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The Experiences of Counselors Treating Individuals with HIV

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According to the World Health Organization, 36.7 million people are currently living with HIV worldwide. Due to the paucity of literature containing current experiences of counselors who have actively or are currently working with people living with HIV/AIDS (PLWHA), this paper explored the counselors' role and significance in HIV/AIDS mental health care services and prevention for treating PLWHA. The purpose of this phenomenological research study is to examine the life experiences of counselors who are actively working with clients who are living with HIV/AIDS. This resulted in the emergence of 6 major themes from the interviews: Soiled HIV Care, It's Just Not the Same Urgency, Therapy Part of the Day, Purely by Accident, In an Ideal World, and Value of Dignity. In addition, counselors in this study described the limitations, implications, and experiences of providing services to PLWHA.

Keywords: HIV, counselors, social justice, phenomenology

Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) are persistent problems worldwide. Worldwide, 36.7 million people are currently living with HIV, and there were 1.8 million new cases in 2016 (World Health Organization [WHO], 2017). At the end of 2016, an estimated 1,008,929 persons were living with HIV in the United States (U.S.) and six territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the U.S. Virgin Islands) (Centers for Disease Control and Prevention [CDC], 2019a). People living with HIV/AIDS (PLWHA) include groups who experience societal marginalization. For example, compared to other races and ethnicities, African Americans have the highest rate of HIV infections (CDC, 2019b). In addition, HIV/AIDS has been socially constructed to be viewed as deviant or associated with immoral behaviors, such as promiscuity and drug use (Corneille et al., 2015). The number of PLWHA has a direct impact on counselors because they address co-occurring disorders such as substance use disorders, anxiety, and depression (Joe, 2018). PLWHA experience significantly higher rates of co-occurring mental illness than the general population co-occurring mental illnesses (e.g., depression is two to five times higher among PLWHA) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016).

Mental Health Counseling, Advocacy, and HIV/AIDS

The American Counseling Association's (ACA) Code of Ethics (2014) emphasizes quality of life, mandating that the counseling profession practice and promote respect for human dignity and diversity. The ACA's code of ethics identifies professional core values within social and cultural contexts by promoting social justice and advocacy. In 2010, ACA delegates agreed on a unified definition of counseling for *the 20/20: A Vision for the Future of Counseling*. Social justice and advocacy are core components of the counseling profession. Counselors have a dual responsibility to their clients and to society

by providing prevention counseling to help reduce the risk of other diseases, as well as helping clients understand the risk of infecting their partners (Graham, 2018). Counselors must be able to assess the vulnerability of their clients engaging in high-risk sexual behaviors, turning to substance use, and levels of depression for adequate treatment (Eason et al., 2016).

Counselors are tasked with a unique challenge when working with PLWHA because the client may present mental health issues (Joe, 2018). HIV counseling offered for PLWHA has three distinct components: risk assessment, sample testing, prevention counseling, and referral with test results (Center for AIDS Prevention Studies, 2004). Yet, HIV counseling is not the same as professional counseling as defined by the ACA; it focuses on educating HIV/AIDS and preventing transmission of the disease, rather than empowering people and focusing on overall mental health. Positive therapeutic relationships and respect for human dignity are essential to counseling sessions and developing other positive relationships. Effective counseling requires a genuine relationship between client and counselor as the therapeutic relationship influences the client's quality of life (Eason et al., 2016). In addition, counselors' respect for human dignity and diversity may influence how they practice social justice and promote advocacy for their clients (ACA, 2014). Respect for human dignity requires counselors to be self-aware of their values, beliefs, and biases, allowing them to be attuned to the client's worldview and experiences.

Mental Health Barriers and Inequity

Unfortunately, PLWHA experience discrimination, which can create a barrier to PLWHA who are seeking mental health counseling. HIV-related stigma, negative attitudes, and maltreatment directed at PLWHA is a contributing factor to the global HIV epidemic (Logie et al., 2011). The stigma associated with HIV devalues and stereotypes PLWHA, which increases vulnerability resulting in a reduction of HIV prevention such as testing and treatment (Logie et al., 2011). The systemic racial bias that exists for PLWHA creates a culture that often pressures healthcare professionals into accepting racial, minority, and HIV stereotypes (Kontomanolis et al., 2017). Clinician bias contributes to healthcare disparities by using stigmatized language used in medical records to describe patient's increases inequity among stigmatized populations (Goddu et al., 2018). An example of the systematic barriers and inequity for PLWAH include limited access to funding for healthcare and funding for HIV education. Although the budget for HIV funding has seemingly increased, funding has been stagnant in recent years because the number of PLWHA has also increased, which has increased expenditures on care and treatment (Rosenberg, 2017). In addition to the lack of funds for education on prevention and intervention medication for HIV, budget cuts also have affected federal government assistance programs. Limited funding is a systemic barrier for PLWHA obtaining assistance with basic needs such as housing, transportation, and medication. PLWHA are deserving of a more equitable, affordable, and unbiased form of care, including mental health counseling.

Counselors know that the stigma and discrimination PLWHA experience can affect the counselor-client relationship and overall health of a PLWHA. Social stigma leads to PLWHA being less likely to adhere to treatment, which can influence the client's medical and mental health (Joe & Foster, 2017). Thus, the counselor's attitude toward the person with HIV/AIDS is crucial to effective treatment of the disease and mental health services (Eason et al., 2016). Counselors have the responsibility to acknowledge their own biases toward PLWHA that may negatively influence their service provision and obtain proper training and education regarding HIV/AIDS accordingly (Lewis et al., 2007).

