers in organizations and public health systems so that a strong network of care exists to support youth.

Mass media advertising

Counseling in Latin American and Caribbean countries is often seen as a treatment for persons living with a mental illness, having a mental disorder or experiencing symptoms beyond normative crises in life. However, people seeking counseling are not necessarily symptomatic, sick, or have a mental health disease, but need some help to resolve an issue that are important enough to affect decisions that can change their future (i.e. parenting a difficult adolescent, solving typical marriage difficulties, helping a teenager understand her relationships). With the pervasive belief that counseling is only for persons with a mental illness, young people often avoid going to counseling for fear of being stigmatized as sick, dysfunctional, or mentally ill. Subsequently, youth-centered counselors can “market” their counseling in school and community settings and use mass media communication to debunk myths surrounding the aims and purpose of counseling. If peer counseling is part of the youth-centered counseling program, these young people involved can influence their peer group tremendously, as young individuals will see that others like them are involved in youth-centered counseling and realize that it can be cool, normal, exciting and helpful to them.

Part B: Youth-Centered Counseling Process



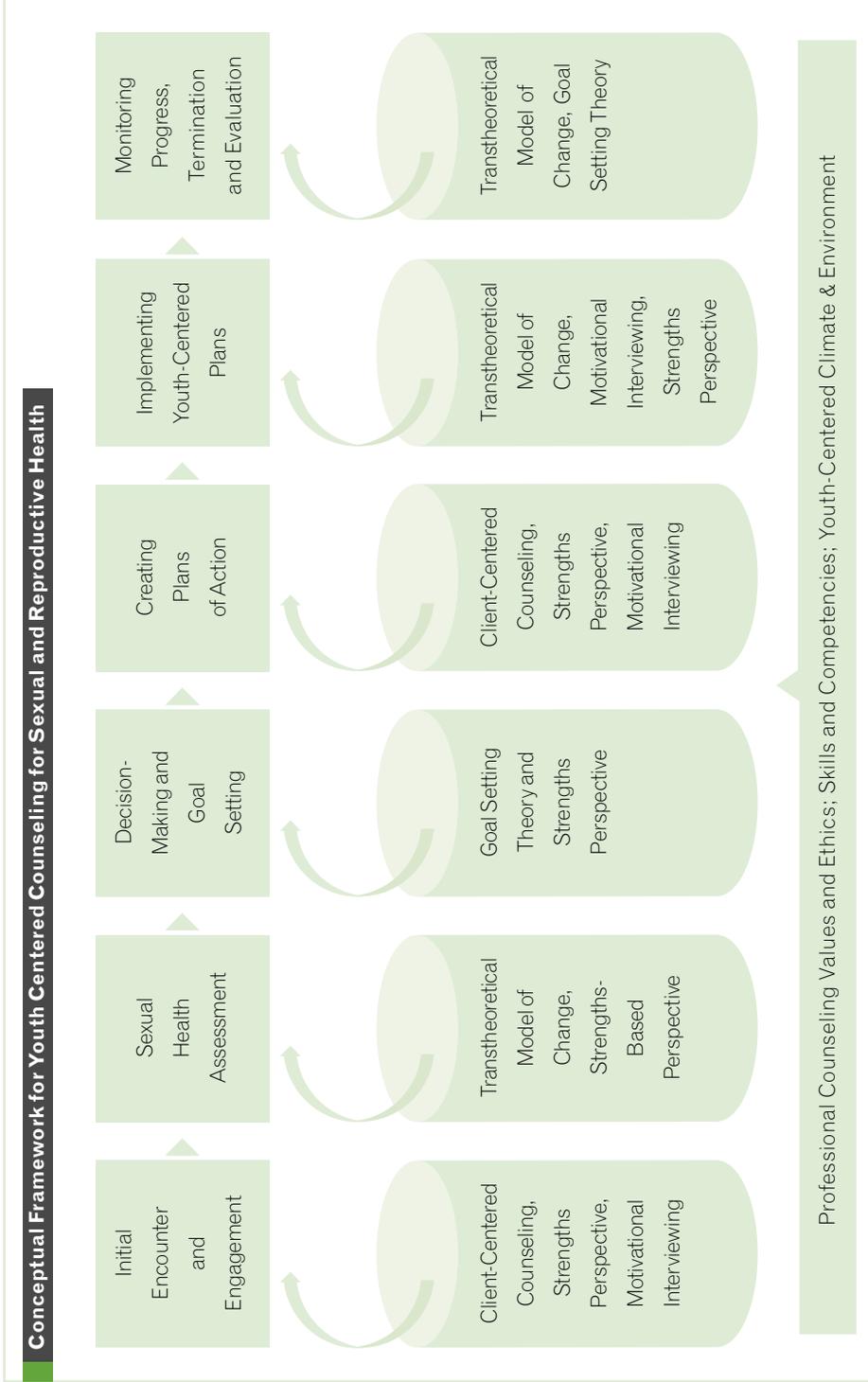
Youth-centered counseling is conceptualized as a possibility-focused process consisting of a *six-step model* that includes:

- Initial encounter and engagement
- Assessment or exploration of the sexual health situation or problem
- Decision-making and setting age-appropriate goals
- Creating plans of action
- Implementing plans
- Monitoring progress and evaluation

■ Youth-Centered Counseling is conceptualized as a possibility-focused process

These six steps are supported by several counseling theories, perspectives and models. An integration of the major assumptions, concepts, skills and strategies of these theoretical frameworks can help a counselor engage in counseling that responds to the needs and wants of youth, is sensitive to the stages of change the youth is in, and provides a safe and non judgmental atmosphere for the discussion of sensitive sexual and reproductive health issues. Furthermore, this integration helps the counselor to view the young person from a strengths perspective, instead of using a paradigm of deficits and pathology, to co-develop goals and explore possibilities of options with the young client and to maximize the counseling session by motivating behavioral or attitudinal change.

The following diagram illustrates the six counseling phases of the Youth-Centered Counseling. Each counseling phase is underpinned by one or more of the theoretical approaches. Each phase (i.e. Initial Encounter and Engagement) uses specific applications



and methods proposed by the different theoretical approaches. For example, during the Assessment phase, the counselor uses the Stages of Change from the Transtheoretical Model to determine the readiness for change of the young client. The counselor also uses a Strengths approach to assessment, applying the principles of the Strengths-based Perspective. While each counseling phase emphasizes unique characteristics of these theoretical perspectives, the counselor uses them in an integrated approach, weaving and overlapping methods and skills to facilitate a smooth counseling dialogue.

Essential Components of Youth-Centered Counseling for Prevention of HIV and Promotion of Sexual and Reproductive Health

The following table provides a succinct picture of how each theory, model and perspective discussed so far informs the counselor about engaging in youth-centered counseling.

Theoretical Underpinning of Youth-Centered Counseling					
Approach	Client-Centered Counseling	Goal Setting Theory (based on behavioral counseling)	Strengths-Based Perspective (based on empowerment theory)	Transtheoretical Model of Change (based on empirical research and behavioral constructs)	Motivational Interviewing (motivation and TTM)
Major Theorists	Carl Rogers (1951)	Albert Bandura (1977, 1997)	Dennis Saleebey (1996, 1997)	Prochaska and DiClemente (1983)	Miller and Rollnick (2002)
View of Human Nature	Emphasis on youth as basically good, positive, forward moving and trustworthy; phenomenological view of self; young person is self-directed and growth-oriented if provided with the right conditions.	Changes in human behavior depend upon learning new behaviors. Behaviors can change through setting goals; goals are founded on what the youth wants to change and on what he expects to happen. Youth have "self-efficacy"-they perceive their capabilities for learning, changing behavior or performing actions.	Youth defined as unique with traits, talents, resources, personal coping strategies and resilience, all of which add up to strengths that can be used to bring about change. Emphasis on open possibilities for choice, control, commitment and personal development.	Young people engage in intentional behavior. Optimistic that young people can change their behavior. This change happens in stages and takes certain processes. Old behaviors can be extinguished and new behaviors established; operant conditioning and social modeling are ways of learning.	People, including youth, are responsible for choosing their behaviors and initiating change. They are in control of their lives and are able to make their own decisions about change.

Theoretical Underpinning of Youth-Centered Counseling

Continued from p.60

Approach	Client-Centered Counseling	Goal Setting Theory (based on behavioral counseling)	Strengths-Based Perspective (based on empowerment theory)	Transtheoretical Model of Change (based on empirical research and behavioral constructs)	Motivational Interviewing (motivation and TTM)
Major Theorists	Carl Rogers (1951)	Albert Bandura (1977, 1997)	Dennis Saleebey (1996, 1997)	Prochaska and DiClemente (1983)	Miller and Rollnick (2002)
Role of Counselor	Stresses holism; Facilitates, focuses on uniqueness of youth; counselor is the technique; emphasis on personal warmth; empathy, acceptance, concreteness and genuineness.	Counselor as teacher, co-director and facilitator; active in sessions; assists young person in clarifying goals and modifying behaviors.	Counselor in equal relationship with youth; models, facilitates dialogue and assesses youth's strengths to discover uniqueness. Interested in exploring the youth's view, meaning of the situation and opportunity it brings.	Counselor asks risk assessment questions to gather relevant and purposeful information. The counselor explores the goals of the youth. Counselor assesses the information and determines the readiness of the youth to change. Counselor matches youth's stage of change with a sexual health intervention sensitive to age, gender and developmental stage.	Counselor provides safe climate (non judgmental, supportive) for talking about sexual health issues. Helps youth understand that they are responsible and able to change.

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Major Theorists	Carl Rogers (1951)	Albert Bandura (1977, 1997)	Dennis Saleebey (1996, 1997)	Prochaska and DiClemente (1983)	Miller and Rollnick (2002)
Goals of Counseling	Self-exploration; openness to self, others; self-directed and realistic; more accepting of self, others and environment; focuses on the here and now.	Works with youth to develop and achieve specific concrete goals and sub-goals. Develops homework and assignments with young person.	Explores youth's current situation including his/her strengths, resources and ways of coping. Explores range of alternatives and solutions to youth's situation. Counseling is centered on getting on with one's life, affirming and developing values and commitments and finding membership in or as a community.	Matches different intervention approaches to people at different stages of change. Works mutually with youth to consider the pluses and minuses attendant to a particular change of behavior. Fosters/nurtures self-efficacy (increase confidence and personal control of life).	Builds therapeutic rapport. Discusses youth's present behavior and valued goals. Makes decisions about behavior change. Collaborates and mutually negotiates solutions. Instills hope.

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Theoretical Underpinning of Youth-Centered Counseling

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Approach	Client-Centered Counseling	Goal Setting Theory (based on behavioral counseling)	Strengths-Based Perspective (based on empowerment theory)	Transtheoretical Model of Change (based on empirical research and behavioral constructs)	Motivational Interviewing (motivation and TTM)
Major Theorists	Carl Rogers (1951)	Albert Bandura (1977, 1997)	Dennis Saleebey (1996, 1997)	Prochaska and DiClemente (1983)	Miller and Rollnick (2002)
Counseling Techniques	Acceptance, clarification; reflection of feeling; use of empathy, positive regard, congruence, self-disclosure; active/passive listening; open-ended questions/statements; summarization.	Thoughtful listening; clarification of values, wants, needs and goals; emphasis on intervention contracts, specific and concrete; uses tasks and assignments. Frames the behavior in terms of skills development. Use of reinforcement-positive, negative.	Key "questioning" on what is working, functioning with youth; openness and inquiry; acceptance of youth's uniqueness; emphasis on relationships; works with incongruent story-lines to highlight strengths of youth and of the situation.	Consciousness-raising; dramatic relief; environmental re-evaluation; self-evaluation; self-liberation; reinforcement management; helping relationships; counter-conditioning; stimulus-control.	Skillful reflective listening; brings awareness of consequences; explores youth's reasons for change; avoids argumentation; uses youth as a valuable resource for finding solutions; focuses on behaviors.

Theoretical Underpinning of Youth-Centered Counseling					
Approach	Client-Centered Counseling	Goal Setting Theory (based on behavioral counseling)	Strengths-Based Perspective (based on empowerment theory)	Transtheoretical Model of Change (based on empirical research and behavioral constructs)	Motivational Interviewing (motivation and TTM)
Major Theorists	Carl Rogers (1951)	Albert Bandura (1977, 1997)	Dennis Saleebey (1996, 1997)	Prochaska and DiClemente (1983)	Miller and Rollnick (2002)
Strengths	Openness and evolving theory; applicable to a wide range of human problems and situations; short term treatment; effectiveness with paraprofessionals and other health and human services providers; positive view of human nature.	Focus on behaviors; focus on here and now; abundance of available procedures; based on learning theory; well-organized framework; well researched; continually growing in sophistication; can be combined with other theories; especially cognitive.	Conceptualizes youth as a resource instead of a problem. Does not ignore problems and concerns but puts them in perspective of all that is going on in the life of the youth. Supported by a solution-focused and positive psychology that centers on creating options and possibilities instead of pathologizing behaviors.	Empirical support that behavioral change relating to health happens in stages. Adaptable to diverse cultural groups. Simple model and easily teachable to paraprofessionals and health and human services providers. Has been applied to HIV prevention and counseling. Conceptualizes people in different stages and provides guide for specific stage-sensitive interventions. Supported by behavioral theory and research.	Provides safe climate (non judgmental, supportive, confidential, and sensitive) for trusting relationship. Non-directive counseling, as it encourages youth to be aware of their options, possible consequences and provides the conditions for them to make their own decisions. Youth participate in the problem-solving process.

Continued from p.63

Theoretical Underpinning of Youth-Centered Counseling

Continued from p.64

Approach	Client-Centered Counseling	Goal Setting Theory (based on behavioral counseling)	Strengths-Based Perspective (based on empowerment theory)	Transtheoretical Model of Change (based on empirical research and behavioral constructs)	Motivational Interviewing (motivation and TTM)
Major Theorists	Carl Rogers (1951)	Albert Bandura (1977, 1997)	Dennis Saleebey (1996, 1997)	Prochaska and DiClemente (1983)	Miller and Rollnick (2002)
Weakness	Lack of concreteness; works best with verbal, bright youth; ignores unconscious and innate drives; deals with surface issues.	Based on rationality of change. Sexual behavior is complex, influenced by biology, psychology, society, and environment.	Seen as positive thinking in disguise. Reframing misery. Pollyannaism. Ignoring reality. Not a mainstream model.	Doesn't deal with the totality of young person's life; just behavior; may be applied mechanically; sometimes difficulty in "doing"; techniques may get in the way.	Intensive focus on cognitive domains. Some youth may prefer a more directive type of counseling.

Source: Adapted with permission from Gladding (1992). *Counseling: A Comprehensive Profession* (2nd Edition). Macmillan Publishing Company, New York.

The following section briefly describes the essential features of each theory, model or perspective, explains how it is applied to the six phases of counseling in sexual and reproductive health and how, when used together, they provide a framework for counseling youth.

Phase 1: Initial Encounter and Engagement

Client-centered counseling

Client-centered counseling is a process that allows an individual to express his problems and resolve difficulties with a minimum of *direction* being provided by the counselor. First developed by Carl Rogers (1951), this approach reduces resistance from clients by allowing them to control the content and pace of the counseling. Furthermore, it provides a space in which the client can “just be” without the expectations of being judged, corrected, interpreted, and directed.

Core conditions for Client-centered counseling

Rogers maintains that there are four characteristics of an effective counselor and that these characteristics are more important than the counselor’s philosophy, theory or technique. The first characteristic Rogers refers to is **genuineness, realness or congruence**. The counselor does not present any professional or personal façade in an attempt to increase the likelihood that the young client will cooperate and respond. This means that counselors need to be themselves. Counselors need to be “real” and authentic with their young client. The second characteristic is **empathic understanding**. This requires that the counselor put herself in the young client’s situation, acquire as great an understanding of the young person as possible and be sensitive to how the youth feels about the situation confronting her. Accordingly, the counselor communicates her empathic understanding to the young client in observable ways.

