Criminalisation for sexual transmission of HIV:
Emerging issues and the impact upon clinical psychology practice in the UK.

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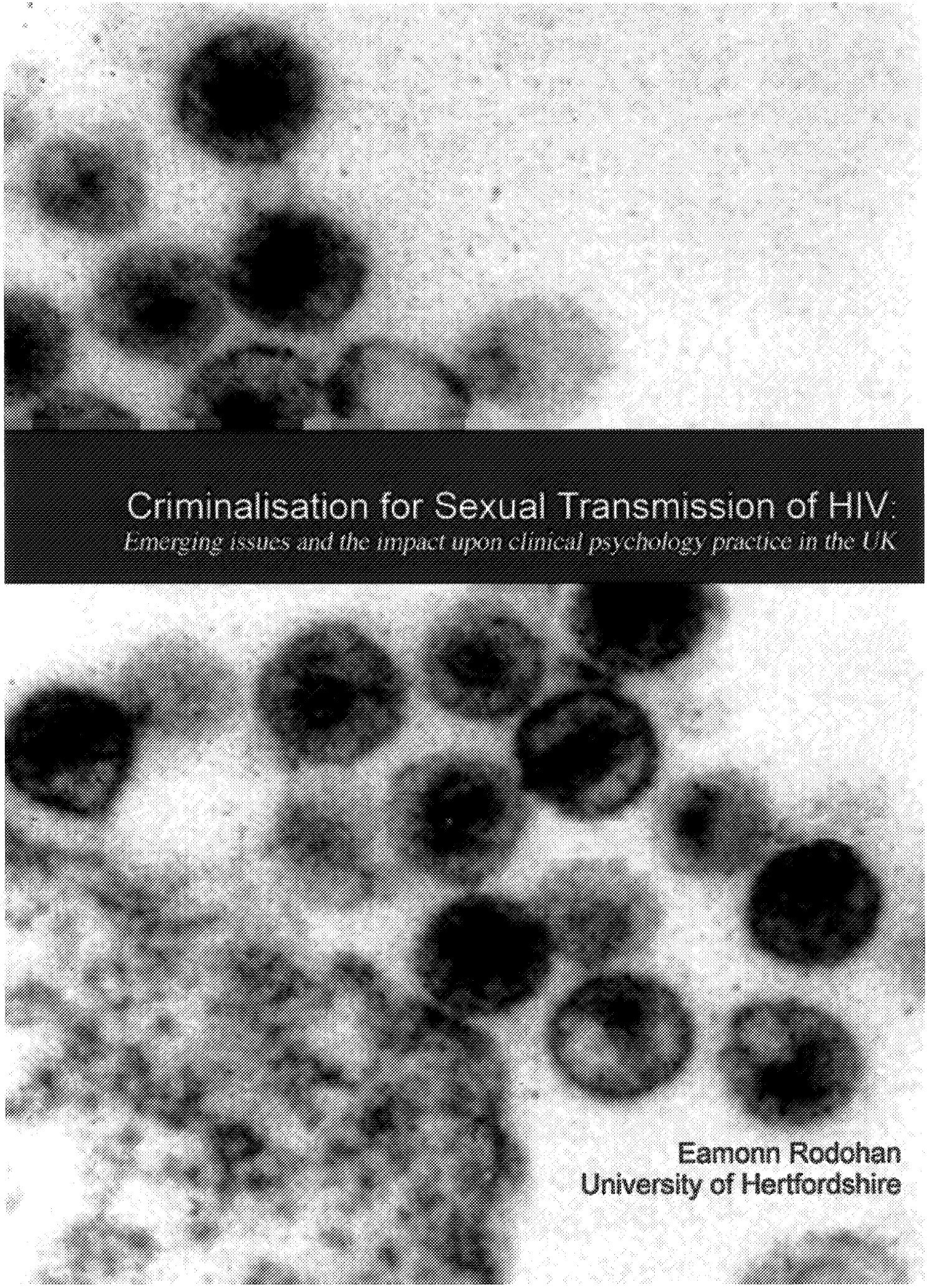
One person's revenge is another person's justice



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Annus Mirabilis

Sexual intercourse began
In nineteen sixty-three
(Which was rather late for me) –
Between the end of the Chatterley ban
And the Beatles' first LP.

Up til then there'd only been
A sort of bargaining,
A wrangle for a ring,
A shame that started at sixteen
And spread to everything.

Then all at once the quarrel sank:
Everyone felt the same,
And every life became
A brilliant breaking of the bank,
A quite unlosable game.

So life was never better than
In nineteen sixty-three
(Though just too late for me) –
Between the end of the Chatterley ban
And the Beatles' first LP

Philip Larkin, 16th June 1967
Refection on the sexual revolution.
(from Collected Poems, Published 1988)

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Abbreviations

ACPO		Association of Chief Police Officers
AIDS	-	Acquired Immune Deficiency Syndrome
BHIVA	-	British HIV Association
BPS	-	British Psychological Society
BASHH	-	British Association of Sexual Health & HIV
BMA		British Medical Association
CBT	-	Cognitive Behavioural Therapy
CPD	-	Continuing Professional Development
CPS	-	Crown Prosecution Service
DCP	-	Division of Clinical Psychology (BPS)
DoH	-	Department of Health
DSM-IV	-	Diagnostic & Statistical Manual of Mental Disorders (4th Edition)
EPR		Electronic Patient Record
E&W		England & Wales
GBH		Grievous Bodily Harm
GMC		General Medical Council
HPA		Health Protection Agency
HIV/SH-Faculty		Faculty of HIV & Sexual Health (DCP)
GP	-	General Practitioner (primary-care doctor)
GUM	-	Genitary Urinary Medicine
HIV	-	Human Immunodeficiency Virus
ICD-10-		International Classification of Diseases & Related Health Problems (10th Edition)
LGB	-	Lesbian, Gay & Bisexual
LGBT	-	Lesbian, Gay, Bisexual & Transgender
MDT	-	Multi-Disciplinary Team
NAM	-	National AIDS Manual
NHS	-	National Health Service
NICE		National Institute of Clinical Excellence
OAPA	-	Offences Against the Persons Act (1861)
PCA	-	Principle Component Analysis (Regression)
PEP	-	Post-exposure Prophylaxis
PN	-	Positive Nation (magazine)
SH	-	Sexual Health
STI/STD	-	Sexually Transmitted Infection/Disease
TA	-	Thematic Analysis
THT		Terence Higgins Trust (UK HIV/AIDS charity)
UAI	-	Unprotected Anal Intercourse
UH	-	University of Hertfordshire
UK	-	United Kingdom
UK-C	-	UK-Coalition (of People-Living-with-AIDS)
UN		United Nations
UNAIDS		Joint United Nations Programme on HIV/AIDS
US(A)	-	United States (of America)
WAC		World AIDS Conference
WHO		World Health Organisation

Abstract

Criminalisation for Sexual Transmission of HIV:

Emerging issues and the impact upon clinical psychology practice in the UK

Abstract

Criminalisation for sexual transmission of HIV: *Emerging issues and the impact upon clinical psychology practice in the UK.*

Eamonn Rodohan, University of Hertfordshire (2010)

Objective: Criminal liability for the sexual-transmission of HIV raises complex questions for both clinicians and service-users regarding their responsibilities and legal obligations to disclose information to others. This is the first research study to address the impact of these issues upon everyday clinical and professional management in the UK. The prevalence and incidence of clinical and HIV-legal issues reported by the 107 psychologists sampled are reported.

Design: A cross-sectional approach comprising two components was utilised: Firstly, questionnaire survey (Response rate 22%) scoping the experiences of practice issues among psychologists from sexual-health and generic settings. Attitudes towards HIV-prosecutions and various measures of professional self-efficacy were also collected. Secondly, three focus groups (N=15) exploring the impact of practice issues upon clinicians' likely confidentiality breaking behaviours.

Methods: Clinical and legal issues are presented. Further statistical analyses explored the interaction of various demographic, clinical and attitudinal variables upon clinician's perceived self-efficacy. Focus Group transcripts analysed using Thematic Analysis (Data-driven approach) with eight emergent themes.

Results: Although no direct involvements in police investigations reported, two instances of psychology notes being subpoenaed plus multiple '*near miss*' clinical experiences described. High proportions of sexual-health psychologists experienced HIV-clients disclosing problematic behaviours, including intentional transmission (9%; N=5) and/or 'reckless' behaviour (72%). Focus groups expressed high levels of anxiety regarding these scenarios associated to multiple influences (interpersonal, clinician, professional and service factors). Quantitative and qualitative results were triangulated to provide a detailed analysis of how psychologists manage the clinical impact of the issues.

Conclusions: Psychologists broadly supported HIV-prosecutions for intentional transmission (81%) but only limited support around '*reckless*' cases (44%), particularly among those sexual-health experienced. Those '*critical*' attempted to mitigate the impact of legal issues by proactively raising awareness among HIV-clients and resisting overly-defensive service changes; whereas those '*less-critical*' were more accepting. Clinical, training and therapeutic implications are briefly considered.

Introduction

Criminalisation for Sexual Transmission of HIV:

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“

in the current climate,

this is something we need to be thinking about ...

but it does pull our professional responsibilities

in different ways

”

Example Quotation 7 (Transcript B: Lines 230-233)

1.0 INTRODUCTION

Criminal liability for the sexual-transmission of HIV raises complex questions for clinicians and service users about rights, responsibilities and legal obligations to disclose information to others. This research addresses the paucity of literature in relation to the impact of **HIV-criminalisation** upon everyday clinical and professional management. As far as the author is aware, this is the first study examining the topic from a clinical perspective, informed by the experiences of UK psychologists. Credible data relating to the practice issues are reported, as well as consideration of how these developments are likely to impact upon psychologists working with people with HIV.

Overview

This chapter introduces the legal situation regarding sexual-transmission of HIV, and summarises the limited literature about these issues in clinical contexts, presented in the following sections:

> Firstly, background information provides the sociological context for the study (1.1); including a brief summary of the psychological health of HIV-positive individuals and overview of service provision for this group (1.2).
>
> Secondly, the concept and components of clinical decision-making relevant to clinician's confidentiality breaching behaviour are considered (1.3); these factors are then discussed in terms of their likely impact upon therapeutic engagement (1.4).

Finally, having developed the rationale for the current study, the research aims are presented (1.5).

1.1 *The Context of HIV-Criminalisation*

This section draws heavily upon the authoritative ethical and legal commentaries presented by McManus (2006) and Chalmers *et al.* (2009). As such it represents an edited analysis of the issues considered relevant to the current study and much of the content is attributable to the original authors.

In many countries, intentional or reckless HIV-infection is considered illegal with individuals charged using a number of legislative options such as *murder*, *manslaughter*, *attempted murder*, or *assault* (Chalmers, 2002). Internationally, a variety of approaches address problematic instances of HIV-transmission, with some countries initiating specific HIV or broader disease transmission laws (e.g. 28 US states - American Civil Liberties Union, 2008; GNP+, 2009; Pearshouse, 2008). Particular areas of controversy relate to whether statutes should be extended to reckless behaviour or include consensual sexual acts. Additionally, a few countries include HIV-exposure (i.e. *'attempted assault'*), even where infection has not taken place.

Legal Developments & Disagreements

In the UK, it was widely believed that HIV-prosecutions could not take place; particularly as the Crown Prosecution Service originally stated (1992) it neither had the powers to act nor was it in the public interest to do so. Following this, the Home Office's (1988) rejection of specific legislation to address the area (proposed by *The Law Commission*), appeared to confirm this impression. However, this false sense of security was short-lived and the *Crown*

Prosecution Service (not constrained by governmental policy considerations) later independently initiated a number of cases with the effect that old generic assault laws were unexpectedly extended to the arena of disease transmission.

As a result, HIV-prosecutions have taken place in Scotland since 2001 (where there is an independent legal system but it is still the '*reckless endangerment*' of others that is seen as culpable and therefore criminally liable), and in England & Wales (which share a legal system) since 2003. The first person convicted was Stephen Kelly and there have been fifteen prosecutions since (E&W: up to April 2009). These latter offences have all been brought under ***The Offences Against the Persons Act*, 1861**, with two sections being invoked:

Section 18 (*intentional provision*); and

Section 20 (*reckless injury provision*).

Although prosecutions were initially brought under the intentional provision, charges were later reduced to '*recklessness*' given the difficulties of proving intent, as have all subsequent cases. Sentences have been between one and ten years (average three), considerably above similar offences unrelated to HIV (James, 2008). Another important factor is that early defendants pleaded guilty meaning the facts of the case were not subject to full legal adjudication. Ironically, the governments failure to enact law reform has resulted in the courts "*creating*" an offence far wider than might have been legislated for. This situation is likely to remain since there is little political mileage in comprehensive legal change or the establishment of a '*criminal code*'.

Criticisms of Legal Bias

A number of legal (e.g. Chalmers) and public health experts (McManus) and voluntary organisations (*THT/NAT*) have written extensively about these cases (e.g. Azad, 2009 analysed trial transcripts) demonstrating how the judicial process interacts with HIV-stigma and poor understanding of HIV-issues. Most notably, Weaitt's (2007) highly critical book considers the Dica trials within its broader political and historical context; concluding the outcome was highly influenced by selective and inaccurate media reporting. It is notable that prosecutions have disproportionately been of migrants and people with poor mental health or other social disadvantage, often already singled out for stigmatisation and persecution (Stine, 2000).

Other factors are also likely to influence whether a prosecution proceeds. All four acquittals, and many unsuccessful investigations, have relied heavily upon scientific evidence and sexual health records to fend-off charges. This is more likely for white gay men; although this group are also subject to more proactive policing around HIV, including intensive questioning about sex lives or being forced to call previous sexual partners and disclose their HIV-status as a result of police contact unrelated to any complaint. Indeed, challenges to the policing tactics adopted (e.g. *THT*, 2008) have led to *ACPO* undertaking a review of guidance covering not only conduct of cases, but also the treatment of suspects with HIV for any offence.

Legal Uncertainties & Ambiguities

The evolving picture suggests HIV-prosecutions are likely only in exceptional circumstances confined to "*extreme cases*" (involving active deceit of multiple partners) but this assessment is subject to continual development. This still

leaves open the possibility of private prosecutions for cases falling short of this standard. Furthermore, offences are not limited to HIV-infection, but extend to any STI considered as '*grievous bodily harm*'. Indeed, there have now also been successful prosecutions for Hepatitis B/C, herpes and gonorrhoea. Additionally, the law may be applicable to other transmission modes. Since the legal basis for convictions can be applied to the transmission of other diseases, there is nothing inherently discriminatory considered about the UK law in this area which is consistent with *UNAIDS* (1999) guidelines that the HIV-virus is not '*singled out*' for special legal attention. However, there may be elements of discrimination at work at varying stages of the legal process.

Currently, local prosecutors have discretion when choosing which law, crime or offence to charge to apply depending on the facts of the case. While this appears to allow for consideration of the most appropriate legal avenue, there are several dangers including that overzealous agents of the law, may practice '*extension of legislation by fear*' (McManus, 2006; *p.*7) – with the effect that HIV-disclosure and condom use are effectively mandated. These difficulties also apply to anxious HIV professionals who may feel obliged (or justifiably inclined) to encourage people with HIV to take excessive steps to protect others who engage in consensual sex with them.

Legal & Ethical Issues for Professional Practice

Another potential danger relates to legal liability of therapeutic professionals, particularly if the person accused is under a professional's *duty of care.* However, whether professionals have a duty to the sexual partner(s) of clients and whether, if they *fail to act*, they are liable is a moot point in law dependent upon particular circumstance. Once again, risk aversion could render all sorts of duties being created without a firm basis which can interfere with proper professional practice. On-the-other-hand, a proper *duty to others* may well exist, rendering the clinician(s) civilly or criminally liable for *aiding* or *abetting* if they do not fulfil their obligations.

McManus concludes that these difficulties raise three primary sets of issues for professionals to balance:

> Firstly, a duty to inform partners (or police) to prevent what is, at the end of the day, a serious offence, ranged *against* the duty of confidentiality;
>
> Secondly, the wider issue of where responsible practice lies and the duty of the professional *against* the prosecution risks for negligence;
>
> Thirdly, the policy considerations of providing treatment which people are entitled to *against* the public health issues of disengaging people with HIV from care under threat of disclosure and prosecution.

A final, perhaps less likely, consideration is that, unlike an Act of Parliament (only applied to future conduct), court judgements have wider application; meaning that prosecutions could be brought for retrospective cases leading to a chain of defendants becoming complainants and so on, with this trend exacerbated by compensation awards.

Confidentiality Issues for Professional Practice

It would be a mistake to presume these difficulties are relevant only to particular psychologists working with HIV-clients, for the ambiguities raise a number of serious issues of importance – related to the fundamentals of confidentiality:

1. Such cases may indirectly establish the legal facts in relation to the case relationship between psychologists and client, with significant implications for confidence and privilege – potentially having *"knock on"* effects on the clinical relationship;
2. Psychologists may find themselves subjected to testify for the prosecution counsel, or having records seized by the courts;
3. The conduct of clinical cases may be placed under intense public scrutiny;
4. The boundaries of clinical relationships may have to be negotiated more carefully, with resulting implications for caseloads and clients' and psychologists' well-being.

These implications also need to be considered in relation to various settings. For example, large metropolitan sexual health clinics where confidentiality is protected by the Venereal Diseases Regulations (1974) will elicit different obligations than small GP practices where the same doctor looks after person(s) with HIV and their partner(s). Similarly, residential/institutional settings, where professionals have some sort of *right of control* or heightened *duty of care,* have different implications than community psychology services.

Professional Guidance for Psychologists

In the UK, psychologists are bound by the Code of Conduct, Ethical Principles and Guidelines (last updated 2006) of the *British Psychological Society.* Members of the *Division of Clinical Psychology* also abide by the Professional Practice Guidelines (1995; updated 2005). Both documents[1] discuss the overriding principles of psychological practice with an emphasis on informing clients of clear boundaries (e.g. sharing information with MDTs or supervisors) under which confidentiality is breachable (e.g., harm to *self*, *others*, or *minors*). Emphasis is also placed on the *duty to inform* clients of confidentiality standards at their '*first point of contact*' (*BPS*, 2006: 6.2.1), and the exceptions to be made for circumstances where the health, safety or welfare of someone else would be put '*at serious risk*' (6.3.1). Specific mention is made to 'partners of HIV-positive clients' in regard to '*disclosure in the public interest*' (6.3.2).

Duty of the Clinician

Although medical doctor-patient communications are generally considered confidential, doctors are not entitled to refuse giving evidence in court. Indeed, the Kelly case specifically rejected an objection along these lines. However, medical ethics has traditionally had a much stronger involvement in the law [than psychology] reflected in the *General Medical Council* guidelines advocating *disclosure without consent* to assist in the prevention, detection, or prosecution of a serious crime (GMC, 2004, *para.*27). Nevertheless, there have been various instances of doctors being disciplined for acting beyond their professional duty relating to HIV (e.g. initiating police investigations or releasing medical records without proper due process). However, counselling and psychological therapies have always retained a different legal position with respect to power than medicine and many psychologists may feel uncomfortable with what they perceive as being compelled to work within the restraints of a medico-legal framework (Smail, 1987).

[1] A synopsis of the relevant sections relevant to 'potential harm' and HIV appears in Appendix D of the Critical Literature Review (Rodohan, 2007)

Standards of Care

Standards of care are established by consulting several expert professionals from a particular community; these practices are then used to develop guidance providing a benchmark of how to fulfil concomitant professional, ethical, and legal obligations when faced with a similar situation (Erickson, 1993). Since Dodds. (2008) made a number of recommendations in response to HIV-prosecutions and service delivery, a number of professional associations have reviewed their guidance clarifying healthcare professional roles and ethical principles in this area (e.g., *BHIVA*, *BASHH*). In the case of the issues raised for psychologists, no standard of reasonable care existed; hence why the *HIV&SH Faculty* are leading a review of psychology guidance in this area on behalf of the *BPS/DCP* – the driver for need of the current study.

1.2 Psychological Health & HIV

The spread of the HIV-pandemic means that eventually HIV-issues are likely to touch everyone in their personal and/or professional lives (Douce, 1983) and psychologists will almost inevitably encounter HIV-infected individuals in their practice (Upadhya & Bluestone, 1994). Erickson (*ibid*) suggests HIV obliges professionals to examine relevant ethical concepts in their personal and professional lives; because treating HIV-patients may stir up conflicting values between therapist and patients (Morrison, 1989). Thus the need to be informed of the complex medical, legal, and social issues provoked (Gray & Harding, 1988) in order to address the arising dilemmas (Van derCreek & Knapp, 1989).

HIV& the Individual

The psychology of persons with HIV encompasses a range of reactions and adaptations during the life-span and across disease phases. It is associated with a broad range of mental health and emotional problems, psychiatric disorders, and neurological syndromes – most likely to develop in vulnerable individuals as a result of the interaction between the person, stressful situations, and the social/emotional supports available (Catalan, 1999). Sexual difficulties have also been widely reported in people with HIV-disease although people with HIV are usually keen to protect their sexual partners (Stephenson *et al.*, 2003), and their HIV-negative partners are keen to remain so (Hedge, 1999). In addition to mood disturbances, poor psychosocial adjustment to HIV is intimately linked to negative health-related behaviours (Antoni & Schneiderman, 1998). For a variety of reasons, HIV-individuals are likely to be disproportionately represented in a variety of medical, psychological and sexual health settings.