Historically, studies continuously emphasized the need for and counselors' interest in continued HIV/AIDS training and education to effectively serve PLWHA (Zeligman & Joe, 2020, Burke & Fair, 2003; House et al., 1995; Hunt, 1996; Kukafka et al., 2009; Shelton et al., 2006). For example, a study conducted by Joe and colleagues (2018) surveyed 111 master-level counselor trainees and examined their perceptions of factors related to comfort in serving clients living with HIV/AIDS. The findings indicated that counselors-in-training perceived that they were not sufficiently prepared to serve PLWHA. Counselor trainees' also thought that the stigma associated with HIV/AIDS could affect their therapeutic relationship with PLWHA, despite "the profession's high emphasis on uncondi-

tional positive regard" (p. 12). Another study conducted by Joe and Foster (2017) found students held biases toward PLWHA, and their attitudes toward HIV/AIDS were related to their level of moral development. Nevertheless, these students provided correct responses to 76% of the HIV/AIDS Knowledge Questionnaire despite these findings. Similarly, a study conducted by Rose and colleagues (2015) found that counselors had adequate knowledge of HIV/AIDS; however, it was unclear if the information was acquired through counseling programs or otherwise.

Thus, there is a difference between students' knowledge regarding HIV/AIDS and their attitudes toward the disease and client populations living with it. Further research identifying and assessing counseling students' attitudes and training to serve PLWHA in the current social context is essential to the mission and purpose of the counseling profession (Joe & Foster, 2017). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) 2016 Standards also supports the inclusion of material that increases the understanding of issues and trends in a multicultural and diverse society into the curricula. However, counselor training for the required knowledge and skills to work with PLWHA is limited and not typically provided by core courses in CACREP-Accredited graduate programs (Joe & Foster, 2017). Major societal issues, such as the experience of living with HIV/AIDS, require counselors to expand their training and improve their competency. Further research in this area is needed to uncover which factors contribute to the experience of counselors working with PLWHA.

There is a current lack of research regarding counselor's experiences working with PLWHA, HIV/AIDS progression to a chronic illness, and the role counseling professionals have in prevention efforts and social justice advocacy for PLWHA. A knowledge gap in the social justice practice of counselors working with PLWHA exists; therefore, the findings allow a deeper understanding of how counselors treat clients with HIV/AIDS. Further, the Multicultural Social Justice Counseling Competencies (MSJCC) framework (Ratts et al., 2016) is an updated paradigm regarding advocacy and there has been limited literature about its effective implementation. The purpose of this study was to examine the lived experience of counselors working with PLWHA. Semi-structured interviews were conducted with licensed professionals working with PLWHA to provide insight into the phenomenon of the work it takes to provide adequate care to PLWHA. The research questions are

1) In what ways has self-awareness contributed to their understanding of their client's living with HIV worldview?
2) How has understanding the client's worldview influence advocacy interventions?

Method

Research Design

Phenomenology looks at thematic data to extract participants' meaning and places emphasis on peoples' lived experiences (Miles et al., 2014). The rationale for using phenomenology is to determine the meaning of counselors' lived experiences and use their perceived experience to comprehensively describe their experience working with PLWHA (Moustakas, 1994). Gaining counselors' meaning of their perceived experiences provided rich data for a comprehensive description (Moustakas, 1994). Using the phenomenological method, the MSJCC theoretical framework examined the counselor's multicultural and social justice competence seeking to understand counselor self-awareness, client's worldview, counseling relationship, and counseling and advocacy interventions (Ratts et al., 2016).

Participants and Procedure

A purposeful sampling criterion was utilized to identify specific sites and participants that helped the researcher understand the problem and the research question (Creswell, 2007). Before data collection, this study obtained approval from the University Institutional Review Board (IRB). Recruitment and screening were done via listservs for counselor educators and students. Participants were

individually contacted via email with a link to the demographic questionnaire through Qualtrics. To employ purposeful sampling, this study selected participants that met criteria by self-identifying as: (a) practicing licensed professional, (b) working experience with PLWHA, and (c) providing individual counseling. A total of thirteen participants were interviewed, one of these participants was excluded due to an inaudible recording. Of the twelve remaining participants, four identified as LPCs, four identified as LMFTs, and four identified as Licensed Clinical Social Workers (LCSW). The questionnaire captured each participant's demographic information, which included (a) ethnicity or racial identity, (b) professional identity, (c) number of years in practice, (d) experience working with clients living with HIV/AIDS, and (e) length of time working with clients living with HIV/AIDS (see Table 1).

Table 1

Participant Demograpics

Pseudonym	Participant Ethnicity	Participant's Client Ethnicity	Credentials	Years of Experience	State	Setting of Practice
Kim	Black/African American	Black/African American	PhD, LCPC	More than 10 years	IL	University
Todd	White	Black/African American	PhD, NCC, LPC, ACS	Less than 10 years	NY	HIV Mental Health Center
Crystal	White	Black/African American; Hispanic; Two or more races	MS, LCPC	Less than 5 years	IL	ASO- Non-profit AIDS Service Org
Alfred	Black/ African American	Unknown	LMFT	More than 10 years	FL	Non-profit HIV/AIDS Org
Stacy	Black/African American	Black/African American	LMFT, MS, CST	Less than 3 years	GA	Private Practice
Lisa	Black/African American	White; Black/African American; American Indian; Other	LMFT, MS	Less than 5	CA	AIDS Healthcare Foundation
Fatima	Black /African American	Black/African American; Hispanic	LMHC	More than 10 years	FL	Residential Therapeutic Community
Clay	White	Black/African American; Hispanic	MS, LCPC	More than 10 years	IA	Public Health Clinic
Kevin	Black/ African American	Black/African American	MSW/MPH	Less than 10 years	MD	Outpatient medical center
Courtney	Black/ African American	Black/African American	MSW, LSW	Less than 10 years	IL	Private Practice
Jax	White	Black/African American	MSW, LSW	Less than 2 years	IL	Supportive Housing Program
Morgan	White	White; Black/African American; Two or more races	LMSW	Less than 3 years	IA	Hospital HIV clinic