The third consists of the **ability to learn from the young client**. This implies that the youth is an expert when it comes to himself; the counselor has competences

only in maintaining the attitudinal conditions in the relationship with the young client so that the client can express freely without fear of judgment. Thus, an effective counselor is a very good listener; one who knows how to *join the process* of the client. Finally, the counselor has **unconditional positive regard for the youth**, meaning that the counselor is positive, non judgmental and accepting of where the youth is at a particular moment, even when the counselor does not approve of the young client's behavior. From this discussion, we can derive some qualities and counseling techniques summarized below:

Youth-Centered Counselors

Are genuine, real or congruent (the counselor is himself in the counseling relationship- no façade, no masks, but are transparent; using appropriate self-disclosure)

Have empathetic understanding by sensing accurately the *feelings, emotions and personal subjective meanings* of the client and communicate this acceptant understanding to the young person. The counselor is in tune to *what* is being said (content) and *how* it is being said (feelings, nonverbal communication). The counselor senses the feelings being experienced by the client and communicates that to the client to facilitate client's awareness of his inner experience

Are intensely mindful to respect and protect the autonomy and self-direction of the young person. The counselor is committed every step of the way to nurture self-determination and human agency. The counselor understands that his role is to provide a nurturing space for the discussion of life issues; not to give advice and direction on somebody's life

Have unconditional positive regard for the young person (accept the youth for who he is). Acknowledges client's dignity, worth, and intrinsic value. Acknowledges the *humanness* of the client. Does not have conditions or expectations of the client. This climate of unconditional acceptance is conducive to facilitating change

Having identified these major qualities, it is important to keep in mind that the young client is what really matters. It does not matter how many techniques and methods we have learned in trainings or read in books as our deep respect for the young client and our authentic relationship with him. Jourard (1971), a psychologist and researcher in

“self-disclosure” explains that when he was beginning his career as a therapist he found that his training in traditional psychotherapeutic techniques were not very useful in his clinical practice, “Through trial and error I found that if I abandoned my psychotherapeutic techniques and presented myself as a fairly intelligent, well-intentioned human being, if I shared some of my experience with problems similar to the ones that my patients were wrestling with, we got a good working relationship going” (Jourard, p. 14). His research in self-disclosure showed that disclosure invites and begets disclosure. He explains that there is no way to force somebody to talk about himself; that all we can do is “invite.” He found in his research that the most powerful and relevant *invitation* he found was to share his subjectivity with his client. Jourard’s work challenges us to not aim mastering a bunch of “*technical tricks*” but be counselors who by our very way of living and being excites transparency, self-disclosure and attracts openness.

Strategies that help implement the four principles of client-centered counseling

◆ Be genuinely interested in your young client

Counselors begin the counseling relationship with the aim to understand who the young person is- Who is this “whole” human being and what is bringing him to counseling? They develop rapport and build trust by being caring, open, transparent, real, friendly, warm, and interested in the young person. Youth-centered counselors may introduce themselves briefly (not using titles) and share what they do in counseling. Counselors can be light in their opening remarks instead of immediately jumping into identifying problems and problem-solving. They are attentive to the youth’s opening remarks and follow his lead by asking him open-ended questions about topics he brings up. A cautionary note, people should not get into counseling with young people if they do not enjoy talking with young people and if they do not have a positive and well-balanced perspective of them.

◆ Be aware of your nonverbal communication

Nonverbal communication (facial and body gestures, body posture) is a powerful form of communication. Nonverbal communication give clues to how a person is feeling, moods he is in or level of attention (How is the young person sitting? What is the young

person looking/staring at? What is his body posture saying to you? What feelings is the young person conveying with her facial expression?). These nonverbal messages and cues informs and enriches the assessment which tells the counselor what is going on with the young client.

In the example below, the counselor communicates to the young person that while she does counseling with youth, and knows a lot about young people's behavior, she does not know it all nor does she have all the answers.

"I am here to provide counseling for young people like you in this clinic... (maintains direct eye contact and gives full attention to the young person) but lots of the things I say, young people already know about, like sex and sexuality..."

By using her tone of voice, she communicates to the young client that she is not the one fully in charge nor does she know everything. By being warm and relaxed, the counselor communicates a friendly and interested demeanor that makes the session less intense and more informal. Furthermore, and perhaps most importantly, she communicates that she is a working partner in the counseling process (implies a joint collaboration, one based on mutual respect and trusts), not an advice giver. By stating that young people know a lot about sex and sexuality, she validates the adolescent's knowledge and experiences.

◆ **Clarify your role as a counselor, the client's role and set boundaries for the counseling relationship**

One way to introduce the young person to the counseling process is to briefly explain the counselor's role and the professional boundaries of the counseling relationship. Boundary clarification and distinction includes being aware of your thoughts, feelings, values and actions, taking appropriate responsibility and identifying potential counselor-client relationship issues (Long, 1996).

To begin the process of setting clear client-counselor relationships, counselors can share very succinctly what they do, the range of clients with whom they work and the types of issues they attend to. In this way, the young person does not feel as if he is the only one ever to receive counseling. This approach can serve two functions. First, it can provide an opportunity to "warm up the session" before discussing sensitive

issues. Second, it can heighten the interest of the young person in counseling. More importantly, this introduction can be used as an excellent opportunity to set boundaries for the counseling relationship. While counselors listen, encourage and work with young people to deal with difficulties, challenges, problems and decision-making, they are not their friends or peers. It is very important to be friendly toward the young person while maintaining an appropriate professional distance that is conducive to a healthy counseling relationship.

◆ **Examples of Introducing Oneself**

“I am a counselor working in the field of sexual and reproductive health. I talk to young people like you about developing healthy habits so that they can learn the skills to protect themselves from diseases.”

“My job is to talk with young people about promoting sexual health. Do you know what that means? (pause) Well it means that we talk about anything you want to talk about relating to being healthy, and this includes healthy sexuality.”

To begin setting the focus of the counseling process, counselors can ask their young clients if they know what counseling is all about. Youth-centered counselors can take this opportunity to clarify what counseling is and what it is not depending on how much the young client knows. Again, they can be light and brief in asking the question in a matter-of-fact way, instead of appearing too serious.

While counselors want to focus the beginning of the counseling session by clarifying their role, the young client's role and the counseling process, they must be careful not to bombard the young person with complex definitions of counseling. They can say things like, *“My name is Julie and I do counseling at this clinic. Have you received counseling before?”* or *“What have you heard about counseling?”* The young client might also ask the counselor the same question and she may respond with something like this, *“Well, I see counseling as being able to listen to someone like you and identify what interests you and what you want to talk about. We can also look at what you need to address or questions you have about sexuality.”*

◆ **Tone of voice**

Tone of voice is the quality of a person's voice. A counselor's tone of voice communicates a lot of information that is not readily apparent. It's not always what counselors are saying or the language they use that young people listen to, but the manner in which they say it. Counselors need to be aware of how they are relating to the young person. Are they talking down to him? Are they talking to him? Are they talking with him? Their tone of voice can be soft, warm, comforting, inviting and caring, or it can be stressed, angry, boring, frustrated, sad or nervous.

◆ **Appropriate Use of Self-Disclosure**

Jourard (1971) explains that a counselor is a professional inviter of self-disclosure; and that the implicit promise is that if a client discloses his personal issues, he will benefit from it beyond the sheer emotional "catharsis." Jourard sees the counselor's major role not as someone who is the master of a bunch of technical tricks, but someone who by his very way of living and being excites admiration and attracts followers. This psychologist began to find in his research and clinical experiences that when he let his clients come to know him within the context of an ongoing dialogue, then he got to know them; and the phenomena called trust and rapport was generated on a much more frequent and sensible basis. Jourard found in his research that authentic self-disclosure played a major role in enhancement of mental health and he also found that self-disclosure begets self-disclosure; that transparency was contagious. He concluded that it made sense for a counselor to be an exemplar of self-disclosure, the way he was inviting his clients to follow. This research is very relevant to our aim in creating a climate of comfort and trust that provides the permission for young clients to discuss intimate sexual concerns and sexuality and thereby validating sexuality as a legitimate health issue.

◆ **Introducing the issue of sexual health**

PAHO defines sexual health as "the experience of the ongoing process of physical, psychological and socio-cultural well-being related to sexuality" (PAHO/WAS, 2000). It is not merely the absence of dysfunction, disease and/or infirmity. For sexual health to be attained and maintained, it is necessary that sexual rights of all people be recognized and upheld (ibid). Youth-centered counselors engage in a counseling assessment to

■ Initiate the discussion by asking general non-threatening questions about the young person's needs, wants, likes and dislikes, paying particular attention to age, gender, and developmental stage.

understand the sexual and reproductive health situation of the young person, including her risks and opportunities for change, and address the youth's counseling needs.

One of the first difficulties counselors may encounter is talking comfortably about sexual issues in counseling, as it can be somewhat intimidating for young people and inexperienced counselors. Counselors need to be very comfortable with topics of sexuality in order to create a

comfortable and safe atmosphere for the young client.

◆ **The use of engaging questions**

How can counselors talk about sexual and reproductive health issues including HIV and STIs with young people knowing that young people often feel uncomfortable talking about sexual issues and commonly do not perceive themselves at risk for getting an STI? What strategies can counselors use to talk about HIV and STIs to youth at a level where they can truly connect, instead of counselors sounding like they are giving a lecture or preaching? How can counselors capture the interest, attention and motivation of young people, who are often very different from their counselors?

There are several ways youth counselors can relate to youth about issues of interest. The counselor can initiate the discussion on sexual health issues by asking some general non-threatening questions, inquiring about the young person's needs, interest, wants, likes and dislikes and paying particular attention to their age and gender. In this way, the counselor communicates early on to the youth that he wants to get to know the young person and is authentically interested in him. Through these questions the counselor can get to know the youth more intimately and begin to develop a rapport, essential for the counseling process. Engaging questions can provide two important functions. First, they can give the counselor the opportunity to get to know the young person and the knowledge she possesses about sexuality and sexual and reproductive health issues.

Second, they can provide the opportunity for developing a trusting relationship between the youth and the counselor. Usually, young people see counselors in expert positions holding "specialized knowledge" about the issues that affect them. This

professional image can sometimes be perceived as a barrier to disclosing important needs and wants of the young person. However, young people can also admire this quality in a counselor who is very knowledgeable about their needs. The counselor's task is to minimize this perceived barrier, if it exists, by being youth friendly and interested in developing a helping relationship with the young person.

■ Counselors should ask relevant and purposive questions that provide meaningful information

◆ **Examples of engaging questions**

"I am interested in getting to know you. Do you think you could share with me..."

"What do you most enjoy doing?"

"What are you interested in?"

"How do you pass your free time?"

"What do you do when you have time to hang out?"

"What annoys you the most?"

"Tell me about the friends with whom you share good and bad stuff..."

"Tell me about the friends you hang out with?"

"Where would you like to start today?"

"What is going on with you today?" "What brings you here today?"

"How would you describe yourself?"

If the young person starts talking, follow his leads, inquiring and clarifying what he knows. If not, give him choices such as:

"Do you want to talk about being attracted to somebody?"

"Do you want to talk about changes in your body?"

Providing options for them to choose what they would like to discuss in the beginning of the session gives them some sense of control over the interaction of the counseling process, and young people enjoy feeling a sense of control, especially when they have been referred to counseling by someone else who may be in authority.

Other examples

“Would you share with me what subjects in school you like...” (if appropriate)

“Tell me, what are you good at?”

“Do you have pets?” Tell me about them.

“What TV (radio) programs you like best? What is your favorite music?”

“What are things that get on your nerves?”

“With who do you share your secrets?”

“What is most fun for you?”

“How is your relationship with your classmates? With your family?”

“How is your relationship with your Mom? Dad?”

“How are you doing today?” “How is school going?”

While engaging questions can serve the purpose for rapport and relationship building, counselors engaged in sexual and reproductive health issues should not bombard the young person with questions, making the counseling interview sound like an interrogation. **Counselors need to ask only relevant and purposive questions that provide meaningful information, can raise awareness of those issues for the young person and can be used in developing a picture of the youth's situation.** One way to avoid making the questioning sound interrogatory is to keep a **conversational tone of voice that conveys warmth, acceptance, compassion, empathy, interest, caring and insight.**

It is also very important to use **age-appropriate questions that speak to the developmental stage of the youth.** Understanding age-appropriate behavior is critical in gaining perspective about opportunities for change and situations confronting youth. Counselors must understand that pre-teens, early adolescents, middle adolescents and late adolescents have different interests, needs and wants, and process and respond to information differently from each other.

■ It is important to use age-appropriate questions that speak to the developmental stage of the youth

Counselors do **not have to start the counseling process by identifying a problem.** Doing so at the beginning can set up the session to be problem-driven.

It is very important to begin with questions of strengths, interests, wants and likes. Asking these strengths-oriented questions to young people levels the “playing field” for them, as they then have an opportunity to display that they are individuals with talents, resources and interests. This counteracts the pervasive notions in many families and in society that youth are problematic. By starting with strengths, the counselor gives the adolescent an opportunity to show “how cool he is” and this can be a refreshing perspective for many of them. In essence, a strengths-based counseling approach is oriented toward seeking solutions and possibilities for the present and future, instead of focusing only on problems, pathologies, barriers, and dysfunctions.

Core concepts of the Strengths-Based Perspective

The strengths-based perspective is an alternative to traditional pathology-based approaches often underlying much of counseling knowledge and practice. Dennis Saleebey (1996, 1997) explains that as counselors, we can use a pathologically-oriented lens or a strengths-oriented lens to view clients. Saleebey posits that clients are unique; they possess traits, talents, capacities, adaptive and coping skills, resilient qualities, and resources, all which add up to internal and external strengths. **By exploring what is functioning in the client’s life and what the person brings to the encounter, counseling becomes a possibility-focused endeavor.** The counselor is interested in exploring the client’s personal accounts and story, which are essential to knowing and appreciating the client. For HIV prevention and sexual and reproductive health counseling, this means that, as counselors, we have to move away from asking clients generic HIV questions or following standard mechanical questionnaires that make the encounter sound like a cold interrogation of sexual practices. Instead, we can create an encounter that is centered around the client’s personal story, the subjective meanings attached to his actions and behaviors and one where the aspirations and dreams of the client become the centerpiece of the counseling experience.

Saleebey (1997) calls for a paradigm shift from counselors seen as experts to one where clients are the experts in their own story and authors of their situation. This orientation is possibilities-focused where personal choice, control, commitment, and personal development are open. Counseling is therefore centered on working with the

client to move on with one's life, affirming and developing values and commitments, and making and finding membership in or as a community.

In establishing an engaging relationship with a young client and beginning the process of behavioral change, youth-centered counseling makes use of principles and practices of Motivational Interviewing posited by Miller and Rollnick (2002).

Core concepts of Motivational Interviewing

Miller and Rollnick's (2002) Motivational Interviewing provides a framework that can help youth-centered counselors facilitate the process of change. Motivational Interviewing is comprised of two equally important phases: Phase I, *building therapeutic rapport and commitment* with the youth and Phase II, *facilitating the process of change through decision-making skills and analysis and behavior change*. Shinitzky and Kub (2001) explain motivational interviewing as expressing *empathy by showing acceptance and truly understanding* the client in order to facilitate behavioral change. This is done in a variety of ways, including *engaging in skillful reflective listening*. Miller and Rollnick explain that ambivalence is normal in the change process and that counselors engage in key assessment questioning to clarify clients' wants and needs. Another technique used in motivational interviewing is called "*developing discrepancies*," where counselors facilitate client *awareness of the consequences* of their behavior and identifying *incongruence* using a non judgmental tone. For example, applying this to HIV-related counseling, a counselor might say, "*You say you want to be happy, but you are engaging in unprotected sex and this makes you feel very unhappy ...help me to understand that...*"

Miller and Rollnick explain that counselors must pay attention to what drives youth behavior and motivation for change, avoid arguing with clients, avoid judging and asking "why" questions (as it breeds defensiveness) and note that any resistance is a signal to the counselor to change counseling or intervention strategies. Shinitzky and Kub further suggest avoiding labels, because talking about the specific problematic behaviors is more productive and less judgmental (clearly describe the problematic behavior instead of using personality labels). Collaboration between the counselor and the client is a central part of motivational interviewing; providing clients with a sense of control and respect in the counseling process, such as developing mutually negotiated options and solutions instead of imposing interpretations, advice or treatment plans.

