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Using Multicultural and Social Justice Counseling Competencies to Conceptualize and Treat People Living with HIV

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Although there are 50,000 cases of new HIV diagnoses each year in the U.S., people are living longer with HIV/AIDS (CDC, 2022). HIV is a manageable condition and with proper treatment and medication management. Marginalized groups are disproportionately affected by HIV/AIDS, which increases the risk of experiencing discrimination for both having HIV and being a part of a marginalized group. People living with HIV/ AIDS (PLWHA) experience discrimination because of the stigma associated which negatively impacts treatment and prevention efforts. There are still many biased and misinformed healthcare providers working with PLWHA; however, counseling professionals have the ethical duty to be social justice advocates. The ACA's Code of Ethics promotes social justice and advocacy with respect for human dignity and diversity. This paper explores the counseling professionals' role and significance in HIV/AIDS mental health care services and prevention, for treating PLWHA via a multicultural and social justice counseling lens.

Keywords: HIV, social justice, multicultural competencies, counseling

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Recent medical advances in treating human immunodeficiency virus (HIV) have contributed to becoming a chronic disease. Previously, an HIV infection appeared to be a death sentence; however, the future for people living with HIV/AIDS (PLWHA) is much brighter as people with HIV live longer (Frieden et al., 2015). While there is no known cure for HIV, individuals living with HIV can live longer with treatment and antiretroviral therapy (ART). A person living with HIV can stay healthy and have little to no risk of transmitting HIV to HIV-negative partners if they take medication. Unfortunately, the stigma and health disparities affecting PLWHA have not made many advancements. Medication, testing, and education for prevention and interventions are not easily accessible. Although HIV is an invisible chronic illness, other marginalized identities are not as easy to hide.

Over the past 30 years, the U.S. HIV epidemic predominantly impacted socially marginalized and disenfranchised communities (Horvath et al., 2010). Most of the people living with HIV are part of marginalized groups, such as low socioeconomic status, race, sexual orientation, and gender. Since people living with HIV are part of a marginalized group, access to medication and adhering to medical protocols can be limited due to factors such as being able to afford the medication or having transportation to access treatment. Professional counseling professionals must understand how these barriers affect clients living with HIV/AIDS. Further, counseling professionals need to be aware of how these barriers, including access, can impact the quality of care they give to PLWHA. There is an array of different prevention and treatment models for PLWHA and most treatment offered is based on ac-

cessibility. Stigma, discrimination, and barriers to adequate health care are constant concerns for PLWHA. Receiving and adhering to medication and treatment management may also be a form of health care discrimination. The stressors that contribute to health care discrimination include difficulties obtaining access to necessary services, such as adequate health care, transportation to the local clinic (especially those in rural communities), or medication management. Additional barriers include homelessness, the use of drugs, and a lack of knowledge about how to find a doctor, depression, and other mental health issues (Dombrowski et al., 2015).

PLWHA are 20 times more likely to have experienced various forms of trauma, such as physical, mental, and emotional (Whetten et al., 2006). In addition to social difficulties, biological and behavioral factors contribute to the HIV epidemic resulting in constraints, access to care, and psychosocial influences (Pellowski et al., 2013). Bridging the gap between medical and psychotherapy models will provide accurate and valuable client care to those living with HIV. PLWHA deserve access to quality counseling that is free from stigma and discrimination. By understanding what contributes to the counseling relationship, counselors and counselors in training will be better equipped to understand the changes needed to provide best practices and adequate care for PLWHA. In addition, a social justice perspective encourages counseling professionals to develop a more balanced perspective between individuals and their clients. This article will discuss HIV/AIDS in counseling literature, the professional roles of counselors in HIV prevention, and describe ways to implement social justice in counseling.