From a psychological perspective, individuals with HIV not only have to address the reality of a potentially life-threatening disease, but also the fact it can be spread to others (Kleinman, 1991). In communities where discrimination, and violence, against persons with HIV are prevalent, disclosure may be extremely difficult and dangerous, especially for women in particular who may find it almost impossible to disclose without severe risks (Cameron, 2008). Contrary to popular characterisations, the most acute problems may occur in settled relationships (Flowers *et al.*, 1997) where HIV-status disclosure can involve admission of sexual infidelity, rape or IV-drug use. There is also the danger of vindictive or vexatious prosecutions from persons previously in relationships, since soured. In short, the politics of the bedroom, and the issues of communication, trust and consent, are a particularly difficult area to deal with.

To complicate matters more, Papathaomopoulos (1989) notes the existence of intentional self-infection with HIV as a means – however inefficient – of attempting suicide.

HIV-Stigma & Discrimination

The epidemiology of HIV is a complex one; it impacts on people differently depending on their sexuality, ethnicity and gender. Hence, it does not distinguish between people at a molecular level but at a socio-economic one. Dodds (2005) has argued that 'as the epidemic moves on so do the ways we collectively and individually interact with it'. She identifies four significant changes in this regard:

1. Those infected are now living much longer due to the success of treatments – making the long drawn out legal process more feasible;
2. Unprecedented number of women being infected – judges have made clear that they see themselves as protecting '*vulnerable*' women;
3. Increasing diagnoses among black Africans – the majority of UK defendants;
4. The '*harm vacuum*' – arguably, harm reduction methods fail to acknowledge the aggrieved feelings individuals may experience when discovering HIV-infection.

From this perspective the trials can be seen to reflect what criminologist Rutherford describes as the '*eliminative ideal*', which 'strives to solve emerging problems by getting rid of troublesome and disagreeable people with methods that are lawful and widely supported' and 'sits with contemporary pressures for social exclusion, and notions of a culture of containment' (1997, *p.*116). He contends that challenges to this trend need to address the instrumental and expressive dimensions of the eliminative ideal. In this context, while the anti-criminalisation public health arguments address the former, one of their reasons for their failure has been not addressing the latter.

Reece (2007, *p.*217) describes broader 'progressive' trends as contributing to the greater regulation of personal lives – the development of (post-)liberalism - representing a movement towards more invasive governance by demanding that individuals internalise new models of '*responsibility*'. Within this model 'psychological norms have replaced social norms, and therapeutic correctness has become the new standard of good behaviour'. Where people fail to internalise these responsibilities, the space has been created for new forms of penalty and (semi-)legal coercion. Bird and Leigh-Brown (2001) have argued that such an environment harms the mental and sexual health of persons with HIV in a way which will far outweigh any benefits to the wider population, particularly as successful HIV-prevention is reliant on the attitudes, skills and well-being of these people. The strongest concern is that HIV-prosecutions reinforce constructions of people with HIV as dangerous or irresponsible; the effect being most pronounced in African men and women, a group already vulnerable from social-exclusion and xenophobic abuse (Weatherburn *et al.*, 1993; Fortier, 2004).

Attitudes and Beliefs & HIV

Herek and Glunt (1988) define HIV-related stigma as the phenomenon of intensely negative reactions and social disapproval of the behaviours transmitting HIV. Several papers have demonstrated the presence of stigma

across populations confirming HIV/AIDS elicits a more fearful and prejudicial attitude than most other diseases (e.g., Kelly *et al.,* 1987a). A certain amount of AIDS-stigma arises from its association with ultimate death (Dworkin & Pincu, 1983). 'Healthy people' use this construction to distance themselves from death by attributing the illness as an affliction of others. This general demarcation allows people to see themselves as removed from the epidemic which affects only very specific '*Others*' (Fullilove, 1989). In society, epidemics disrupt the normal functioning of the primary social group resulting in the punishment or isolation of the out-group seen as responsible.

Although there is substantial literature regarding attitudes, beliefs, and behaviours associated with HIV and HIV-transmission, there are few studies regarding HIV-criminalisation directly. Only two investigations were found, including an online/postal survey conducted by the *UK-Coalition of People Living with HIV* (*UK-C*, 2005); the other consisted of qualitative interviews with US psychiatrists (Klitzman *et al.*, 2004). In the American study, the psychiatrists strongly supported HIV-criminalisation based on presumed increased condom-use and HIV-disclosure. Interestingly, this finding conflicts significantly with the UK-C study[2] reporting almost half (47%) of people living with HIV sampled supported intentional HIV-prosecutions, and only 11% for '*recklessness*'. Although the study's small sample size and self-selection make it difficult to generalise the findings, it does highlight the potential for a disjunction in attitudes regarding these matters between professionals and their HIV-clients. The current study has replicated the UK-C survey for completion by psychologists, in part, to assess this factor.

Public Health Implications

The protection and promotion of public health is one of the most important functions of the modern state (Scamell & Ward, 2009). Effective responses include the monitoring and surveillance of disease within populations informing service provision at a community level to facilitate behavioural change. Although traditionally, public health policies have focused upon the *containment* and *isolation* of infection, more recently '*critical concepts*' have challenged notions that the protection of human rights are not only incompatible but essential to the effective management of the HIV-pandemic.

Contemporary public health theory suggests punitive measures are counterproductive, largely because they foster the stigma driving the epidemic (e.g., Landsell, 1991; Lange, 2003). It is argued that as long as HIV-discrimination continues, the result will always undermine effective HIV-prevention, treatment and care (Aggleton *et al.*, 2005), not least because those at highest risk of HIV-infection distance themselves from the disease in public, social and intimate settings. Overall, the practical, emotional and social implications influencing disclosure issues suggest it is not as straight forward as the legal system infers. It can also be argued that HIV-criminalisation will increase expectations of HIV-positive disclosure leading some people to believe that the law affords them a degree of protection. This belief contrasts with the public health message of a shared responsibility for safer sex.

The spectrum of positions on HIV-prosecutions can be characterised by two extremes; those who oppose, believe it will result in reduced HIV-testing; with

[2] The published results for the UK-C study are available in Appendix 3.2 since the findings are used for comparison to psychologist-respondents' ratings reported within the results section.

others believing it will curb HIV-infection via a deterrent effect. An examination of the professional and ethical literature shows unequivocal support for HIV-criminalisation is most common among professionals in the criminal justice system. Most health promotion experts (e.g., Dodds *et al.*, 2005) severely criticise this view as '*highly simplistic*'; demonstrating limited understanding of health promotion approaches alongside basic transmission facts and the complexities of sexual behaviour. Although it is certainly true that some acts made illegal tend to become less common in the population as a whole; whether the law can have the same impact on sexual behaviour is an unknown. For many, the key argument against HIV-criminalisation is that it represents "the thin edge of the wedge" for more coercive public health measures. In contrast, community-level based approaches are most effective when they prioritise the rights and dignity of people with HIV; supporting people to engage in behaviours which reduce that risk. Importance is also given to the importance of early HIV-diagnosis and treatment – thereby reducing infectiousness.

BPS Response to HIV-Prosecutions

Although the stance of the *BPS* is officially neutral regarding HIV-prosecutions, the issue has been addressed by responses to various consultation documents which draw attention to the probable underestimation of the impact of HIV-prosecutions 'already affecting a wide range of service provision' at a time when norms around disclosure of HIV-status are shifting' (Flowers, 2006, *p.*1). The response is critical of the consequences of HIV-prosecutions upon HIV-stigma/discrimination, highlighting the many healthcare workers struggling to balance the resulting ethical and professional dilemmas.

1.3 Clinical Decision-Making

The discourse of law repeatedly finds itself using a rhetoric dependent upon the meaning and legitimacy of other forms of knowledge (e.g. medical, epidemiological, sociological etc.). These distinct yet plural traditions order the social problem of HIV-transmission as an issue using the legal grammar of crime which institute the structure of experiences we use to construe the virtue of persons. To this extent, clinical knowledge of HIV is ordered around the calculation and management of risks where the arguments, conduct and circumstances of behaviour function to index risk – reformed, reshaped and reorganised around juridical categories in terms of the *dangerous individual* and the *common good* (Rush, 2009).

Attributions of Dangerousness

The concept of danger does not describe actual harm but merely signals that the potential for, or the possibility of, harm exists (Simon, 1990). Neither is it an inherent quality in an individual (Seagright & Pound, 1994) but lies on a continuum of infinite '*degrees of risk*' activated in any given context by psychological and social issues (Sonkin, 1986). However, because the task of professionals includes evaluating *potential for harm*, clinical evaluations fall into a dichotomy of *dangerousness* versus *non-dangerousness* (Kaufman, 1991). Unfortunately, a large body of research demonstrates the high level of inaccuracy in mental health professionals predicting dangerousness (Biegler, 1984; Ewing, 1991) with an accuracy outcome of less than 50% (Carter, 1995).

Concepts of Risk

Most studies regarding clinical decision-making around HIV-risk issues have been undertaken in the US following the infamous *Tarasoff* decision which

established a duty to protect by physicians and psychotherapists towards third-parties. The decision by the California Supreme Court (Tarasoff I, 1974, 529, *p.*2d at 566; cited in Fukero, 1988) compelled psychotherapists to warn potential victims of patients who presented a threat of imminent danger to them, even if the protective intervention requires a breach of confidentiality. The verdict declared 'protective privilege ends where public peril begins' creating a precedent for a specific '*duty to warn'* rather than a more general '*duty to protect'*.

Totten *et al.* (1990) investigated whether practicing mental health professionals applied dangerousness and victim identifiabiliy (i.e. factors in the Tarasoff decision) when they make confidentiality breaching decisions regarding their HIV-patients. Results suggested these US clinicians breached confidentiality more and perceived higher dangerousness with HIV-patients than for IV-drug users or bisexuals. However, in a similar US study, Stewart and Reppucci (1994) found '*dangerousness*' did not increase the likelihood of clinicians breaching confidentiality. They found patients with AIDS were perceived as significantly more dangerousness than homicidal patients, yet clinicians were less likely to warn their sexual partners of potential risks. Although the relevance and generalisability of these studies to UK practice is debatable, both studies illustrate how differential *risk ratings* can be assigned to categories of patients and influence the intervention(s) selected.

Notions of Culpability

Greater hostility and stigma tends to be assigned to diseases in which individuals are seen as responsible for having the disease; in which the disease is fatal; in which there is fear of transmission; and where the disease leads to highly visual expressions; all of which are associated with HIV/AIDS (Fullilove, 1989). Indeed, the sensationalist reporting has reinforced prejudicial perceptions historically attached to HIV. For example, Lisa Powers (Head of Policy, *THT*) states 'in all cases media statements significantly misstated the case as deliberate instead of reckless behaviour, and characterised the accused as predatory' (Positive Nation, September 2006). Clearly, there has been a '*blurring*' between the boundaries of intentionality and recklessness.

Healthcare Discrimination

Generally, research outlining the similarity of the stigmatisation of people with HIV and towards homosexual patients more generally, has been used to suggest the presence of a sexual orientation bias within the healthcare system (Simone, 1996). Thus, where self-inflicted concepts are combined with negative perceptions, there is a risk of negative judgement and punitive treatment of the patient by the healthcare system.

Herek & Glunt (1988) suggests that similar to nineteenth century epidemics when physicians first defined *venereal insontium* (venereal disease of the innocent), medical responses to the HIV-epidemic have resulted in the implication that those affected are '*blameable victims*' (Albert, 1986). For example, A.M.Brandt (1988) extensively discusses the parallels of the processes of the HIV-epidemic with the syphilis epidemic. Kelly *et al.* (1987b; 1988) began researching this area and found significantly more stigma by medical students, physicians and nurses to patients with AIDS than other illnesses. Schwartbaum *et al.* (1990) investigated which variables influenced breach of confidentiality decisions of primary care physicians. Results indicated

physicians differentially applied interventions by gender, race and sexual orientation. In addition, patients with AIDS have generally been seen as having less moral integrity (e.g., Hunter & Ross, 1991).

There is then no doubt that professional and ethical practice is a potent and dynamic area where changes in research, legislation and professional/ethical guidelines all reflect incremental and paradigm shifts (Tribe & Morrissey, 2005). Given the importance of these issues, it is essential to explicate the factors influencing the way professionals discharge their duties to protect patients and society in general. Increased knowledge of these factors help to inform psychologists about how the complex medical and social issues interact with their own professional values when they make critical decisions impacting upon the lives of their patients and beyond.

1.4 Therapeutic Engagement

In their model of therapy, specifying the interrelation of output, process and outcome components, Orlinsky *et al.* (1994) stress the absolute centrality of the therapist-client relationship within the therapeutic system. The input variables reflect the environment of the *therapeutic system* before treatment starts and the institutional and cultural patterns of society constitute the overarching context for therapy. These exert a direct influence on the *therapeutic delivery system,* and are an indirect influence on the therapeutic contract. Professional characteristics such as therapist's orientation and experience and the client's treatment history also influence the participant's expected roles and how they understand their goals and tasks. At the centre of the model, the facets of the *therapeutic bond* most sensitive to influence are *interactive coordination* and *mutual affect*. The compatibility of the client-therapist expectations determines the level of contractual consensus achieved and these expectations influence how each contributes to forming a *therapeutic bond*. All these factors, may impact the *therapeutic alliance*, considered the 'most robust predictor of treatment success' (Safran & Muran, 2001, *p.*1).

Centrality of Confidentiality

Issues of confidentiality are highly likely to impact upon the therapeutic encounter since they alter the '*therapeutic frame*' in which therapy is offered (Langs, 1979, Casement, 1999) and may challenge therapeutic neutrality (Gray, 1994). Barrett (1996) suggests that knowing when an obligation to others overrides confidentiality or determining the benefit of becoming more personally involved with a client requires a systemic model that minimises decisions contaminated by counter-transference issues that could pose a danger to clients and others. This can be particularly difficult when working with HIV-issues which often infringe on the ethical areas related to confidentiality identified by psychologists as most troublesome: blurred, dual, or multiple relationships; competence working with new populations or unfamiliar client issues; and service-related pressures (Pope & Vetter, 1992).

Self-Efficacy Factors

Finally, a therapist's own sense of self-efficacy, defined as a person's beliefs about their '*inner capabilities*' (Bandura, 1997, *p.*160) also impact on the development of the therapeutic alliance. Self-efficacy therefore acts as a causal factor upon therapist willingness to work with this client group, and a sense of confidence and competence to do so. In this regard, Maslin (2003c) investigating the specific factors enhancing and inhibiting psychologist's self-

efficacy when working with asylum seekers (many of whom were HIV-positive), found an overlapping range of issues broadly grouped into service, professional, transcultural and personal factors associated with *''therapist ideology''*. She argues there is a need for a greater evidence base to inform service policies and practice with this client group. Although not directly concerned with HIV, the study provides some understanding of which multiplicity of factors impact upon therapist self-efficacy relevant to the type of client group in the current study. Although transcultural differences cover language and cultural differences between therapist-client (which may not necessarily be applicable to all HIV-clients), it seems reasonable to assume that issues of difference more generally would be highly pertinent to the current topic of investigation, particularly in light of the literature highlighting the integral influence of HIV-stigma/discrimination.

Effective Clinical Care

Effective clinical care depends on scientifically valid, sensitive and reasonably full understandings of how interventions can alter human motivation and action (Landau-Stanton & Clements; 1993). Healthcare providers need to assess the impact of their treatment and preventative education by rigorous evaluation of changes in knowledge, attitudes and behaviour. If this is not done, it is not possible to evaluate whether a programme is effective and goals have been met. An understanding of human sexuality in a systemic context is also required, since issues pertaining to membership of minority groups, disenfranchisement and prejudice may need to be addressed. These issues impact at a political and economic level, as well as at an individual level. Indeed, failure to consider them may lead to failure in therapy (Landau-Stanton & Clements, 1993).

1.5 Research Aims & Objectives

The issue of people infecting sexual partners intentionally with HIV is not new to debate in the social sciences (McManus, 2005) although there appears to be a distinct lack of empirically directed research into these issues. No doubt, this is due to the many ethical and practical difficulties rendering investigation into such a highly controversial topic almost impossible. Indeed, given the lack of available literature, it is difficult to judge the extent of the phenomenon and establish the realities separated from '*urban myths*' and less reliable influences. More recently, a number of high-profile HIV-prosecutions internationally has renewed interest in what is popularly known as '**Biological GBH**'. Even though somewhat problematic from a scientific perspective, this term's usage has entered the popular psyche becoming inextricably linked to public perceptions. However, the focus of academic attention has rightly centred upon the use, and role, of the law as an appropriate measure in the continuing HIV-pandemic.

There are serious public health implications arising from any HIV-criminalisation policy; although the extent they hinder preventative measures such as testing, early treatment and HIV-disclosure are unclear and contested. What is clear is that the arena of HIV/AIDS involves complex social and cultural norms, and important issues of *stigma*, *taboo* and *inequality*. Therefore, it is likely that legal processes apply culturally inappropriate expectations of risk, recklessness or communication especially to persons from minority communities; thus reinforcing prejudicial attitudes and exacerbating discrimination among those already disproportionately affected by HIV. The way which these factors may

impact upon professionals working with HIV-issues will depend on the publicity convictions receive, whether further cases are brought and if so, how the law develops in this area.

Particularly pressing questions apply to the obligations of confidentiality, where frank discussion of sexual behaviour and history are important. Changes to legal precedent potentially extend the circumstances where clients would effectively be admitting criminally liability. What obligations are there for sexual health workers reporting individuals to the police? Will there, at least, be a fear that this will occur, damaging honest accounts of sexual behaviour and effective psychosocial intervention? A further difficulty is where to *draw the line* when determining how *'risky'* sexual behaviour needs to be before it is considered problematic and addressed, and how? From a professional viewpoint, the complexities are serious, especially as the inherent ambiguities means there are no absolute certainties to these questions.

Ultimately the clinical relationship and the freedom of clinicians to respond may be brought into court, testing issues of professional privilege. The spectre of psychologists being tried by media for their decision-making judgements is raised, or more horrifyingly the prospect of legal action. In such precarious circumstances, psychologists are best protected by rigorously following professional guidance. However, best clinical practice also needs to foster trust and confidence among service users by ensuring those seeking support in their sexual relationships are helped to develop responsible HIV-prevention strategies best suited to their individual circumstances. These are key ethical difficulties affecting psychologists which need to be both balanced within clinical practice and addressed at a policy level.

Statement of the Problem

The above information presents the rationale for the exploration of issues included within the study, of which, the principle research aims can be summarised as follows:

> This research addresses the impact of recent prosecutions for sexual-transmission of HIV upon everyday clinical management. In particular, the study attempts to clarify the professional issues raised for psychologists, particularly in relation to confidentiality. Finally, the likely impact upon therapeutic engagement with HIV-clients including the interaction of therapist and client factors are investigated.

Research Objectives

The objectives of the study relate to various identified factors tentatively hypothesised as potentially impacting upon clinical practice, focusing upon the following main areas (related variables *emboldened*):

1. To understand **awareness of professional practice issues,** particularly related to confidentiality (Survey section A),

2. To assess the **influence of relevant self-efficacy factors,** including contact with HIV-clients and sexual health experience (Survey section B);

3. To gain understanding of **psychologists' attitudes towards HIV-prosecutions** (Survey section C);

4. To ascertain any **training and service needs** in regard to the above (Survey section D).

The above hypotheses relate primarily to the stated sections of the questionnaire survey which allow for some empirical data analysis of the factors concerned. However qualitative data derived from the focus groups analysis also provided further information in regard to how some of the above factors impacted upon therapeutic work, particularly in relation to HIV-clients. Thus the final tentative hypothesis to be investigated can be stated as:

5. To assess **beliefs regarding the clinical impact upon work with HIV-clients,** particularly factors inhibiting/enhancing the therapeutic sphere (Focus group analysis);

Thus, it is hoped that the study will provide information needed for psychologists working in this sensitive area at a time when the issues are still evolving. The adopted design incorporated a combination of methods providing complimentary information from a variety of perspectives, an advantage frequently cited by those employing multiple methods (Robson, 2002) which are now described in the Methodology section which follows.

Method

Criminalisation for Sexual Transmission of HIV:

Emerging issues and the impact upon clinical psychology practice in the UK

“

I have encountered quite a few people recently

who come very fearfully asking about it...

there is a general climate of fear about it

especially among those newly diagnosed

”

Example Quotation 6 (Transcript A: Lines 160 -169)

2.0 METHODOLOGY

2.0.1 Project Overview

Study Design

The principle research aim was to generate findings both '*landscape*' and '*portrait*' in nature. Reflecting this intention, the cross-sectional design incorporated two components:

1. The primary **survey** objective was to provide a general scoping exercise of the prevalence and incidence of practice issues (e.g. the impact of HIV-prosecutions upon the contextual '*landscape*' of clinical practice).

2. Secondly, **focus groups** providing a more in-depth '*portrait*' explored how practice issues impact upon the therapeutic sphere (particularly the interaction between psychologist/client factors).

These objectives acted as a driver for adopting a methodological triangulated approach, where qualitative and quantitative methods produce more varied data. This process involved development and confirmation of findings through convergence of different perspectives, whereby the information obtained complements each other by facilitating both a broad (quantitative) perspective, as well as more detailed (qualitative) analysis of practice issues around HIV-criminalisation. It is hoped that by combining these approaches, the findings embody a plurality of group experiences and individualised perspectives. Willig (2003) suggests that point at which these different perspectives converge represents '*reality*'.