This empowers young clients, helping them to have a major part in finding solutions for themselves. This perspective is consistent with our view of the counseling process and of working with the adolescent and youth populations.

Finally, Miller and Rollnick (2002) explain that our role as counselors is to support *self-efficacy*. Again, very specific techniques are employed here: *instilling hope* in clients, *facilitating choices*, *nurturing and encouraging self-determination and autonomy*, *providing a range of alternatives* (instead of two choices) and encouraging and supporting desired healthy behaviors.

It is important that counselors help young clients see that they are in control of their lives (ibid). This is an important dimension of motivational interviewing since the focus is on helping the young client understand his behavior and the range of options he has in choosing to change. In this manner it is *non-directive*, as it encourages young clients to be aware of their options and possible consequences, and provides the conditions for them to make their own decisions. As young clients ultimately bring about change in their own lives, it is imperative that the encounter help them understand that they are *responsible and able to change*.

Phase 2: Counseling Assessment

After **establishing a warm and comfortable atmosphere** where the youth feels safe and secure to talk about sexual and reproductive health issues, the counselor begins to assess the client's sexual health situation. Assessment provides information at each step of the counseling process and is an integral part of providing relevant and meaningful interventions to youth.

Assessment is also central to utilizing the strengths perspective. Cowger (1994) provides some useful guidelines for conducting strengths-based assessments that can be adapted to working with young people, thus appreciating that young individuals have strengths and resources that can be used to resolve their current challenges. Cowger

■ Sexual health assessment questions can clarify counseling needs, strengths of the youth and current situation confronting the client

explains that counselors give importance to the young person's understanding of the facts, believe the young client, explore what the young person wants and expects from the counseling service, orient the assessment toward personal and environmental strengths, utilize the assessment to discover the uniqueness of the client and develop assessment questions in simple language the youth can understand. Avoid blame and blaming in the assessment process as this deters motivation to address the problem (Ibid). Cowger encourages counselors to share their assessments with their young clients so that the questions and processes of the assessment are not a mysterious, secretive and puzzling experience.

Each youth must be approached on an individual basis in the counseling assessment process, and there are certain characteristics that may influence the extent and approach to counseling used. The first is age, or, more importantly, **developmental stage of the young person**. A 13-year-old male youth who is just entering puberty and has not had sexual intercourse would need a different approach from the 18-year-old female who has had a child. This example also illustrates a second important characteristic, which is gender. In the case of females, issues such as menstruation and pregnancy prevention should be addressed and may provide an easier segue for

delving into HIV/STI-related discussions. A 14-year-old male may wish to brag about his sexual adventures, whether they are true or not, but a 14-year-old girl is less likely to be forthcoming and may also couch her responses in romantic, love-based terms as opposed to “sex.”

Third, **sexual orientation** is a sensitive topic requiring special attention. As societal beliefs concerning sexuality continue to evolve, it is essential to explore adolescents' understanding of their own sexual identity and its effects on their well-being.

Culture is a fourth consideration in addressing sexual health concerns among young people. Youth-centered counselors should understand their young client's cultural background, specifically the language and possible sexual taboos about sex within a given culture or religion. Finally, **values** have an inherent influence on sexuality. It is important that counselors understand their own values regarding sexuality and recognize situations in which these values may negatively or positively affect the counseling session.

There are general principles regarding interviewing techniques that are extrapolated from principles of client-centered counseling and motivational interviewing. The first recommendation is to avoid using “*why*” questions. These types of questions tend to make the young person defensive and are generally counter-productive. Instead, it is advised that providers use open-ended questions, encouraging adolescents to discuss their current situation and elaborate on the reasons and context for specific behaviors for example, “*What can you do to avoid pregnancy?*” Also, a question such as “*How do you and your girlfriend decide to have sex?*” is more effective than “*Do you and your girlfriend decide to have sexual intercourse by talking?*”

- ✦ **Do not invite a negative answer by asking a “Have you ever...” question.**

In an embarrassing situation it would be easy to reply “No.” Instead, one should ask “*When was the last time you...?*” or “*How often do you...?*”

- ✦ **Use language that the young person will understand.**

If there is doubt regarding the interpretation of a word, it may be useful to have the young person describe their understanding of what a specific word means. Using proper medical terms such as “penis,” “vagina” and “anus” is recommended. But to develop rapport and comfort, counselors can also use local terms youth are using and then expose them to medical terms. These should be explained with

models or drawings, if necessary. In general, a counselor should avoid using a complex word when they can use a simple one. For example, use terms such as “sex with men/women” instead of: “homosexual/heterosexual sex.”

Basic sexual health questions

Based on sexual health research in adolescents, the highest risk factors associated with acquisition of STIs and HIV are the following: early onset of sexual intercourse; multiple sexual partners; alcohol and drug use with sexual activity; unprotected sexual intercourse; and sexual coercion. Based on these factors, some of the following questions have been proposed by Ross, Channon-Little and Rosser (2000) and Spain (1998) as an initial sexual health assessment during the gathering of information and assessment process. **These questions should NOT be asked of every adolescent;** counselors will need to judge which questions are important.

Basic Sexual Health Assessment for HIV and STIs

“I would like to review any sexual health concerns you may have. Is that OK with you?” Getting the permission of the young person to proceed in this direction is essential to continuing to develop trust in the counseling process and showing respect.

With young adolescents (early teens) begin by asking them to describe what they understand by the word sex: *“What do you understand by the word ‘sex?’”* Ask: *“How do you find out about sex?”* This question helps to clarify where the young person is learning about sex and gives an idea regarding the accuracy of the information.

Then move on to: *“What sexual experiences have you had?”* This can be the first questions for older adolescents. The counselor can give choices such as: kissing, masturbating, heavy petting (you can develop a short checklist with local terms that young people use in your area so they can check it off).

Then ask about sexual intercourse activity (making love, sexual penetration, having sex, sexual intercourse). Perhaps the best way to proceed is with a question asking them if they are aware of any other type of sex and provide examples if they are stuck. (Again, you can attach a short

Basic Sexual Health Assessment for HIV and STIs *Continued from p.80*

list with words such as sucking, oral sex, sexual penetration). Then ask them if they have done any of the things that they and the counselor have listed or are listed in the checklists: *“Have you been sexual or engaged in any of the behaviors from the checklist with males or females or both?”* (Do not use “women” or “men” because these terms can be misunderstood as age-specific as with older men and women instead of males or females their age).

An additional question may be to ask if they think about (imagine, fantasize) doing any of these things with males, females or both? (This question helps in assessing sexual experimentation, sexual orientation). Ask: *“Are you presently being sexual with anyone?” “What behaviors are you engaging in?”*

Assess frequency of sexual intercourse:

“Have you engaged in any of these sexual behaviors in the past three months? In the past year? In the past 5 years?” Ask them with approximately how many people have they done these things in the past 3 months and year. Remind them that sexual means anything that has been shared earlier from the checklists or any additional behaviors they may later remember.

These questions serve to introduce a more detailed discussion of HIV. In addition, they may stimulate young clients to carefully consider past and present circumstances and behaviors.

There are many benefits of learning one's HIV status. For young persons who are HIV positive, it presents the opportunity for antiretroviral therapy, opportunistic infection prophylaxis, prevention of HIV transmission to others, tuberculosis screening and other medications (if needed). Preventive immunizations and medical monitoring may delay onset of AIDS and prolong life.

- *Assessing risk of HIV through blood transfusions: “Did you receive a blood transfusion between 1978 and 1985?”(if age- appropriate)*
- *Assessing substance use and abuse: “Have you, even once, used any recreational drugs such as alcohol, injected drugs, marijuana, crack cocaine, ecstasy?”*
- *Assessing HIV knowledge: “What have you heard about HIV?” or “What have you been told about HIV?”*
- *Assessing AIDS knowledge: “What have you heard about AIDS?” or “What have you been told about AIDS?”*

Response given for the question above provides an opening for educating about symptoms of STIs. If they know the typical symptoms of STIs, including HIV, assess if they have had them. For example:

Basic Sexual Health Assessment for HIV and STIs *Continued from p.81*

- *Assessing STI/STD knowledge: “What have you heard about sexually transmitted infections or sexually transmitted diseases?”* (You can list particular STIs as examples. It is better to have a chart or list in your office that display their names and illustrate their symptoms). You may also ask: or *“What have you been told of sexually transmitted infections?”*
- *“As much as you can remember, what sexually transmitted infections or diseases have you had? Or “Have you had a sexually transmitted disease?”*
- *“What sexually transmitted infections or diseases have any of your sexual partners had?”*
- *“Have you had tuberculosis?”*

Make sure to give them the opportunity to ask questions from you: “What questions or sexual concerns do you have at this time?” or “What sexual concerns are you dealing with now?” “Is there any question you would like to ask me?” “Are there any other concerns we have not brought up today that you may want to talk about?”

Source: Adapted with permission from: M.W. Ross, L.D. Channon-Little and S.B.R. Rosser (2000). *Sexual health concerns: Interviewing and history-taking for health practitioners*. F.A. Davis Company, Philadelphia

Adapted with permission from J. Spain (1988). *Sexual, contraceptive and pregnancy choices: Counseling adolescents*. New York: Gardner Press.

Tips for taking sexual histories during the assessment phase

- ❖ Be clear and factual when talking about sexual behavior and sexual health issues
- ❖ When appropriate, use pictures, diagrams or drawings to illustrate our point.
- ❖ Be aware of what your nonverbal language is communicating when talking about sexual matters.
- ❖ Answer all questions and when you do not know, say so frankly and say that you will seek the answer and get back to the young client. Make sure you follow up by seeking the answer and getting back to the young person.
- ❖ Be relaxed and friendly. Your comfort, openness and appropriate self-disclosure with talking about sex and sexual health issues can be contagious- transparency begets transparency. Remember that the counseling relationship in itself is a learning opportunity for the youth.
- ❖ Answer questions precisely and to the point.
- ❖ Ask purposeful questions; questions that inform your assessment. Do not bombard the young person with irrelevant questions that do not inform your assessment. Your data gathering is providing you with the opportunity to assess for current or future sexual health concerns including possible problems, diseases and opportunities for preventing them.
- ❖ Start with non-threatening questions and move to more intimate sexual health questions.
- ❖ Use an open, positive and interested demeanor when introducing sexual health questions.
- ❖ Start with other areas of health (smoking, exercise, nutrition) and then weave sexual health questions into the session.
- ❖ Observe the young client's non-verbal behavior. What is her body language conveying to you? Observe the young person's ability to talk about sex. Her communication can tell you about her assertiveness or negotiation skills regarding sexual behavior.

Adapted with permission from M.W.Ross, L.D.Channon-Little, and S.B.R. Rosser (2000). *Sexual health concerns: interviewing and history taking for health practitioners*. Philadelphia: F.A. Davis Company.

- Simplify goals in sexual assessments of pre-adolescents and early teenagers making them easy to understand. Some pre-adolescents may give concrete answers to all questions, so you need to be specific and keep question's content and construction simple.
- Assess young clients' knowledge of human sexuality, asking them if they have any questions about sex and sexuality; acting as a resource for sex education should be seen as part of your role in promoting overall healthcare.
- Taking a sexual history from the very young is considered inappropriate unless there is reason to believe that sexual activity may have occurred (Ross, Channon-Little and Rosser, 2000). Taking such a sexual history requires special training and may require referral to a child psychiatrist or psychologist. Ross, Channon-Little and Rosser recommend providers take sexual histories from mid-adolescence through late adulthood. For adolescents who are assumed to be sexually active, sexual health questions should be asked.

Assessment questions for unplanned pregnancy and STIs

If the young person is sexually active, ask:

"How old are you?" (Younger adolescents may be afraid or embarrassed of getting accurate information from others)

"Are you in school now? What is school like for you? What are your plans for further study?" (Young girls who are not doing well in school and have a low-self-esteem may view having a baby as an alternative means of gratification)

Assess knowledge of pregnancy: "How does a girl get pregnant? That is, what do you know about how a girl gets pregnant (puberty, age, time of month)? How do you protect yourself from unplanned pregnancy? For Females: Have you been pregnant? How many times?" (If appropriate) ■

■ If the young person is sexually active, ask: “How old are you?” (Younger adolescents may be afraid or embarrassed of getting accurate information from others).

“Are you in school now? What is school like for you?” (Young girls who are not doing well in school and have a low-self-esteem- may view having a baby as an alternative means of gratification).

Assess knowledge of pregnancy: “ How does a female get pregnant? That is, what do you know about how a female gets pregnant? When can a female get pregnant (puberty, age, time of month)? How do you protect yourself from unplanned pregnancy? Have you been pregnant? How many times?” (If Appropriate)

Tips on talking about birth control (Ross, Channon-Little and Rosser, 2000)

- ✦ First, it is important to ensure the young person feels safe enough to honestly discuss her sexual health concerns.
- ✦ Start by finding out how much the young person knows about sex, and then discuss what kind of sexual activity may be occurring.
- ✦ When discussing options for preventing pregnancy help her be aware of her choices. Present some options such as delaying sexual activity, safer sex methods, the correct use of condoms, and the pill, information that will be helpful for most young people.
- ✦ Helpful approaches include remaining non judgmental, inviting the young person to ask questions or raise any issue of concern; and praising and encouraging the young person for being responsible to seek consultation.

Spain (1988) explains that adolescents who have difficulty using contraceptives are often characterized by a lack of basic knowledge about sexual and reproductive health, may feel uncomfortable and embarrassed about their sexual behavior,

have difficulty acknowledging to themselves that they have sexual intercourse and feel guilty about their sexual relations and behavior. They may have been raised in homes with strict rules and have had little or no discussion with their parents about sexual issues, have no opportunity to discuss and clarify their own values about sexuality and have difficulty talking with their parents about their sexual relationship. She recommends asking questions that are specific to the youth's sexual relationships such as:

- “ Am I talking to someone who clearly understands reality?
- Am I talking to someone who acknowledges conflicts and difficulties and attempts to solve them?
- What is this client being realistic about (so I can use them as examples for her)?”

Adapted with permission from: Spain, J. (1988). *Sexual, contraceptive and pregnancy choices: counseling adolescents*. Gardner Press, Inc., New York.

Problem and risk identification

Based on the information obtained from the assessment questions, the next step in the counseling process is to make sense of the information collected. It is important for the counselor to clearly understand what the pressing sexual health issues are concerning young clients and their level of risk of developing sexual health problems, such as acquiring and transmitting an HIV/STI, getting pregnant or fathering a child, or needing treatment for a disease.

During the assessment phase, it is helpful for the youth-centered counselor to clearly understand the needs of the young client.

Synthesis of the information

In order to make sense of the information gathered, the counselor can ask herself the following questions:

- "Does the young person need help to have a realistic understanding of the sexually transmitted infection he has?"
- "Is the young client deeply worried about having contracted HIV or an STI?"
- "Does the young client have an incorrect perception of how HIV is transmitted and need more accurate information?"
- "Is the young client HIV positive and seeking counseling to deal with coping or is he seeking access to medical treatment?"
- "Does the young client want to change his sexual behavior (such as unprotected sex) in order to prevent HIV or STI infection?"
- "Does the young person have needs related to decisions about her sexual activity and contraceptive use that can be met through a counseling relationship?"
- "Does she need information and can I provide that information?"
- "Are her current feelings, attitudes or behaviors interfering with her using contraceptives or condoms?"
- "Is she having difficulty making a decision?"
- "What suggestions can we both come up with?"
- "What are the options she can come up with to address her concerns?"
- "Is the young client already incorporating healthy habits and needing support to maintain the new behavior?"