Counseling Literature on HIV/AIDS

HIV/AIDS research has been limited in the counseling literature within the past few decades. Research on HIV/AIDS in counseling literature was highest during the 1980s and 1990s (Joe, 2018). However, there is a lack of current studies focusing on the counseling of PLWHA in the counseling literature in the ensuing 30 years. Specifically, there is a lack of literature concerning HIV/AIDS in the US on advocacy and social justice for PLWHA, or evidence-based practice while working with PLWHA. In the ACA's *Journal of Counseling and Development*, 58 articles about HIV/AIDS have been published to date; however, only six have addressed counseling professionals' training or attitudes toward HIV/AIDS and PLWHA (Joe & Foster, 2017). Most of the articles were published prior to 2000 and the more recent articles include HIV/AIDS as one of several topics, including attitudes toward lesbian, gay, bisexual, transgender, and queer (LGBTQ+) clients.

There is a need to explicitly acknowledge the role of mental health counseling professionals who work with people living with HIV/AIDS (PLWHA). Several past and current studies focus on the training, knowledge, skills, and attitudes of counseling professionals -in-training regarding HIV/AIDS (Kukafka et al., 2009). A study with 62 approved Council for Accreditation of Counseling and Related Programs (CAREP) and found about one-half of counselor education programs that responded to the study offered no training in even basic information about HIV/AIDS (Hunt, 1996). The study reported approximately a quarter of the programs offered a course on HIV/AIDS or at least a large section of a curriculum focused on HIV/AIDS issues.

An estimated 70% of mental health counseling professionals were serving clients with HIV and only 40% of those counseling professionals reported having training about HIV/AIDS in their graduate programs (Ullery & Carmey, 2000). Unfortunately, CACREP-accredited programs may not have infused HIV/AIDS training into their courses because recent studies have found counseling professionals who have adequate knowledge of HIV/AIDS also report not receiving training in this area through their counseling programs (Rose et al., 2015). Preparation for HIV/AIDS is limited in most graduate training programs and not the norm for the CACREP-accredited counseling programs (Joe & Foster, 2017).

Another study that focuses on counseling professionals -in-training surveyed 111 masters-level counseling trainees in counseling programs across the U.S. in conjunction with factors they believed would affect a counselor's comfort serving clients living with HIV/AIDS (Joe et al., 2019). Several themes emerged and were conceptualized using Bronfenbrenner's ecological model of development to

contextualize the findings and their implications. Knowledge and fear were prominent themes, which indicated the counselor trainee's concerns about their preparation levels and personal beliefs affecting the therapeutic relationship.

Contrastingly, a study focused on counselor trainees as well as counseling practitioners examined the relationship of a vocational rehabilitation counselor's years of experience as a rehabilitation counselor with their previous training, age, sex, and experience in working with PLWHA (Glenn et al., 1998). Results indicated that training and experience have a positive influence on the rehabilitation counseling professionals' perception of knowledge and skills regarding clients who are living with HIV, although years of experience was not significantly correlated with perception, knowledge, or self-reported skill levels (Glenn et al., 1998). Knowledge, skill, and perception were important factors to consider when examining counseling professionals working with clients living with HIV/AIDS. However, the studies only surveyed counseling psychologists, counseling psychologists-in-training (doctoral students), and vocational rehabilitation counseling professionals. This provides another example of the lack of research of mental health professionals' experience, knowledge, skill, and perception of HIV/AIDS.

Education and training varied widely among the counseling staff in one study (Kukafka et al., 2009). Therefore, the clinical providers were those without professional counseling credentials and as a result, the study does not include professional counseling professionals exclusively. The study included 19 HIV/AIDS clinic counseling professionals who provided 20 or more hours per week of psychosocial support to PLWHA. The purpose of the decision-support tool was to improve the clinical provider's knowledge, reduce practice error, and assist clinical providers when working with PLWHA (Kukafka et al., 2009). Evidently, the literature about the need for increased training on HIV/AIDS for counseling professionals -in-training, clinical counseling professionals, and psychologists has been studied. However, there are no studies examining mental health counseling professionals' experience, or their roles in HIV prevention and advocacy when working with PLWHA.