This study included semi-structured interviews that included specific open-ended questions designed to provide flexibility and a deeper understanding of the phenomenon (Patton, 2002). The MSJCC theoretical approach's four developmental domains framed the interview; questions were designed to understand the influence of oppression on the mental health and well-being of PLWHA. The interviews were conducted through Zoom for 20-45 minutes; participants shared transcripts to ensure their experiences were conveyed accurately and to ask clarifying questions about responses provided.

Data Analysis

The codebook was shared with a peer debriefer to eliminate bias and increase accuracy and trustworthiness; 115 original codes were found during the first cycle. Throughout this process, data found to be "irrelevant, repetitive, or overlapping" was eliminated (Patton, 2002). Feedback from the peer debriefer resulted in 35 codes after several cycles of data reduction. The codes led to six emergent themes, that were then clustered to develop textual descriptions. The final step was textual description, which is used to describe the phenomenon in an in-depth manner (Moustakas, 1994). Textual description begins with epoché, which is defined as being free of prejudgments and preconceptions (Moustakas, 1994). The participant's voice was maintained and the researchers used textual descriptions as a thread to demonstrate the occurring phenomenon and created themes using the participant's words. Trustworthiness was established using a combination of procedures in collecting and analyzing data. The audit trail created within this study was generated from journal entries, notes, and reflection on her role as the researcher and as an instrument. The reflective journal was maintained to record critical reflections about the research process, document participants' stated beliefs, and document the researcher's biases and thought process. The twelve interviews were multi-layered and intricate as they provided the participants' experiences as well as their clients' experiences living with HIV.

Results

This phenomenological study aimed to obtain a deeper understanding of the experience of counseling professionals working with PLWHA. The constructivist approach allowed for the participant's words to be used as emergent themes. Data analysis resulted in the emergence of six major themes from the interviews: Soiled HIV Care, It's Just Not the Same Urgency, Therapy Part of the Day, Purely by Accident, In an Ideal World, and Value of Dignity.

Theme 1: Soiled HIV Care

Counselors displayed MSJCC by being attuned to their values and beliefs, were sensitive to the worldviews and cultural experience of their clients, and acknowledged the influence power, privilege, and oppression had on shaping their counseling relationships with their clients. The MSJCC model recognizes the negative influence of oppression on the mental health and well-being of both the counselor/allied professional and client and how both are influenced by the context of their social environment. Lisa stressed that at her clinic "there's a huge gap in services available at that level. Not to mention a therapist of color." Courtney stated that a lack of funding "makes testing [for HIV] harder . . . it makes going to the doctor harder [and] when clinics shut down . . . people die." Alfred explained how political issues surfaced during sessions. Participants reported that there were not many accessible clinics or doctors, which further limited receiving adequate care. Kim stated, "a problem is that HIV care is so soiled." Jax's clients expressed anxiety regarding losing social benefits due to the government shutdown. Fatima stated, " . . . most of my clients were from the LGBTQ . . . community . . . [Trump's election] was . . . a major blow to my clients and I probably spent a lot of those sessions kind of just processing that with them."

In Solution-Focused Brief Therapy, the miracle question refers to a method of questioning that invites the responder to envision and describe in detail how the future will be different when the problem is no longer present. Participants were asked, "If you had a magic wand and could change the

healthcare system for PLWHA what would you change and why?" Jax said, "make medications easier to take [by providing] a different delivery system for my clients." Crystal wanted the healthcare system to be "simple, comprehensive and just equal across the board. Courtney expressed her desire to have "doctors knowing what they're talking about and medications [that] are not for profit." Fatima wanted healthcare providers to be " . . . more sensitive . . . and . . . a lot more available, accessible."

Theme 2: It's Just Not the Same Urgency

Most of the participants reported their client's experiences as their own experiences, thus supporting the MSJCC framework. Since the counselors were aware of their values, beliefs and biases, it allowed them to be attuned to the client's worldview and experiences. Participants separated their clients by "older generation" as "long-term survivors" and the "younger generation" as "newly diagnosed." The long-term survivors (early 1980's to late 1990's epidemic) have had to contend with the dual impact of government policy and HIV medical advancements.

Todd articulated the experiences of long-term survivors as, " . . . the trauma [they are] dealing with . . . generated the belief that they would not live longer than a few months and . . . that kind of internalization of the trauma that was then translated as 'I'm going to die at any minute.'" As one of Todd's clients put it, "[he is] always waiting for the axe to fall." Many of the symptoms associated with taking highly active antiretroviral therapy (HAART) long-term or of aging with HIV/AIDS have not been. Alfred emphasized the "lack of urgency," regarding the "seriousness of the issue itself." In fact, Alfred stated that younger clients characterized HIV/AIDS as something "you just pop a few pills [for] and [you'll] be all right." According to Lisa's experience, "They're [younger generation are] less likely to use protection and things like that. And so, they're . . . constantly in and out of the clinic." Lisa further said, "Unfortunately, I think [there is] less . . . discrimination as far as the younger generation is concerned because they're accepting of one another." Lisa's statement suggests that the experience of discrimination is different for the two generations because the gains in civil rights for the LGBTQ community has created a pathway for greater acceptance of those newly diagnosed, whereas in the LGBTQ survivors were subject to prejudice.