Adapted with permission from: J., Spain (1988). *Sexual, Contraceptive and Pregnancy Choices: Counseling Adolescents*. Gardner Press, Inc., New York.

Based on the synthesis of this assessment or the “picture” of the young client, the counselor determines counseling needs and co-develops an action plan with the client.

What if the young client wants an HIV test?

Pretest counseling

Pre-test counseling should also be client-centered and sensitive to the cultural values and sexual identity (natal sex, sex roles, sexual orientation, gender identity) of the young person. In addition, counseling should be developmentally appropriate for the

■ Assessing the young person's ability to cope, understand and give informed consent for the HIV test is essential.

individual's age and learning skills and consistent with the young person's language, dialect, terminology and style of communication.

Counseling and testing of adolescents requires understanding age-specific development and behavior patterns, such as emerging sexuality, feelings of invulnerability and experimentation with risk-taking behaviors. Assessing the young person's ability to cope, understand and give informed consent for the HIV test is essential. Visual demonstrations, repetition and explicit language help reinforce provided information. Young women in particular, may need to learn, discuss and practice negotiating condom use with their sexual partners as suggesting condom use has been linked to an increased risk of violence.

Pretest counseling should include:

- ⊕ Providing detailed information about HIV/AIDS and transmission of the virus and checking for understanding.
- ⊕ Describing behaviors that put a young client at risk for HIV exposure.
- ⊕ Discussing methods to reduce risk of exposure, including use of latex condoms.
- ⊕ Discussing possible obstacles and personal resistance to adopting risk-reduction practices.
- ⊕ Clarifying the meaning of a negative HIV test result (i.e. young client is NOT immune from HIV and must protect himself).

- Clarifying the meaning of a positive HIV test result (i.e. client may transmit HIV infection to others).
- Clarifying the meaning of false positive and indeterminate results.
- Discussing the availability of anonymous testing, confidentiality of test results and country reporting laws.
- Inquiring how the young client will cope in the event of a positive test. The potential impact on personal life, school, family, friends, sexual partners, (employment for working youth) and possible ramifications concerning these issues should also be discussed.
- Asking the young client to identify someone with whom test results may be discussed. This is particularly important for adolescents.
- Obtaining consent (being informed of local policies, laws and country statutes regarding testing of minors).
- Making arrangements for a return appointment to receive test results. Where applicable, making same-day follow-up for results of rapid testing.

Posttest counseling

Posttest counseling is imperative, regardless of the test result. It provides an opportunity to discuss risk-reducing behaviors with both seropositive and seronegative clients. Counselors must be aware of local laws governing HIV and AIDS reporting, and issues of confidentiality.

■ Posttest counseling is imperative, regardless of the test result.

Posttest counseling should include:

- Giving test results and explaining that a negative result does not imply immunity to infection, and explaining that a positive result means that the young person is infected and can infect others.
- Reviewing routes of transmission and risk-reduction strategies in simple and clear language.
- Assessing the young client's understanding of the test result and their psychological state. Talk about involving supportive persons as necessary.

Centers for Disease Control and Prevention (1993). Recommendations for HIV testing services and outpatients in acute-care hospital settings; and Technical guidance on HIV counseling. *MMWR*, 42(No. RR-2).

- Providing psychosocial support and referring to human services organizations, support groups, other counselors in the community.
- Providing information on national and local HIV/AIDS resources if indicated.
- Providing referrals for medical follow-up and beginning to develop an INDIVIDUAL medical care plan for the young client (this point is for physicians and nurses; for other providers, such as counselors, referral should be made to sensitive and caring physicians or hospitals in the community).
- Discussing the importance of notifying needle-sharing or sexual partners and the option of contact-tracing (as per local health department). Be sensitive to the risk of violence to young women that may result from partner notification.

Phase 3: Setting Age-Appropriate Goals

Goal Setting Theory

Breinbauer and Maddaleno (2005) assert that facilitating personal goals is an important element of adolescent identity development, helping young clients to picture, model and evaluate themselves in the future instead of responding only to the needs of the moment. Bartholomew et al. (2001) hold that goal setting leads to better performance because people with goals exert themselves more, persevere in their tasks, concentrate more and, if

■ Difficult goals can be achieved only if a person accepts the challenge and has sufficient self-efficacy and support

necessary, develop strategies for carrying out their intended behavior. Strecher et al. (1995) maintain that goals should be stated in terms of desired behavior (“I will always use latex condoms; I will always take care of myself...my health, my body”) instead of as health outcomes (“I will avoid HIV”).

Notably, setting a goal does not automatically instill motivation (ibid) and may even be counterproductive, particularly if the goal conflicts with other goals. For example, the goal of “having unsafe sex with as many partners I can” may conflict with the goals of staying HIV negative.

Centers for Disease Control and Prevention (1993). Recommendations for HIV testing services and outpatients in acute-care hospital settings; and Technical guidance on HIV counseling. *MMWR*, 42(No. RR- 2).

Setting a goal that is somewhat difficult yet feasible leads to better performance than does setting an easy goal or no goal at all (Locke and Latham, 1990). However, difficult goals can be achieved only if a person accepts the challenge and has sufficient self-efficacy and support. Goal setting can be less effective when goal-related tasks are complex (Cervone et al., 1991; Wood et al., 1987), the individual is unable to perform behaviors related to the goals (Locke et al., 1984) and the individual is not committed to the goals (Erez and Zidon, 1984). We believe that issues of sexual behavior are often complex because sexual behavior is influenced by physical, mental, emotional, social, and environmental factors. All these come into play when making difficult sexual decisions and practicing safer sex methods or delaying sexual activity. Thus, it is important for counselors to help young people set realistic and achievable goals and provide a safe and private space for dealing with the intense feelings, emotions and resistance that accompanies changing what is familiar and already established as a habit and adopting new behaviors.

■ Breaking a goal into a series of tasks or subgoals can help to prevent hesitation or the postponement of goal-related activities

Strategic analysis, a cognitive activity that breaks a goal into a concise series of tasks or subgoals, is recommended (Strecher et al., 1995). Subgoals or smaller goals are more tangible and help to prevent hesitation or the postponement of goal-related activities (Bandura, 1982). However, effective counseling does not end with the setting of goals; providing individualized feedback and reflecting the inner experience of the client through empathetic listening is also critical.

A counselor who understands the barriers of the young client and how other young clients have addressed these barriers may have a more realistic sense of the range of goals to set.

Strecher et al. suggest that behavioral change goals be considered only when the client wants to change and is motivated to act, and after careful consideration of what is going on in the client's life. We recommend that youth-centered counselors do a thorough and thoughtful assessment of the client's situation before determining which goals will be pursued. For example, by providing the young person with an opportunity to address pertinent questions can shed light on the reasons and motivations for engaging in unsafe sexual behavior or putting himself at risk.

To set goals, Strecher recommends:

- Conducting a careful and thoughtful analysis of the situation
- Determining the youth's commitment to addressing the situation
- Exploring the youth's ambivalence or resistance and feelings about the goal
- Analyzing the tasks required to address the situation and corresponding feelings and thoughts about what needs to be done
- Developing specific sub goals or smaller goals for larger goals
- Exploring with the young person his underlying reasons (hidden meanings ascribed) for engaging in unsafe sexual practices and
- Determining the young individual's self-efficacy for performing the behavior

Adapted with permission from V.J. Strecher et al (1995). Goal setting as a strategy for health behavior change. *Health Education Quarterly*, 22 (2), 190-200.

Strecher explains that self-efficacy is the belief that one can change his own behavior or achieve a goal. If the young client demonstrates low-self-efficacy, counselors need to explore the underlying reasons for this and address them before moving on to implementation.

The development of well-formed goals is essential and should be negotiated between the counselor and young client (Berg and Miller, 1992). Small goals are easier to achieve than complex ones, but counselors need to strike a balance so that goals are not too easy or too hard to achieve. Goals also should be concrete and easy to follow, and be stated in behaviorally specific terms. They should be expressed in positive statements and in the presence of something—for example, “I will be writing down my feelings of anxiety” rather than the absence of something, “I don't want to feel anxious anymore.” Counselors can encourage young persons to recognize that first steps move them toward their desired ends. For example, “*Knowing what I like and don't like helps me deal with pressure from my friends;*” “*Setting my personal boundaries with my friends helps me to assert myself.*”

Counselors should **listen** to the challenges and situations that youth express and make sense of the information, giving feedback to the young person in a way they understand, and helping them make sense of the situation. For instance, a young female client may want to discuss using a condom with her boyfriend. The female client may express that she is nervous about bringing up the topic and is afraid that

her boyfriend may think that she is having sex with other young men. The counselor may empathize with the young client and communicate her understanding of her nervousness and fears. She can let her know that being perceived as having other sexual relationships can be hurtful or make her feel as if her sexual partner does not trust her. The counselor may suggest that they role play the conversation she is to have with her partner. The counselor can take the role of the boyfriend and they can begin to practice how best to have a discussion on condom use. The counselor can come up with some questions and concerns the boyfriend may have. The young client can practice what she is going to say in case they are asked. If her second goal is to obtain condoms, the counselor may provide the condoms directly from the practice setting (clinic or human services organization), or by letting the youth know where they may be most easily obtained.

It is important that prior to implementing a behavioral change, the youth-centered counselor understands the young person's readiness to change. For example, if a young female is having sex without using condoms but does not perceive herself at increased risk of getting an STI, she would be considered to be in the precontemplation stage according to the Transtheoretical Model of Change. At this point, she would be considered at-risk for acquiring an STI, including HIV, but not necessarily at a stage of committing to change her behavior. Consciousness-raising, which is achieved by giving relevant information regarding STIs/HIV and the use of safer sex practices, is the most appropriate counseling strategy at this stage.

The youth-centered counselor can use innovative and creative strategies to share this information. For instance the counselor can share a personal story of another young person who was dealing with the same issues (she would of course, maintain the person's anonymity and abide by confidentiality) or use appropriate self-disclosure and share her own similar decision-making or experience. Appropriate self-disclosure helps the young person to relate to counselor at a human level where both have experienced and confronted something similar. For example, if a young woman tells the counselor that she has just started to date again and enjoy her space after a break-up with her boyfriend, the counselor can touch on times when she enjoyed being alone. Appropriate self-disclosure must be used strategically. It can't be used in such a way to discount or take away from the client's story. But it can be used sparingly to connect and "join the

client” in the counseling experience. Through listening to the story, the young client can begin to become aware that she can be in the same situation. However, if the young person subsequently realized that it was “risky” to have unprotected sex and is worried about getting an STI, she would then be seen as being in the contemplative stage. This is a time in which a young individual is actually thinking about the problem and may weigh the advantages and disadvantages of the problematic behavior. At this point it would be most appropriate for the youth-centered counselor to open up discussion exploring the reasons why she engages in risky behavior and highlighting the advantages of adopting the healthier behavior. For example, what is keeping her from using condoms? Has she ever discussed the possibility of condom use with her partner(s)? Does her partner(s) object to using condoms? Is it difficult for them to obtain condoms?

Phase 4: Creating Plans of Action

The importance of collaboration

It is more effective to collaborate as much as possible with the young person, rather than *prescribing* an intervention, as appropriate in the planning for behavioral change. By working in partnership with the young person and receiving her input in formulating what she wants to do, chances for resistance are reduced. Furthermore, young persons can freely contribute useful and relevant ideas that can increase the effectiveness of the intervention, thereby increasing the chances for success. *By involving the young person in creating the plan of action*, the youth-centered counselor is able to *personalize the intervention* to increase its relevance.

It's more effective to collaborate with the young person instead of prescribing interventions. What do we mean by collaborating?

- ⊕ Not advising
- ⊕ Not telling young people what to do
- ⊕ Not preaching or lecturing
- ⊕ Not behaving like an expert
- ⊕ Not being in control of the person's life choices, alternatives, options
- ⊕ Not imposing one's values, one's truth on others
- ⊕ Not labeling and diagnosing
- ⊕ Not focusing on pathologies and weaknesses

Collaborating with the young client means:

- ⊕ Nurturing self-determination and client's choice
- ⊕ Allowing the young client to express themselves freely without fear
- ⊕ Respecting the young client's dignity and worth
- ⊕ Working with the young client as a partner
- ⊕ Taking a stance of a learner
- ⊕ Taking a tentative stance when making assessments and checking in with the young client to see if their situation is accurately understood
- ⊕ Exploring strengths, potentials, dreams, wishes, interests, needs and wants
- ⊕ Believing in young client's resilient qualities ■

Take small, realistic steps

How does a young person move from knowing what he wants to change to making it happen? Youth-centered counselors help their young clients devise simple plans for achieving their sexual health goals. Youth-centered counselors can help their young clients *brainstorm activities and practical strategies* that can help them take “small steps” toward change. Small and realistic steps that are easy to achieve create opportunities for small successes for the young client. These small successes are more immediately seen and are very important for young people who have difficulty envisioning long-term changes. By being able to experience how small steps can be taken successfully,

young clients begin to believe that change is possible and that they can be the people they want to be.

The counselor's major task is to help devise *personal* and *relevant* individual plans that are concrete and doable and that reflect the young person's needs and wants so as to set the young person for success. Below is a discussion of Prochaska and Diclemente's Transtheoretical Model of Change (Prochaska and Diclemente, 1983; Diclemente & Prochaska, 1998) that can be used in developing sensitive interventions that match where young people are in the change process.

Transtheoretical Model of Change (TTM)

There are three major constructs in the TTM:

- ✦ Stages of Change
- ✦ Processes of Change
- ✦ Levels of Change

The emphasis of the Transtheoretical Model is on intentional behavior (Prochaska, DiClemente and Norcass, 1992). There are three major constructs in the model: stages of change, processes of change and levels of change (DiClemente and Prochaska, 1998).

Stages of Change (SOC)

The stages of change consist of five stages along a continuum that depict a person's motivation and interest in altering a current behavior. As individuals move through these stages, they achieve successful behavioral change (ibid). These stages are: precontemplation, contemplation, preparation, action and maintenance.

Precontemplation is the stage in which the young person does not recognize that there is a problem or is unwilling to change a problematic behavior. **Contemplation** is the stage in which the young person is considering changing her behavior and often is in a decision-making process and dealing with ambivalence and resistance. **Preparation** is the stage in which the young person has determined that the adverse

consequences of maintaining her current problematic behavior outweigh the benefits and has committed to change. The individual alas is actually preparing to change.

The action stage is when the individual actually changes or modifies her behavior. The **Maintenance** stage occurs 3 to 6 months after the new behavior has been implemented and consists of lifestyle modification so that new behaviors are stabilized and to prevent the client from reverting to the old behavior (Cassidy, 1997; DiClemente and Prochaska, 1998). The two boxes below summarize the major assumptions of the Transtheoretical Model and the key stages of change as applied to youth.

Key Assumptions of the Transtheoretical Model as Applied to Youth

Young people's behavior change occurs in small steps- As a counselor, do not expect that people can take big steps in changing their lifestyle or behaviors, or unhealthy habits. Habits are learned and practiced for many years and to unlearn a behavior takes time; it is better to take small "baby" steps than to change in a cold turkey manner. This is not to say that people are not capable of drastic or dramatic changes. Many people can stop a health behavior suddenly. However, majority of people take time and small steps in changing an unhealthy habit. The more do-able the goal, the more opportunity for success.