Counseling Professionals Role in HIV Prevention & Advocacy

The significant difference between the HIV counselor and a professional counselor, such as a mental health or rehabilitation counselor, are credentials. Anyone can be a HIV counselor or mental health professional if they take the required training and have similar experience working with testing. However, it takes more credentials and training to be considered a professional counselor. HIV prevention counseling does not require advanced degrees or extensive experience; however, training is critical (Busby et al., 2013). Although there are differences in client-centered HIV counseling and professional counseling, there are some similarities. For instance, professional counseling professionals conduct intake assessments to enhance their efficiency in helping a client. Professional counseling professionals use psychological tests for screening, diagnosis, treatment planning, goal identifications, and progress evaluations. In comparison, the HIV-CTS risk assessment is the foundation of the HIV pretest counseling, where the counselor helps the client to take "ownership" of their risk for HIV infection (CDC, 1994). The risk assessment is taken to develop a personalized HIV risk reduction plan based on the client's skills, needs, and circumstances (CDC, 1994).

Both HIV counselors and professional counselors need to adhere to cultural competence curricula to reduce racial/ethnic inequities (Lie et al., 2012). The CDC's counseling and testing services seem to focus on the public and not the individual person and does not require a genuine therapeutic relationship with the clients. Low health literacy affects around one-third of all adults in the United States, but it impacts racial and ethnic minorities, as well as people of lower socioeconomic level, disproportionately and contributes to health disparities (Lie et al., 2012). Every health professional can help reduce disparities by acknowledging the existence of a health professions culture as well as their own assumptions and biases, employing appropriate communication skills, and utilizing team resources to identify, diagnose, and address low health literacy and cultural differences (Lie et al., 2012).

Although there have been few high-quality studies on the impact of provider cultural competence training, improvements in knowledge, abilities, and attitudes have been associated with improved patient outcomes (Lie et al., 2012). To maintain the dignity of a PLWHA, there needs to be an emphasis on the person's overall well-being and not the disease. The ACA's code of ethics encourages counseling professionals to respect human dignity, provide services to diverse populations, and promote social justice and advocacy. Effective counseling for PLWHA requires a genuine relationship between client and counselor, as the therapeutic relationship influences the client's quality of life and prevention of further transmission of HIV.

Historical Context for Public Health Professional Role in HIV Treatment

In the past, the primary role of the counselor was to counsel PLWHA through the process of death and dying while providing suggestions on how to prepare themselves for deteriorating health (Zeligman & Barden, 2015). A person with a terminal illness commonly faces three primary issues: fear of death, need for hope, and creation of life meaning (Zeligman & Barden, 2015). The historical role of counseling professionals working with PLWHA have focused on crisis and grief counseling (Zeligman & Barden, 2015). When HIV medication is used appropriately, HIV can become a secondary issue for persons living with HIV. The medication can suppress the viral load, making the disease more manageable. However, while the viral load is suppressed, mental health concerns rise. Mental health concerns for individuals living with HIV include cognitive impairment, dementia, alcohol and drug use, major depression, posttraumatic stress disorder, and borderline and avoidant personality disorder (Freeman et al., 2005). Thus, PLWHA require a continuum of unique counseling services to be available to them (Rose et al., 2015). Yet, the literature on both mental health and rehabilitation counseling has been scant since the 1980s (Joe & Foster, 2017), specifically, there is limited information discussing current counseling techniques that are evidenced-based.

Furthermore, psychiatrists, social workers, psychologists, marriage and family therapists (MFTs), and other public health professionals have the responsibility to acknowledge and restructure biases toward PLWHA and obtain proper training and education regarding HIV/AIDS treatment and interventions (Kundu, 2007). Although each profession has a role in providing healthcare to PLWHA, the amount of research, training and interventions vary in each discipline. For example, within counseling psychology, HIV/AIDS is discussed in relation to how vocational psychology and health psychology intersect in working with PLWHA (Werth et al., 2008). Counseling psychology literature also examines health care concerns, disabilities, confusion regarding career issues and discrimination and the importance of social justice within the literature (Werth et al., 2008). Psychiatrists working in the area of HIV/AIDS oversee the psychopharmacological interventions and balance the role of physician, consultant/liaison, educator, and therapist (Werth et al., 2008).