Development of Design Process

Integral to the initial design development, was attendance at related conferences during 2006, including:

HIV/AIDS & THE LAW: THEORY, PRACTICE & POLICY
Keele Institute for Law, Politics & Justice (HIV/Law Project) -10th March

CRIMINAL PROSECUTIONS for the SEXUAL-TRANSMISSION OF HIV
HIV&SH-Faculty -19th May

ADDRESSING SEXUALITY WITHIN CLINICAL PSYCHOLOGY
HIV&SH-Faculty -1st December

During the second conference, the researcher led a workshop to generate initial hypotheses informing the design (e.g. developing the vignette scenarios). A brief review was later published in the *HIV&SH Faculty* newsletter (Shaw, Butler, & Rodohan; 2006b, Autumn) and Clinical Psychology Forum (Shaw *et al.,* 2006a, August) raising awareness of the project.

Ethical Approval

The University of Hertfordshire Research Degrees Committee registered the study with ethical approval obtained from the **UH (Psychology Department) Ethics Committee** (Appendix 2.1: Letter of approval). As participants were recruited from non-clinical populations, *NHS* COREC registration was not necessary. Informed written consent was obtained from focus group participants

and confidentiality of session content was discussed at the start of each group. Survey respondents indicated consent via questionnaire completion.

Research Data
The study produced two-fold sets of data from three groups of participants:

Survey (Quantitative)
Design included (disproportionate stratified) sampling of two independent subgroups, including:

- Psychologists from general clinical settings, less likely to have clinical experience with HIV-clients;
- Psychologists from sexual health settings and/or with sexual health experience, more likely to have experience with HIV-clients.

Focus groups (Qualitative)
A number of whom also reported returning questionnaires, included a diversity of:

- Psychologists with sexual health experience forming a sample of '*experts*'.

An over-view of both components follows relating to the design and participant factors unique to each, commencing with the focus group methodology

2.1 Questionnaire Survey

2.1.1 Design

Survey
The questionnaire (Appendix 2.7) was designed for this study to explore the influence of HIV-prosecutions and clinical issues with therapist factors (specifically sexual health experience); construction was guided by Rodeghier (1996). Development was formed through reflection with the clinical research supervisor, including consideration of the flip-chart materials produced by workshop attendees. Subsequently, and independent of this process the **prototype questionnaire** was reviewed by Barbara Hedge, a clinical psychologist with extensive experience of both sexual health issues and clinical psychology training/development.

Further refinements incorporated this invaluable feedback before two further sexual health experienced psychologists were asked to review and trial the questionnaire for ease of completion, accuracy and understand-ability factors. Raters suggested completion took between ten minutes (for respondents filtered away from sections relating to experience with HIV-clients) to 20 - 30 minutes (when completing these sections). Minor corrections/amendments improving clarity were incorporated into the final draft circulated.

Information Provided
Questionnaires included a brief synopsis of the *OAPA* (1861), with neutral commentary taken from the (at the time, draft) Faculty guidelines. The purpose of this information was to clarify respondents' knowledge of the proper legal/professional situation, in order to ensure an adequate understanding of the relation between issues needed. The objective of this intervention was to control

the possibility of misinformed respondents completing the survey by providing a minimum information baseline, rather than to introduce any undue bias.

2.1.2 Measures

Variables
Selection of variables corresponded to the research objectives/hypotheses previously outlined:

> The survey aims to explore the impact of HIV-prosecutions upon psychology practice by comparing willingness, confidence and competence to work with HIV-positive clients **(dependent variables)** with a combination of demographic, attitudinal, and clinical variables (e.g., sexual health experience) considered relevant to therapeutic factors **(independent variables).**

Questionnaires included open-ended (related to demographics, clinical practice issues, attitudes, and training received) and forced-choice questions (self-rated statements of self-efficacy).

Self-report Questionnaire
Pre-existing (attitudes survey) and other measures were compiled in order to collect data to assess particular aspects of the study; these were reflected in the design described below:

> Section A (respondents filtered):
> Firstly, **contextual information (including measures of demographic and clinical practice descriptors)** completed by all.
>
> This section later collected **indicators of the prevalence of relevant clinical issues (specifically confidentiality)** by those with HIV-client experience.
>
> Section B (all respondents):
> Five-point Likert scale with statements rated by participants regarding **feelings of self-efficacy regarding the professional issues related to clinical working with HIV-clients.**
>
> The 18-item scale rated perceived competence, perceived confidence and awareness/willingness factors related to professional practice. The expert reviewer's input was specifically solicited for guidance upon this measure. Further information reporting the method of construction and properties of the emergent scale are presented in the Procedure section (2.1.3)
>
> Section C (all):
> **Attitudes to HIV-prosecutions and beliefs regarding the impact upon HIV-prevention held by applied psychologists**.
>
> This section replicated (with minor amendments to question wording) the UK-Coalition (of People Living with HIV&AIDS) online and postal survey on 'Criminalisation of HIV-Transmission' - published in *Positive Nation* magazine (May 2005 edition). Preliminary results (i.e. initial descriptive statistical data) of the survey published online (August 2005) is used as a

comparison to the psychologists' responses in the current study (reference copy in Appendix 3.2).

Section D (all):
A final (optional) section eliciting **relevant training experiences, training needs, and service issues** with space for qualitative responses and general comments.

2.1.3 Procedure

Sampling Strategy
To enable recruitment of two proportionately sized groups, six-fold more surveys were distributed to the generic clinical group as it was judged this group's response would be lower. Initial sample size (500) was estimated to generate a study of approximately one hundred lower than the 30% rate usual for surveys of this kind (Viljoen & Wolpert, 2000).

Power is defined as the probability of rejecting the hypothesis when it is false and thus should be rejected (Cohen, 1992). It is related to the probability of making a Type-II error (i.e. failing to detect a difference when one exists). Power is equal to 1 (the probability of a Type-II error) and varies as a function of sample-size, effect-size, measurement error and sampling distribution. As novel exploratory research, there was no previous guidance on possible effect-sizes. However, with an assumed moderate effect-size, a total sample size of approx. 100 would achieve a desirable power level of 0.8 with an *alpha* of 0.5.

Survey Distribution
In total, 440 questionnaire packs titled *'Clinical Practice & Emerging HIV-Issues'* were sent (September 2006) to a systemic random sample from the general membership of the *Division of Clinical Psychology* (*BPS*), and to all 61 post-qualified members of the *HIV&SH Faculty* (Total distribution = 501).

Strategies (advocated by Viljoen & Wolpert, 2000) utilised to maximise response rate, included:

- Pre-paid envelopes and covering letters;
- Reminder letters sent a fortnight later;
- Questionnaires headed with the official BPS/Faculty logo;
- Experienced BPS mailing division staff conducted participant selection procedures and survey distribution.

Statistical Analysis
Questionnaire responses were transferred into variable data and input into SPSS (v.12); consultation with research tutors informed the statistical process guiding subsequent analysis.

Qualitative comments were collated manually - broadly based on a content analysis approach (Robson, 2002).

Professional Self-Efficacy Scale
One of the aims of including the questionnaire's self-efficacy section was to construct a psychometric measure of professional self-efficacy towards HIV-issues related to clinical practice. Respondents were asked to indicate the extent of their agreement or disagreement with each statement related to

clinical practice with HIV-positive clients on a (mostly) five point scale.

Consequently, ratings to these 18-items were applied to factor analysis with a view to generating an appropriate scale.

Response Pattern Analysis

Generally, responses covered the whole scale ('*strongly-agree*' to '*strongly-disagree*' (with the exception of B.11 - '*strongly-disagree*'). Additionally, all items had more than 2 responses per category cell (with the exception of B.13 - only one response). Table 2.1 outlines the analysis conducted:

Table 2.1: Mean responses ratings per category (Part B: Self-efficacy scale)

Response category	Total responses (18-items)	%-total responses (18-items)	Mean per category
(5) Strongly agree	199	**10%**	11
(4) Agree	513	**26%**	29
(3) Neither agree or disagree	518	**27%**	29
(2) Disagree	598	**27%**	33
(1) Strongly disagree	107	**6%**	6
Total	1939	**100%**	107

Subsequently it was decided to retain all five categories for analysis rather than collapse responses.

Item Analysis

Most respondents rated all items and there was little missing data; however, one respondent failed to answer six items (B.9, B.15, B.16, B.17, B.18), and two respondents on item B.6. The missing values command was used to replace these data with values derived from the series mean of the overall responses from that item.

To identify homogenous items within the scale, inter-item correlations were calculated. As B14 and B18 - both reflecting concerns - poorly correlated (corrected item-total correlations: 0.094; 0.017 respectively) and were removed from the item pool:

B14. I have ***concerns*** **regarding litigation or that I may be prosecuted** if I do not encourage clients to disclose their HIV status to sexual partners
B18. I feel **current DCP confidentiality *guidance is adequate*** to cover HIV criminalisation and related confidentiality issues

Subsequently, the average inter-item correlation (0.451) was good, but did not suggest multi-collinearity.

Scale Reliability

Cronbach's *alpha* is an index of reliability associated with the variation accounted for by the true score of the underlying construct (hypothetical variable) being measured. The items within the overall scale index were highly correlated (*alpha* =0.930), well above acceptable levels indicated by Nunnaly (1978). Thus it was concluded that the scale was a reliable and valid measuring instrument from which to indicate the quantity of the perceived professional self-efficacy among respondents.

2.1.4 *Participants (Survey)*

Data-Collection

Nine non-participants contacted the researcher declining participation, typically as they no longer practiced. A small number of individuals requesting participation (*'snowball'* effect) were also sent packs (both included in the calculation of the reported response rate).

Questionnaire Returns

In total 107 responses were included for analysis; the (adjusted) response rate was 22%:

110 completed questionnaires were returned (October 2006 deadline); three (2.7%) from non-psychologists (health advisor, counsellor & psychotherapist) were excluded from the data-set[1].

2.1.5 *Sample Descriptors (Demographic Information)*

The basic sample descriptors concerning the nature of the obtained sample are described below:

Profession

95% (N=102) were clinical psychologists and 5% (N=5) counselling psychologists:

All five counselling psychologists indicated sexual health experience (presumably from among the *HIV&SH Faculty* membership).

Ethnicity

97% (N=104) of respondents self-identified as White (either British/ Irish/ Other):

The remaining three respondents were Mixed White/Black, Mixed White/Asian, and Chinese - according to National Census 2001 classifications (*OPCS*, 2001).

Gender

78% (N=84) of respondents were female, and 21% (N=22) male[2].

Age

The median age of respondents was 40 years (range 26 - 77)[3].

Sexual-Orientation

In total, 18% of respondents (N=19) self-identified as either gay or bisexual, 82% (N=88) of respondents were heterosexual:

As only 5% (one male/ four female) identified as bisexual, the gay and bisexual categories were combined to create a *'non-heterosexual'* variable[4] (for convenience it is simply referred to as *'gay/bisexual'* hereafter). This merged group included 10 males and 9 females.

---

[1] One respondent failed to indicate any profession but perusal indicated it was from a psychologist, and so it was retained.

[2] One respondent (0.9%) failed to indicate gender.

[3] Two respondents did not indicate their age.

[4] This group included three respondents identifying their sexual-orientation (as: *'queer'*, *'lesbian'*, or *'non-discriminatory'*) within the *'other'* response option.

HIV-Status

The majority of respondents (99%) did not identify as HIV-positive:

Within this group; 68% (N=72) self-identified as HIV-negative, 31% (N=33) as HIV-unknown/HIV-untested, and one (0.9%) preferred not to say. Only one respondent (0.9%) identified as HIV-positive.

2.1.6 Clinical Practice Descriptors

The following presents the clinical characteristics of respondents; including general and sexual health experience:

Theoretical Orientation

The majority (64%) indicated CBT as the primary theoretical orientation used in clinical practice[5]:

The remaining 36% (N=39) non-CBT group were represented within the psychoanalytic/dynamic (8%), systemic (12%), humanistic (5%), and the open-ended '*other*' (typically eclectic/integrative -11%) response categories.

Clinical Experience

The following presents information related to general clinical experience:

Years Post-Qualification

The median years post-qualification was 8 years (range 0.5 - 53):

The male median was 14 (range 0.5 - 31), and 7 years for females (range 1 - 53)[6].

Number of Clients Seen

The most frequent response (mode) was more than 1000 clients, selected by 29% of the sample (N=31):

However overall, responses were widely spread among options (see Table 2.2 below):

Table 2.2: Clinical experience (number clients seen) of respondents

No. of clients	Frequency	%	Cumm. %
1 – 100	16	15.0%	-
101 –250	20	18.7%	33.6%
251 – 500	22	20.6%	42.2
501 – 1000	18	16.8%	71.0
1000+	**31**	**29.0%**	100%
Total	107	100%	

1. Median ratings have been emboldened for reference on this and subsequent tables.

[5] Within this calculation, seven answering 'CAT' (37% of 'other' responses) are included (total N=68) as the model includes a significant cognitive component.

[6] Four respondents (one male/three female) failed to respond (total N=103).

Sexual-Health Experience

The majority (62%) did not have sexual health experience; the high proportion (38%; N=41) which did was unsurprising as this subgroup was specifically recruited (see Table 2.3 below)**:**

Table 2.3 Level of sexual-health experience

Category	Frequency	% Total (sample)	Cumm. Total (SH-Exp'd)	Cumm. % (SH-Exp'd)
Less than 1 year	6	5.6%	6	5.6%
1 to 3 years	6	5.6%	11	11.2%
3 to 5 years	7	6.5%	19	17.7%
More than 5 years	**22**	**20.6%**	**41**	**38.3%**

The level of SH-experience among this subgroup also varied with 53% having more than 5 years (range 6 to 19 years; median=10).

Service Setting

27% (N=29) of the sample indicated currently working in a sexual-health, GUM or HIV-service settings:

The remaining 73% worked in a diverse range of settings/services; the next largest subgroup was those reporting to work with 'adults' (N=33).

Experience with HIV-Positive Clients

A large proportion (52%; N=55) of respondents had experience of working with HIV-clients:

Table 2.4 below outlines their level of HIV-experience:

Table 2.4: Level of experience with HIV-clients

Category	Frequency	% (Total sample)	Cumm. Total (HIV-Ex'd)	Cumm. % (HIV-Exp'd)
0 (no experience)	**52**	**48.6%**	-	-
1 – 10	19	17.8%	19	17.8%
11 – 50	9	8.4%	28	26.2%
50 – 100	8	7.5%	36	33.7%
100+	19	17.8%	**55**	**51.5%**
Total	107	100%		

Among respondents in sexual health settings (N=29), all had experienced HIV-clients, and only one respondent who did not.

However, 15 respondents within the generic clinical group (i.e. without sexual health experience) had experience of HIV-clients (14% of overall sample; 27% within the HIV-experienced group).

2.2 Focus Groups

2.2.1 Design

Selection of focus group and thematic analysis tools were made following consultation with criteria for judging the quality of qualitative research proposed by Henwood and Pidgeon (1992). The guidelines recommend good practice for ensuring rigour while acknowledging creativity; the rationales for use are described below:

Data Collection
Focus groups are discussion based interviews involving multiple respondents. It is the '*focussed*' ('*external stimulus*') and staged (i.e. by a '*moderator*') nature that separates it from other types of group interviews (Millward, 1995). Over recent decades, the method has gained a substantial foothold within applied (particularly health) psychology. One advantage of this method (opposed to individual investigation) is its '*isomorphism*' to the process of opinion formation and propagation in everyday life, in that 'opinions about a variety of issues are generally determined not by individual deliberation but through communication with others' (Albrecht *et al.,* 1993, p.540). Since social representations originate in communication and interactional processes, they are forged by people attempting to make sense of their lives; which provide a basis for action (Millward, *ibid*). This method therefore facilitates the investigation of social representations – their structure, processes, and identity-related phenomena (Breakwell, 1993).

For these reasons, focus groups were chosen as the appropriate tool for allowing flexibility to maximise thinking amongst participants. The exploration of clinical decision-making generated data derives from a closer understanding of psychologists' perspectives of the issues, providing an insight into the complex interpersonal processes operating during therapeutic work with this client group.

The use of a specific clinical vignette, designed for this purpose, provides a stimulus for participants' experiences, and an opportunity to explore specific clinical issues (e.g., confidentiality and professional responsibilities) arising in these contexts. Uses of vignette have also been used to investigate HIV-criminalisation (from the perspective of HIV-individuals, e.g. Dodds & Keogh, 2006).

2.2.2 Measures & Procedure

Clinical Vignette
An unfolding format was adopted, calculated to allow fluidity in discussions mirroring the therapeutic pathway of clients with psychology services.

Two vignettes (Appendix 2.2) were developed from recent clinical scenarios known by the author's supervisor. Both examples had evolved into multi-disciplinary discussions regarding the responsibilities of the professional team involved.

Vignette A was trialled during a pilot group, but the agreement was the case appeared too extreme, enhancing group consensus rather than generating wider debate.

Subsequent experience confirmed **Vignette B** presented more moderate (yet sufficiently complex) clinical dilemmas, the nuances of which resonated closer to participant's experiences and evoking greater variety in viewpoints. The vignette presented the events described briefly below:

> A young gay male client/patient recently HIV-diagnosed with a number of continuing sexual partners varied among anonymous-casual and semi-regular partners, including a (self-identifying heterosexual) married man with children. Later, other sexual partners become identifiable as also being clinic patients. The psychologist is presented with the dilemma of how to manage this knowledge within the team when their client's sexual partners are subsequently also diagnosed HIV-infected.

Ethnic characteristics were purposely not attributed to the example to allow participants to freely interpret and/or consider varied options.

Focus Group Protocol

Informed written consent was obtained prior to each group's commencement; following consideration of the ethical issues related to respecting the confidentiality of the discussions, as well as how concerns about another participant's clinical practice should be responded to appropriately. In all cases, it was agreed that participants should raise any concerns privately and directly to the other clinician involved. Discussions were semi-structured; firstly, by use of the vignette and then (in the latter half) by the discussion protocol below:

1. In the first instance: the researcher-moderator commenced by reading a portion of the **vignette** and asking: '*What do you think are the issues here and what would you do?*' (e.g. Group A: Lines 11 - 12). During case discussions, researcher's input was minimal (limited to clarifying queries) allowing free expression of viewpoints. Progression to the next stage occurred when the researcher assessed discussions had been exhausted).

2. Themes from the aforementioned workshop guided further **exploration of professional/clinical issues**. Open-ended questions invited consideration of specific aspects related to clinical issues (e.g., '*...how does that affect your practice and what concerns would you have...?*' (Group A: Line 843). In actual event, the researcher needed to intervene little, as all discussions were lively, spontaneous and fluid, covering a wide range of anticipated topics. Participants were encouraged to relate personal experiences and similar scenarios.

Feedback was highly positive; comments suggested participants enjoyed discussions as well as being professionally valuable. Durations were between 65 and 90 minutes (vignette lasting approx.1 hour).

2.2.3 Focus Group Participants

Participants were selected for experience working with sexual health issues, and HIV-positive clients:

Pilot Group

Composed of four members of a regional Sexual Health Special Interest Group

present during their quarterly meeting (Sept. 2006).

Main Groups
The remaining three groups were primarily recruited by mailing invitations to London/South East based members of the *HIV&SH Faculty*. Additional volunteers indicated interest after receiving the questionnaire. Groups were held during September/October 2006 at HIV/GUM-clinic psychology departments with relatively homogenous groups reflecting the hosting team; with a few additional (usually 1 - 2) participants who tended to be familiar with other members.

Selected locations represented a cross-section of clinical populations (e.g., significant gay male, Black/African heterosexual, and mixed client base). Between six and four participants (Total 15: 4 male/ 9 female) participated in each group. No other demographics were collected.

2.2.4 Thematic Analysis (TA)

Qualitative research 'is issue driven seeking exploration of the social world of respondents, and meanings that inform their understanding' (Flowers *et al.,* 2000, p.71). The use of TA is particularly suited to the study of local interactions related to the social context in which they occur. It facilitates greater flexibility to generate new thematic categories derived from participants' subjective meanings ascribed to events, and their associated phenomenal and social worlds (Pidgeon, 1996). The aim of the process has been to foster explanations that fit the data well; achieved through the iterative process of constant comparison and theoretical sampling – described by Bulmer (1979) as a 'flip-flop' between ideas and research experience.

Because TA is grounded in both essentialist and constructionist paradigms, Boyatzis (1998) characterises it not as a specific method, but as a tool to use across methods. In the current study, TA has been used for identifying, analysing and reporting patterns (themes) using a data-driven analytic form (i.e. neither primarily theoretical deductive nor purely inductive). This form allows for consultation with the literature as part of the thematic coding process of identifying and representing patterns within the data-set in relation to important aspects of the research question.

One of the benefits of TA is its flexibility unlike many other qualitative methods tied to, or stemming, from a particular theoretical epistemological position such as conversation analysis (CA) or interpretative phenomenological analysis (IPA) where there is little variation in how the method is applied (Braun & Clarke; 2006, *p.*78). It is argued that through its theoretical freedom, TA provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of the data. In this way, TA differs from other analytic methods that seek to describe patterns across qualitative data at the semantic content level before providing a secondary interpretation at the latent level. In contrast, TA attempts to incorporate and integrate latent aspects into the analysis (i.e. the interpretative thematic level) in order to derive themes which are closer to the data examining the underlying ideas, assumptions, and conceptualisations shaping the semantic content (descriptive thematic level) (Braun & Clarke; 2006, *p.84*). The endpoint is the reporting of the content and meaning of the patterns (themes) in the data in an attempt to theorise the

significance of the patterns and their broader meanings and interpretation (Patton, 1990).