Youth's behavior change takes time- As a counselor, expect that individuals will need enough time for clarification of needs, wants and goals, values, decision-making and commitment. They will need time for experiencing intense feelings related to decision and new behavior, relapse and re-commitment to change. Change is NOT AUTOMATIC. Our counseling intervention must be sensitive to the fact that young individuals will be in different stages of the change continuum. What this means is that there will be young persons who know exactly what they want and how to get it, there will be others who do not know nor perceive that they are facing a problem. Counselors do not take a position of "Just do it" or "Just say NO." They understand that not everybody who wants to change is ready for it. Therefore they match where individuals are in the change process (their stage) with a specific counseling strategy.

Behavior change in young people does not necessarily happen in a linear fashion but can spiral back to previous stages (relapses)- This means that youth-centered counselors can expect their young clients to move back and forth in deciding to change and in changing their behavior. Once a decision has been made to change a behavior, it does

Key Assumptions of the Transtheoretical Model as Applied to Youth *Continued from p.96*

not mean that the person will now move to the action stage and actually implement the new behavior. The change process is not linear but cyclical. People will one moment decide to take action and another moment may decide to go back to the old behaviour. This is normal. Relapse is not a negative thing to happen. It is a normal part of the change process. For example, a young female can decide in counseling to talk to her partner about having hepatitis and go home and change her mind or postpone her conversation. A young man may decide to leave his girlfriend and may change his mind a moment later. Changing one's mind is a normal part of the decision-making process. Counselors must help young people explore their feelings, emotions, thoughts, resistance, ambivalence and perceptions so that young people can understand their own process of change.

Young individuals who relapse into their old behavior can learn something new that helps them take up the new behavior again- Falling back to old habits can teach young people what to avoid the next time around. For instance a young man who wants to stop smoking marijuana learns after having given in to his friends to avoid going to a street corner where his friends hang out. A teen mother learns to consistently use contraceptives after her first pregnancy. A young adolescent learns to use condoms on a regular basis after he is exposed to an STI. A young teacher learns to keep a healthy distance from his students after he is accused of not keeping his personal boundaries. In other words people can learn by the mistakes they do. Mistakes offer people a great opportunity to see where they went wrong; it offers them the chance to grow and avoid repeating the same mistakes. Therefore mistakes are really not failures; in fact they are great teachers.

Prior to implementing a behavioral change with young people, one must assess and determine their readiness to change- Many “interventions” do not work because the assumption is that people are ready to change. Therefore counselors must assess where the client is at in the change process. An old axiom in social work is “to meet the client where he is at.” This rings true for counseling in HIV prevention and sexual and reproductive health. By informing people about disease transmission and the use of contraception is not enough. It is good but not enough. If people would readily change with the information passed on to them then it would be effective and that would be the end of the story. But change does not happen with information alone. People get conditioned to behave a certain way and unlearning a pattern of behavior takes

Key Assumptions of the Transtheoretical Model as Applied to Youth *Continued from p.97*

time, patience, reflection, and processing. Counselors explore clients' feelings, emotions, thoughts and cognitions to help them become aware of themselves, of their ambivalence, of their resistance, and motivations. This is where counseling offers the opportunity to accompany the process of change of the client and is a major departure from mere "education." Counselors asks questions, probe for clarification, point out discrepancies and incongruence, confront with respect in order to help clients move through the process of change and achieve the goals they want to achieve.

Key Stages of Change as Applied to Youth (SOC)

Precontemplation: Young person is unaware of problem or need for change

Examples:

- José drinks and drive. He does not see this as a problem.
- Rebecca injects drugs and shares needles with her friends. She does not see herself as vulnerable to being infected with HIV.
- Mario has many male sexual partners. He is into public sex and usually does not have time to use condoms. Because he selects "healthy" looking guys, he thinks he is safe from HIV and other STIs.
- 24 year old Armando is still "sleeping around" with other young men and does not see this as a problem to his marriage with his new wife. He does not perceive himself vulnerable to HIV because he is the insertive partner.
- Carlos, a transvestite, dresses up as a woman every Thursday and Friday and goes down to a bar to "pick up straight men." Even though he was severely beaten once for "misleading" a "heterosexual" male he continues to engage in sexual behavior that puts him at risk for violence.

Freddie frequently uses the internet to "hook up" with other men. He would go to their place or meet in public spaces for sex. Although he engages in unprotected oral sex he takes his chances with acquiring STIs.

Contemplation: Young person is thinking about the possibility of change

Examples:

Key Stages of Change as Applied to Youth (SOC) *Continued from p.98*

- Pedro is overweight and is thinking that this year he must lose weight.
- Marcus is diabetic and loves deserts. He has spoken to a local nurse about wanting to control his eating habits.
- As long as Bernardo can remember he has felt he was born in the wrong body. He does not feel he is a man but a woman. He is really thinking on seeking a sex change.
- Paula has three girls and a boy and she is thinking on using condoms with her husband to avoid being infected with HIV. She does not trust that he is monogamous in their marriage.
- Esther, 17 years, is thinking about talking to her close female friend about her strong attraction to her.
- Bertha is "out" to her closest friends about her lesbian identity. She is thinking on telling her parents about who she is.
- Roberto is thinking on having a serious talk with his male partner about using condoms regularly.

Preparation: Young person is motivated and committed to change

Examples:

- Abel smokes heavily- he wants to quit. He comes to you to help him stop.
- Armando spends half of his day every day surfing the internet for pornography. He is neglecting his school work and his part-time job- He wants to stop and seeks help from you.
- Pablo gambles everything he touches. He spends most of his salary on gambling. His wife has threatened to leave him if he does not stop, he goes to see a mental health worker.
- Sergio is worried about his girlfriend not having the habit of wearing seat belts. He discusses this problem with his girlfriend and she has promised to begin using seatbelts.
- Sebastián finally buys condoms and lubes and keeps in his backpack just in case he needs it.
- Socorro has decided to seek help from a physician to deal with her anxieties.
- Elsa bought a special AIDS bracelet to remind her to use condoms consistently to keep being negative.
- Teodoro has decided to not frequent a video store with unsanitary booths for sex
- Tomás and Guadalupe, upon the suggestion of a counselor, decided to buy a book on sexual intimacy to improve their sexual relationship.
- Valentín goes to a clinic to get sterile new needles for his drug use instead of sharing needles with his buddies.

Key Stages of Change as Applied to Youth (SOC) *Continued from p.99*

Action: Young person engages in new behavior

Examples:

- Theresa starts jogging.
- Sancho begins to regularly use condoms.
- Sara talks to her children about sexuality and sex.
- Santiago begins to see a counselor in his school.
- Alejandra begins to take her medication to avoid headaches.
- Cruz asserts himself with his family.
- Eloisa talks with her husband about his lack of closeness to her.
- Modesto buys condoms and lube and uses it with his girlfriends.
- Osvaldo avoids going to the gay saunas.
- Raul goes to a support group for co-dependents.
- Soledad throws away her cigarettes and tells everyone she is close to that she has stopped smoking.
- Wilfredo talks to his sexual partners about his HIV status.
- Adela confronts her boss about his sexism at work.
- Adrián takes her adolescent daughter to see a physician to talk about contraceptive options.
- The Sanchez couple seek marriage counseling with a family counselor.
- Ursula leaves her husband.
- Carla makes a report of her husband sexual abusing her 11 year old son.
- Pepe, a male to female transgender, is consistent with her new gender role and dresses up in women's clothes.

Maintenance: Young person continues to implement new behavior

Examples:

- Alejo continues to avoid using cocaine.
- Blanca avoids unprotected vagina sex with her partners.
- Adolfo continues to stay away from commercial sex work.
- Tito keeps walking every evening to keep healthy.
- Chuy continues to avoid sweets, desserts, and soft drinks to control his diabetes.
- Nuri continues avoiding getting involved in "messy" relationships.
- Paco continues to see the local psychiatric nurse for counseling.
- Sarita keeps using contraceptives, especially condoms.
- Camila keeps talking about sexuality, sex, and healthy relationships in her home.

Processes of Change (POC)

DiClemente and Prochaska (1998) have identified 10 processes of change that are responsible for the movement from one stage to another. The first five consists of *cognitive and experiential processes including consciousness raising, dramatic relief, environmental reevaluation, social liberation and self-reevaluation*. **Consciousness-raising** consists of encouraging young clients to increase their level of awareness, seek information or gain an understanding about their problem. **Dramatic relief** is the experiencing and expressing of feelings and emotions about one's problems. **Environmental evaluation** consists of examining how one's own problems affect the physical environment especially other people. **Social liberation** consists of increasing alternatives and listing options for problematic behaviors, such as recognizing that safer sex methods are "cool" and they contribute to sexual well-being and over all wellness. **Self-reevaluation** consists of assessing how one feels and thinks about herself in relationship to a problem (Prochaska et al., 1992).

The five *behavioral processes are counter-conditioning, helping relationships, reinforcement management, stimulus control, and self-liberation* (ibid). **Counter-conditioning** entails substituting alternative behaviors for problematic behaviors (for example, exercising to relief anxiety, stress and sexual urges instead of seeking sex from strangers or a teenager deciding to engage in kissing and caressing instead of having sexual intercourse). **Helping relationships** are defined as those that provide unconditional positive regard, acceptance, and support (for example, counselors establish rapport with their young clients, accept them as human beings with intrinsic worth and dignity, use appropriate self-disclosure to invite transparency, build trusts and provide psychosocial support). **Reinforcement management** is the use of positive reinforcements and appropriate goal setting (this is another term for positive reinforcement or rewarding good behavior, for example, acknowledging a young person for asserting her self with her peers, encouraging and praising a young female that has began to talk to her boyfriend about protecting herself from STIs, praising a teenager for quitting smoking, making positive remarks to a group of adolescents who have formed a health and well-being club, praising a group of gay men for discouraging unsafe sex). **Stimulus control** refers to restructuring the environment so that the stimuli or triggers for the undesired behavior are controlled (Shinitzky and Kub, 2001). What this refers to is avoiding cues that trigger

our behavior. As humans we are conditioned to behave in such a way when we are “triggered” by something else. For instance a cozy rocking chair can trigger someone to smoke if that is where the person is used to smoke, a specific public bathroom can trigger someone that is used to going there for public sex to return, drinking alcohol can trigger someone to engage in unprotected sex if getting drunk precedes unsafe sex, a certain drug such as ecstasy can trigger a young person to have sex with people she may not have selected when sober if that is a pattern of behavior. These are all external stimulus that can directly influence behavior, therefore stimulus control means controlling or avoiding that specific stimulus. **Self-liberation** is defined as making a firm commitment to change (Prochaska, Redding and Evers, 2002) therefore deciding to abstain from a specific sexual behavior or delaying sexual activity can be a meaningful and self-liberating decision. Leaving an abusive relationship, divorcing a controlling partner, consistently using contraceptives, adapting healthy eating behaviors, avoiding getting involved with immature people can all be self-liberating and self-actualizing. These ten processes of change are summarized below.

10 Processes of Change as Applied to Youth (POC)

Experiential or Cognitive Processes:

Consciousness-Raising—The young person gains an awareness and understanding of the sexual health concern or situation confronting him. Being informed and knowledgeable about the issue; not being in denial, not being blind of the problem. Being conscious of potential risks and vulnerabilities. By counselors providing information and educating the young client they raise consciousness. This is the job of culturally and contextually relevant sexual and reproductive health media campaigns including HIV/AIDS and STIs brochures, pamphlets, and posters. Forums, talk shows, debates, community meetings, town hall meetings, seminars, workshops, theatre, and conferences and press conferences raise consciousness too. By becoming an “askable” physician and health provider and legitimizing the issue of sexual health as a very important part of overall health and well being and including it in routine health visits we raise consciousness.

Dramatic Relief—Young person experiences and shares feelings about his situation. The person cries, vents, expresses his anger, hurt, or betrayal. The counselor’s job is to allow a safe

10 Processes of Change as Applied to Youth (POC) *Continued from p.102*

and secure space for the full expression of these feelings without a need for quick advice giving or need to fix anything. Tolerance for listening to problems and dealing with strong emotions is necessary. Some people do not have a strong tolerance for dealing with strong emotions such as anger, disappointment, hurt, betrayal. Allow the youth to express freely his feelings and emotions. The most important concept to remember is that people sometimes can not decide to change a behavior or act on what they have decided to do because they are still experiencing feelings and emotions that have not been fully expressed. When emotions are expressed, people often are more clearer in making decisions.

Environmental Reevaluation—Youth examines how his problem(s) affects his environment, including other people, such as his family, friends, and peers. Counselors help young people evaluate how their behavior affects other people. By doing this they help young people become less self-centered and more empathetic to others. For example, a young person can examine how his life would change if he gets infected with HIV. He can learn about what HIV would do to his body, how it would affect his sexual relationships, work, family, and life goals.

Social Liberation—Youth increases alternatives for problematic behaviors by replacing them with healthy behaviors and habits. Counselors work with young people to come up with suggestions, options, and solutions to problems, conflicts and situations. Through the assessment of a client's situation, counselors tap into young person's internal and external strengths, interests, coping styles, and resilient qualities and use these to co-construct goals and a plan of action.

Behavioral Processes:

Self-Liberation—Making a firm commitment to change unhealthy behavior. Making a decision requires a change of thoughts, feelings, or attitude and a clarification of values. Self-liberation can be explained eloquently with a quote from Ralph Waldo Emerson who once said "The ancestor to every action is a thought." People know and feel when they have made a decision to change. They feel energized and motivated to act.

Counter-Conditioning—Youth substitutes alternative behaviors for behaviors that put her in problematic situations. A young man chooses to chew gum instead of smoking, a young woman who wants to lose weight begins to eat more fruits and vegetables instead of eating fatty foods, a mother chooses to talk more frankly and honestly with her husband instead of playing the victim's

10 Processes of Change as Applied to Youth (POC) *Continued from p.103*

role, a young woman chooses to refuse having sex with her partner instead of being pressured to give in, a young male asserts his sexuality instead of living in fear and denial.

Helping Relationships—Youth provides and/or receives acceptance, trust and support. Five important ingredients essential for the facilitation of behavioral change are: 1). a non judgmental attitude 2). An accepting, nurturing and safe atmosphere 3). Openness and transparency, through the use of appropriate self-disclosure 4). An unconditional positive regard and respect for the client 5). An ability to assess verbal and nonverbal communication and demonstrate empathetic understanding of the young client.

Reinforcement Management—Youth receives rewards, positive reinforcement (encouragements, praise), and sets personal goals. Everyone needs a little encouragement and support. Counselors provide such reinforcements to motivate young people to take action or maintain a new healthy lifestyle. Organizational psychologists talk about the importance of providing “emotional strokes” to encourage and motivate people; this includes giving compliments, recognizing achievements (small or large), expressing praise, admiring, congratulating, applauding, and celebrating successes. This is also very relevant for young people. Young people need to be commended when they do good work. Better yet, they need to be asked to assess how they feel they did; this provides opportunity for self- assessment and self-regard.

Stimulus Control—This entails removing reminders or avoiding cues to engage in the unhealthy behavior and adding cues or reminders to engage in the healthy behavior. Examples of cues and stimulus that influence young people to put themselves at risk for sexual health problems include: drugs, alcohol, negative peer pressure, unsafe public places for hook-ups.

Using the Transtheoretical Model (TTM)

In implementing the Transtheoretical model, youth-centered counselors must first make a thorough assessment of the young client’s health situation (see section on strengths-based perspective, guidelines for strengths assessment) and identify the stage of change (see discussion on stages of change) of the young client by interviewing him using a series of open-ended questions. Coury-Doniger et al. (2000) provide a table

with assessment issues, questions and techniques targeting behavior and determining stages of change, which we have adapted below for the youth population.

After the counselor identifies the problematic behavior and the opportunities for change, she moves to identifying the young client's goal or target behavior(s). The counselor must then re-examine the client's stage of readiness or preparedness for adopting that target behavior.