Social workers have an important role in delivering prevention intervention and developing new interventions for PLWHA in various outpatient treatment settings (Gaston et al., 2015). The role of the social worker is to be the mediator between PLWHA and health care providers to foster HIV medication adherence for PLWHA and retention in HIV care (Gaston et al., 2015). The goal for social workers working with PLWHA is to focus on behavior change as an intervention and promoting treatment adherence (Mitchell & Linsk, 2004). Currently, there is limited research on MFTs' attitudes toward PLWHA or their knowledge of HIV (Serovich & Mosack, 2000). More research is needed to understand the specific role MFTs have in prevention, intervention, and treatment efforts for PLWHA. This may begin with training of these counselors and MFTs. It is a major issue that most programs only have one multicultural or diversity course and only one ethics course during masters training programs, further, these are seldom required in doctoral programs (Finney et al., 2020).

The Benefits of Counselors in HIV Treatment

The role of counselors providing care to PLWHA is significant because they can provide a supportive relationship strong enough to help clients who are willing to adhere to treatment. Individuals without

access to appropriate mental health care are more likely to transmit HIV than individuals who are aware of their infection (Feldman et al., 2012). The integration of mental health into HIV/AIDS initiatives and programs may improve the health of people living with HIV/AIDS. Mental health services need to be part of the overall care of PLWHA. Counselors have the skills to assess for mental health and substance use disorders and treatment. The HIV counseling professionals at counseling and testing sites will need to be trained and adequately supervised during the process of referral for mental health services. Counselors must collaborate with HIV/AIDS organizations for continued advocacy and intervention for mental health, including substance use disorders.

In efforts to eradicate AIDS, the NHAS revisited the domestic response to a future free of new HIV diagnoses by the year 2030 (White Office of National AIDS Policy [WHONAP], 2022). The NHAS provides approaches to help reduce the number of new HIV diagnoses by reducing HIV-related disparities and improving the overall outcome for access to healthcare (WHONAP, 2022). The objective is to make new HIV diagnoses rare and if diagnoses do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance, will have unfettered access to high-quality, life-extending care, free from stigma and discrimination (WHONAP, 2022). The CDC provides recommendations for PLWHA about who should be on their health care team, which includes a mental health counselor.

Mental Health and HIV/AIDS

Mental illness among individuals living with HIV/AIDS profoundly affects physical wellness. Thus, PLWHA requires a continuum of unique counseling services to be available to them (Rose et al., 2015). Unfortunately, PLWHA often have mental health concerns and inadequate access to health services (Pokhrel et al., 2018). According to SAMHSA (2016), PLWHA are 20 times more likely to have experienced various forms of trauma, such as physical, mental, and emotional. Increased high-HIV-risk activities are related to abuse (Whetten et al., 2006). Sexual and physical trauma are associated with increased risk-taking behaviors (such as injection drug use (IDU) or high-risk sexual behavior), therefore, increasing the risk of transmitting HIV (Whetten et al., 2006). Furthermore, childhood abuse has a long-term effect later in adulthood on PLWHA, including depression, maladaptive coping, and re-victimization (Pellowski et al., 2013).

PLWHA also experiences the psychosocial effects of disease progression, which include the onset of physical complications and HIV-related symptoms such as depression and suicidal ideation (Eason, 2016). PLWHA have an increased risk for developing mood, anxiety, and cognitive disorders (National Institute of Mental Health [NIH], 2016). Other mental health concerns for individuals living with HIV include cognitive impairment, dementia, alcohol and drug use, major depression, posttraumatic stress disorder and borderline and avoidant personality disorder (Freeman et al., 2005). Depression in PLWHA ranges from 5% to 20%; however, it is not accounted for by their medical status. Similar rates of depression have been found among PLWHA IDU (Pellowski et al., 2013).

Substance Use Disorder

HIV transmission is influenced by social conditions as well as an individual's risk behaviors such as substance use (Pellowski et al., 2013). PLWHA experience significantly higher rates of co-occurring mental illness than the general population co-occurring mental illnesses; depression is two to five times higher (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). As a result of substance use, protective actions such as condom use are reduced, leading to HIV transmission, and therefore increasing infectiousness (Pellowski et al., 2013). Individuals with HIV have a higher risk of substance abuse. SAMHSA (2016) reports that PLWHA have a high rate of alcohol and drug use and 24% reported receiving treatment for substance use disorders. PLWHA are 10–28% more likely to have co-occurring substance use disorders and mental illnesses (SAMHSA, 2016). Although numbers associated with IDU have decreased overall, the rate of opiate addiction has increased and more than half of the people who inject drugs report sharing needles (Frieden et al.,

2005). Substance use counselors collaborate interprofessionally to understand better the possible side effects of HIV medication and the interaction with substance use treatment (Joe, 2015).