Procedure

All four groups (including pilot) were taped and professionally transcribed verbatim without editing according to accepted conventions (O'Connell & Kowal, 1995). Transcripts (Appendices 2.3 - 2.6) were cross-checked for accuracy: few errors (mostly attributing narrative to wrong participants or omitting minor portions of difficult-to-hear sections) were found, in which case the contextual information held by the attending researcher proved valuable. Participant contributions are anonymised and references compromising psychologist/client identity removed. Detailed review of the narratives used the approach and process advocated by Braun and Clarke (2006), as described below:

1. A brief review and reflective-thematic sorting involved documenting excerpts by key words capturing the essential quality of the subject matter in the text (e.g., stigma and discrimination) with subsequent separation generated by the initial coding framework (following data-driven analytic TA principles).

2. Secondly, separation of (thematically labelled) comments and sorting into distinct categories representing second order themes. Once a core set of themes emerged, it was possible to identify latent themes (e.g. fear/anxiety) with associated clinical issues (e.g. engagement) emerging across all transcripts. Comparison of similarities and contrasts across categories included reference to exchanges between participants, analysed holistically in order to determine the context of expressions of opposing views.

The analysis attempted to capture the meaning attached to phenomena as well as presenting the range and intensity of issues expressed among groups. Parallel to this process, the research supervisor also conducted secondary analyses to enhance rigorousness:

3. The supervisor coded Transcript A independently: crosschecking of coding accuracy consisted of inter-reliability analysis comparing the application of thematic codes with coding undertaken by the author. Approximately 80% consistency was observed, with minimal disagreements regarding labels attached to excerpts rather than substantive disparity relating to content meaning. These discussions were also useful for clarifying boundaries, indicators and exceptions to thematic codes – thus providing a means for testing the integral validity of the coding.

4. Once the coding framework was agreed, the remaining transcripts (Groups B&C) were analysed, with the supervisor then inspecting additional excerpts chosen at random for consistency.

Data from the pilot focus group was not included in the thematic analysis presented although comparison of the pilot group transcript with the final thematic coding suggested good resonance. The process of trialling the pilot group was useful only for refining the stimulus materials, particularly the clinical vignette, used during the subsequent groups held. However, experiences of actual clinical scenarios offered by the pilot group participants have been included within the listing provided in Appendix 3.6.

Overall, eight exhaustive thematic categories were generated and have been reported with the following principles in mind. The task of the write-up is to tell the complicated story of the data in a way which convinces the reader of the merit and validity of the analysis; whereby the narrative goes beyond description and makes an argument in relation to the overall research questions. Although a clear sense of the scope and diversity of each distinct theme is made, the description of it attempts to clearly link back to the original research questions by using additional analyst narrative and illustrative data extracts. Extracts are used to illustrate particularly vivid examples of themes and (wherever possible) are embedded within the analytic narrative to demonstrate the prevalence of, or make sense of the complexity of the themes. This is done not by recognising the primacy of the participants' experiences but also by acknowledging the ways individuals make meaning of their experience; and in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and the other limits of '*reality*' (Braun & Clarke; 2006, .*p*.81).

Having summarised the characteristics of the survey sample and the method of analysis for the focus group data, both sets of results are presented almost immediately following consideration of their presentation.

2.3 Comparison of Survey & Focus Group Findings

Firstly, quantitative findings are presented, followed by an over-view of the thematic analysis, with excerpts of particular interest and clinical relevance. Commentary focuses upon exploring how the interaction of clinical and situational factors may effect therapeutic practice.

By reporting the meaning of statistical results in relation to these constructs, the author attempts to triangulate the quantitative findings in relation to the qualitative constructs emerging from the focus group data. For example, the thematic meaning of quantitative associations related to sexual health experience can be explored further within the accounts of focus group respondents. Thus, providing greater '*depth*' and '*richness*' to the survey data, relating the prevalence of clinical issues to their impact upon psychology practice, as described in the lived experiences of focus group participants.

Results - Questionnaire Survey

Criminalisation for Sexual Transmission of HIV:

Emerging issues and the impact upon clinical psychology practice in the UK

“

It's not when this will happen,

because it's only a matter of time...

but what's going to happen with this when it does?

”

Example Quotation 4 (Transcript A: Lines 73-81)

3.0 RESULTS

Overview

For clarity, results are presented in two sub-sections related to the main aims of the study, including:

Survey Results

Findings (3.1) appear corresponding with the sections of the questionnaire:

1. Descriptors of the prevalence of **clinical issues** with HIV-positive clients (3.1.1);
2. Analysis of self-efficacy factors including **willingness, confidence and perceived competence** to work with HIV-positive clients (3.1.2);
3. Reported **attitudes** towards HIV-prosecutions, and impact upon health promotion factors (3.1.3);
4. Quantitative (and some qualitative) data reports **training received, training needs, and departmental policies** (3.1.4).

A brief summary of statistical analyses exploring the **sample** of respondents relevant to potential sampling bias concludes this section (3.1.5).

Focus Group Results

Qualitative analysis relates the **themes around psychologists' attitudes towards HIV-criminalisation** and the impact of relevant clinical experiences upon their practice with HIV-clients (3.2).

Descriptive Labels

To simplify reporting of results, rather than using the full descriptive meaning of variables longhand, labels are used to conceptualise the construct or phenomenon (e.g., the influence of a construct upon clinical practice) under investigation.

For example:

Description	Composition/construct
SH-experienced:	(group with sexual health experience) used to describe the effect of SH-experience between groups

Since the purpose of analysis is not simply to report demographic findings, but interpret the significance of these constructs in relation to the research hypotheses, the author argues that this approach is justified.

Output of Statistical Analyses

Although a complete analysis of the data was conducted, findings essential to answering the research objectives only are presented. Whereas statistically significant findings are reported in full; only *p* values in parenthesis follow non-significant results. SPSS tables for major analyses are provided in Appendix 3.1 for confirmatory reference.

To ensure consistency of statistical descriptions across cases, the following reference system (Reg & Parker, 1992, p.203) is adopted for reporting effect

values (e.g. Cramer's *V*):

0.0 and under 0.1	- negligible
0.1 and under 0.2	- weak
0.2 and under 0.4	- moderate
0.4 and under 0.6	- fairly strong
0.6 and under 0.8	- strong
0.8 and under 1.0	- very strong

3.1 Questionnaire Survey

Initial Responses

Seven respondents commented on the direct clinical relevance of the study, including:

> *"...the important issues that you are exploring formed discussions within our team on a weekly basis. The general consensus was that we were lacking formative guidance on these issues, mostly in part because of a lack of healthcare/legal consensus on the best course of action. This lack of information is partly due to the complexities of applying a general law to complex human behaviours and coping strategies, and individual cases vary considerably. More information (particularly for medics) on the nature of sexuality and sexual behaviour" is one of the training needs we identified."*

> *"I think this will be a useful and timely resource for planning future needs and training requirements in the light of the criminalisation legislation [...] I think your study is very timely and will be of great interest to people in the HIV world. I do hope you will have the energy to publish this important piece of research"*

Additionally, 35 respondents (33%) requested notification of the findings. As encouraged by UH Research Degrees Regulations: Schedule C (point 6.2) a copy of the preliminary survey results has also been provided to the *HIV&SH Faculty.*

3.1.1 Part A: Clinical Practice Descriptors

This section reports results surveying clinical practice issues. Analysis refers only to those respondents with experience of HIV-clients (i.e. filtered Questions A12 - A19 focussing upon the prevalence of safer sex discussions and confidentiality related issues – e.g. note-taking and recording). Of these 55 respondents: Forty (73%) had SH-experience[1], and fifteen (27%) generic clinical experience[2].

Respondents were asked to indicate on a (mostly 5 point) scale: *'How often in your recent practice...'* the prevalence of safer sex discussions and confidentiality related issues (e.g. note-taking). Later, the incidences of legal related issues were solicited. A synopsis of the main findings is presented with commentary highlighting some of the more interesting observations. Tables presenting full statistical results are provided in Appendix 3.1 for further reference (and have been prefixed by A to indicate their location).

Safer Sex Discussions (Table A3.1: Q.12a)

Overall, 80% (N=44/55) of respondents reported having safer sex discussions with their HIV-clients (at least, on some occasions):

These included 95% of the SH-experienced subgroup compared to 40% of the generic group (55 point difference). The median response among the whole group overall and the SH-experienced subgroup was *'usually'*. However, among the generic subgroup it was *'never'*.

[1] All 29 from SH-settings are included within the SH-experienced subgroup.
[2] The single SH-experienced respondent without HIV-experience was excluded from analysis.

Note-taking Safer Sex Discussions (Table A3.2: Q.12b)
80% (N=44/55) of HIV-experienced respondents reported recording details of safer sex discussions in clinical notes:

Again, the SH-experienced subgroup did so more commonly (95% v. 40% - 55 point difference):

HIV-Disclosure Discussions[3] (Table A3.3: Q.12d)
82% (N=45/55) of respondents reported having discussions around disclosure of HIV-status to sexual partners, with their HIV-clients:

This included 92% of the SH-experienced subgroup, and 53% of the generic subgroup (39 point difference).

Confidentiality Information (Table A3.4: Q.12c)
85% (N=47/55) of respondents reported discussing specific details relating to the limits of confidentiality with HIV-clients:

Among these were 90% of the SH-experienced subgroup and 73% from the generic subgroup (24 point difference).

Raising Confidentiality Issues (Table A3.5: Q.12e)
Overall, 62% (N=34/55) of respondents raised confidentiality issues with HIV-clients during discussions regarding sex or sexual partners:

This included 65% of the SH-experienced, and 53% from the generic subgroups (12 point difference). Again, no differences among those in SH-settings were observed within the SH-experienced group.

Note-taking Confidentiality Discussions (Table A3.6: Q.12f)
84% (N=46/55) of respondents reported noting confidentiality discussions in clinical records, either generally or specifically:

The SH-experienced subgroup more commonly (20%) reported not noting confidentiality discussions, compared to the generic group (7%) – 13 point difference:

Changed Clinical Practice (Table A3.7: Q.12g)
Overall, 34% (N=19/55) of respondents reported having changed aspects of their clinical practice in recent years:

This included 43% of the SH-experienced subgroup (N=17/40), compared to only 13% (N=2/15) of the generic subgroup – 30 point difference.

Of the 19 who had changed their practice, 16 commented, including: discussing legal issues related to HIV-disclosure, and being more pro-active regarding disclosure to sexual partners most commonly. Interestingly, one respondent reported stronger sentiment towards not breaching confidentiality in response to HIV-prosecutions. Further information relating to the qualitative responses for this question, are outlined overleaf in Table 3.1:

[3] This question is presented out of sequence in order to place it within context of the themes presented

Table 3.1: Qualitative Responses to Q.A12g (additional information)

***Question A12g* (Additional Information)**	**Q.12g (yes) N=19 (%)**	**HIV-Exp'd %**
If yes [changed practice], **please briefly describe how:**		
Discuss legal aspects of disclosure/clients' legal responsibility to prevent infection *	**4** (21%)	7%
Promoting proactive disclosure to others	**4** (21%)	7%
Discuss HIV-criminalisation/prosecutions	**2** (11%)	4%
Amended record keeping/note-taking	**2** (11%)	4%
Cautious regarding legal action	**2** (11%)	4%
Responding to changes of prognosis/medication	**1** (5%)	2%
Do not break confidentiality	**1** (5%)	2%
Missing *	**3** (15%)	5%
Total	**19** (100%)	35%

* Both categories include one respondent from generic clinical settings

HIV-status Disclosure to Client's Sexual Partners (Table A3.8: Q.A13)
24% (N=13/55) reported having (at least once) considered disclosing a client's HIV-status without consent to their respective sexual partners:

Although this total includes 28% of the SH-experienced group (N=13), perhaps surprisingly also 2 (13%) from generic settings also responded. All 11 of the SH-experienced participants reporting considering disclosure related to sexual partners (i.e. 28% of the overall total) worked in SH-settings. Perhaps surprisingly, two (13%) from generic settings responded. One related to a cognitively impaired client requiring a capacity/competence assessment (including consideration of risk to others in a forensic secure setting).

HIV-Disclosure to Other Professionals (Table A3.9: Q.A14)
44% (N=24/55) of respondents reported having considered disclosure of clients' HIV-status to other professionals:

Respondents within the generic group reported so more frequently (60% v. 38% of those in SH-settings - 22 point difference). Among the 15 SH-experienced respondents who had considered disclosure to other professionals, 13 worked in SH-settings (45% of those in this setting). Respondents cited disclosure to GPs and other medical (including mental health) professionals, as well as immigration and child-protection, as shown in the full listing of qualitative responses in Table 3.2 overleaf:

Table 3.2: Qualitative Responses to Q.A14a (additional information)

Question A14a (Additional Information)	Generic N	SH-Exp N	Q.12g (yes) Total N	Q.12g (yes) % (N=22)
If yes [disclosure to professionals], **please briefly describe to whom and the circumstances:**				
GP	3	6	**9**	40%
Medical professionals	3	5	**8**	36%
Multidisciplinary teams	2	5	**7**	32%
Mental health professionals	0	6	**6**	27%
Legal/Immigration	3	2	**5**	23%
Housing/Social care	2	1	**3**	14%
Child protection (abuse/neglect)	0	2	**2**	9%

Multiple responses possible per respondent therefore do not equal 100% (no missing answers)

The high rate of contact with GPs among the SH-experienced group might be considered surprising given the confidential and anonymous status of GUM clinics, and the tendency for psychologists in generic settings routinely providing feedback to referrers and GPs.

Police Investigations (Q.A15)

Although no psychologists had been contacted personally by police, two commented that the team's Consultant had received requests (on one occasion each) for information regarding HIV-clients:

Both examples (N=2/55) were from psychologists with SH-experience working in SH-settings (7% of the SH-setting subgroup; and 4% of the SH-experienced subgroup). Both comments indicated that the medical Consultant assumed responsibility as a liaison for police enquiries. One resulted in a court report on behalf of the Defence (with consent), the other having given resuscitation advice in a life-threatening situation.

Subpoena for Psychology Notes (Q.A16)

Only one psychologist (with SH-experience) had been served a subpoena to provide access to psychology notes by court order:

Overall this represented 1% from the overall sample. Notwithstanding, this represented 2% of HIV-experienced respondents (or 3.5% among those from SH-settings). Additionally, another respondent indicated the Consultant had been instructed to provide access to medical records.

Client Disclosure of Intentional HIV-transmission (Q.A17)

9% (N=5/55) reported clinical experiences with HIV-clients of situations where they had been made aware of behaviour(s) that could potentially transmit HIV intentionally, thereby possibly considered to be criminal:

All were from the SH-experienced subgroup working in SH-settings (17% of all from SH-settings; or 12% of the SH-experienced subgroup – representing 5% of the overall sample). In response to these scenarios, all reported team discussions (100%), often including supervisors (80%) and management (60%). However, no respondents reported contacting the police directly (or pro-actively).

Client Disclosure of Reckless Sexual Behaviour (Table A3.10: Q.A18)

A large proportion (55%) reported clinical experience of discussions suggesting reckless sexual behaviour, potentially considered criminal:

These 30 respondents included, 65% of the SH-experienced subgroup (N=26/40), but also 26% from generic settings (N=4/15). Of the SH-experienced respondents reporting potentially reckless sexual behaviour, 21 worked in SH-settings (72% of all those from this setting). Most reported subsequent supervisory discussions (73%), discussion with the wider team (63%), and/or managerial consultation (40%). Four respondents reported '*keeping it to myself*' (inaction), with only one raising it with the HIV-client. In addition one example related to provision of the court report (on behalf of the defence party) aforementioned, with client consent. The full range of responses is shown in Table 3.3 below:

Table 3.3: Qualitative Responses to Q.18a (additional information)

Question A18a **(Additional Information)**	Generic N	SH-Exp N	**Q.18a (yes) Total N**	Q.18a (yes) % (N=30)
Please indicate what course of action, if any, you took after receiving this information [potentially criminal, reckless behaviour]:				
Discussed in supervision	2	20	**22**	73%
Discussed with team	1	18	**19**	63%
Discussed with manager	2	10	**12**	40%
Kept to self	0	4	**4**	13%
Medical & nursing professionals	0	2	**2**	7%
Discussed with patient	2	0	**2**	7%
Consultation for court report	1	0	**1**	3%
Discussed with police	0	0	**0**	0%

Multiple responses possible per respondent therefore percentages do not equal 100%

Consultation of Professional Guidelines

Mostly respondents described greatest consultation with NHS Trust Policy, followed by the BPS Code of Conduct for professional related issues:

Interestingly, reliance upon Trust policy was a greater consideration among those with SH-experience (100%) and/or in SH-settings (88%) than those from generic settings (0%). Referral to *HIV&SH Faculty* guidelines was greatest among those in SH-settings (58%). Perhaps surprisingly nine volunteered not making use of any documents. The full range of responses are shown in Table 3.4 overleaf:

Table 3.4: Responses to Q.A19 (Professional guidance)

Question A19	% Generic (N=11/15)	% SH-Exp (N=34/40)	% SH-setting (N=25/29)	Q.18a (yes) Total N	Q.18a % (yes) (N=45/55)
When deliberating over confidentiality issues, what documents do you refer to when deciding what course of action to follow?					
NHS Trust Policy	-	100%	88%	**34**	76%
BPS Code of Conduct	100%	92%	100%	**31**	69%
DCP Prof. Practice Guidelines	100%	88%	82%	**31**	69%
Departmental Policy	-	88%	95%	**22**	49%
Faculty of HIV&SH Guidelines	9%	52%	58%	**14**	31%
Do not refer to documents	0%	26%	32%	**9**	20%

Multiple responses possible per respondent therefore percentages do not equal 100%

Summary of Emerging HIV-issues

Although responses among the HIV-experienced respondents were well spread across the available range, some generalisations can be made between those working in generic clinical settings and those with SH-experience.

Benchmarking Clinical Practice

Table 3.5 overleaf summarises information for Q.A12a-f characterising the overall level of clinical practice (particularly confidentiality related) standards reported. The left column indicates the range of responses for the main group. The second column illustrates the median response category in descriptive terms. Finally, two columns present the median response for both subgroups. The first figure indicates the proportion indicating best practice (i.e. '*always*') and the second figure the cumulative proportion indicating the minimum practice standard (i.e. '*sometimes*'). The percentage in parenthesis refers to the percentage point difference between these two markers; suggesting the spread of responses across the continuum.

Similar to other clinical bench-marking systems (e.g. Clinical Outcomes in Routine Evaluation – CORE: Evans *et al.*, 2000), colour-coding has been adopted for presentation of median ratings: RED ('*never*' category); AMBER ('*sometimes*' or '*usually*'); and GREEN ('*often*' or '*always*') – e.g. the left green section indicates that the overall median response for question 12c was indicative of average practice (i.e. confidentiality limits were often discussed). The threshold of 'average practice' used has followed the precedent established by other clinical benchmarking systems (particularly CORE). However, it should be noted that adopting an alternative threshold to report against (e.g. '*usually*' or '*always*' responses as an indicator of best possible practice) would have resulted in a less nuanced picture (since the majority of cells would have been highlighted in red as below standard).

Table 3.5: Summary of Clinical Practice Standards – Questions 12 (a-f)

HIV-Experienced (Main Group)	***Questions A12 (a – f)*** **Median Responses**	**Generic Clinical** Subgroup	**Sexual health Experienced** Subgroup
Always –Sometimes (% Difference)	**Category Description (Median)**	Median & Cum. N	Median & Cum. N
22% - 80% (62%)	Q.A12a - Usually discuss safer sex with HIV-clients	60% **Never**	68% **Usually**
22% - 80% (62%)	Q.A12b - Usually note safer sex discussions in the clinical records	60% **Never**	68% **Usually**
20% - 82% (62%)	Q.12d - Usually discuss disclosure of HIV-status	40% **Usually**	70% **Usually**
45% - 85% (40%)	Q.A12c - Often discuss confidentially limits	53% **Always**	60% **Often**
13% - 62% (49%)	Q.A12e - Sometimes raise limits of confidentiality during sexual discussions	53% **Sometimes**	65% **Sometimes**
11% - 84% (73%)	Q.A12f - Record confidentiality discussions in general terms only	93% **General terms**	80% **General terms**

1. Coding values/categories: (4) Always; (3) Often; (2) Usually; (1) Sometimes; (0) Never

Findings suggest comparatively good levels of professional standards among psychologist-respondents involved in clinical work with HIV-clients, although the wide range of scores suggest room for improvement (i.e. in comparison of best practice possible to average practice reported). Although the two red sections correspond to the generic clinical subgroup, (both regarding safer sex discussions, and/or recording) this could either highlight a potential training need/skill deficit, or otherwise possibly reflect that HIV-clients may not present with relationship, or sexual related, issues commonly in these environments.