Todd advocated, "We were just beginning to see that there are some pretty negative [side effects] . . . [to being] on antiretroviral [medication] for that period of time [since 1996] . . . is leaking into mental health." Presumably, the positive effects of current medication encourage those who are newly diagnosed to continue sexually risky behaviors. Courtney said, "I can't work with this person . . . . I'm not specialized in HIV . . . and that's not how it works." An ethical, MSJCC counselor may naturally be self-aware of their limited knowledge, however, professional development would increase their ability to work with PLWHA. Due to Jax's knowledge of Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), he helped a client, who used to struggle to adhere to his recommended medication schedule, to maintain his adherence. Alfred discussed his colleagues' (who do not work with PLWHA) lack of knowledge about the available medications, saying, "they didn't even know that PreP and Truvada existed."

Theme 3: Therapy Part of the Day

Wearing Many Hats

Morgan shared her experience working in an HIV clinic, having to meet with several clients within a day, and the majority of her work was "[finding] some local resources for [where] patients tend to live [if it's], you know, too far . . . " Nine out of the twelve participants reported that they had previously worked or were currently working at an agency. Fatima shared, "it was a lot of running around . . . some days I would be split between the two facilities . . . " She described this experience as "a lot of juggling multiple hats at the same time or running from task to task. So, [it's] very busy." Kevin conducted "referrals, follow ups and linkage to care." Additionally, Kevin reported he had to consciously ensure that he allocated time to "see several clients and provide mental health therapy . . . 100% of my caseloads are wrap-around services for clients who are HIV-positive." Three participants mentioned

'wrap-around' services, which meant they were connecting their clients to resources for housing, finding funding to cover the cost of medications, and facilitating their access to healthcare providers who had experience working with PLWHA. Crystal said, "Some of my clients have been to therapy before, but many of them come to therapy because of the wrap-around services." Todd explained, " . . . we were really good at helping with coordination of care . . . the collegiality that I found in the HIV community was really important to the clinical work that I was able to accomplish."

Never Losing Sight of Meeting Clients Where They're At

Participants discussed their therapeutic interventions, their constant dealing with their clients' trauma, and how they recovered from fighting for and with their clients against social injustice. Participants' theoretical orientations ranged from general humanistic approaches to specific techniques designed to help clients unpack and process trauma. Crystal described her approach to working with her clients by adapting a non-judgmental stance and by practicing radical acceptance. Crystal stated, "for the most part, unless they're newly diagnosed with HIV, usually it's not the presenting problem [primary concern] . . . I think that says something about how far we've come for people living with this illness . . . people are just so stable with the illness." The presenting problems for PLWHA are usually not centered around their HIV status but on other social and emotional issues. Clay's advice was to "Never lose sight of meeting clients where they're at . . . " Other mental health issues such as depression, schizophrenia and borderline personality disorder-common mental health concerns for PLWHA. Lisa's explained that a applying a specific therapeutic approach can be difficult when a client requires more time. Clay believed the most effective technique for this population was " . . . to be trauma informed . . . there's such a high level of trauma and shame and stigma."

Layers of Past Experience's and Trauma

Most participants mentioned the trauma PLWHA experienced after receiving a positive diagnosis or how a diagnosis could trigger existing trauma. Crystal stated, "While the HIV diagnosis might not be traumatic by itself, in my experience, the diagnosis almost always triggers existing trauma, usually from childhood, that has not been dealt with yet . . . " Crystal mentioned how in some cases clients experienced trauma " . . . because of their HIV infection and once the shock of that wears off a lot of those 'old wounds' from the past [surface]" Clay stated, "HIV and AIDS was almost kind of a tip of the iceberg and . . . many people were not dealing with the deeper layers [of the] problem." Clay explained " . . . getting them [the clients] on meds [was] the problem [because] many of them would drop out of care." Trauma potentially disrupts medication management as "[clients] would not be compliant with the care because . . . people were not dealing with the underlying, deeper layers that led to why they were not engaging [in safer sex], not retaining care and not taking their medication . . . " Clay confirmed that, " . . . 85 to 90% of all of the clients [he has] all have some degree of trauma. [He performs] an Adverse Childhood Events (ACE) . . . screening for everybody." The ACE assessment tool has 10 questions about emotional neglect, physical abuse, witnessing the abuse of parents, parental divorce and their feelings of insignificance. A higher ACE score indicates the respondents' risk of poverty, substance abuse, and mental and physical health issues. According to Todd, " . . . those identified traumas were sexual assault . . . or some other form of abuse . . . interpersonal violence . . . and . . . with a small minority of people really being able to identify HIV . . . as the foundational trauma."

For Me, Coping Helps

Wearing multiple hats and offering a range of services can lead to exhaustion or even compassion fatigue. Stacy learned to cope with hearing about clients' positive diagnoses, "coping helps or a form of coping for me is doing research so that I am very knowledgeable on the subject . . . where I can give them hope." Clay stressed the need for self-care, "I run the risk of potentially having my gas tank getting empty and at the end of the day, I am no good to nobody." Morgan stated, " . . . kind of being able to leave that [client stories] here and not take it home with me because it does weigh very heavy on you." Alfred shared, "I didn't realize how much you had, how much it [client stories] had affected me until I left the field [HIV clinical setting]." Lisa created working relationships because it was her way of maintaining her emotional and mental wellbeing. She said, "Supervision is imperative. It is so important. And being able to talk to colleagues there within the clinic . . . " Unfortunately, not all clinical en-

vironments are conducive to supervision as a method of self-care. For a new counselor or practicum/ internship student, having this type of patient would naturally cause stress which may be reduced with supervision.