Five Dimensions of Risk Behavior for Identifying and Staging Behavioral Change		
Assessment Dimension	Assessment Dimension	Likely Target and Stage
Relationship	What is your relationship situation? Are you sexually involved? How long (ago)?	<p><i>Target Behavior or Behavioral Goals:</i></p> <p>If youth has no sexual partner(s)—Goal is to delay sexual activity and enhance sexual self-efficacy skills (learn about sexual boundaries, limits, knowledge of self, and sexual and emotional needs, sexual communication, and sexual negotiation, knowledge of contraceptive use including using condoms correctly, safer sex methods and knowledge of risk reduction strategies).</p> <p>If youth is sexually active within a mutually monogamous relationship—Goal is to learn their own and their partner's HIV/STI status and learn about sexual self-efficacy skills (see above).</p> <p>If youth is sexually active and has multiple partners—Goal is to use a condom (male or female) for every sexual encounter with all partners and enhance sexual self-efficacy skills (see above).</p> <p>If youth's partner has multiple partners, or is unsure about partner's status—Goal is to use a condom (male or female) for every sexual encounter with all partners and enhance sexual self-efficacy skills.</p>

Five Dimensions of Risk Behavior for Identifying and Staging Behavioral Change <i>Continued from p.105</i>		
Assessment Dimension	Assessment Dimension	Likely Target and Stage
Attitudes about, and history of, condom use	What is your current experience with condoms? What is your past experience with them? Tell me about using them with your partner(s)? In what situation? What makes you use them? What makes you avoid them? Do you see the need to use them?	Stage of the Target Behavior: Precontemplation (sees no need to change current behavior; attitude) Contemplation (should change, but... not yet...) Ready for Action (beginning to change, wanting to start using contraceptives, wanting to start using condoms, or avoid doing specific high risk sexual behaviors)
Testing for HIV/STI	How do you feel about getting an HIV test? When did you had an HIV test? And for your partner, has she/he been tested? When? Do you see the need for a test? What would keep you from getting one?	Action (change for 3-6 months...actually changing, engaging in safer sex methods, and avoiding high risk behaviors) Maintenance (change > 6 months.. Maintaining the new behavior and keeping it up.)
Substance Use	What is your experience with drug use? When did you use? How long did you use? What type of drugs did you use? Tell me about your partner's experience with drugs?	

Source: Adapted with permission from P.A. Coury-Doninger et al. (2000). From theory to practice: Use of stage of change to develop and STD/HIV behavioral intervention. Phase 2: stage-based behavioral counseling strategies for sexual risk reduction. *Cognitive and behavioral practice*, 7(4), 395-406. New York: Association for Advancement of Behavior Therapy.

Matching Stages of Change with Counseling Strategy for the Transtheoretical Model			
Precontemplation to Contemplation	Contemplation to Preparation	Preparation to Action	Action to Maintenance
<p>Consciousness Raising</p> <ul style="list-style-type: none"> - Counselor gives information - Counselor discusses pros and cons of keeping problematic behavior - Counselor educates on STIs, HIV/AIDS among youth - Counselor educates about sexual risks and safer sex - Counselor educates about intimacy, sexuality, sexual needs, and factors that put young people at risk - Counselor discusses prevalence of STIs in youth's community 			<p>Reinforcement Management</p> <ul style="list-style-type: none"> - Counselor helps youth identify rewards for healthy behaviors and habits - Counselor explores internal motivations of youth to understand what rewards can be developed for healthy behaviors - Counselor uses encouragement, praises and emotional strokes with the young client
<p>Dramatic Relief</p> <ul style="list-style-type: none"> - Counselor shares stories of others, respecting confidentiality - Counselor employs active listening with client 	<p>Self-evaluation</p> <ul style="list-style-type: none"> - Counselor works with youth to explore her ambivalence or resistance towards change - Counselor offers substitutes and options for current problematic behavior 	<p>Self-liberation</p> <ul style="list-style-type: none"> - Counselor works with youth to develop a plan of action - Counselor discusses sub-goals and helps devise behavioral easy-to-understand goals 	<p>Helping Relationships</p> <ul style="list-style-type: none"> - Counselor works with client to identify support in family, friends and community - Counselor provides psychological support while the youth is changing behavior or addressing his goals

Matching Stages of Change with Counseling Strategy for the Transtheoretical Model <small>Continued from p.107</small>			
Precontemplation to Contemplation	Contemplation to Preparation	Preparation to Action	Action to Maintenance
<p>Dramatic Relief</p> <ul style="list-style-type: none"> - Client empathizes and expresses feelings and emotions - Counselor models self-disclosure and transparency 	<p>Self-evaluation</p> <ul style="list-style-type: none"> - Counselor explores how the behavior affects young client's self image, self-esteem. 	<p>Self-liberation</p> <ul style="list-style-type: none"> - Small realistic implementation steps are discussed, with timelines - Counselor encourages youth in coming up with ideas and healthy coping strategies 	
<p>Environmental Reevaluation</p> <ul style="list-style-type: none"> - Counselor helps young client to understand the impact of his behavior on others (i.e.; discussion of what an HIV diagnosis would mean to his life, work, relationships, family) 			<p>Counter-conditioning</p> <ul style="list-style-type: none"> - Counselor helps youth client find substitutes for unhealthy behaviors <p>Stimulus control</p> <ul style="list-style-type: none"> - Youth avoids cues that trigger behavior (i.e. avoids getting drunk in bars) <p>Social Liberation</p> <ul style="list-style-type: none"> - Youth becomes a role model (i.e. engages in HIV prevention efforts in community)

Source: Adapted with permission from Coury-Doninger et al. (2000). *Use of stage of change to develop and STD/HIV behavioral intervention*. New York: Association for Advancement of Behavior Therapy.

Using counseling strategies matched to SOC

◆ Precontemplation and contemplation stages

The young person in this phase might not have enough information to recognize that change is needed to address a problem, or may possess strong feelings that resist change. Interventions matching this stage are aimed at informing and educating the young client and increasing his knowledge or awareness of the problem or addressing the client's underlying emotional obstacles to change. Coury-Doniger et al. (2000) provides some specific counseling strategies for information giving that can be used to assist the young client in recognizing the need for change and calling into question his previous beliefs.

- 1 Information Giving (Consciousness-Raising):** Youth-centered counselors can provide general and personalized information to young clients about STIs and HIV, sexuality, and sexual and reproductive health issues including high risk and low risk sexual practices and the use of safer sex methods. Coury-Doniger et al. encourage providers to present information in a format that is concise and is culturally and linguistically appropriate, and which allows the young client to ask questions, clarify and react to the information presented. Consciousness-raising may also be used in the contemplation stage. Coury-Doniger lists eight strategies for providing specific information that counselors can use, as illustrated below.

■ Sharing the perceived need for change motivates commitment, builds confidence and is a first step in the development of any personal long-term plan.

Counseling Strategy: Information Giving	
Youth's Risk Assessment	Have young person discuss perception of his HIV/STI risk and compare that with the factors known to influence one's risk of acquiring an infection.
HIV/STI/cocaine connection (and other drugs)	Explain connection between cocaine (and other drugs) and HIV; for young clients with syphilis, (or other STI) explain the connection between syphilis and HIV.
Mucosal immunity	Explain synergistic relationship between STIs and HIV and describe how STIs increase both susceptibility and communicability of HIV. Describe the mucous membrane surfaces of the vagina, urethra, rectum and mouth and how they are affected by STI infections to appropriate male or female youth.
Seroprevalence of HIV/STI in youth's community	Discuss what is known about local HIV/AIDS prevalence – percent of gay men/gay youth, non-gay identified men who have sex with men (MSM), commercial sex workers, women and youth living with HIV/AIDS in the local area/region/community.
Future fertility	Discuss the risks of ectopic pregnancy and infertility related to STI complications of pelvic inflammatory disease and epididymitis; discuss young client's desire for future pregnancies, relationships between STIs/HIV and poor pregnancy outcomes, neo-natal infection, etc.
Use drawings of stick figures	Use drawings of stick figure diagrams of the young client's actual sex partner situation to illustrate how their partner's behaviors can impact their own HIV/STI risk.
Rate your relationship (rate scale)	On a scale of 1-10, ask youth to assess their risk of STI including HIV and then the risk of their partner(s). Discuss their perception if the risk ratings are different. This will help the youth to evaluate their risk of HIV/STI.

Source: Adapted with permission from Coury-Doninger et al. (2000). *Use of stage of change to develop and STD/HIV behavioral intervention*. New York: Association for Advancement of Behavior Therapy.

◆ **Contemplation Stage**

1 Exploring Ambivalence (Self-Reevaluation): Young clients can often resolve their ambivalence when they identify their underlying feelings and emotions and when they have an opportunity for expressing their perceptions and thoughts about their situation (telling their story without judgmental reactions). According to Coury-Doniger et al. (2000), “altering risk behaviors is often perceived as giving up something that is familiar, automatic, and pleasurable and is meeting specific needs.” It’s important for counselors to help young clients recognize which needs and wants they have and try to fulfill them using substitute healthy behaviors that reduce their risk for infection with HIV or other STIs.

◆ **Preparation or Ready-For-Action Stage**

The youth-centered counselor’s main counseling task at this stage is to help the youth identify the steps necessary for change and develop the necessary skills to enhance *sexual self-efficacy* and *sexual self-esteem*. This is done by encouraging, supporting, and listening to the client. Coury-Doniger et al. (2000) explain that clients who are ready for action often need to articulate a step-by-step plan of how they might implement their specific HIV/STI risk reduction. This process helps to clarify any doubts the young person may have, provides for mistakes to be made in a safe environment, allows for supportive feedback to be given and, most importantly, provides an opportunity for the youth to visualize and specify the steps she needs to take. The counselor’s main task at this stage is to build the confidence and *self-efficacy* of the young client by encouraging the youth to become self-aware of her sexual and nonsexual needs, smart about taking care of her body and her health and assertive in communicating with sexual partners her need and desire for *self-preservation* and *self-care*. According to Coury-Doniger et al., sharing the perceived need for change with significant others creates commitment, builds confidence and is a first step in the development of any personal long-term plan.

Skills-building techniques include coaching, role-playing, rehearsing sexual communication and negotiation skills and encouraging the young person to practice these skills with close friends or people whom she trusts. By practicing these skills

and receiving direct and constructive feedback, the adolescent can improve her communication skills to better negotiate sexual behaviors. Skills may include the use of condoms (male and female), developing standard statements to use when communicating with partners and learning how to communicate using nonverbal cues (for example, looking a partner in the eye when talking about sex).

◆ **Action and Maintenance Stage**

When young clients begin to implement their new or modified behavior, they still need support and encouragement. The counseling tasks in this stage consist of helping young clients refine, adjust and more firmly establish the new behaviors, especially when confronted with unexpected consequences and disruptive life events (Coury-Doniger et al., 2000). During this stage, counselors help prepare youths to solve actual or anticipated problems and build on successes by focusing on what has worked before in same or similar situations.

The maintenance stage is characterized by engaging in the new or modified behaviors after 6 months of consistent change. However, clients can still relapse to their old behavior patterns (Prochaska and DiClemente, 1983; Coury-Doniger et al., 2000). At this stage, *reinforcement management*, the maximizing of *helping relationships*, the use of *counter-conditioning techniques*, *stimulus control* and *social liberation* are all important.

1 Reinforcement Management: Youth-centered counselors can help young clients identify and understand what they really like to do and use these activities (positive life affirming, enriching, non-destructive, positive) as rewards. These rewards can be used even for the smallest of changes that the young person undertakes (Coury-Doniger et al., 2000). For instance, a 17-year-old young male who is no longer drinking and having unprotected sex with unknown partners can reward himself by doing something he has not done in a while, such as going camping, visiting a nature park with his friends, going to the movies, or playing his favorite music.

2 Identify Helping Relationships: Changing one's behavior entails letting go of the familiar. This can be very difficult as habits are hard to break. This is especially true for sexual behaviors that give pleasure, enhance a

sense of well-being, affirm us as sexual beings. Young individuals often need support when confronting the uncertainty of change. Social support can be found in school peers, friends, family members, school counselors, teachers, or sexual partners. Young people can also identify activities or events happening in their community that provide more formal ways of support, such as support groups. Counselors can help young people identify persons or groups that can provide such support.

3 *Finding Substitutes (Counter-Conditioning)*: Providers can help youths identify the needs being met by their sexual risk behaviors and explore safer alternatives (Coury-Doniger et al., 2000). For example, a counselor can suggest that a youth substitute getting drunk and one-night stands with dating and developing healthy and wholesome friendships or relationships.

4 *Avoiding Cues (Stimulus Control)*: Research on smoking cessation and addictive behaviors shows that behavior becomes patterned by environmental, psychological or emotional mood state cues that stimulate the behavior. Similarly, many clients explain that specific mood states or environmental cues such as people, places and events evoke their sexual behavior, including that which is high risk. The challenge for the counselor in this instance is to help the young person identify the cues that evoke such behavior and find alternatives to them. In one case, a young male was engaging in unsafe sexual encounters in the public restrooms. He reported that he would go to the public rest rooms when he was most anxious. The counselor was interested in understanding what was triggering his anxiety. He asked him what he was making him anxious and found that the behavior was triggered by his fears that his father would discover his sexual attraction to other males. This anxiety was compounded by his fears of dropping out of school. The counselor helped the young man become aware of his triggers and taught him to use relaxation techniques to manage his anxiety. Furthermore, the counselor encouraged him to avoid going to that specific public restroom (the triggering cue) when he felt anxious and connected him to a support group for LGBT (lesbian, gay, bisexual) youth. In this case, a combination of substitution (using relaxation techniques), avoiding cues (not going to

that specific restrooms) and helping relationships (counselor providing trust and space for expression of self and going to a support group) helped the young man change his risky behavior.

5 *Becoming a Role Model (Social Liberation)*: A common intervention used in HIV prevention, becoming a role model, helps to prevent relapses in behavior. Counselors can encourage young clients who have reached the Maintenance Stage to be role models.

In developing interventions that are sensitive to the readiness for change of young clients, counselors need to also respond to individual situations and developmental stages of the client. Vernon (1993) suggests some helpful tips for developing interventions with youth:

Tips for developing interventions with youth

Make plans that are specific and personal. Don't develop plans that are meaningless to the youth and unrelated to the current situation.

Be practical and concrete with plans suited to age-appropriate interventions. Don't be complex and sophisticated with very young adolescents. Don't design plans that are hard to follow through.

Give homework and have assigned due dates. Don't create long term plans without specific dates and tasks for completion.

Find supportive persons who will encourage and support youth to achieve their goals. Don't work in a total vacuum. Where appropriate, use parents or family for collecting key information and support for the intervention.

Find resources in the community for youth to use, i.e. books that are relevant. Don't promise to find resources in the community and forget to bring them to counseling.

Have the young person record progress of his plan in a private journal kept in a safe and secure place. Don't assign a journal if the client does not have privacy to keep it in a safe place or lives with a family that does not respect her personal space.

Adapted with permission from A. Vernon (1993). *Developmental assessment and intervention with children and adolescents*. Alexandria, VA: American Counseling Association.

Tips for developing interventions with youth *Continued from p.114*

Provide external motivation: Praise and encourage the client, compliment ideas given for the plan and for small successes. Don't criticize ideas, laugh or ridicule them. Don't ignore small successes.

Ask young clients questions to ensure they understand all the steps of the plan. Don't assume the young client understands all of the goals and plans.

Use language that is appropriate to the age of the youth and rephrase as necessary. Learn their "lingo" to facilitate better communication. Don't use professional counseling jargon to communicate with young persons.

Phase 5: Implementing Youth-Centered Plans

After the intervention has been selected, the next stage is implementation. This stage may occur in several ways: (a) immediately following the design of the intervention, within the same session; (b) as a homework assignment for the young client to implement between sessions; (c) as a step-by-step implementation, in which a segment of the intervention is worked on, followed by additional steps after successful completion of the first; and (d) a combination of all three.