Professional Related Issues

Having presented a general indicator of current clinical practice among psychologist-respondents engaged in clinical work with HIV-clients, an overall brief sketch of the range and prevalence of professional issues related to HIV-prosecutions including legal/police involvements are summarised below:

- Overall, 34% (N=19/55) reported **changing aspects of their clinical practice** in recent years; mostly to include legal aspects to disclosure discussions, or being more proactive advocating HIV-disclosure (Q.A12);
- 24% (N=13) had **considered breaking confidentiality** to disclose a client's HIV-status to their sexual partners in both generic and SH-settings (Q.A13);
- 44% (N=24) considered **disclosing clients' HIV-status to other professionals** (usually medical/health) (Q.A14);
- Two psychologists (in SH-settings) reported that the team's Consultant

had been **approached by the police** for information regarding HIV-clients (Q.A15);

- One psychologist (in SH-setting) had been issued a **sub-poena** to provide access to psychology notes (Q.A16);
- 9% (N=5/55) reported clinical experiences of HIV-clients disclosing information relating to **potentially intentional HIV-transmission** (17% of those in SH-settings) (Q.A17).
- 55% (N=30/55) reported HIV-clients disclosing **potentially reckless sexual behaviour** (considered possibly criminal); including 72% among psychologists from sexual health settings (Q.A18).
- Overall 94% of psychologists said they usually referred to *NHS* Trust policy, with 58% in SH-settings citing the *HIV&SH Faculty* guidelines (Q.A19).

3.1.2 Part B: Professional Self-Efficacy Scale

The following section reports findings from the 16 item scale (reported in Method 2.1.3) aimed at tapping into aspects of self-efficacy related to clinical practice in light of HIV-prosecutions. The relationships between self-efficacy dimensions with group membership were explored using the index as an exploratory factor to compare ratings by the demographic and clinical variables identified, as well as enable some preliminary reporting of possible relationships between factors.

Self-efficacy & Clinical/Demographic Variables

Firstly, differences in mean ratings by group membership were explored - inspection of distributions and box-plots confirmed appropriate t'test use. Within the overall sample, significant differences were found between subgroup means for all groups (HIV-experience, SH-experience, SH-setting, sexual orientation) for the self-efficacy index. As the index is a measure of self-efficacy working with HIV-clients, this was to be expected – Related statistics: Appendix 3.1.

Mean scores for subgroups among those with HIV-experience only (N=55/107) were also investigated to further explore the above differences in self-efficacy, as detailed in Table 3.6 overleaf:

Table 3.6: T-test significance scores for self-efficacy ratings by HIV-experienced subgroup membership

Subscales/ Scale Total N=55	SELF-EFFICACY	
(*p* values – one-tailed)	Mean (St.D)	*t* (*p*)
SH-Experience Exp'd (N=40) Non-Exp'd (N=15)	55.92 (10.6) 47.13 (7.59)	**-2.933 ([a]0.001**) ****
Service-Setting SH-Setting (N=29) Non-SH (N=26)	55.31 (11.1) 51.54 (9.79)	-1.330 ([a]0.534)
Gender (*N*=54) Male (N=17) Female (N=37)	56.58 (14.4) 52.4 (8.21)	+1.360 ([a]0.09)
Sexual Orientation Gay/Bisexual (N=16) Heterosexual (N=39)	51.79 (8.49) 57.75 (13.9)	**-1.944 ([a]0.029*) ***

** highly significant (p<0.01) **significant* (*p*<0.05) [a]Levene's equality of variances not assumed

As expected, significantly higher ratings on the overall index were observed by the SH-experienced and gay/bisexual subgroups.

Pearson's correlations were then used to explore these associations since correlation co-efficients can be interpreted as effect-sizes, as shown in Table 3.7 below:

Table 3.7: Pearson's correlation co-efficients for self-efficacy ratings by HIV-experienced subgroup membership

Subscales/ Scale Total N=55	SELF-EFFICACY	
(All p values – one-tailed)	*r*	(*p*)
SH-Experience Exp'd (N=40) Non-Exp'd (N=15)	**+0.374 (0.002*)**	
Service-Setting SH-Setting (N=29) Non-SH (N=26)	+0.18 (0.095)	
Gender (*N*=43) Male (N=17) Female (N=37)	-0.185 (0.09)	
Sexual Orientation Gay/bisexual (N=19) Heterosexual (N=88)	**+0.258 (0.029*)**	

**significant* (*p*<0.05) emboldened
There were no significant results for theoretical orientation

Although both effect-sizes identified were moderate, the association with SH-experience was modestly stronger (i.e., r =+0.37).

Ratings of Concerns[4]

The two concern items excluded from the self-efficacy scale are now reported separately, as these items were not found to correlate (suggesting these are not overlapping concerns with the focus varied across subgroups).

Litigation Concerns

Overall within the sample, the median rating for concerns regarding litigation was neutral (3) but moderately skewed towards lack of concern (mean=2.91; St.Dev. 0.76; skew +0.16):

No significant differences were found in respect of HIV-experience, or other subgroup membership within the sample (with the exception of sexual orientation; gay/bisexual subgroup less concerned – p=0.013, one-tailed). However overall, most groups did not differ in the level of concern expressed regarding litigation.

Ratings to this item were then analysed by subgroup among those with HIV-experience only:

As shown in Table 3.8, Non-significant differences were found for the gay/bisexual subgroup only, who were more likely to rate their concerns lower than their counterparts.

Table 3.8 Comparison of mean scores by sexual orientation subgroup for HIV-experienced respondents – Question B14

Question B14	Descriptives (Mean scores)			T Test	
Grouping Variable Total N=55	**Mean Score**	**St. Dev.**	**Skew + / -**	***t*** (*df* =53)	***p*** one-tailed
Sexual Orientation					
Gay/Bisexual (N=16)	2.44	0.73	+1.43	-2.386	[a]**0.01***
Heterosexual (N=39)	2.97	0.84	+0.05		

*Indicates *significant* (p<0.01) [a]Levene's equality of variances not assumed

1. Three point scale: Lack of concern (2); to Concerned (4)

DCP Guidelines - Concerns

Within the overall sample, the median rating for concern regarding the DCP guidelines (i.e. disagreement they are adequate) was also neutral, but moderately skewed towards lack of concern (mean 3.19; St.Dev. 0.552; skew +0.6):

However among subgroups, significant differences were observed for HIV-experience, sexual orientation, SH-setting and SH-experience; all these groups were more likely to have greater levels of concern (Table 3.9 overleaf):

[4] As these items had the least spread among items within the scale, responses were first collapsed into three categories (e.g. '*strongly agree*' & '*agree*' became '*general agreement*').

Table 3.9: Comparison of differences in mean scores by subgroups for the overall sample – Question B18

Question B18	Descriptives (Mean scores)			T Test	
Grouping Variable Total N=107	**Mean Score**	**St. Dev.**	**Skew + / -**	***t*** (*df* =105)	***p*** one-tailed
HIV-Experience Exp'd (N=51) Non-Exp'd (N=50)	3.32 3.04	3.33 0.44	-0.31 +0.18	-2.756	**0.004***
Service-Setting SH (N=26) Non-SH (N=75)	3.45 3.09	0.57 0.52	-0.4 +0.13	-3.087	**0.002***
Sexual Orientation Gay/Bisexual (N=19) Heterosexual (N=88)	3.47 3.13	0.7 0.5	-1.0 +0.25	-2.548	**0.006***
SH-Experience Exp'd (N=38) Non-Exp'd (N=63)	3.34 3.09	0.66 0.45	-0.49 +0.36	-2.304	**0.01***

*indicates *significant* ($p<0.01$)

1. Three point scale: Lack of concern (2); to Concerned (4)

Again, ratings from this item were analysed according by subgroup membership among the HIV-experienced only, as shown in Table 3.10 below:

Table 3.10: Comparison of mean scores by theoretical orientation subgroups for HIV-experienced respondents – Question B18

Question B18	Descriptives (Mean scores)			T Test	
Grouping Variable Total N=55	**Mean Score**	**St. Dev.**	**Skew + / -**	***t*** (*df* =53)	***p*** one-tailed
Theoretical Orientation CBT (N=33) Non-CBT (N=22)	3.19 3.55	0.58 0.59	-0.93 -0.03	-2.235	[a]**0.015***

*indicates *significant* ($p<0.05$) [a]Levene's equality of variances not assumed

1. Three point scale: Lack of concern (2); to Concerned (4)

Non-significant differences were found for all groups, excluding theoretical orientation. The non-CBT subgroup only were more likely to rate their concerns regarding adequacy of *DCP* guidelines higher than their counterparts.

Summary of Professional Self-efficacy Findings

The following brief synopsis outlines the associations found with self-efficacy ratings:

Self-Efficacy Index

Within the overall sample, significant differences were found between subgroup means for all groups (HIV-experience, SH-experience, SH-setting, and sexual

orientation) for the self-efficacy index, as would be expected for an index which is a measure of self-efficacy working with HIV-clients.

Mean Differences (Table 3.6)
Among those HIV-experienced, mean scores in the overall index by the SH-experienced and gay/bisexual subgroup were significantly higher. These factors accounted for between 26% - 37% of the variance in responses (moderate effect-size - Table 3.7)

Concerns

Although the two concern items were neither inter-related, nor correlated with the self-efficacy scale(s), differing concerns were observed among the subgroups:

Litigation (Table 3.8)
Overall within the sample, ratings for litigation concerns were neutral but moderately skewed towards lack of concern:

- However among the HIV-experienced respondents, significant differences were found for the gay/bisexual subgroup who rated their concerns lower.

DCP Guidelines (Tables 3.9 & 3.10)
Within the sample, concerns regarding the adequacy of the DCP guidelines were neutral, (skewed towards no concern) although the various SH-experienced subgroups and the gay/bisexual subgroup all rated significantly greater levels of concern.

- However, among those HIV-experienced, no such differences were found within any of the SH-experienced subgroups except those not using a CBT-orientation had higher levels of concern.

Generally variations in the levels of concern reported were moderate.

3.1.3 Part C: Attitudes towards HIV-criminalisation

A summary of results replicating the UK-Coalition survey is now reported - refer to Appendix 3.2 for a full summary of UK-C (2005) published results. For ease of comparison, findings from both surveys are presented adjacent to each other in bar-chart format (exact statistics relating to the frequencies reported by psychologists are provided in the additional tables provided within Appendix 3.3). Results from this current study are labelled BPS (2006), and the UK-Coalition survey as UK-C (2005)[5].

Question C1:	***In your view should the Crown prosecute [intentional and/or reckless HIV transmission]?***

Overall, results indicated very high support among psychologist-respondents for HIV-prosecutions:

In total 81% of psychologists indicated supporting prosecutions for either

[5] Sample size for both surveys: 107 (BPS) and 233 (UK-C). In the UK-C survey, 71% (N=165) identified as HIV-positive and 29% (N=68) did not identify as HIV-positive (Total N=233).

'*intentional*' and/or '*reckless*' HIV-transmission; compared to 64% of all UK-C respondents. The percentage point difference between both surveys for these two response categories combined is 17%.

The greatest contrast in responses can be observed in the relative lack of support among psychologists for '*don't prosecute*' (6%) compared to the UK-C sample (34% - 28% point difference). A summary of responses relating to Q.C1 for both surveys appears below:

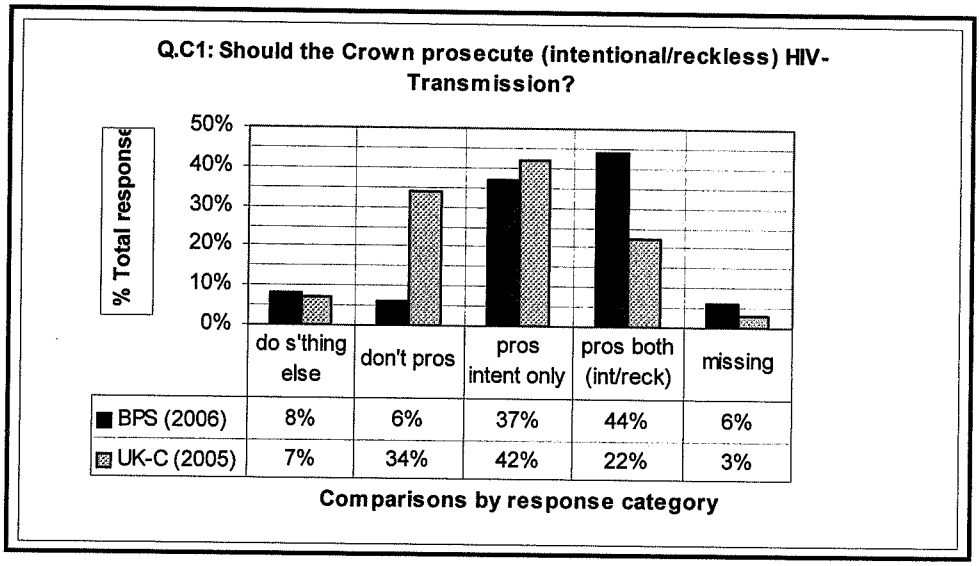


Figure 3.1: Comparison of BPS & UK-Coalition surveys – Question C1

Attitudes Towards HIV-Prosecutions (HIV-Status Groupings)

To assess differences in support for HIV-prosecutions among the psychologist sample in comparison to the HIV-status groups within the UK-C survey, responses were also compared to each subgroup separated[6]:

The disparity of support among psychologists for 'intentional/reckless prosecutions' relative to the UK-C sample is more distinct when compared to the HIV+ group alone (i.e. 44% of psychologists supported prosecutions for both intentional/ reckless transmission compared to only 11% of HIV+ UK-C respondents - 33% point difference) – as shown in Figure 3.2 overleaf:

[6] The single HIV-positive psychologist's responses have been excluded to allow a true contrast between (non-HIV) psychologists and the sero-discordant groups within the UK-C sample.

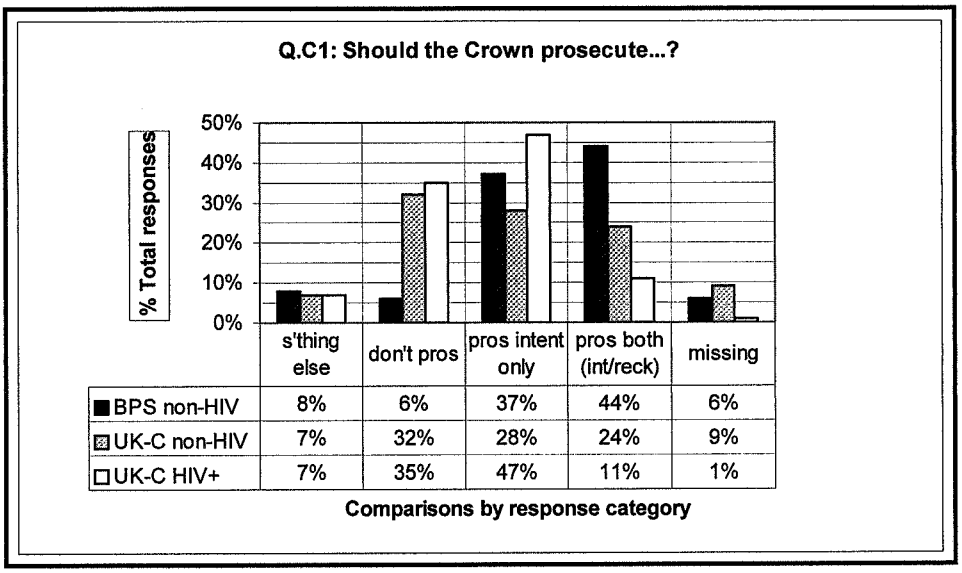


Figure 3.2: Comparison by HIV-status group for BPS & UK-C surveys – Question C1

Attitudes Towards HIV-Prosecutions (Psychologist Groupings)

To explore differences in support for HIV-prosecutions within the psychologist sample, ratings from Q.C1 were analysed[7] using cross-tabulations to determine the variations in response frequencies by subgroup membership, as shown in Table A3.11 of Appendix 3.3:

Significant variation in the response frequencies of responses was observed among respondents of the following subgroups: SH-experienced (Cramers' *V*=0.389, *p*=0.001 one-sided), **Gay/Bisexual** (*V*=0.351, *p*=0.001), **as well as among those working in SH-Settings** (*V*=0.305, *p=0.001*) **and the HIV-experienced** (*V*=0.273, *p*=0.023).

As a whole, members of all the above subgroups were significantly less likely to want to pursue HIV-prosecutions and if considered were more likely to support prosecution for *'intentional only'* transmission. These tendencies demonstrated moderate effect-sizes.

In general, analyses of psychologist responses using comparisons with the non-HIV/HIV+ subgroups (UK-C survey) showed more differentiated (although smaller) findings and therefore are only presented relating to the remaining questions[8].

Question C2:	***Should the government change the law, which has been used to criminalise HIV-transmission?***

Attitudes Towards Changing the Law (HIV-Status Groupings)

The largest difference (20% points) observed was between support by

[7] Responses to Q.C1 were recoded to combine the '*do something else*' and '*don't prosecute*' categories (value=0) for analysis.

[8] Comparisons with the combined UK-C sample appear in Appendix 3.3 for information.

psychologists and the lack of support among the UK-C HIV+ subgroup, for creation of a law for 'intentional/reckless' transmission:

The second largest difference (17% points) was also with the HIV+ group, who tended to favour a law for '*intentional transmission*' only:

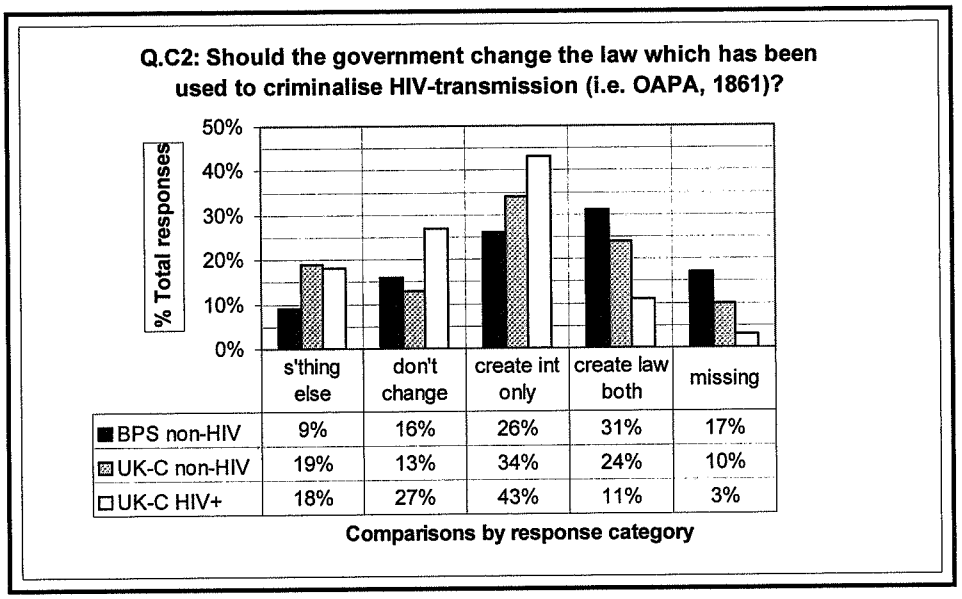


Figure 3.3: Comparison by HIV-status group for BPS & UK-C surveys – Question C2

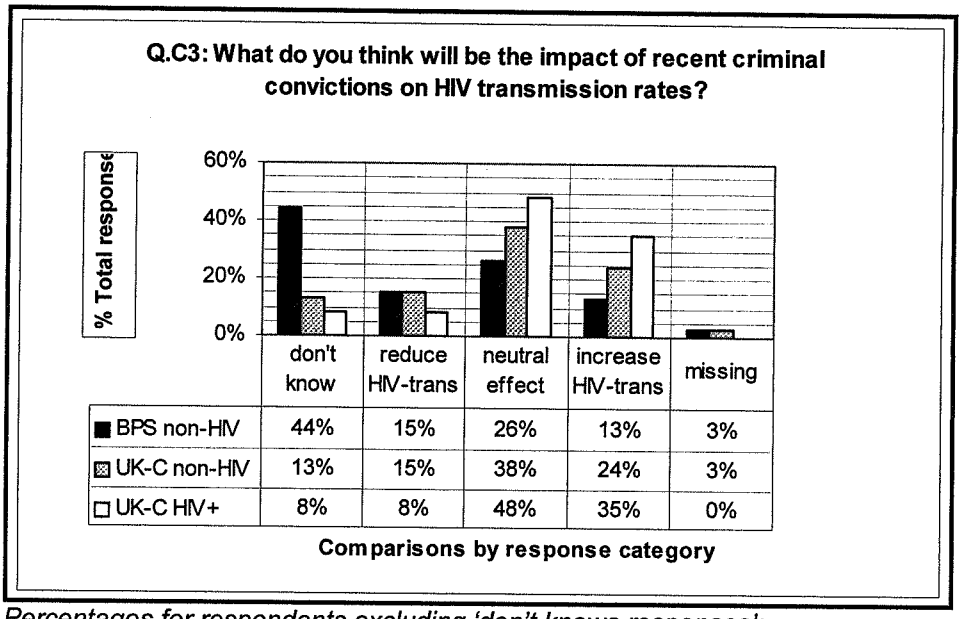
Attitudes Towards Changing the Law - Psychologist Groupings

The only significant variation observed was among the sexual orientation grouping, with the gay/bisexual subgroup (Cramers' V=0.277, p=0.02 one-sided) **moderately less likely to be inclined towards supporting creation of a law including *'reckless transmission'*** – as shown in appendixed Table A3.12.