Unfortunately, HIV care centers are not screening for substance use within their clinics (SAMHSA, 2016). In fact, in ten HIV care clinics, only 35% of patients reported talking to their provider about their alcohol use (SAMHSA, 2016). Prevention of HIV among people who use substances can be difficult because of social and structural factors (Logie et al., 2011). For example, people who use substances are likely to have complex health and social needs, such as homelessness and unemployment, and have experienced various forms of violence (SAMHSA, 2016). Counseling professionals have an essential role in supporting and promoting treatment adherence for PLWHA. Counseling professionals have a vital and challenging role working with PLWHA to better manage their disease (Kukafka et al., 2009). The psychosocial needs of PLWHA are complex and require a wide range of knowledge and comfort regarding sensitive matters concerning HIV (Kukafka et al., 2009). Various mental health disorders result in substance use; consequently, substance use negatively affects their adherence to antiretroviral therapy (Pokhrel et al., 2018).

Further, professional counseling professionals can address co-occurring disorders such as substance use disorders, anxiety, and depression, which is common among PLWHA (Freeman et al., 2005; Joe, 2015). Professional counseling professionals are needed to help support prevention efforts because the mental health support from counseling professionals will increase empowerment among PLWHA, motivate medication adherence, and improve their self-efficacy (Joe, 2015). With improved self-efficacy and increased empowerment, PLWHA may adhere to medication requirements and, as a result, prevent the transmission of HIV. Counseling professionals and other public health professionals are responsible for acknowledging their biases toward PLWHA that may negatively influence their service provision and obtaining proper training and education regarding HIV/AIDS accordingly (Lewis et al., 2007). Supporting the social justice and advocacy movement, "counseling professionals, take on the active role as advocates, educators, researchers and policymakers for individuals with HIV/AIDS" (Lewis et al., 2007, p.54).

Implementing Multicultural and Social Justice Counseling Competencies

A social justice perspective encourages counseling professionals to develop a more balanced perspective between individuals and their clients. Therefore, the theoretical frameworks used to support studies related to counseling PLWHA need to incorporate this perspective. There is a need for research on advocacy competencies to help with validity and reliability, as well as help bring advocacy to the forefront of the profession (Ratts & Hutchins, 2009). There is a paucity of literature on counseling professionals' experiences working with clients living with HIV/AIDS or their experience with social justice advocacy strategies while working with clients living with HIV/AIDS (Ratts & Hutchins, 2009). Although there are several studies that focus on the attitudes, beliefs, and knowledge of counseling professionals -in-training with respect to HIV/AIDS, there is a dearth of literature examining how a counselor's attitudes, beliefs and knowledge impact the overall treatment for PLWHA from a sociological perspective. Using the MSJCC as the sociological model, this study examines the multicultural and social justice competence of the counselor, seeking to understand (1) counselor self-awareness, (2) client worldview, (3) counseling relationship, and (4) counseling and advocacy interventions (Ratts, et al., 2016).