Theme 4: Purely by Accident

The theme *Purely by Accident* aligns with self-awareness with the MSJCC because a self- aware counselor is cognizant of their strengths and limitations but are willing to do professional development, self-reflection, and reading. This theme focuses on the intentions and motivations of the participants, how they began working with the population, and their preparation and training to work with PLWHA. Clay believed PLWHA were a marginalized population that had been continually mistreated by providers. Morgan shared,

> "... it really inspired me because ... the men who have sex with men community really ... that's a large part of the clients they see.... I do have friends and family who identify with that community and so, it just kind of like personal reasons as well as ... I like to fight against the stigma, and I like to educate people."

No one thing or person in particular influenced Stacy to "work, particularly with that population. I think they're just like a lot of the other clients [who] call [and] need services. They need help and I'm not opposed to helping them." Alfred admitted working with PLWHA was "purely by accident" despite the experiences of his mother and brother in social service. He stated, "I never thought I would do that kind of work." Similar to Alfred, Lisa, and Crystal, had prior work experience unrelated to working with PLWHA. Lisa stated, "It was not intentional on my part to be perfectly honest." Graduate courses for social work, counseling, and marriage and family therapy usually require students to get experience by in practicum or internship. Fatima shared, "I never intended to work with that population ... but once I graduated, an opening [for] a therapist [became available at] that organization and I decided to just go with it ... probably one of the best decisions I ever made." Morgan said, "My MSW program really encouraged ... different internships ... We also had a yearlong program to integrated care. And so, part of that was focusing on health care and chronic illnesses." Tom reported, "I kept recognizing that there was this untapped need for trauma work in that population." Crystal stated, "I want to say we did ... it was in ethics, maybe. I remember us talking about [it] ... if we have a client who ... has HIV and is not using protection, like, do we have a duty to warn type of thing." Alfred suggested, "What they should've had, in addition to bringing that person in ... [were] doctors and HIV social workers and other clinicians come in and speak to ... what is going on with HIV-positive people." Courtney's program discussed how the presentation of the information seemed demeaning to people of color. Kim said, "in just the real world of working with people [whose needs] intersect with various government agencies and access to resources ... and being able to help them." Lisa confirmed, "So the little bit that they did give me [training on HIV] ... at least I was somewhat aware, but I don't think I've got enough to help prepare me." Clay stated, "what I often have said to staff that I've trained, [is to] give clients a safe place to be, meet them where they're at and advocate for them as they need to be advocated for."

Theme 5: In an Ideal World

Participants were asked two miracle questions, "In a perfect world, besides the cure for HIV/AIDS, what would you give your clients to help with their overall quality of life?" and "If you had a magic wand and could change the healthcare system for PLWHA, what would you change and why?" Participants wanted to give them the things they typically couldn't but should have been able to in a system where they had the power and resources to do so.

Maslow's Hierarchy

Each participant discussed how the basic needs of their clients were not being met. Those basic needs were similar to those discussed in Maslow's Hierarchy of Needs Theory, including survival (safety,

shelter and food), love/belonging, and self-esteem. Clay stated, " . . . if they don't have a roof over their head, if they don't have food, if their basic Maslow's hierarchy needs aren't being met . . . the priority is not going to be taking their meds and keeping appointments." Morgan stated, "Because we have such a good program to support funding for HIV . . . we can cover their medications, but some people can't afford insurance, some people can't afford their medications, so people can't afford housing and housing is healthcare . . . " Clay said, " . . . what we try to do is meet the clients where they're at, trying to address barriers . . . Do they have a place to sleep? Do they have insurance? Do they have food? And there's more . . . it could be other factors." Participants were challenged to address the social and political barriers limiting access to care while making sure the clients were virally suppressed. Kevin reported that a lot of his clients were " . . . very low income", so they had difficulty "finding long term housing [and] keeping housing because of the mental health component and staying medically adherent . . . " Todd and his agency, " . . . spent a lot of time just making sure that we had enough stable housing for the clients . . . that wasn't always possible. So, homelessness and the potential for homelessness was an ongoing issue for most of the clients." Morgan explained, "One of the qualifiers for the program is being homeless or at risk of homelessness . . . Because of homelessness that also means that . . . they're not going to be . . . consistent with meds." Even when the basic needs *were* being met, they still encountered obstacles to fulfilling the sense of being loved and of belonging. Those who identify as LGBTQ or have positive HIV status have generally been ostracized by friends and family. Social support has been, and remains, a vital component for a better quality of life of PLWHA. Jax stated, "People who are isolated die many years sooner than people that have social support systems." Similarly, Todd said, "older men in the African American community still wanted to be a part of a church community, a part of a faith community . . . and felt stigmatized by the faith community that they grew up in."

Todd identified that "HIV stigma is very high when you're an older gay man with HIV or AIDS diagnosis. It makes it even more difficult because most people want to have safe sex . . . even just having sexual relationships becomes much more difficult." Lisa shared, " . . . that's what most of my clients miss . . . the connection to family." Clay stated, "help them to be their authentic selves . . . An ideal world or a perfect world [would be to] give clients opportunities and access to the basic food, shelter, insurance, housing, dignity . . . " Morgan shared, "The ability for them to . . . [remove] that shame that comes with the label of being HIV-positive . . . probably be the top thing . . . to overcome shame was to heal from that shame or to overcome stigma."