Question C3:	***What do you think will be the impact of recent criminal convictions on HIV-transmission rates?***

Impact of Prosecutions on HIV-transmission (HIV-Status Groupings)

A high proportion of psychologist-respondents (44%) stated '*don't know*', perhaps reflecting lack of knowledge or interest in HIV-issues. Figure 3.4 summarises responses by HIV-status groupings, including additional percentages below the actual table relating to the proportion of responses excluding those respondents who indicated '*don't know*' responses) - overleaf:



Percentages for respondents excluding 'don't knows responses':
BPS: 27% reduced; 47% neutral effect; 23% increased.
UK-C non-HIV: 19% reduced, 50% neutral effect, 51% increased,
UK-C HIV+: 9% reduced, 53% neutral effect, 39% increased.

Figure 3.4 Comparison by HIV-status group for BPS & UK-C surveys – Question C3

Among those psychologists <u>not</u> expressing *'don't know'* to this question, most (47%) rated a neutral effect upon HIV-transmission rates:

Although similar proportions within the UK-C sample also rated a '*neutral effect*', interestingly the non-HIV subgroup rated '*increased HIV-transmission*' <u>higher</u> than both the HIV+ subgroup or psychologists (51% v. 39%/23% – refers to percentages below table):

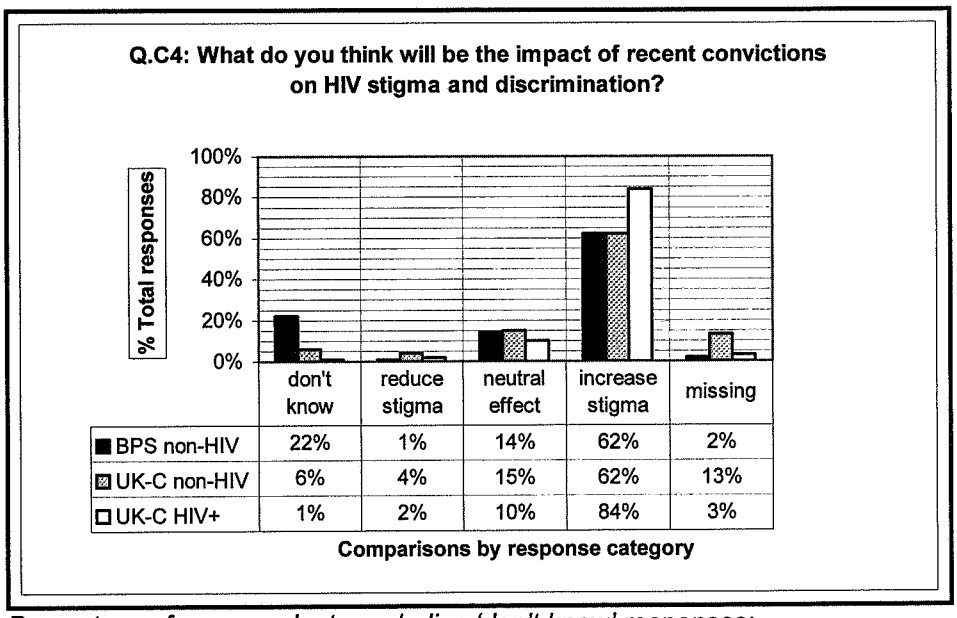
<u>Impact of Prosecutions on HIV-transmission (Psychologist Groupings)</u>
All the following subgroups demonstrated a significant tendency towards rating *'increased HIV-transmission'* as a consequence of HIV-prosecutions[9]: those working in SH-Settings (Cramers' V=0.496, p=0.001 one-sided), **the SH-experienced** (V=0.485, p=0.001) **and HIV-experienced** (V=0.421, p=0.004), **as well as the gay/bisexual subgroups** (V=0.316, p=0.03) – with moderate to fairly strong effect-sizes observed:

Full statistics are shown in the Table A3.13 of Appendix 3.3.

Question C4:	***What do you think will be the impact of recent convictions on HIV stigma & discrimination?***

<u>Impact on HIV-Stigma/Discrimination (HIV-Status Groupings)</u>
The majority from all groups (62%-84%) agreed that recent convictions for HIV-transmission would increase HIV-stigma & discrimination *(Table 3.5):*

[9] Again, the '*don't know*' response category was excluded from calculations.



Percentages for respondents excluding 'don't know' responses:
BPS: 1% reduced; 18% neutral-effect; 80% increased.
UK-C non-HIV: 2% reduced, 5% neutral-effect, 76% increased,
UK-C HIV+: 2% reduced, 11% neutral-effect, 88% increased.

Figure 3.5: Comparisons by HIV-status for BPS & UK-C surveys – Question C4

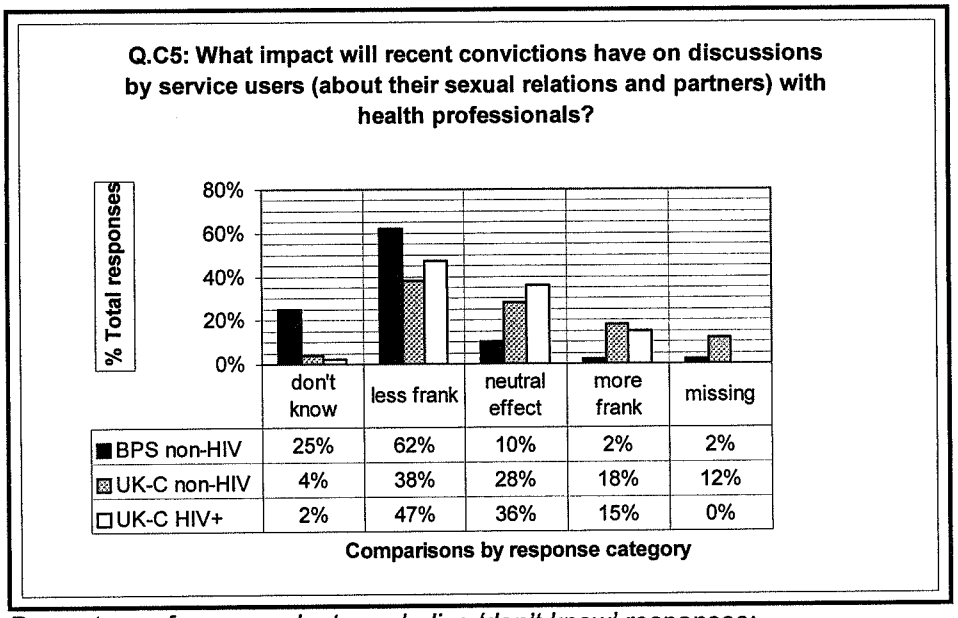
Similar and substantial proportions from both surveys held this belief. Likewise, no significant variations were observed for psychologist subgroups' responses.

Question C5:	***What impact will recent convictions have on discussions by service users with health professionals?***

Impact upon Health Professional Discussions (HIV-Status Groupings)

Overall, 62% of psychologists rated their belief that discussions with health professionals would be less frank following recent HIV-prosecutions:

This compared to 38%/47% of the non-HIV/HIV+ subgroups from the UK-C sample respectively – shown overleaf.



Percentages for respondents excluding 'don't know' responses:
BPS: 84% less frank; 14% neutral-effect; 3% more frank.
UK-C non-HIV: 46% less frank, 33% neutral-effect, 21% more frank,
UK-C HIV+: 48% less frank, 36% neutral-effect, 40% more frank.

Figure 3.6: Comparisons by HIV-status for BPS & UK-C surveys – Question C5

The high percentage of psychologist-respondents rating discussions as '*less frank*' can be observed more distinctly among the remaining respondents once those indicating '*don't know*' are excluded from the analysis (i.e. calculations below graph). Here, although only 3% of psychologists considered such discussions would be '*more frank*', whereas 40% from the HIV+ subgroup suggested so (37% point difference).

No significant variations were observed in the response frequencies between any psychologist subgroups suggesting similarity of opinion.

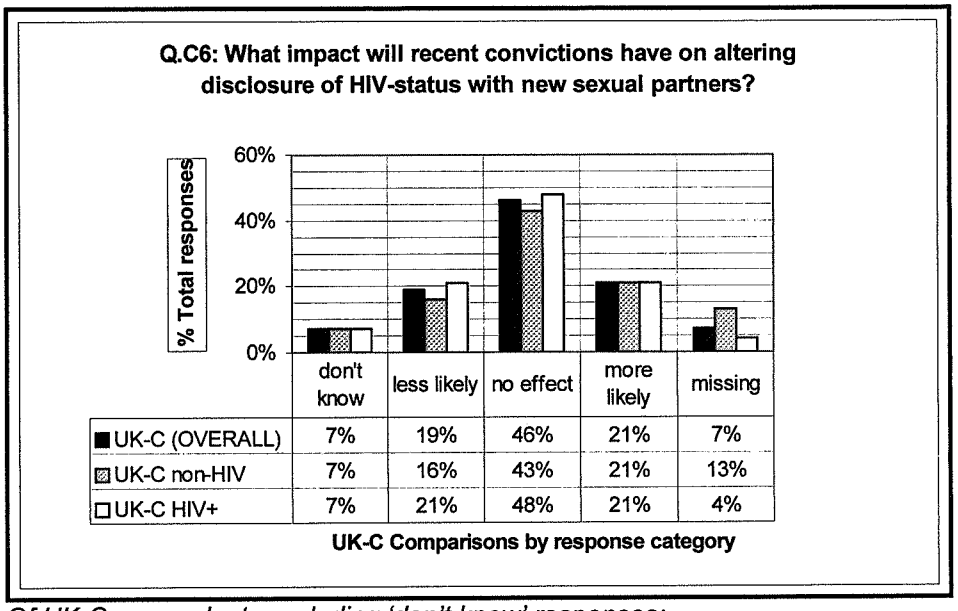
Questions C6-8:	***What impact will the recent criminal convictions for sexual transmission of HIV have on altering disclosure of HIV-status with new sexual partners [...]?***

The UK-C survey asked respondents on the effect of prosecutions upon disclosure generally (i.e. HIV-status not specified), whereas the current survey asked psychologists to rate the effect upon individualised HIV-status possibilities separately.

UK-C Survey Responses

Among the UK-C sample, both non-HIV and HIV+ subgroups rated the effect upon altered HIV-disclosure to sexual partners similarly:

The majority rated '*neutral effect*' (43% - 48%), with the remainder split almost proportionately between '*less likely*' (16% - 21%) and '*more likely*' (21%), as detailed in Figure 3.7 overleaf:

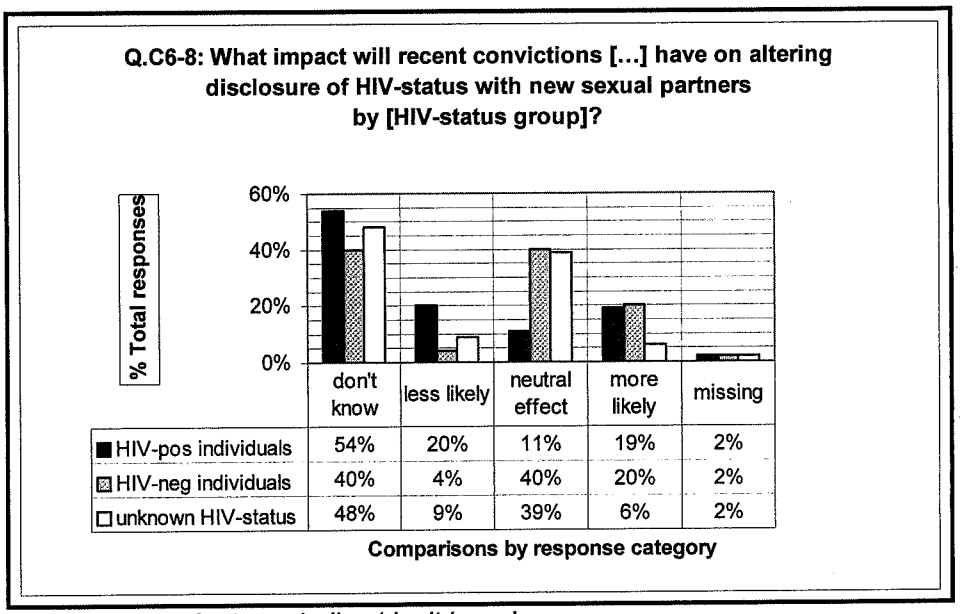


Of UK-C respondents excluding 'don't know' responses:
All sample: 22% less disclosure, 54% neutral-effect, 25% increased.
Non-HIV subgroup: 20% less disclosure, 53% neutral-effect, 28% increased.
HIV+ subgroup: 23% less disclosure, 53% neutral-effect, 24% increased.

Figure 3.7: Comparisons of UK-C response totals – Question C6

Psychologist Survey Responses

A summary relating to the impact upon HIV-status disclosure (specified separately) appears below:



Of BPS respondents excluding 'don't know' responses:
HIV+ individuals: 40% less disclosure, 22% neutral-effect, 38% increased.
HIV- individuals: 6% less disclosure, 63% neutral-effect, 31% increased.
Unknown status: 16% less disclosure, 73% neutral-effect, 11% increased.

Figure 3.8: BPS response totals – Questions C6-8

Although a large proportion of psychologists stated '*don't know*' to these questions[10], the following inferences can be made based on the responses from the remaining respondents:

- Opinion was divided upon the effect upon HIV-positive individuals disclosing their HIV-status to sexual partners;
- The majority rated a '*neutral effect*' upon the disclosure of HIV-status among HIV-negative individuals (63%) and those with unknown HIV-status (73%).

In conclusion, although psychologists appeared to be in general agreement regarding the neutral impact of prosecutions on the HIV-disclosing behaviours of HIV-negative individuals, there was no such consensus of opinion regarding the effect upon HIV-positive individuals.

Although precise comparisons with the UK-C sample cannot be made, the majority of UK-C respondents rated a neutral effect upon individuals generally.

Summary of Attitudes to HIV-Criminalisation

The following synopsis outlines the attitudes reported by psychologist-respondents, including comparisons with UK-Coalition survey findings (below):

HIV-Prosecutions (*page 40)*
Overall, 81% from the psychologist sample supported prosecutions for either '*intentional*' and/or '*reckless*' HIV-transmission:

- Support among psychologists was relatively higher than the UK-C sample, showing greatest disparity when compared to the UK-C HIV+ subgroup.

Among psychologists, the gay/bisexual, SH- and HIV-experienced subgroups as well as those in SH-settings were all significantly less supportive of prosecutions for '*intentional*' HIV-transmission (moderate effect-sizes).

Law/Legislation Change *(p.42)*
Overall, the psychologist sample was moderately more favourable towards supporting a law including '*reckless*' HIV-transmission than the UK-C sample;

- The largest disparity in attitudes was between psychologists and the HIV+ subgroup (20% points).

However, significantly less support among psychologists within the gay/bisexual subgroup was observed in this respect (moderate effect-size).

Impact on HIV-Transmission Rates *(p.43)*
Overall, psychologists were less likely to believe that prosecutions would result in increased HIV-transmission than the UK-C survey:

- Among the psychologists who did not answer 'don't know' (i.e. the remaining 56% of the sample) to this question, most rated a 'neutral effect' (47%), the UK-C non-HIV subgroup rated '*increased transmission*' higher than both the HIV+ subgroup, or psychologists.

[10] No statistically significant variations in responses were found among subgroups.

Among psychologists with SH- or HIV-experience, and those in SH-settings or gay/bisexual subgroups, ratings were significantly more likely to rate '*increased transmission*' (fairly strong to moderate effect-sizes).

Impact on Stigma/Discrimination *(p.44)*
Overall, psychologists were more likely (62%) to rate '*increased stigma/discrimination*' resulting from HIV-prosecutions:

- There were no significant variations in responses among psychologist subgroups, and similar response profiles were observed with both UK-C subgroups, suggesting general agreement.

Impact on Discussions with Health Professionals *(p.45)*
Both psychologist and UK-C respondents believed that HIV-prosecutions would make sexual related discussions with health professionals 'less frank':

- Notably, only 3% of psychologists (*excluding the proportion of respondents answering 'don't know' to this question*) considered discussions would be '*more frank*'.

Impact on HIV-Disclosure to Sexual Partners *(p.46)*
Among the UK-C sample, both non-HIV/HIV+ subgroups rated the effect upon altered HIV-disclosure similarly with the majority (43% - 48%) rating '*neutral effect*'; and the remainder split proportionately between '*less*' or '*more likely*'.

- Among psychologists opinion was divided upon the effect upon HIV-positive individuals. Although the majority rated '*neutral effect*' upon HIV-negative individuals (63%) or those with HIV-status unknown (73%).

However, there was no significant difference among psychologist subgroups regarding the impact of HIV-prosecutions upon HIV-disclosure.

3.1.4 Part D: Training Needs & Service Policies

The following section reports training and departmental policies surveyed [although this section was optional, few respondents (N=3/107) did not provide information]. Main findings comparing responses from the HIV-experienced, SH-experienced and SH-setting subgroup respondents are presented, as well as a basic content analysis of responses. The cross-section of qualitative comments below illustrate the diversity of responses presented with the full listing presented in Appendix 3.4 in addition to the full statistical tables relating to findings reported in this section.

Training Received

Overall, 39% (N=42/107) of psychologist-respondents reported having received some training relating to HIV-issues (Table A3.25). **However, some of these specified this was basic HIV-awareness training received many years ago.**

Among those respondents with HIV-client experience, 51% had received training compared to only 27% of the generic group (Table A3.14); whereas among the SH-experienced respondents, 64% had received training (similar to those currently working in SH-settings - 62%) – Table A3.15:

Of the 42 respondents answering this question affirmatively, 37 indicated additional information: Of these, 83% indicated some training relating to HIV-criminalisation, HIV-prosecutions or legal issues. The most frequent response (30%) was from those who had undertaken continuing CPD within their teams, as shown in Table 3.11 below:

Table 3.11: Q.D1a (Training received)

Question D1a **(Additional Information)**	**N**	Q.D1a % (yes) (N=37/42)
Have you received any formal training regarding sexual transmission of HIV or any associated issues related to clinical practice? **If *yes*, please describe briefly:**		
Former basic training (e.g. nursing or HIV-awareness courses)	11	30%
Emergency situation training	1	3%
Transmission issues (basic)	8	22%
Specialist placement	2	5%
Basic training sub-total	22	58%
Team CPD	**11**	**30%**
***HIV&SH Faculty* Workshop**	**7**	**19%**
Reading group	**4**	**11%**
Induction training (HIV-legal issues)	**3**	**8%**
Home Office/CPS	**2**	**5%**
Law & legal issues (generic)	**2**	**5%**
Voluntary sector training (legal issues)	**2**	**5%**
HIV-criminalisation training sub-total	**31**	**83%**
Missing	5	14%
Total comments from 37 respondents	53	

Multiple responses possible per respondent therefore percentages do not equal 100%

Interestingly, three psychologists indicated HIV-legal issues training as part of their induction. The remaining 58% of comments indicated basic training, generic in nature, including former professional training (e.g. nursing) or attendance at HIV-awareness courses.

Additional Information

Comments from (HIV-experienced) psychologists with training, included one faced with a *'national emergency'* (presumably related to a high-profile legal case). Some indicated the issue was a regular topic at team meetings. One stated that in-house training by a Trust solicitor had been unsatisfactory:

All my Training was done within this context since we were faced with a national emergency
Yes. Involved in health education since [year], numerous conversations via statutory and NGOs (THT). Updated via reading and discussion with colleagues. I [...] make every effort to keep up with evidence based knowledge on transmission
Yes – I am a provider of training. Have had some training by a Trust solicitor – this was clearly a disaster! He was clearly homophobic and sexually prudish!!
Yes. I work in a medical-setting and our weekly teaching has regularly covered this area, from all angles – bio-psycho-social
Attended a couple of conferences/workshops/presentations. Has been a topic of discussion at staff meetings at work. Have kept abreast of issues on internet based HIV-treatment/prevention websites

Comments from (HIV-experienced) psychologists without training included those with training being organised.