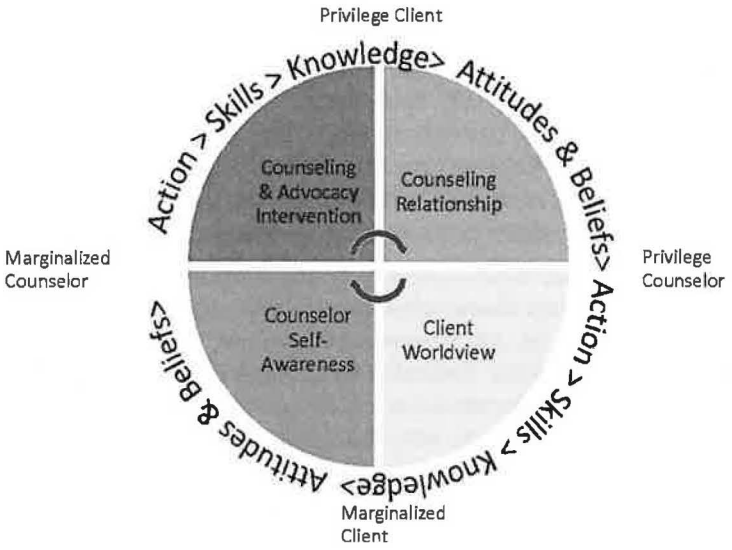
The Multicultural and Social Justice Counseling Competencies (MSJCC) is a conceptual framework with four developmental domains that reflect multicultural and social justice competencies into counseling theories, practices, and research (Ratts et al., 2016). The goal of these competencies "is to serve as a resource and provide a framework for counseling and other helping professionals" (Kenney et al., 2015, p. 2). Multiculturalism gives counselors an awareness of inequities experienced by their clients from marginalized groups and the privileges imparted upon privileged groups (Ratts et al., 2016). To understand the experience of counseling professionals working with PLWHA, it was important to examine that experience through a social justice and advocacy perspective, because

PLWHA are a marginalized population that require multidimensional services for overall quality of life.

The MSJCC acknowledges the multiple intersecting identities are an important part of understanding the complexities of health experiences (Ratts et al., 2016), especially for individuals who are living with HIV and identify as a member of a marginalized group. The tenets built into the core of MSJCC are multiculturalism and social justice, which reflect the charge to counseling professionals and other helping professionals to integrate multiculturalism and social justice into their counseling practice (Ratts et al., 2016). The MSJCC model is also embedded with the aspirational counselor competencies: attitudes and beliefs, knowledge, skills, and action (see Figure 1).

Figure 1

Multicultural and Social Justice Counseling Competencies (MSJCC)



Joe and Foster (2017) examined counselor aspirational competencies regarding attitudes, beliefs, knowledge, and skills. Counseling professionals committed to implementing the multicultural and social justice framework into their counseling practice, required the attitude and belief in the importance of advocacy in counseling. Further, it is important counseling professionals are knowledgeable on relevant multicultural and social justice theories to use as a guide to foster the skills necessary for social justice intervention for their client or community.

The aspirational competencies surround each quadrant which represents the developmental domains to signify the importance of counseling professionals' self-awareness, as it extends to clients, the counseling relationship, and counseling and advocacy interventions and strategies (Ratts et al., 2016). The MSJCC is a model with different layers that lead to multicultural and social justice competence: (1) counselor self-awareness, (2) client worldview, (3) counseling relationship, and (4) counseling and advocacy interventions (Ratts et al., 2016). However, Figure 1 shows a visualization of the cyclical pattern, signifying the relation to each quadrant. The counselor's awareness of the client's worldview is examined through interview questions developed for this study; for example, "how knowledgeable are you about your client's worldview?"

The quadrants for privilege and marginalized statuses are used to illustrate the intersection of identities, dynamic of power, privilege, oppression, and the marginalized and privileged status of counseling professionals and clients operating within a counseling relationship (Ratts et al., 2016). To understand a counselor's experience, it is imperative to understand the intersection of identities, starting with the MSJCC quadrants as privileged and marginalized statues between the client and counselor.

Understanding the client's worldview is for both the marginalized and privilege counselor to determine how the client's concerns are connected to their social group and HIV status in society. The quadrants also reflect the fluidity of identity between the client and counselor, since an identity that is prevalent at one moment in time may not be in the next, depending on the scenario (Ratts et al., 2016). The influences of oppression on the mental health and well-being of both the client and counselor is a by-product of their environment and their marginalized and privileged statuses. Counseling professionals operationalizing within the MSJCC integrate multiculturalism and social justice into their work with clients at an individual and systemic level.