Be an Aggressive Advocate

Clay described a time when he was aggressively advocating for clients to have better access to the local mental health clinic. When noticing the flawed system of the clinic, he took the initiative to design and create better avenues for clients to access mental health services, "I've always seen myself as an advocate." Jax explained, "I don't usually go out and protest, but talking with people about HIV . . . I do try to participate . . . in anything that kind of raises further awareness like this or other [studies]."

Really One of the Most difficult Things to Do

The different ways participants work with their clients are all forms of empowerment for the clients. Todd stated, "To me, the empowerment of clients is . . . a resolution of trauma. That's why I became a traumatologist." Alfred explained, "I encourage everyone to advocate for themselves . . . help people become an empowered consumer and to remember that . . . " In these ways, empowerment equated to small seeds planted during sessions that had the potential to develop into a movement that could change clients' worlds. For PLWHA empowerment begins by reducing stigma and normalizing HIV for clients.

Theme 6: "Value of Dignity"

Larger Categories of Identity

There are many layers to identity which includes, race, ethnicity, sexual identity, gender preference, age, and socioeconomic status. Each additional marginalized identity compounded the clients' experiences of discrimination and stigma. Participants were required not only be cognizant of these different identities, but also respond to them and their associated needs. Kim explained many she worked with, "had relationship issues and family discord and difficulties with housing or finding a job . . . those same issues that everybody else has." Fatima said, "most of . . . [my] clients that I would see had a lot of co-occurring issues, but specifically with HIV, there was a lot of distress because of stigma . . . ." Kevin mentioned, "I deal with clients that are HIV-positive and suffer from mental health . . . borderline personality disorder, bipolar I and II schizophrenia, schizoaffective PTSD, major depression, a situational depression . . . multiple axis one and axis two mental health issues."

Stigma

PLWHA frequently experience discrimination because of the stigma associated. Clay shared, "I don't think I realized the profound level of stigma [and] shame that was out there in terms of the view of HIV . . . we have so much work to do with primary care." Lisa explained, "A lot of patients, would go to the Beverly Hills clinic because they don't want to be seen in another clinic in their community . . . " Clay talked about perpetuation of stigma within the political structure towards LGBT and PLWHA. He stated, "we have a political structure, that isn't necessarily always culturally sensitive . . . " Further he said, "Reducing stigma, reducing shame, reducing bias, universal health care for everybody . . . dignity and respect for all clients and . . . cultural sensitivity." While HIV is an invisible chronic illness, PLWHA choose to disclose their status to family, friends, loved ones and healthcare providers. Unfortunately, HIV disclosure still evokes negative reactions from the people they hoped they were safe with.

The way my Mother/Father Raised me

Lisa and Clay talked about their values and backgrounds and how these influenced their current practices. Lisa said, "The way that my mother raised me . . . we weren't allowed to call people names and . . . we treated them [people] with respect and vice versa. That's what mattered." Clay stated, "I remember as a young child, my dad's focus [was] fighting for the underdog. I think all clients need to be treated with dignity."

People are People

Jax made a profound statement noting the difference between *understanding* someone's experience living with HIV and *knowing* what it is like to experience HIV. Jax said, "I can't know what it's like to be an undocumented woman in her fifties with several chronic health conditions and no access to income [and] who's HIV-positive . . . but her whole kind of history and everyone's history is so complex." Lisa shared, "I already knew two people . . . that were . . . close to me that passed away from HIV . . . ." Kim said "I bring a personal history to wanting to care for, to be engaged with and help those who are HIV-positive. I had my own need to do that." Todd further explained his personal experience with HIV and stated, "I lost friends . . . it was a very, very frightening time to be a gay man . . . So, that very much informs the way that I approached it . . . as a clinician." Crystal disclosed her HIV status at the beginning of the interview and with the help of medication she had been able to lead a normal life.

Discussion

Theme 1: Soiled HIV Care

Each participant shared experiences that echoed common threads about healthcare, social justice, and adequate care for PLWHA. While the research question for this study sought to understand the lived experiences of counselors working with PLWHA, it was impossible to ignore the participants' secondary descriptions of their clients' issues and experiences with healthcare. This theme discussed the systematic forms of oppression such as the limited access to funding for healthcare for PLWHA, limited funding for HIV education, and the stagnant funding in recent years. The budget for HIV funding has seemingly increased; however, this is because the number of PLWHA has also increased, which resulted in an increase of expenditures on care and treatment through mandatory programs such as Medicare and Medicaid (Rosenberg, 2017). However, closer analysis of the U.S. budget for HIV shows that funding for HIV has remained stagnant since 2010 after accounting for inflation (Rosenberg, 2017).

Budget cuts also have affected federal government assistance programs like Ryan White. Limited funding has impeded the degree to which PLWHAs can access basic needs such as housing, transportation and medication. Receiving adequate care or access to medications like Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP). Marginalized populations, such as those who identifying as LGBTQ and living with HIV, have become fearful about the increasingly hostile political and social climate. Participants shared their clients' concerns about Trump and safety as an HIV-positive LGBTQ person. Responses illustrated their lack of faith in governmental and societal systems.