Training Needs

Overall, 69% (N=74/107) of psychologist-respondents reported having some training needs relating to HIV-issues

Among those with experience of HIV-clients, 73% indicated training needs compared to 65% of the generic group (Table A3.16); whereas among respondents with SH-experience, 61% had self-identified training needs, a slightly higher proportion to SH-settings (55%) – perhaps because those in SH-settings constituted many of those having already received training in Q.D1 – Table A3.17. Of the 74 respondents answering affirmatively, 66 indicated additional information; with 6% (N=4) stating training was non-essential. Most remaining comments (N=70) referred to clinical/legal issues raised by HIV-prosecutions, or explicitly 'legal liability' – see Table 3.12 below:

Table 3.12: Q.D2a (Training needs)

Question D2a **(Additional Information)**	**N**	Q.D2a % (yes) (N=66/74)
Do you feel you have any training needs related to dealing with sexual transmission of HIV issues in your clinical practice? **If *yes*, please describe briefly:**		
Law (legislation, case-history) & legal issues	**12**	**18%**
More information (confidentiality/ethical)	**11**	**17%**
Inform practice change	**11**	**17%**
Legal liability	7	11%
HIV-awareness (update)	3	5%
Applicability to own service	2	3%
Policy dissemination	1	1.5%
Training for discussing sexual-transmission	1	1.5%
Not essential	4	6%
Missing	8	11%

1. Single response per respondent only

Comments from (HIV-experienced) psychologists with training needs included many suggesting urgency. A common concern related to confidentiality and legal issues. One raised the differing law/legal system in Scotland:

Definitely, especially the changing nature of litigation in these circumstances and the responsibilities of clinicians. Helpful to have some forum to discuss these issues with other clinical psychologists working in the area and agree on clear guidelines for good practice
Not me personally, but I know colleagues who are desperate for training/supervision. I also worry about colleagues who think they DON'T need training/discussions on this topic
Yes. My responsibilities for discussing criminal transmission with clients, note-taking and how (if at all) our rules of confidentiality need to be altered. NB – Also addressing client fears and increased stigma due to prosecutions and media coverage of this issue
Fundamentally – as a psychologist what is our RESPONSIBILITY LEGALLY!? We can know too much about clients and what do we do with that information!?
There needs to be continual updating of a fast moving situation – events/ court cases can quickly change case law and this has implications for our clinical practice/confidentiality/responsibilities as clinicians

Comments from (HIV-experienced) psychologists without training needs appeared to be from experienced clinicians or those with related training. Many expressed that training and clear guidelines were important for professionals to avoid misunderstanding and/or malpractice. *For example:*

However I would welcome all my colleagues getting training on the law and having a chance to discuss cases. This is an emotive topic and people can misinterpret the law as meaning that professionals have to make people disclose
No – but the legal issues and responsibilities have been unclear. Good guidelines for practice have been missing: BASHH are in the process of publishing guidelines much needed in a very challenging area of work
No, but I believe all clinicians need regular and ongoing briefings on current status of the law, and to have a say in how to maintain best practice consistently
Not until any further changes to the law made – feel guidelines are sufficient (just about) at the moment

Most from generic settings commented training would be useful (or at least, insufficiently awareness of the issues); many appeared to work with vulnerable populations (e.g. learning disabilities or at-risk adolescents) or particular settings (e.g. forensic or drug/alcohol). Indicated training needs were for update briefings regarding the legal situation and confidentiality/ethical implications. Some suggested accessing further information if a HIV-client presented. A representation of comments appears below:

I hadn't really considered it prior to receiving this questionnaire – but it has made me realise that I do have training needs on these ethical issues, confidentiality with this specific are [sic]
I would if I worked with anyone who was HIV-positive. I would need an update on current knowledge about transmission and safe practices, likelihood of transmission through different practices etc
Training on all of the issues identified here would be very valuable

Psychologists (generic settings) without training needs suggested infrequent (if ever) contact with HIV-clients (including one indicating a former client had a HIV-positive partner but always '*scrupulously protected his identity*').

Service Policy

Overall, 60% (N=64/107) of respondents reported not having (or at least not being aware of) a departmental policy related to HIV-transmission:

19% (N=19) reported having a policy, or being in the process of developing one.

- Among HIV-experienced psychologists, 28% indicated a departmental policy (i.e. 21% detailed & 7% under review) compared to only 6% of the generic group – Table A3.17:
- Among SH-experienced respondents, 39% indicated a policy (detailed or under review), slightly lower than those from SH-settings (45%) – Table A3.18:

18/19 respondents answering affirmatively, commented: Three indicated their service policy was to inform the sexual partners of clients' HIV-status (where reluctant themselves, and sexual partners were also known patients). Generally, responses indicated that SH-services were taking a more pro-active role in encouraging HIV-disclosure and HIV-testing – refer to Table 3.13

overleaf:

Table 3.13: Q.D3 (Policy principles)

Question D3 **(Additional Information)**	**N**	Q.D3 % (yes) (N=18/43)
Please briefly outline below the principles of any policy regarding clinical practice and HIV transmission issues within your service:		
Under review/being developed	**4**	**22%**
Seek advice of line/service manager	**4**	**22%**
Disclose HIV-risk to known clients only	**3**	**17%**
General confidentiality only	**3**	**17%**
Follow *HIV&SH Faculty* lead	2	11%
Increased emphasis on HIV-transmission risks	1	6%
Encourage HIV-testing	1	6%
Missing	1	5%
Total Comments	18/43	42%

Comments from HIV-experienced psychologists suggested some services reviewing their policies, with medical professionals leading this approach within teams. A number stressed the need among psychologists for caution while awaiting updating of relevant guidance (e.g. *BHIVA, BPS*), or resistance towards more rigorous practice and/or policy change. *For example*:

If another client of the service is being put at risk of HIV-transmission by a client of our service, the HIV-positive person is encouraged within a time frame to disclose their HIV-status. If they fail to do this, their consultant doctor will take it upon himself to disclose the client's status and offer their sexual partner an HIV-test
There has been a move in the last few years for the clinic to move towards disclosing to known partners of positive patients – which is a change as in the past this wasn't addressed as much with patients. That we advise clients re: disclosure and safer sex, that we document these discussions. That we consult with senior clinical staff regarding any cases where we are concerned about client risk to others
We are reviewing policy in light of convictions and will comply with BHIVA guidelines as we work as part of a multidisciplinary team that is clinician led. It's important that professionals do not overreact to this and think of best practice for the welfare of our patients and contacts. Notes have always been potentially subject to court proceedings. I think staff should contact their legal department if notes are requested by the police.
Criminalisation of the sexual behaviour of HIV+ people is unjust and scape-goating placing entire responsibility for the safety of the encounter upon the HIV-positive person. Issues of coercions, lack of power are not addressed in making the HIV+ solely responsible for 'safety'

Finally, a number of psychologists (N=14/107; 14%) also commented positively on the timing or usefulness of the survey.

Summary of Training & Policies

The following brief synopsis summarises training/policy information reported:

Training Received *(p.49)*

Findings suggest comparatively good levels of training (51%) among psychologist-respondents involved in clinical work with HIV-clients (compared to the generic group –14%):

- However, training among psychologists in generic-settings tended to be more HIV-awareness orientated. Whereas, SH-experienced psychologists reported training directly related to HIV-prosecutions.

Some psychologists in SH-settings indicated training was now received during induction to new posts.

Training Needs *(p.51)*
Overall, 69% of all respondents (N=74/107) indicated some training needs related to HIV-transmission and the implications from prosecutions:

- 73% (N=40/55) of psychologists with experience of HIV-clients reported need for further training, most commonly related to more specialist information regarding confidentiality and legal/professional implications;
- Psychologists in generic-settings were more likely to indicate more basic needs (e.g. update briefings), particularly among those working with vulnerable populations or forensic/drug & alcohol settings;
- 61% of SH-experienced psychologists, and 55% in SH-settings reported unmet need; comments suggested this was prioritised. Some reported frustrations regarding how to manage sensitive information disclosed by HIV-clients;
- Many SH-experienced psychologists without identified training needs reported training essential for clinicians working in this area to avoid misunderstanding and/or malpractice.

Some psychologists working with HIV-clients also highlighted that training was required on how to approach, respond and discuss problematic sexual behaviour issues, including specific mention of Motivational Interviewing.

Service Policy *(p.52)*
Overall 19% of all psychologists reported (some kind of) departmental policies in response to HIV-prosecutions, including 45% of those from SH-settings.

Many comments suggested services becoming more pro-active encouraging HIV-testing and HIV-disclosure (to sexual partners). Others highlighted the need for professional restraint and consideration of the wider issues in clinical practice around HIV-clients.

3.1.5 Assessing Sampling Bias within the Survey

An over-representation of gay/bisexual respondents within the survey was anticipated; also predicted was a positive association between SH-experience and experience with HIV-clients. To assess the extent these demographic factors influenced findings, statistical analyses (outlined in McCormick & Hill, 1997) explored the composition of subgroups, including associations with specific clinical variables.

The following presents a summary of these findings (expanded in Appendix 3.5):

General Clinical Experience
As no significant differences in post-qualification experience with sexual

orientation, HIV-experience or other clinical variables were observed, findings therefore are unlikely to be primarily an artefact of differences in relative levels of general clinical experience between subgroups.

Demographic Factors

Inspection of descriptive and frequency data explored the proportion of gender/sexual orientation respondents within the sample:

- Heterosexual Female Subgroup (71%)
- Heterosexual Male Subgroup (11%)
- Homosexual (Male/Female) Subgroups (9%) each

Any demographic imbalances apparent are likely an artefact of both the comparatively higher proportion of sexual orientation minority groups working in SH-settings, and/or this group's increased towards the research topic.

More surprisingly ethnic minorities were under-represented (less than 3%) among the sample, with none within the gay/bisexual subgroup.

Sexual Health Experience

To investigate the inter-relation of these specific demographic factors, associations between the SH-experience of respondents was explored further: As male and female respondents were as likely to work in SH-settings, or have SH-experience as not, analysis focused upon the levels of SH-experience between and within the sexual orientation subgroups.

Within the overall sample, gay/bisexual respondents generally had greater SH-experience than their heterosexual counterparts:

The association was highly significant and the tendency demonstrated a fairly strong effect-size (Cramer's *V*=0.439) accounting for **19% of the variance** in frequencies of SH-experience between these groups. However further exploration within the SH-experienced subgroup alone (N=55/107), showed non-significant differences in the level of SH-experience between sexual orientation or gender subgroups suggesting similarity among respondents within the SH-experienced subgroup overall.

Experience with HIV-Clients

HIV-Experience has been measured according to respondents answering positively to experience with HIV-clients (i.e. exposure).

The following summarises the composition of respondents with HIV-experience, including associations with other clinical/demographic variables:

- As expected, having SH-experience was significantly correlated with the number of HIV-clients seen confirming these were largely overlapping groups (**53% variance**):
- Only 16% (N=3/19) of the gay/bisexual group did not have experience with HIV-clients (**9% variance**):
- Within the overall sample, males were significantly more likely to have HIV-experience (**7% variance**):
- All 10-gay/bisexual males and six (of nine) female gay/bisexual

respondents had experienced HIV-clients (**19% variance**):

The association between gay/bisexual orientation and experience with HIV-clients was highly significant, however these correlations demonstrated only moderate effect-sizes upon the sample overall. For example, although 84% of the gay/bisexual group (N=16/19) had HIV-experience, this only represented 30% of the overall group (N=16/55). Within (the overall sample) those in the heterosexual group were as likely to have HIV-experience as not (44% vs. 56%) and neither were differences found between levels of HIV-experience within the sexual orientation subgroups.

Summary of Sampling Factors

While the observed over-representation (gay/bisexual SH-experienced respondents) potentially skews statistical results (particularly, findings of psychologist' attitudes towards HIV-prosecutions); it must be remembered that this sampling method was required to achieve a reasonable sized group of SH-experienced respondents to compare differences between the interaction of psychologist's attitudes and clinical experiences. The limitations of the selected sample are that indications cannot be over-generalised (to psychologists as a homogenous population). However despite the relative (gay/bisexual male) over-representation within the sample, both genders was balanced.

Therefore, it was concluded that the proportion of the sexual orientation (sub-) groups within the sample was an adequate reflection of the diversity of sexual orientations among psychologists working in these settings. Additionally, the sample's composition allowed the opportunity to explore these factorxs interaction upon survey findings.

Demographic Summary

This deductive synopsis indicates the general characteristics attributed to significant groups participating in the survey. These characteristics typify the majority of respondents[11]:

All groups were comparable in terms of relative general clinical experience, however, respondents typically shared the following similarities:

- White/British, 40-year old,
- HIV-negative, female heterosexual,
- Clinical psychologist (8 years qualified; 1000+ clients),
- Not working in a sexual health setting or any SH-experience.

However, although half the sample had experience with HIV-clients, those respondents with HIV-experience were more likely to share the following characteristics:

- Gay/bisexual (either male/female),
- Working in a sexual health setting with SH-experience (19 years),
- Moderately greater experience with HIV-clients (100+ vs. 50-100).

[11] Typical refers to the dominant characteristics within the groups based on reported findings.

This group formed a sizeable subgroup within the sample but did not appear to dominate the survey's findings.

Results - Focus Groups

Criminalisation for Sexual Transmission of HIV:

Emerging issues and the impact upon clinical psychology practice in the UK

“

...these issues we are getting pressured to think about

now this is the law

and that would be a feature in my mind...

so that would affect my dynamic for sure

”

Example Quotation 22 (Transcript A: Lines 53-59)

3.2 Focus Groups Results

The focus of the qualitative findings presented here is upon providing a general thematic over-view of the issues related to the impact of HIV-criminalisation upon clinical practice as articulated by the focus group participants:

Thematic Categorisation

Overall eight thematic categories provided the greatest explanatory power to the analysis. Coffey and Atkinson (1996) suggest that forming clusters of themes is a useful way to organise the code: that is, to organise the array of identified themes that appear to have a relationship with each other. A cluster can be thought of as a higher-order theme or meta-theme which assists in presenting the analysis or interpretation in a meaningful manner coherent to the reader. Constellations of individual themes are therefore presented within the framework of the following three overarching domains. These domains pertain to issues relating to the socio-political, therapeutic and clinical/legal spheres which emerged, as shown below:

DOMAIN 1: *(Themes 1 & 2)*	**The impact of HIV-Criminalisation upon the socio- political context**
DOMAIN 2: *(Themes 3, 4 & 5)*	**Power and judgement within the therapeutic sphere**
DOMAIN 2: *(Themes 6, 7 & 8)*	**Complexity of new legal and clinical issues**

A diagrammatic representation conceptualising the format of the thematic analysis appears in Figure 3.9 overleaf. Related themes have been clustered into domains representing different modalities of the therapeutic system broadly reflecting the Orlinsky *et al.* (1994) model of psychotherapy. For example, themes related to the institutional and cultural patterns of society which constitute the environment of, and context for, therapy (the *'input variables'*), have been placed adjacent to each other on the outskirts of the diagram. Similarly, themes related to the therapeutic role and function which influence the compatibility of the client-therapist's therapeutic bond have been clustered in the central ring. Finally, themes related to the ethical issues identified which may place professional and legal limitations to confidentiality, and therefore an effective therapeutic alliance, are placed at the core of the model. In this way, the diagrammatic representation might be thought to be conceptually similar to Bronfenbrenner's (1979) Ecological Model of Development whereby the contexts are nested within each other. For example, the socio-political context is overarching and encompasses the other two domains; and similarly, the therapeutic domain encompasses the clinical and legal issues as well as its own specific themes.

As can be seen, the diagram also shows a horizontal plane crossing through the diagrammatic model and dividing the encircled thematic domains by the *'critical'* and *'less critical'* strands of participants which emerged from the analysis. This reflects the two broad strands to the responses expressed towards HIV-prosecutions (i.e. opposed and qualified support respectively), each informing participants' understandings of the wider issues involved; and thus how the themes were articulated by different strands during the focus...

Criminalisation for sexual transmission of HIV:

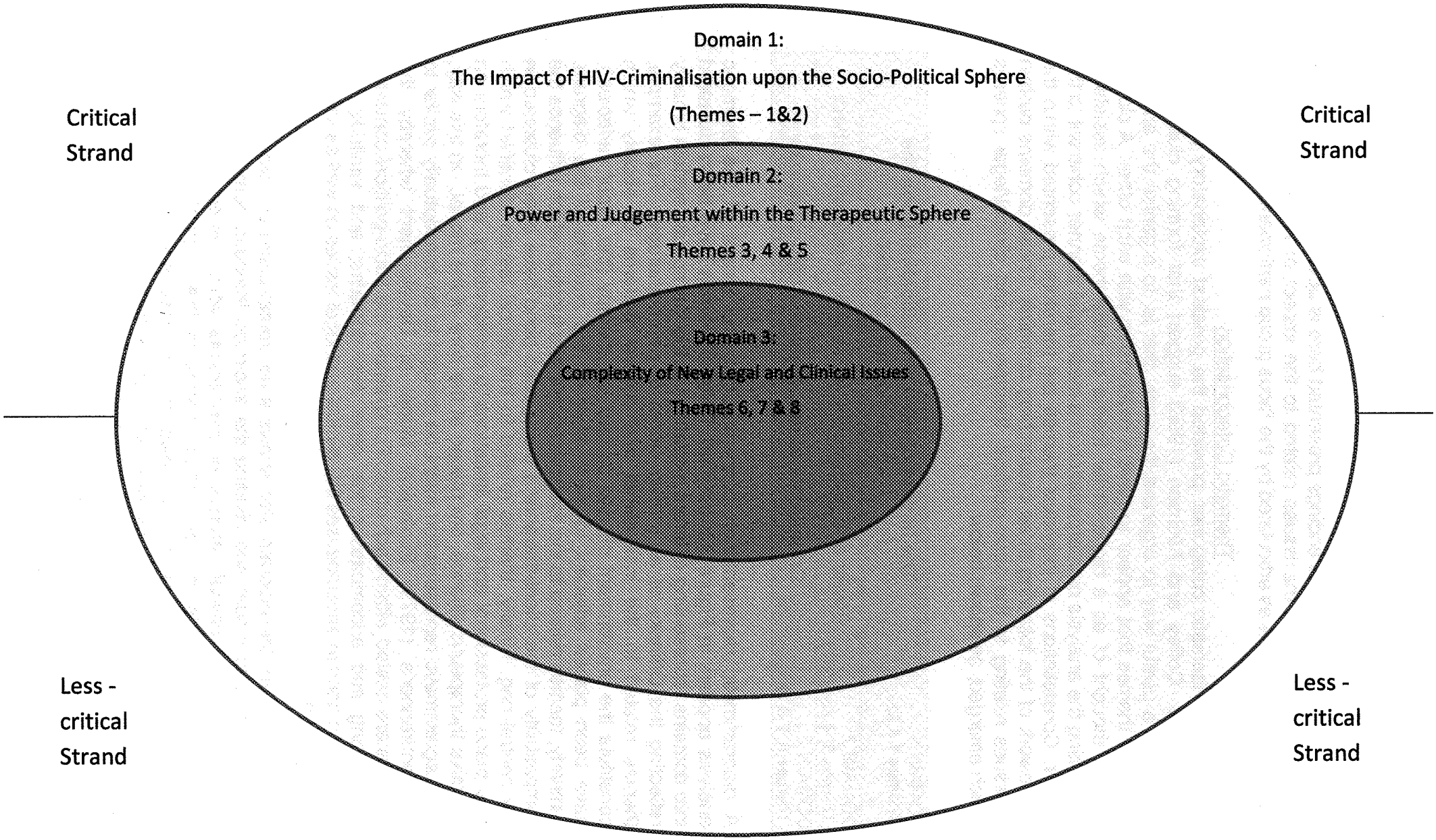


Figure 3.9: Diagrammatic representation of thematic analysis

group discussions. However, this '*stranding*' does not represent part of the thematic methodology used, yet it does reflect a main finding integral to the analysis; that is, that although there was largely consensus among the participants regarding the clinical issues impacted by HIV-criminalisation, how each grouping perceived these issues appeared to be strongly influenced by their a-priori stance towards HIV-prosecutions. As these differing perceptions were found to be prevalent throughout the analysis, they have been outlined at the start (in the introduction to Domain 1) as an aide to the reader's comprehension. The decision to adopt such a strategy was based upon two important considerations:

> Firstly, initial attempts at presenting the thematic analysis without introducing the concept of participant strands until the analysis' conclusion was unnecessarily confusing and resulted in undue duplication and cross-referencing of concepts. Review of initial drafts of the thematic write-up by the research supervisors, and subsequent discussions, recommended that for the purposes of clarity consideration be given to framing the findings within the context of this factor from the outset. Further reflection by the researcher of the experience of facilitating the focus groups, and noting the clear divide in the opinions expressed, suggested that this accurately reflects the general tone of the discussions and had not influenced the process of categorisation and coding of the actual themes which had emerged (since this presentational matter was employed after coding had been completed).
>
> Secondly, reference to the literature documenting the process and theoretical underpinning of thematic analysis appeared to support this practical decision on how to present the thematic units identified. For example, Boyatzis (1998, *p.*160) quotes Wolcott (1994) as stating that 'descriptive use of thematic analysis is desirable if the methodology chosen for the study requires it'. Furthermore 'neither does it preclude using the information to portray the themes and describe the units of analysis [...] if using both aspects of thematic analysis enhances the clarity of results or findings and ease of communication'. Boyatzis (1998, *p.*161) suggests that this does not violate any tenets of qualitative methods as long as it has not influenced the determination of validity of the themes or code. Thus aspects of the [research] inquiry and its communication to others can be enriched through use of the qualitative '*depth*' of the thematic information, as long as there is consistency of judgment (i.e. reliability) throughout the reporting.

The coding format prescribed in Boyatzis (1998, *p.*31) for structuring a useful, meaningful code have been followed, as is now described. Firstly, thematic labels which are conceptually meaningful, close to the data, and communicate the essence of the theme have been developed. In this case the labels adopted aim to reflect the flavour of latent themes associated with specific clinical issues. Secondly, a definition of what the theme concerns (i.e. the characteristic or issue constituting the theme) is given. The themes themselves are presented using descriptive indicators illustrated by relevant excerpts[12] where appropriate.

[12] Some quotations have been simplified (i.e. removal of '*you know*' etc) although the meaning has not been altered. However, unedited excerpts used are emboldened within the transcripts contained in Appendices 2.3 - 2.6 to enable the reader to place them within context if wished.

Descriptive indicators are a description of how to know when the themes occurs (i.e. indicators on how to '*flag*' the theme within the data-set). Finally, boundaries to descriptive indicators (or '*qualifications*' as named in these findings) are also employed selectively in order to compare and contrast the perspective of different groups of respondents in relation to identified themes.

Boyatzis suggests formatting the thematic analysis in this manner is desirable to 'capture the qualitative richness of the phenomenon' under investigation.