Research Recommendations

A future study could have a survey designed with a quantitative approach to measure social justice and advocacy competence, and the skills, knowledge and attitudes of counseling professionals working with PLWHA, using MSJCC as a framework. Research into the attitudes, knowledge and beliefs regarding HIV is not new to the counseling literature considering there are several past and current studies (Kukafka et al., 2009) focused on aspirational and developmental competencies of counseling professionals in training. Therefore, a mixed-methods study could be developed to research counseling professionals' social justice and advocacy competence, skills, knowledge, and attitudes.

According to Horvath et al. (2010), people who have a chronic disease or disability use the internet for health information in a different way than those who do not. Obtaining health information and social assistance via the internet appears to be an important type of active coping and social support. Internet-based tools aimed towards persons recently diagnosed with HIV/AIDS (PRDHA) may be more beneficial if they first help people understand what it means to be HIV positive and how HIV affects the body, as well as what treatment options are available and where they can seek social support (Horvath et al., 2010). Only a few internet resources have taken a step-by-step approach to addressing PRDHA's needs (Horvath et al., 2010). Education programs to help HIV-positive individuals interpret online information have proven to be helpful, and programs like these should be made more widely available, especially to help those who are newly diagnosed find reliable HIV information (Horvath et al., 2010).

Further, health literacy and cultural competence educators can create more effective training interventions for their learners, improve training translation to future practice, and improve precision in assessing patient-centered training outcomes (Lie et al., 2012). Patient satisfaction, quality of life, adherence to therapies, and clinical indices are examples of patient-centered outcome indicators that are far distant from training (Lie et al., 2012). A combined call for research funding increases the chances of bringing attention to the importance of rigorous training program design and evaluation. Education as an independent intervention to enhance health outcomes, as well as comparative efficacy studies of educational interventions, require resources (Lie et al., 2012).

A counselor's role in HIV/AIDS treatment and prevention is vital. Literature about HIV/AIDS predominantly focuses on counseling professionals' trainees', knowledge, attitudes and beliefs concerning HIV/AIDS. More research is needed to further understand counselors' experience working with this population. HIV/AIDS has continued to become a more manageable condition that is not as debilitating as it once was due to recent advances in treatments (Samson & Siam, 2011). However, HIV/AIDS continues to persistently serve as one of the top severe health issues worldwide (World Health Organization [WHO], 2017). People living with HIV/AIDS (PLWHA) who experience the stigma and discrimination associated with this type of illness deserve a more equitable and unbiased form of care, including mental health counseling. The ACA's Code of Ethics (2014) mission statement

emphasizes quality of life and affirms that the counseling profession should practice and promote respect for human dignity and diversity. The professional core values within social and cultural contexts by promoting social justice and advocacy; however, within counseling research, studies show a lack of focus on the multicultural and social justice counseling competencies among counseling professionals working with PLWHA. Counselors are encouraged to look at the success of strategies that mitigate barriers counselors face when advocating for clients (Field et al., 2019). Further, research remains stagnant on mental health treatment for HIV/AIDS, especially from the perspectives of the counseling professionals providing services to PLWHA. Even fewer are articles discussing systemic theories being utilized to treat HIV. A case study explored how both medical family therapy and structural family therapy can be utilized to treat an incarcerated mother living with HIV and her family (Tadros & Finney, 2019). The family's hierarchy, roles, rules, and boundaries were restructured and resulted in better relational outcomes for mother and daughter. More studies are needed that utilize a systemic lens to treat individuals and their families experiencing the various impacts of HIV.

Conclusion

Understanding the role of counseling professionals requires an understanding of PLWHA and their experiences seeking mental health counseling and basic needs assistance. It is vital professional counselors not only have knowledge about HIV prevention but also understand the multifaceted concerns for people living with HIV. Counseling professionals working with PLWHA know how stigma and discrimination can affect the overall health of an individual. Social justice for PLWHA is vital in the prevention of HIV/AIDS; yet prevention efforts are impeded due to the stigma surrounding HIV that causes people to not want to disclose their status to their partners or limits their desire to seek out testing on their own (Burke, 2015). Implementing a multicultural framework for clients will help counselors become more self-aware, understand their client worldview, improve the overall counseling relationship, and promote advocacy interventions.

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