Theme 2: It's Just Not the Same Urgency

With proper treatment and medication management, HIV is no longer a death sentence. HIV impacts marginalized groups disproportionately, resulting in an increased risk of discrimination for both having HIV and for being a part of a marginalized group. HIV-related literature within the counseling, social work, and marriage and family therapy has focused on the medical advancements in treatment for HIV over time (Joe et al., 2019). However, participants shared a thought-provoking perspective of how the changes with HIV/AIDS over time has caused generational differences. For the long-term survivors, aging with HIV had more complications and concerns than younger generations. Researchers have suggested older PLWHA are likely to experience more mental health and psychological problems than younger PLWHA (Li et al., 2014). Aging with HIV is difficult for older PLWHA because non-AIDS conditions such as cardiovascular disease, lung disease and cancer increase with age (Li et al., 2014) impacting their quality of life and well-being. The older generation may not consider themselves to be at risk of HIV infection or mistake HIV symptoms as normal aging (CDC, 2018). Another common issue for both younger and older generations is the lack of condom use. Consequently, they are at risk of other sexually transmitted diseases (STDs). Older people are less likely than younger people to discuss their sexual activity and drug use with their doctors (CDC, 2018). Furthermore, doctors are less likely to ask their older patients about their sexual activity and drug use (CDC, 2018). It is important to understand the subtle differences between older and younger generations and the seriousness associated with a positive HIV status. These survivors have experienced systematic difficulties such as the fear of losing healthcare benefits and funding resources that aid unemployment, housing, food stamps and transportation.

Theme 3: Therapy Part of the Day

The theme "Therapy Part of the Day" was given its title because a participant shared that after doing case management, she would then go on to the therapy part of the day. Counselors displayed actions associated with multicultural justice, discussing their desires to create a world that is safe, welcoming and culturally affirming for PLWHA. One participant shared her role as a mental health provider for PLWHA and described it as "wearing many hats." Despite the exclusion criteria for this study of

participants having limited case management hours, 58% reported spending over 50 hours on case management. To provide the wrap-around services their clients needed, the participants had roles. A few reported the need to never lose sight of meeting the client where they were at. For one participant, it meant being non-judgmental, for another, it meant psychoeducation. PLWHA are 20 times more likely to have experienced trauma (SAMHSA, 2016). The diagnosis sometimes triggers other deeply rooted traumatic experiences from the past which are worsened by stigma, discrimination and biased experiences in health care settings. Trauma can also negatively influence medication adherence after a person is newly diagnosed as HIV positive. Shame, guilt and underlying traumas can cause a newly diagnosed to leave care and not adhere to medication regimens. The risk of experiencing burnout is very high within the mental health field, especially working with marginalized populations.

Theme 4: Purely by Accident

The theme "Purely by Accident" aligns with self-awareness within the MSJCC because self-aware counselors are cognizant of their strengths and limitations but are willing to undertake professional development, self-reflection, and reading. Counselors' intentions of working with PLWHA was assumed to have been the motivation to educate themselves, however, findings suggested intentionality did not influence their desire to learn more about PLWHA. Some participants discussed how their experience gave them the courage to bring awareness to HIV by educating their communities. All participants reported having little to no HIV education in their program. Most of the participant's reported learning about HIV at practicum and internship sites. Participants who identified as LMFT or had a masters in marriage and family therapy, reported taking a course in human sexuality that only minimally discussed HIV. It is a gatekeeping responsibility to ensure students are multicultural and social justice competent about various populations. Findings indicated counselors were cognizant of their strengths and limitations working with PLWHA. The intrinsic factors to develop self-awareness requires professional development, self-reflection, reading and immersion within communities. This knowledge helped participants become attuned to their clients' worldviews and compelled them to be empathetic of their clients' experiences. Counselors' attunement was so profoundly established that they identified their feelings and thoughts about their clients' experiences as their own.

Theme 5: In an Ideal World

This theme aligned seamlessly with MSJCC because it showed what counselors are capable of when they operationalize within all quadrants of the MSJCC. The role of counselors is to be social justice advocates at both the individual and systemic levels. The historical role of counselors working with PLWHA focused on crisis and grief counseling (Zeligman & Barden, 2015). However, counselors' duties and responsibilities included more than counseling, yet, these individuals were committed to protect and serve PLWHA. Several participants reported their client's basic needs were not being met. The fundamental goal for counselors working with PLWHA is to keep their clients' viral load low and to prevent the spread of HIV. Participants shared their clients' difficulties with discrimination that led their clients to not trust the healthcare system. Participants reported that "one of the most difficult things to do," was to help clients find those basic needs of belongingness and safety from other people within their communities. Another difficulty was empowering someone to advocate for themselves. Participants were given the opportunity to imagine an ideal world for their clients, said they would have liked to normalize HIV.

Theme 6: Value of Dignity

The commitment to expand multicultural competence requires counselors to use a wide-lens approach to acknowledge the multiple intersecting identities and to understand the complexities of the health experiences (Ratts et al., 2016) of PLWHA. Learning about the participants' experiences working with PLWHA was impossible without also understanding their clients' experiences living with HIV/AIDS. Most of participants reported their clients' experiences as their own experiences, thus

supporting the MSJCC framework. Participants were knowledgeable of relevant research and data about HIV and the dynamics of stigma, discrimination, power, privilege, and oppression among marginalized and privileged clients.

Participants acknowledged the multiple intersecting identities of their clients and the complexities of health experiences for PLWHA. Stories of facing oppression fueled the participants desire 'to live in a perfect world without stigma.' Furthermore, participants interview responses in this study confirmed the mission statement within the ACA's Code of Ethics (2014) stating counselors should practice and promote respect for human dignity. Regrettably, HIV/AIDS has been socially constructed to be viewed as deviant or associated with immoral behaviors such as promiscuity and drug use (Corneille et al., 2015). In turn, PLWHA internalizes this shame and guilt. Participant's respect for his client's human dignity led him to action, he provided his client with proper burial services. In addition, PLWHA's marginalized status is coupled with negative stereotypes associated with the disease. The racial tension in the U.S. has increased the likelihood of discrimination for marginalized groups. This is alarming for PLWHA because they are three to four times more at risk of discrimination, violence, poverty and limited access to mental health care than the majority (Chang et al., 2009).