In working with younger clients, it is important to remember that, because their sense of time is so immediate, it may be necessary to identify one aspect of a problem, design an intervention and move directly to implementation in a short period of time. The advantage of this approach is that it shows the youth that something can be done, which makes the current challenge or situation seem less overwhelming. The possible disadvantage is that the entire process is more piecemeal. Youth-centered counselors need to consider with whom they are working and tailor the process accordingly. Furthermore, after this intervention has been selected and implemented, the counselor

Adapted with permission from A.Vernon (1993). *Development assessment and intervention with children and adolescents*. Alexandria, VA: American Counseling Association.

and the client can return to further assessment of the situation and then reenter the planning stage to target another issue.

Youth-centered counselors must use their judgment to determine how much of the current challenges to address, and at what pace to proceed with interventions. To some extent, this depends on the age of the youth and on the magnitude of the problem. If the behavior interferes strongly with daily living and is causing a great deal of distress to the client or to others, it is advisable to work on portions of the problem and intervene sooner, recycling back to assessment as necessary.

Implementing plans for behavioral change should be done when the young person is ready for action or preparing to take action. The action stage is when the young person actually modifies her behavior. At this point, it would be appropriate for the counselor to check with the youth to confirm and validate if her set goals for change are still relevant and accurate. Youth-centered counselors are aware that goals may change for a young client and must remain open and flexible to deal with these changes. Having decided on a specific action, the young person is ready to implement and put into practice what he has intended to do. During this phase, the young person may experience some anxiety as change involves dealing with the unknown. Youth-centered counselors must be keenly aware of how the youth is managing the changes. At this stage it is very important to provide encouragement and support to the young client. Youth-centered counselors must continue to empathize with the young client in dealing with any fears or uncertainties they may be experiencing at the time of change.

Interventions also can be implemented successfully as a homework assignment. Not only does this reinforce concepts discussed during the counseling session, but it also is particularly helpful for younger individuals whose recollection from session to session is often limited. Homework assignments can assume a variety of formats:

- **Reading:** pamphlets, booklets, books, biographies, fiction, nonfiction, poetry, magazine or newspaper articles.
- **Writing:** journals, diaries, poetry, fiction, letters to express emotions or clarify thoughts.
- **Behavioral tasks:** risk-taking exercises, task completion, learning and practicing new skills such as sexual communication and negotiation.
- **Observing/viewing:** specific movies, television programs, ways in which others behave or approach situations.

It is very important to encourage the young client to participate in the homework assignment. The counselor can explain the purpose of the task in the homework assignment, and how this will help the youth achieve identified goals.

■ The best intervention at this point is continued encouragement, positive reinforcement and a focus on an overall healthy lifestyle

Working on segments of an intervention also contributes to its effectiveness. For instance, with an anxious teenager, behavioral interventions need to be developed and implemented in a carefully structured hierarchy by breaking down the ultimate goal into manageable steps that are in tune with the youth's developmental abilities. If too much is initiated too soon, the youth may get overwhelmed and the entire procedure may fail. Although dividing the intervention into successive parts takes careful planning and patience, it is well worth the effort in the long run.

The final stage of behavioral change is known as the maintenance stage and usually continues for several months following the implementation of the new behavior. The best intervention at this point is continued *encouragement, positive reinforcement* and a focus on overall healthy lifestyle in order to maintain the desired behavior change. This can best be accomplished by setting up periodic visits, *praising* and *encouraging* the young person whenever she engages in the behaviors that she has set forth to accomplish. It is equally important that the young person realize that resolutions to change often break down and that consistent behavior change is not easy. The counselor should explain to the young client that relapse is a normal part of the change process and that there may be instances where she will be tempted to engage in risky behaviors. The youth-centered counselor should explain that in the event that she engages in her old behavior, she might experience strong emotions such as shame or guilt. The young person must feel that the counselor is on her side and will support her when she is successful as well as when she relapses.

Phase 6: Monitoring Progress and Evaluating Change

How do we know if the intervention worked? This is the main question to ask during the evaluation stage. Characteristically, when counselors do not know if challenges and situations have been resolved it is because they have not adequately exploited evaluation opportunities. Time constraints, lack of commitment or momentum, lack of evaluation skills or fear of evaluation often interfere with this critical step. The intervention may be implemented, and things may temporarily improve, but unless a systematic evaluative procedure is exercised, the implementation process is incomplete. Without a deliberate examination of what did or did not work, the problem increases in severity and intensity, which prompts the young client or others to seek help again. By allowing the problem to become more severe, subsequent change efforts become more difficult.

Ongoing evaluation and gradual termination are recommended when the counselor sees little or no improvement or when goals have been achieved. When appropriate, involving significant others in the evaluation process can provide key insight into whether things are improving outside of the counseling room (and with client's permission). In counseling about sexual matters, the youth's partner may also be a part of the evaluation process if appropriate and the youth has given permission to include her partner. A short evaluation session could provide critical information of what has worked and what issues still need to be addressed. A phase-out process could provide further evaluation and support. Vernon (1993) explains that by considering evaluation as an integral part of the intervention process, a feedback loop is established. That is, based on the evaluation, it may be necessary to return to the planning stage and design and implement new strategies to address various aspects of the problem.

Part C: Evaluating Provider's Own Youth-Center Counseling

Sexual behavior change can be facilitated when the young person identifies exactly what he wants to change and explores any ambivalences or resistances he may have towards changing. Exploration of subjective meanings and inner experiences attached to his behavior provides him with a closer understanding of himself and clarifies what options he has to improve his behavior. So far, we have said that a youth-centered counseling moves away from strict data collection (clinical interrogation of sexual questions and risk behavior) and information giving (purely educating clients on disease transmission) between a provider and a young person to a more dynamic and collaborative process where the provider “joins the client” by developing trust and rapport, creates a safe and confidential space for self-disclosure, empathizes with the young person and gets in touch with his inner experience. By asking meaningful and relevant questions, the provider assesses the situation and along with the young client work at identifying options for the resolution of the problem or concern. The relationship and conversation is personalized to the specific client and relevant to the young person as the provider takes the time to respond to the individual issues and concerns of the youth. The young person is not treated as a generic and passive recipient of information, but is active in identifying the presenting problems and concerns, setting goals and sub goals, identifying strategies for taking action, making her own decisions about changing and reflects on her progress (Miller, 1993; Rogers, 1959; Nolan, 1995).

The following matrix has been designed to help providers implement and evaluate their youth-centered counseling practice, maximizing the opportunities to develop the conditions necessary for change, collaborate in a respectful and partnership approach, identify the readiness for change, and explore the ambivalence and factors that might impede or enhance change in young people.

Youth-Centered Counseling Checklist				
At the beginning of the counseling interview, did I (the provider):	Not Applicable	Not Demonstrated	Partially Demonstrated	Clearly Demonstrated
1. Practice in a setting that was private, attractive and comfortable for young people? Did I make any effort to assure a safe and secure space for discussing sensitive sexual and reproductive health issues? Did I avoid physical barriers such as desks between myself and my young client?				
2. Briefly introduce myself, my role and explain counseling in sexual and reproductive health in a way that was non-threatening and easy to understand by the young person?				
3. Begin to establish a warm, open and trusting environment? Did I demonstrate interest, respect and friendliness for my client as he walked in? Did I welcome my young client and give him my undivided attention? Did I ask him open-ended questions to get to know him?				
4. Clarify issues and conditions of confidentiality and availability for providing counseling? Did I make it clear that counseling was completely voluntary and that the young client could withdraw from the process at anytime?				
5. Use non-technical terms, avoid professional jargon and use easy-to-understand language appropriate to my client's age? Did I use neutral language when referring to sexual partners?				
6. Attend to the young client by providing appropriate eye contact (depending on cultural norms of the client), observe and attend to young client's non-verbal behavior (what was his body language telling me?), do anything to help make the young person feel more comfortable in the office? (did I provide a comfortable chair, and remember the young client's name; was I sensitive to facial gestures of my young client?).				

Youth-Centered Counseling Checklist		Not Applicable	Not Demonstrated	Partially Demonstrated	Clearly Demonstrated
At the beginning of the counseling interview, did I (the provider):					
7. Demonstrate a comfortable and natural relaxed posture with my young client? Was I sitting comfortably, talking in a relaxed and assuring tone? Was I genuine and authentic in my relationship with my young client? (i.e. really interested in her?)					
8. Establish rapport through asking general questions (i.e., hobbies, interests, school, relationships with family and pastimes) before inviting the young client to share what brought him to counseling? Did I use appropriate self-disclosure to model openness and trusts?					
9. Inquire about the client's intentions or reasons for coming to counseling? (for coming to see me)?					
10. Ask meaningful and relevant key sexual health assessment questions that helped both of us have an understanding of his current situation? Did I give an opportunity for my young client to share his situation / concern without interruption?					
11. Demonstrate unconditional positive regard (deep respect for the client, acknowledgement of worth and dignity of person) for the young person when listening and attending to the young person's verbal and nonverbal communication? Was I non judgmental about the young person's behavior or situation, even if I did not agree with everything the youth was doing? Did I display characteristics of warmth, openness, trust, respect, self-disclosure and acceptance? Did I validate the young person's subjective inner experiences, emotions and feelings?					

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Youth-Centered Counseling Checklist

When discussing sexual behaviors and current sexual health situation did I (the provider):

1. Use open-ended questions to explore relevant issues, hidden meanings, and facilitate the young client's active involvement in the process? Did I explore the young person's subjective reasons for doing things? i.e., "What does it mean for you to have a baby right now?" "What does it mean for you to have sexual intercourse with your boyfriend?" "What does it mean to you to talk to your partner about using condoms?"

2. Assist my young client in identifying and clarifying potential ambivalence about what she wanted or needed to happen? Did I work with the young client to identify internal and external barriers and resources or strengths for change? Did I ask questions about any conflicts, inconsistencies or discrepancies with the client's goals, intentions and behaviors? i.e., "I hear you want to protect yourself from getting HIV, yet you also want to keep having unsafe sex, which puts you at great risk for contracting HIV and other STIs. I am confused about these two things as they seem to be conflicting with each other. Help me to understand how having unsafe sex will help you protect yourself from an STI?"

Clearly Demonstrated

Partially Demonstrated

Not Demonstrated

Not Applicable

Youth-Centered Counseling Checklist

Continued from p. 122

When discussing sexual behaviors and current sexual health situation did I (the provider):

	Not Applicable	Not Demonstrated	Partially Demonstrated	Clearly Demonstrated
<p>3. Practice being non-directive? Did I listen empathetically to my young client and respond to his experiences and feelings? Did I avoid telling the client what to do and what to decide? Did I avoid using persuasion and manipulation? Did I allow the young client to come up with possible options and help the client understand the consequences of each of the alternative options? Did I allow my young client to make an informed decision?</p> <p>4. Co-develop specific, realistic and manageable goals with the young client? Did I use the interview opportunity to clarify what my client's situation was (assessment) and verbally communicate my assessment of the situation in simple understandable language? Did I focus on important concerns of my client and work together with him to explore what he desired and wanted to change? After this exploration, did I work with the client to come up with achievable goals? Did I respond to the nonverbal behavior of my client when making that decision, i.e. laughing, crying, looking down, being tense? Did I validate the experiences and feelings of my client when making a decision, i.e., "You are making a tough decision right now about how you want to be sexual with others. This is hard for you right now because, quite frankly, you like having sex with your partners. How are you feeling right now about that decision?"</p>				

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Youth-Centered Counseling Checklist

When discussing sexual behaviors and current sexual health situation did I (the provider):

5. Did I ask my young client about how she was making sense of the information shared or learned regarding topics like contraceptives, condom-use, sexuality, sexual behavior? Did I go beyond merely giving information and education? Did I explore what my young client has learned or remembered from our dialogue? i.e., “You have remembered a lot of information about using the pill, it shows you have excellent memory. Now talk to me about what we discussed in regards to the possible effects of taking the pill?”

6. Assess the stage of change of my young client? Did my verbal responses and interventions respond to or match the stage of change my client was in? Were my interventions sensitive to the gender and developmental stage of my client? Were the options we came up with appropriate for the age of my client? Did they correspond to what boys or girls would be interested in at that age? Where my suggestions sensitive to client’s sexual orientation?

Clearly Demonstrated

Partially Demonstrated

Not Demonstrated

Not Applicable

Youth-Centered Counseling Checklist				
<i>Continued from p.124</i>				
Closure: Before ending the counseling interview, did I (the provider):	Not Applicable	Not Demonstrated	Partially Demonstrated	Clearly Demonstrated
1. Sum up the counseling interview in a way that brings closure to the session? Did I ask the young client if there was anything that had not been touched on that would be important to discuss in order to best serve him? i.e., "What other concerns do you have that are important to talk about?"				
2. Review support systems (like external and internal resources and strengths, friends, pleasurable and safe activities) and possible barriers to change (ambivalence, stress, losses, fears, doubts, anxieties)? Did I reassure my client that change can happen in small manageable steps? Did I instill hope in the client?				
3. Protect the autonomy of my young client by supporting my client's self-determination in the decision-making process, clarifying options and consequences for alternative options, support the self-efficacy and choice of the young client to proceed with her action plan?				
4. Negotiate the next step for counseling regarding the plan of action and goals?				

Continued from p.125

Youth-Centered Counseling Checklist

Closure: Before ending the counseling interview, did I (the provider):

- 5. Verbally reinforce my client's effort to discuss or initiate change?
- 6. Provide options and alternatives that were ethical (right to precise sexuality information, non-maleficance, beneficence, responding sensitively and serving youth, respecting the dignity and worth of the young person, intervening with integrity and professional competence)?

Clearly Demonstrated

Partially Demonstrated

Not Demonstrated

Not Applicable

Section Three

Literature Supporting the Core Components of the Youth-Centered Counseling Model



Section Three

Literature Supporting the Core Components of the Youth-Centered Counseling Model

Theories, Models and Perspectives



This literature section provides the reader with a brief background of the theories, models and perspectives behind youth-centered counseling and explains how they have each been implemented to change various health-related behaviors including sexual behavior. We wanted to include this empirical review in order to provide the reader a closer look at how these theoretical approaches have been used, and how they have been effective in bringing about individual behavioral change. These selected theories by no means suggest that this is the only effective means of engaging youth in counseling. However, each of these approaches can be readily applied to working with youth in facilitating change in a way that is consistent with PAHO's philosophy and practice with young people. The authors of this guide hope that an integration of the views, assumptions of change and application of the practice skills derived from these theoretical orientations with their empirical support are useful to counselors working with youth in sexual and reproductive health matters.

Client-Centered Counseling: Background and Evidence

Nearly one third of the people who have contracted HIV/AIDS worldwide are young persons ages 15 to 24. When the ages of 10 to 14 are included, that number increases to fifty percent (UNAIDS, 2002). Furthermore, a study of youths in Mexico, South Africa and Thailand found that sexually experienced and inexperienced youth alike believed themselves to be at the same level of risk for contracting HIV/AIDS, thus indicating a need for appropriate interventions (Stewart, McCauley, Baker et al., 2001).

However, a review conducted several years ago under the auspices of the Joint United Nations Programme on HIV/AIDS (UNAIDS) found education programs have limited impact on youth behavior (Grunseit, Kippax, Aggleton et al., 1997). This review summarized a substantial amount of the available evidence and concluded that although high quality, effective education programs can help delay sexual initiation, protect sexually active youth from HIV and other STIs and reduce unplanned pregnancy rates, they were only maximally effective before the onset of sexual activity. The efficacy of counseling on the prevention of HIV and other STIs in youth also has, until recently, been deemed questionable. A meta-analysis of 27 controlled studies assessing sexual behavior before and after HIV counseling and testing indicated that such counseling and testing only reduced risky sexual behavior in individuals who had already been infected with HIV (Weinhardt, Carey, Johnson and Bickham, 1999).