Clinical Implications

Participants have given voice to PLWHA by sharing their clients' experiences and highlighting their clients' experiences with discrimination and stigma. The stories shared incorporate multiculturalism and social justice into their counseling practice. Research suggests counselors who have specific knowledge in HIV are more willing and able to treat people experiencing the full range of issues related to the disease (Britton et al., 1999). For example, one participant shared his clients' experience of taking several medications that he did not have to take, simply because he was unaware of a new single pill-a-day option. Jax's knowledge about PreP was advantageous because it made his client's medication regimen simple, thus increasing adherence. More dialogue about PEP and PrEP is essential for all mental health professionals because they can share this information with their at-risk and PLWHA.

Furthermore, both counselors in training and practice are encouraged to become members of the American Counseling Association (ACA) and join the subdivisions related to social justice and advocacy. Within the ACA, there are 18 divisions aimed to enhance the professional identity of counselors and provide materials for counselors to strengthen their knowledge and skills to work with diverse needs of the counseling community. For example, the Counselors for Social Justice (CSJ) branch is a community of counselors, counselor educators, graduate students, and community leaders working towards equity and to end oppression and injustice affecting the community. PLWH needs advocates in the counseling profession and becoming a CSJ, and ACA members support the profession and increase awareness of health disparities experienced by PLWHA.

Counselor Education and Supervision

Results suggest counselors working with PLWHA received little to no training on how to work with PWHA and received most of their education at their place of employment or through self-study or professional development. Counselors would benefit from access to the experiences of counseling professionals working with PLWHA to better prepare counseling students (Britton et al., 1999). Accrediting bodies such as CACREP (2016) support the inclusion of material into the curricula, increasing the understanding of issues and trends in a multicultural and diverse society. Complex issues surrounding HIV/AIDS can be infused within the curriculum for various courses. The experiences of counselors working with PLWHA can be valuable in practicum and internships where students engage in new role-taking experiences that create the cognitive dissonance necessary for personal and professional development. For instance, implementing HIV education within case conceptualizations or role play activities would increase awareness of the multi-dimensional issues a client may present with.

Multicultural and Social Justice Competencies (MSJCC) Conceptual Framework

The MSJCC model recognizes the negative influence of oppression on the mental health and well-being of both counselors and client and how the context of their social environment influences them. MSJCC endorses social justice advocacy into various counseling modalities. Participants were attuned to their values and beliefs, were sensitive to the worldviews and cultural experience, and acknowledged the influence power, privilege, and oppression had on shaping their relationships with their clients. Themes one, Soiled HIV Care, and five, Be an Aggressive Advocate, fit into the counselor advocacy intervention domain of the MSJCC because they both address the systemic oppressions PLWHA face and provide ways in which participants advocated for their clients. The findings suggest the counselors applied their skills, and MSJCC by sharing their interpretations of how the clients' worldviews and experiences shaped their counselor-client relationships. MSJCC begins with counselor' self-awareness (Ratts et al., 2016); thus, results aligned with the developmental domain. PLWHA who experience stigma and discrimination are deserving of a more equitable and unbiased form of care. Supporting social justice and advocacy, "counseling professionals take on the active role as advocates, educators, researchers and policymakers for individuals with HIV/AIDS" (Lewis et al., 2007, p. 54). Although HIV treatments have changed drastically, the stigma has not. Further, culturally appropriate interventions and techniques are required when working with racially minoritized as well as underserved populations (Tadros et al., 2021; Tadros & Owens, 2020).

Limitations and Future Research

The results illuminate the experiences of counseling professionals working with PLWHA. While the qualitative research design was appropriate for this study, qualitative tools, such as interviews are not generalizable. A pronounced limitation is the concept of socially desirable responses. Counselor responses may appear to be empathetic and kind because to voice otherwise would make them appear prejudiced and not look good. In addition, a recent case study utilized structural family therapy and medical family therapy to treat a daughter and her incarcerated mother living with HIV (Tadros & Finney, 2019), more research studying the usage of systemic therapies with PLWHA is warranted. Further, other articles have called for research to be done with incarcerated populations utilizing MSJCC (Carrola & Brown, 2018), since incarceration has been associated with higher rates of HIV, we suggest exploring the intersection of using MSJCC, systemic therapies, incarceration, and PLWHA.

In addition, studies about the experiences of older PLWHA are needed within the counseling literature. For example, a study could examine the differences and similarities between older and younger PLWHA and their experience living with HIV. A qualitative study could explore the experiences of each generation through two focus groups to better understand their individual stories. Similar to a study conducted by Li et al. (2014), the quantitative study could measure each generations' levels of depression, well-being and quality of life. In addition, further research can examine trauma and the use of Adverse Childhood Experience (ACE) questionnaire for PLWHA. This type of study may justify screening for these issues and activating interventions when individuals have overly adverse responses to their positive diagnoses.

A study may ask questions about how counselors reacted in their experiences working with PLWHA. While the counselors provided profound experiences of their clients' oppression, the interview questions seemed to elicit responses that elaborated more on their experiences than the counselors'. Perhaps journal entries or written prompts could prompt more of the counselors' thoughts and feelings about working with PLWHA. Additionally, future research should include a larger sample as well as other allied professionals. More literature is needed to understand the specific role counselors have in prevention, intervention and treatment efforts for PLWHA. Lastly, a study compares each mental health professional's program, for example, whether or not they had undertaken courses that addressed or had training in HIV/AIDS. This may provide commonalities and differences with each profession.

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