Yet a multi-center randomized controlled trial was conducted comparing the effects of didactic HIV prevention messages and intensive client-centered counseling among a large sample (5,758) of heterosexual, HIV-negative patients aged 14 years or older seeking STI examinations (Kamb, Fishbein, Douglas et al., 1998). After six months, it was found that the subjects who received client-centered counseling were significantly more likely to use condoms 100 percent of the time and had contracted appreciably fewer new STIs. Moreover, after twelve months, the reduced rate of STIs contraction was found to persist among those who received client-centered counseling. Most notably, the reduction of STIs was greater for adolescents than for the majority of other groups.

The trial, known as Project RESPECT, was conducted in five public STI clinics in cities throughout the United States between July 1993 and September 1996. The results provide the strongest evidence to date of the effectiveness of a client-centered approach to HIV prevention and underscore the importance of distinguishing HIV client-centered counseling from health education (Kamb, Fishbein, Douglas et al., 1998). This is not to say that providers need not be prepared to provide accurate information regarding the risks of different behaviors, the modes of HIV/STI transmission, etc.. Rather, it means that such information must be tailored to the behaviors, circumstances and needs of the individual who is being counseled. A client-centered approach allows the counselor to adapt such information to the client's particular stage of change, priorities and goals (Norton, Miller and Johnson, 1997).

The client-centered approach is also supported by psychotherapy outcome research, research that suggests that 70 percent of successful psychotherapeutic outcomes are the result of the client/therapist relationship and the client's own resources (Duncan, Hubble and Scott, 1997). Furthermore, the research supports the belief that therapeutic success is contingent upon the existence of an open, trusting, collaborative relationship or alliance between client and therapist (Frank and Gunderson, 1990). Research also shows a strong relationship between the absence of such a collaboration and client noncompliance with treatment (Bozarth, 1999).

The client-centered approach rests on the hypothesis that the individual contains immense resources for self-understanding and for changing his self-concept, attitudes and behaviors (*ibid*). Carl Rogers (1951), the acknowledged progenitor of the client-centered approach, maintained that, within a therapeutic context, these resources could only be accessed within a climate that facilitates such resource accessing. Accordingly, Rogers asserted that the client is most likely to change when the therapist (1) does not distance himself from the client by erecting a professional or personal façade, (2) has a positive, non judgmental attitude toward whatever the client expresses during a given moment, (3) correctly senses the personal feelings and meanings that the client is experiencing and (4) communicates understanding to the client.

It should be noted that the client-centered approach consists of more than just the empathic understanding response process and thus is not identical to it (Watson, 2001). The client-centered therapist or counselor, by definition, must have the capacity to adapt to each client as an individual and must be capable of making the language adjustments required for the promotion of mutual understanding (Brodley, 1999). Important forms of interaction other than the empathic understanding response are fashioned by the counselor's nondirectiveness and confidence in the natural propensity toward growth or actualization (Rogers, 1951). Nondirectiveness specifically refers to the client-centered counselor's mindfulness for respecting and protecting the client's self-direction and autonomy and is premised on the view that the client, not the counselor, is the expert regarding himself (Rogers, 1951).

Augmenting the Client-Centered Approach: The Transtheoretical Model (TTM)

Although the client-centered approach has become increasingly comprehensive over time, a major weakness is that it does not sufficiently address the stages of development that clients may potentially pass through (Maddi, 1996). Nevertheless, this shortcoming is more than adequately compensated for when the client-centered approach is placed in the context of the Transtheoretical Model (TTM). Developed by Prochaska and DiClemente (1983), the Transtheoretical Model operates from the premise that human beings go through similar stages of change without regard to the type of theory being applied. The TTM consists of two fundamental components, namely, the five stages of change and ten essential processes of change. The five stages of change depict a sequence of change that individuals seem to go through. They are: (1) precontemplation; (2) contemplation; (3) preparation; (4) action; and (5) maintenance.

Precontemplation is the stage at which the individual has no intention of altering her behavior. When the individual begins to consider changing her behavior, she is considered to have entered the contemplation stage. This leads to preparation, the stage at which some behavioral steps have been taken toward the individual's objective or at which she has decided to act in the immediate future. The next stage, action, commences when the person actually begins to change her behavior. The final step, maintenance, assumes that the individual has been successful at making the change and is in the process of sustaining such change (Prochaska, Redding and Evers, 1997).

The ten main processes of change are activities that people use to progress through the stages of change. They provide clients, therapists, counselors and intervention programs with a road map for behavior change. They consist of the following: consciousness raising, dramatic relief, self-reevaluation, environmental reevaluation, self-liberation, developing helping relationships, stimulus control, counter-conditioning, reinforcement management and social liberation (Prochaska, Velicer, Rossi et al., 1994).

In sum, the Transtheoretical Model implies that different intervention approaches are needed for people at different stages of change. That is not all; it also provides a guide

as to which processes are most effective at each stage of change. The Transtheoretical Model also embraces the concepts of decisional balance and self-efficacy (Prochaska and Velicer, 1997). Derived from the Janus and Mann model of decision making (1977) and simplified as a result of a series of studies conducted by Prochaska, Velicer, Rossi et al. (1994), decisional balance refers to the individual act of considering the pluses and minuses attendant to a particular change of behavior.

The Effectiveness of the Transtheoretical Model

The Transtheoretical Model (TTM) was born out of prospective, retrospective and cross-sectional studies investigating the various means whereby individuals relinquished the habit of smoking, studies that utilized factor and cluster methods of analysis (Wyatt, Tucker and Romero, 1997). Subsequent to the aforementioned studies, considerable support has been found for the Transtheoretical Model. The majority of the empirical support for this model has been the result of studies investigating addictive behavior, smoking cessation in particular (Prochaska, Velicer, Rossi et al., 1994). Siqueira, Rolnitzky and Rickert (2001) used the TTM to examine the relationship of nicotine dependence, stress and coping methods. The study consisted of 354 clinic patients between 12 and 21 years of age, all of who reported past or present smoking. A study conducted by Woodby, Windsor, Snyder et al. (1999) to determine predictors of smoking cessation among a sample of 435 pregnant Medicaid recipients sought to determine if the stages of change comprising the TTM predicted changes in smoking behavior during pregnancy. The results indicated that the predictors of non-smoking status during the third trimester were self-efficacy, exposure to environmental tobacco smoke, exposure to patient education and the duration of smoking habit, thus confirming the research utility of the Transtheoretical Model.

The TTM has been validated and applied not only to smoking cessation but also to an assortment of behaviors such as exercise, diet and contraceptive use (Ozer, Brindis, Millstein et al., 1997). Moreover, simple approaches based on the four stages of change have validated the extensive effectiveness of the model (Kirby, 1997). In a review of the literature, Ashworth (1997) found six trials that compared stage-based interventions with non-stage-based interventions. The results of these trials suggested that staged interventions were more effective than non-staged interventions.

More specifically, studies confirm the utility of the Transtheoretical Model with regards to youth sexual behavior. One study used the TTM to assess the effectiveness of a peer-education program in reducing risk behaviors associated with AIDS, conducted among rural tenth graders in the southern US. Subjects were divided into comparison groups that either received leadership training or no intervention. Both groups completed an extensive survey that measured written knowledge, attitude and behavior at the beginning, end and eight months subsequent to the commencement of the training. By the time of the last survey, the trained peer educators reported a significant increase in knowledge of AIDS risk behavior, frequency of conversations with peers about birth control/condoms and sexually transmitted diseases, condom use self efficacy and consistent condom use. Moreover, the other teen participants reported substantial increased condom use and decreased unprotected intercourse (Smith, Dane, Archer et al., 2000).

The Transtheoretical Model has been found useful in determining the readiness to use condoms and contraception among 3,784 women in four cities recruited in both community facilities not targeted to HIV positive women and medical facilities for HIV positive populations. The study showed that although the stages experienced by participants were in correspondence with the Model, the distribution of condom and contraceptives varied according to the facility (O'Campo, Fogarty, Gielen et al., 1999).

Research has determined that interventions must match the culture of the audience targeted. Interventions that are most effective at changing adolescent attitudes and behaviors tend to be culturally appropriate (Wyatt, Tucker and Romero, 1997). One study combined African and African American frames of reference with the stages of change model in order to influence sexual decision-making among young female adolescents (Johnson, Johnson, Heurich et al., 1998). The study indicates that the Transtheoretical Model is adaptable to different cultures.

Although the research regarding the specific applicability of the Transtheoretical Model to HIV/AIDS prevention is sparse, Prochaska, Velicer, Rossi et al. (1994) have held that cross-sectional data supports the use of the TTM to HIV/AIDS prevention. Moreover, the same researchers have noted that certain processes of change are useful in HIV/AIDS prevention, some of which are more applicable at certain stages. Thus, it is essential that the each individual's stage of change be identified, and that the most

appropriate interventions are used for that stage. Individuals at the precontemplation stage, for example, would consist of those who are not aware of the risk of AIDS, who underestimate their own risk of contraction or who, for some reason, do not intend to stop engaging in risky behaviors (Valdiserri, 1992). At this stage, individuals tend to be defensive about their behavior and are resistant to change. Accordingly, increasing levels of knowledge and awareness of the risk of AIDS (for example, consciousness-raising), would be the most appropriate process. Individuals at the contemplation stage, on the other hand, are aware of risky behaviors, are seriously considering changing their behaviors and, therefore, are in need of considerable encouragement, support, positive reinforcement and additional relapse prevention methods (ibid).

Although effective, the Transtheoretical Model works best with adjunctive and complementary approaches. Two such approaches are goal setting and motivational interviewing.

Goal Setting Theory

Goal Setting Theory has its roots in Bandura's social cognitive theory (1977). This theory holds that changes in behavior are contingent upon the setting of goals, goals that are founded on outcome expectations related to such changes and the tasks and self-efficacy expectations necessary to accomplish those goals (Bandura, 1982).

Self-efficacy is a key concept in goal setting theory and is defined as the individual's perceived capabilities for learning or performing actions at given levels (Bandura, 1997). Numerous studies have demonstrated that self-efficacy is a key predictor of client compliance with preventive health programs (O'Leary, 1992) and exercise regimens (McAuley, Lox and Duncan, 1993).

Self-efficacy, motivation, learning and the ability to engage in self-evaluation of progress all improve the individual's capacity for self-regulation. Self-evaluations of progress strengthen self-efficacy and sustain motivation. Goals have a positive impact on these factors (Bandura, 1997). Goals motivate people to put forth the necessary effort to meet demands, persist and help to foster the commitment necessary for behavior change (Locke and Latham, 1990). Goals also focus the attention of the individual on pertinent tasks, requisite behaviors and potential outcomes, and to assist in the selection and application of correct strategies (ibid). Research has found that goal-directedness

and personal identity are positively related to personal well-being, as well as a host of life outcomes (Goldman, Masterson, Locke et al., 2002). Furthermore, a set of studies conducted by a group of researchers determined that self-evaluation was related to goal-setting behavior (Erez and Judge, 2001). Goal attainment has been found to further contribute to the building of self-efficacy and results in individuals selecting new, more challenging goals (Schunk, 1995).

It should be noted that although goals can enhance self-regulation, such enhancement does not take place automatically, for the specificity, proximity and difficulty of goals are of critical importance (Schunk, 2001). Research has shown that proximal, short-term goals result in higher motivation and better self-regulation than more temporally distant, long-term goals (Bandura, 1997; Boekaerts, Pintrich and Zeidner, 2000).

Motivational Interviewing

Motivational interviewing is a goal-directed, client-centered counseling style that seeks to effect a change in behavior by assisting the client in investigating and resolving ambivalence (Baker and Dixon, 1991). As such, it is an intentionally directive technique. There are, nevertheless, specific and trainable behaviors that are characteristic of a motivational interviewing style. The behaviors that are foremost include the attempt to understand the client's frame of reference via reflective listening, the articulation of acceptance and affirmation, the eliciting and selective reinforcement of the client's self-motivational statements and confirmation of interest, desire, intention, and ability to change (ibid).

There are a host of controlled studies that show motivational interviewing techniques to be as effective as twelve-step facilitation and cognitive-behavioral techniques. One such study examined the effectiveness of brief motivational interviewing on pregnant alcohol drinkers in reducing fetal alcohol exposure. Over forty pregnant drinkers were randomly assigned to two groups, one receiving written information on the risks associated with the consumption of alcohol during pregnancy, another receiving a one-hour motivational interview. Two months later, the participants with the highest blood alcohol concentration at the early stages of pregnancy who received the motivational intervention showed a significant reduction in blood alcohol concentration. The researchers concluded that motivational interviewing could be used to promote a

decrease in drinking among high-risk pregnant women (Handmaker, Miller and Manicke, 1999). Notably, Miller (1993) replicated studies with heavy drinkers and found that an empathetic therapist style was predictive of decreased drinking.

Motivational interviewing techniques have been found to be most effective for individuals who are at the precontemplation and contemplation stages, the most challenging of all for counselors and therapists (Miller, 1993). Furthermore, brief counseling sessions of five to fifteen minutes have been found to be just as effective as longer interventions (WHO Brief Intervention Study Group, 1996). In another study, 160 hospitalized psychiatric patients diagnosed with substance use were randomly assigned to receive either a motivational interview or a self-help booklet. The study determined that motivational interviewing was modestly effective in the short term, indicating the need for continued outpatient intervention, particularly in the case of cannabis use (Baker, Lewin, Reichler et al., 2002).

In another study, subjects were randomly assigned to either a single-session standard evaluation or an evaluation enhanced by motivational interviewing techniques. The results found that the participants who were exposed to motivational interviewing were significantly more likely to attend at minimum one additional session after the first evaluation. Thus, the results of this study indicate that motivational interviewing and perhaps other modifications could increase the participation of recovering substance-abusers. More significantly, this study represents an addition to the large body of research that supports the use of motivational interviewing with individuals who use alcohol (Carroll, Libby, Sheehan and Hyland, 2001).

Early research indicated that exposure to motivational interviewing helped to minimize HIV risk in substance abusers (Baker and Dixon, 1991). A more recent randomized clinical trial evaluated an HIV-risk reduction intervention based on the use of motivational interviewing and other behavioral models. The data gleaned after the intervention and during follow-ups suggested a strengthening of risk reduction intentions and knowledge among the participants in the program relative to a control group. Furthermore, participants whose risk reduction intentions were flawed increased their condom use and were more likely to refuse unprotected sex (Carey, Braaten, Maisto et al., 2000).

It should be noted that it is best that the counselor focus on the strengths of a client rather than his weaknesses when using motivational interviewing. When a counselor concentrates on a client's weaknesses, he is effectively contributing to the erecting of barriers that impede the client's use of personal power, thus violating the central tenet of the client-centered approach. Indeed, such an emphasis reinforces the inherently unequal nature of the counseling relationship and can lead to self-fulfilling prophecies (Cowger, 1994).

Motivational interviewing, client-centeredness, goal setting and the strengths perspective are all compatible with the Transtheoretical Model. Whereas the latter is aware of the potential stages a client may go through while in the process of changing, goal setting provides the client with an important tool for effecting personal change on her own, with the support of motivational interviewing. However, it is important to remember that the notion of client-centeredness serves as the core around which the entire model revolves. Accordingly, all of the above-described constructs must be implemented and integrated in such a way that the principle of client-centeredness is not compromised.

Further Reading for Counselors



Further Reading for Counselors



The following readings may be useful for health providers and counselors in search of additional technical information. Each reference has been selected because of its relation to adolescents and youth, counseling, sexuality, HIV/AIDS, health promotion, disease prevention, and development issues. The publications listed below are by no means exhaustive and are not necessarily endorsed by the authors or by the Pan American Health Organization/WHO. They are presented to give readers an idea of the materials available.

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