The number of participants articulating aspects of descriptive indicators across the data-set (signified by use of '*the majority*', '*many*', '*some*', '*few*', etcetera) has been used to broadly indicate the relative strength of themes, (c.f. Braun & Clarke, *ibid)*

Thematic Analysis

An introduction to each domain briefly conceptualises the commonalities between related themes, before elaborating specific clinical issues of interest to each theme within the domain separately:

3.2.1 Domain 1 (Themes 1 & 2)

DOMAIN 1: (Label)	**The impact of HIV-Criminalisation upon the socio- political context**
Related THEME 1:	***HIV-prevention: Policy uncertainty, ambiguity of legal impact & professional insecurity***
Related THEME 2:	***Anxiety & fear: Reflecting, reinforcing & addressing HIV-related stigma & discrimination***

The consensus among all focus groups was that HIV-criminalisation currently dominates the field of HIV-issues suggesting a wide-reaching socio-political impact. Although no participants reported direct involvement with a prosecution, actual examples (see Appendix 3.6) included cases described as '*near misses*'.

All groups recognised that although the occurrence of cases directly impacted is currently low, the clinical issues raised are becoming more common. For example, the following participant reported a police complaint following HIV-diagnosis. Although not entirely clear which (or if all) individuals were clients at the same GUM clinic, the possibility of this situation arising led to a multidisciplinary discussion regarding the ethical dilemmas raised:

> *P6: "It's interesting because it will evolve [...] a week ago I found out in the clinic somebody went to the police station who was with two gay men, one didn't want to disclose to the other but the other found out and he went to the police, and the positive man was treated in our clinic, and now we are losing contact with him so we don't know what's happening but we thought, what if someone found out that we knew their [sexual] partner was positive and we didn't tell them so they started to get angry in some way. Maybe it's not when this will happen 'cos it's only a matter of time, but what is going to happen with this when it does?"*
>
> *EXAMPLE 4 (A: 73-81)*

As well as alluding to an increase in the phenomena of allegations, the

expectation that such a scenario will inevitably arise within clinical practice was considered '*high risk*' due to the uncertain professional implications.

It was also evident that there were broadly two strands among participants in their attitudes expressed towards HIV-prosecutions (i.e. opposed and qualified support) which influenced their judgement of its socio-political impact. As these attitudes also appeared to inform the participants' understandings of the clinical issues involved, and therefore are referred to throughout the analysis, they are outlined below:

Opposition to HIV-Criminalisation (*critical strand*)

These participants were more likely to identify the issues as '*political*', attributing moral undertones to the motives behind the policy's implementation. Participants in Group A (and one in Group B) reflected this position more consistently, objecting to the use of the criminal law per-se as undermining human rights approaches to HIV-prevention:

P8: *"I think the criminalisation thing is not to do with public health it's basically a moral position really and where people sit with regard to retribution..."*
EXAMPLE 1 (Group A: Lines 340-341)

This strand was supportive of the profession adopting a higher profile influencing policy development, although this was considered too political for the BPS.

Qualified Support of HIV-Criminalisation *(less critical strand)*

This strand broadly expressed some support for a more stringent legal policy, although still expressing some reservations around its implementation. Commonly these participants described disillusionment that psychological approaches to HIV-prevention have had limited effectiveness, emphasising how the law could potentially operate as a wider prevention mechanism for achieving behavioural change.

Participants explicitly supportive of prosecutions (at least in some circumstances) were few (i.e. only two). Comments indicated their belief in the principle that individuals could sometimes be morally justified to make use of legal redress regardless of the wider sociological impact from such actions:

P2: " I'm not sitting on the fence but I do agree that legally people should be held responsible for if you want to use the legal term reckless behaviour where they do harm people even if there are psychological explanations for why they do that [...] but I also agree with the other side that because HIV's stigmatised and the groups affected by HIV are hugely marginalised that it's hugely complicated"
EXAMPLE 2 (C: 1761-1766)

Also within this strand, were a greater number who sympathised with the message of prosecution if not entirely its application (including many from Group B). These focussed upon the pragmatic difficulties of synthesising legal and professional responsibilities, including ways the message from prosecutions could be re-constructed within the clinical context more usefully:

P2: *"...some of the things that are in law, they are hopefully good messages for society and I think one of those is that you do think about other people, about their health and you take responsibility for that yourself when you are in relation to, for example, disclosing your HIV status, I mean that is a good message and if that has to be backed up in law and kind of publicised then that's not a bad thing by itself."*
EXAMPLE 3 (A: 1229-1234)

Although these participants acknowledged concerns regarding the shared responsibility of safer sex (expressed by the critical camp), they also stressed responsibility for others' welfare.

Both themes relating to the socio-political context are now presented in greater depth:

THEME 1:	***HIV-prevention: Policy uncertainty, ambiguity of legal impact & professional insecurity:***

Definition

Both strands described the destabilising impact upon HIV-prevention policy. This situation was compounded by the lack of direct empirical knowledge regarding the impact of HIV-criminalisation on an individual, social or epidemiological level.

The following excerpt and descriptive indicators demonstrate this theme:

P2: *"...if you look at it on a global level, Britain has a success story at managing HIV, we don't have an epidemic ranging out of control [...] people come to this country to learn about how we address HIV and that's because there has always been a harm reduction philosophy throughout services here [...] instead of using the law as a blunt instrument to clamp down on people or behaviour [...] so why are we reversing that by going for a policy that's completely at odds with what's been working really well here''*
EXAMPLE 5 (A: 667-675)

Indicator 1: Policy implications

Concerns expressed were not confined to clinical considerations but also extended to the impact upon the wider social context:

All discussions referred to how prosecutions have altered the socio-political landscape for HIV-prevention to some extent either directly (i.e. implications for clients/professionals) or indirectly by contrasting philosophical differences between a health education (non-judgemental/neutral) and legal approaches (judgemental/critical). These altered the social and cultural environment within which the therapeutic system is located.

Qualification

The critical strand were more concerned that recent legal developments signalled a change in policy:

These participants considered the current framework of evidence based interventions (e.g. harm minimisation) are being undermined as a result.

Indicator 2: Epidemiological consequences

All groups were concerned that criminalisation could adversely impact

efforts to normalise and de-stigmatise HIV:

These issues were related epidemiologically, for example through the effect on sexual risk behaviour and HIV-disclosure. Participants referred to professional uncertainty regarding the influence upon infection rates, reporting the need to establish an evidence base by monitoring international trends. However, the current socio-political climate created ethical and practical difficulties for conducting and disseminating research in this area, particularly when '*sensitive*' findings could lead to increased discrimination for affected communities.

Indicator 3: Professional insecurity

Criminalisation raised professional anxieties, particularly regarding the implications for clinical and ethical issues:

Commonly, these related to the difficulties of working in an environment-in-flux. Some suggested that health professionals in the UK were relatively unaccustomed to working with legal issues with tensions reflecting difficulties adjusting to a more litigious climate. Fear of being held professionally liable was considered to be driving the collective need for reviewing service policies, reflecting the theme of individual versus shared responsibility echoed through discussions on HIV-disclosure. This institutional anxiety was contributed to by the structural and organisational changes in the NHS also impacting upon professional roles.

THEME 2:	***Anxiety & fear: Reflecting, reinforcing & addressing HIV-related stigma & discrimination***

All groups expressed concerns that HIV-criminalisation may increase HIV-stigma and discrimination, particularly in relation to the disproportionate effect upon vulnerable groups. Therefore the therapeutic sphere may be impacted by social discourses that both reflect and reinforce negative stereotypes.

> *P2: "...people bring it as an issue and I have encountered quite a few people recently who come very fearfully, asking about it [...] what I am picking up from people is a huge anxiety, a fear of being criminalised just for being [HIV] positive even when they have disclosed [...] there is a general climate of fear and panic out there especially for people who have been newly diagnosed"*
>
> *EXAMPLE 6 (A: 160-169)*

Indicator 1: Reflecting stigma/discrimination

There was a consensus that HIV-criminalisation was closely linked to the issue of HIV-stigma and discrimination:

Participants cited examples of discourses around prosecutions reflecting prejudicial attitudes (including racism, sexism and homophobia), including clients presenting with difficulties related to fear of prosecution. Critical strand participants commented that prosecutions to date have focused attention strategically upon specific disadvantaged groups (e.g. asylum seekers) in order to create a legal precedent. In deconstructing the meaning of HIV-criminalisation, the historical context of the law's involvement at different stages of the epidemic was cited.

Indicator 2: Reinforcing stigma/discrimination

Different levels of discrimination interact to disproportionately effect some communities affected by HIV more than others:

Criminalisation introduced new legal dimensions for the relationships of people living with HIV influencing their ability to be open within their own communities and beyond. Experiences of stigma/discrimination influenced adjustment to an HIV-diagnosis and thereby determined attitudes and beliefs towards HIV-disclosure. Additional comments reflected the paradoxical experience that contrary to stereotypes of HIV-individuals (as sexually irresponsible), some clients responded by refraining from sexual relationships, contributing to loss of support and/or self-esteem. Comments expressed that prosecutions could ultimately detract from the aims of HIV-prevention because it increases the difficulty of disclosure in sexual settings and provide a disincentive for HIV-testing.

Indicator 3: Stigma/discrimination & therapy

Participants were mindful of the need to address negative discourses implicitly or explicitly alluded to within therapy:

Many comments supported experiences of HIV-clients raising prosecution within the context of media reports. Therefore, the issue of HIV-disclosure (outside therapy) mirrored client engagement (i.e. the ability to be open within clinical settings). Also considered were systemic factors, including institutional and professional racism or homophobia impacting upon clients' reluctances to discuss sexual issues, or access services more generally.

3.2.2 Domain 2 (Themes 3 - 5)

DOMAIN 2:	Power & judgement within the therapeutic sphere
Related THEME 3:	***Awareness & re-assurance: Information, misinformation & knowledge***
Related THEME 4:	***Keeping it on the (hidden) agenda: Therapist confidence, competence & willingness***
Related THEME 5:	***Engaging with transference (colluding with blame & shame): Formulation & supervision***

Common to this constellation of themes were the tensions created by the unusual dual role of psychologists within sexual health settings, inherent within their health promotion and therapeutic functions. Discussions identified how the increasing emphasis placed upon public health approaches have affected the context that psychologists work in, as well as their professional responsibilities:

> P2: *"...this does feel important particularly in the current climate with all of these moves towards criminalisation [...] and that is something that we need to be thinking about it but it does pull our professional responsibilities in different ways"*
>
> *EXAMPLE 7 (B: 230-233)*

Most participants (including those supportive of prosecutions) were therefore anxious to separate their public health responsibilities from their therapeutic function wherever feasible:

P2: *"...I will talk about how I am going to put my health promotion hat on and I wonder if we could have that difficult conversation..."*
EXAMPLE 8 (B: 225-227)

And:

P5: *"...and I need to say that to you and then backing away, almost like you are stepping out of role and into another one"*
EXAMPLE 9 (C: 1675-1676)

Many favoured utilising health advisors for notifying sexual partners wherever possible allowing for responsibilities to be addressed in a way also safeguarding client anonymity. Although there was mixed opinions regarding whether partner notification required client consent, this was considered problematic in other ways (e.g., the client/partner may be indirectly identifiable when doing so).

Generally, it was agreed that the legal issues potentially discouraged clients from discussing sexual issues more openly with professionals:

P2: *'...I think in order to really help people address their emotions about being diagnosed you have to have some kind of safe therapeutic space and it feels like that isn't there now"*
EXAMPLE 10 (A: 532-533)

Although the level this interfered with the therapeutic relationship depended upon whether the intervention focus was more directive (e.g. primarily health education driven):

P6: *"...but I think also that the position you take as a clinician affects how empathic you are able to be, how much space there is and what you are trying to do, and if you are trying to do health education there's not so much space for it, there just isn't because you have a sense of what's right or necessary and it just feels different..."*
EXAMPLE 11 (A: 1302-1306)

However, it was noted that the nature of clinical work often included discussing sexual or relationship matters making this distinction difficult in practice.

The following three themes identified the main factors influencing how clinicians managed the impact of these issues upon the therapeutic sphere:

THEME 3:	***Awareness & re-assurance: Information, misinformation & knowledge***

Responding to client's concerns requires clinicians to be aware of ongoing legal developments in order to provide accurate information. However, paradoxically greater awareness increased anxiety for many clinicians regarding the lack of clarify around professional responsibilities.

Indicator 1: Providing information & addressing misinformation

Responding to client's anxieties provides an opportunity to raise awareness of HIV-legal issues in a constructive manner:

Participants opposed to prosecutions expressed this in terms of empowering HIV-clients in order to protect themselves from possible legal action:

> P2: *"...as psychologists what we are in a position to do and what we do have a responsibility for is to give information about the legal issues by saying if you have sex with this person being HIV as you now know you are and you don't tell them and you don't practice safe-sex then there is a risk that you might be charged with reckless behaviour and inflicting grievous bodily harm on that person..."*
>
> *EXAMPLE 12 (B: 996-1000)*

One service adopting a more pro-active stance (by raising legal issues with all HIV-clients and producing a service user leaflet) reported this initiative was appreciated and such actions also signified that it was permissible to discuss related difficulties within the therapeutic context. Although it was felt that there is an increasing awareness of legal issues, frequently clients had wrongly formed the impression that HIV-disclosure was a legal requirement. However, other clients lacked almost any knowledge, particularly those unaware of the UK legal system.

Indicator 2: Reassurance & confidentiality

Clients often expressed concerns within the context of the clinician outlining confidentiality in the first session:

Clinical practice varied of how much detail was given discussing confidentiality limits or whether to include risk of HIV-infection as a specific example relating to harm. However most clinicians doing so reported that re-assurance was subsequently necessary. The following participant describes the apprehensions that can arise when clinicians emphasise confidentiality limits:

> P3: *"...I am just thinking of this client I saw yesterday who was asking me lots and lots of questions about confidentiality, what were the limits, what are the exact circumstances under which I would have to break confidentiality, he was very anxious about it and it turned out that part of it was around this issue and part of it was around his recreational drug use [...] but I don't know why this should feel different to other potential criminal activities that people are disclosing to us in a room [...]*
> P4: *because if we know there's potential harm, we do have limits of confidentiality"*
>
> *EXAMPLE 13 (B: 462-472)*

The above comment also illustrates the uncertainty of some psychologists differentiating between illegality and potential harm.

Qualification

A further dilemma expressed was what to do with information regarding potential harm once disclosed:

The following exchange reflects the desire of participants to avoid situations escalating to police involvement whenever possible:

> P1: *"...I have never been in this position – what would I do? Whom would I tell and tell them what? You know tell the police that somebody may have sex in the future that might not be protected*
> P?s: *(laughs) what's the police going to do with that information? [...]*
> P1: *you know that's when it becomes absurd, you can't police this*
> P4: *well, I mean you don't want to get the police involved, do you?"*
>
> *EXAMPLE 14 (B: 485-495)*

Participants agreed that the risk of litigation (for clinicians and clients) increased the importance of clarifying confidentiality limits and that this measure could be utilised proactively to pre-empt discussions wandering into uncertain territory. Alternatively, participants commented that having 'hypothetical conversations' were also not without difficulties.

THEME 4:	***Keeping it on the (hidden) agenda: Therapist confidence, competence & willingness***

Participants related self-efficacy to their level of experience of working with HIV-clients and exposure to HIV-related issues. Experienced clinicians appeared more able to utilise transferable skills and reported feeling greater confidence negotiating sensitive issues.

Indicator 1: Responding to hidden agendas

Participants acknowledged the difficulties talking about sexual matters openly and considered this could be particularly so for HIV-clients:

The ways professional issues impacted upon clinical considerations were frequently referred to as '*agendas*'. It was reported as rare for referrals to explicitly state '*reckless behaviour*' although some reflected underlying professional anxiety (whereas the client presented with other concerns). These perspectives interacted with the psychologist's understanding of their own role:

> *P2: "...there's sort of psychologists very much working with the agenda that the patient's bringing but then [...] being referred by the health advisors or whoever to work on these issues so there is that sort of conflict of agendas [...] and a conflict of people saying you are not to go there, and it's a difficult one to kind of balance but I suppose I feel that (pause) it's not my responsibility to tell somebody what to do or to even necessarily force that to be on the agenda..."*
>
> *EXAMPLE 15 (B: 212-220)*

Similarly, a hidden agenda may also be inferred through implicit messages communicated by clients:

> *P2: ...it's easier to present things like I've been diagnosed and I'm really struggling with that and what that means to them but it's much harder for them to talk about, particularly any ongoing unsafe sexual practices that they have now they're positive so men I've worked with have kind of said it in a small way, not presenting it as a problem but I think they are definitely communicating something very important to me and I suppose because I understand the implications of what they are saying and because professionally and personally I do see it as an important issue and an important clinical problem, I pick up on it but I wouldn't say people present it, they don't*
>
> *EXAMPLE 16 (C: 98-106)*

This participant later reported their willingness to raise concerns stemmed from their belief that passing on HIV would be '*psychologically problematic*' (C:210 - 231) for clients.

Qualification

Generally, experienced therapists appeared more aware of not 'taking issues at face value' or making assumptions attributed to group identity:

These appeared more competent identifying and raising potential issues, or in the words of one participant:

> P2: *"... to have it on your radar as part of your agenda"*
>
> *EXAMPLE 17 (C:1470)*

Indicator 2: Therapist confidence & legal issues

All groups discussed the difficulties raising legal issues with clients:

Comments illustrated that most participants reported confidence discussing sexual issues, but did not feel as competent raising legal issues:

> P2: *"...I don't think I have ever brought in issues around legislation with anyone and I think part of that is because I'm not really sure of just what to say at this point (laughs) because I don't know whether I have got my facts straight really and I suppose not really knowing whether this conversation I am having with them could be subpoenaed if I write it up. Those kinds of things, what is my responsibility in terms of disclosing this thing? That's why I haven't had these discussions."*
>
> *EXAMPLE 18 (B: 384-390)*

Keeping issues on the agenda was described as a delicate balance between expressing concern without unduly forcing issues, better addressed incrementally over successive sessions or at another appropriate time. Lack of confidence leading to persistently putting off such matters was also suggested as contributing to avoidance by therapists.

Qualification

Increasing awareness of HIV-legal issues was generally more anxiety provoking for less experienced clinicians:

More experienced participants appeared able to draw upon skills and knowledge gained from other settings positively influencing how they perceived their competence:

> P1: *"...but is our role as psychologists shifting in some ways, you know new skills? Because I was thinking when I work with clients who are asylum seekers I do a lot of that, informing them about the latest law and what rights do you have so actually I guess we are doing that already but we haven't been doing it about this issue – you know it's about having to do it about something new"*
>
> *EXAMPLE 19 (A: 147-152)*

Indicator 3: Awareness & willingness

Experienced participants appeared more able to address issues within discussions regarding client's relationships or presenting difficulties:

For example, below the following more experienced clinician (P1) questions P3's earlier statement that legal issues never needed to be raised by the psychologist unless sexual risk issues were explicitly presented by clients:

> P1: *but I'd be surprised if you didn't, I was just trying to think about any patients where this hasn't been relevant, I think if you picked up the last 20 gay men that you saw, I bet you it would come up because it comes up in the context of have you got a partner? What do you do for sex? [...] Is your partner HIV positive or negative?*
>
> *EXAMPLE 20 (C: 1494-1501)*

Although P3 indicated that they were willing to address legal issues, they were

(perhaps) less skilled at picking-up on associated (relationship and sexual) issues arising from implicit client communications.

Qualification

Some participants (within the less critical strand) appeared more willing to introduce legal issues with HIV-clients considered unwilling:

In these examples, participants reported difficulty holding back from expressing their emotional reactions with these HIV-clients, perhaps with the effect of imposing this agenda more:

> P1: *"...but that's the thing I feel I've got to, I can't help it, it makes me cross to be honest if people just go "oh well, you know, you know" [...] I'm sure we all feel the same and I feel a bit bad for feeling cross and thinking it (laughs) and hope that it isn't going to colour the way that I speak to the patient but see quickly I'm thinking, what are you doing spreading HIV all round the place..."*
>
> *EXAMPLE 21 (C: 1521-1532)*

THEME 5:	***Engaging with transference (colluding with blame & shame): Formulation & supervision***

Notions of culpability influenced how the therapist approached the client, as well as how clients perceived the therapist's position in relation to the law. The clinician's ability to separate personal beliefs from their professional role was an important factor for establishing empathy.

Indicator 1: Notions of culpability

Many participants acknowledged how they approached clinical risk had been impacted by recent prosecutions:

All groups discussed how this impacted upon the therapeutic dynamic:

> *P3: "... these issues we are getting pressured to think about now this is the law and that would be a feature in my mind. If this was a vignette 4 years ago maybe it would be more he's just sort of not adjusting to his sexuality but now it's getting that enmeshed in trying to give him that space yet wanting to know what you're doing this week or and I don't know how I'd do or say that but it would be in my mind so that would affect my dynamic for sure."*
>
> *EXAMPLE 22 (A: 53-59)*

Examples cited how issues of power within the therapeutic relationship could lead to the therapist being perceived as authoritarian or persecutory (leading to disengagement). For example, fear of judgement by the therapist may evoke feelings of shame or guilt in the client, contributing to denial regarding the individual's own role in their HIV-infection or beliefs that they deserve punishment. The following illustrates how these interactions may influence clinical issues:

P2: *"...when they have spoken about it, I've picked up that they felt relieved particularly because they have been concerned about the way we would talk to them about it and the way we might be judgemental or not allow the whole topic to be opened up for thinking and understanding rather than come in a rather simplistic way and say that's not acceptable, that's not ok, in a judgemental way and that's really important because I do think there's a lot of shame and guilt involved"*

EXAMPLE 23 (C: 114-119)

Some participants suggested overly strong emotional reactions in newly diagnosed clients could indicate poor adjustment, particularly where trauma was a factor. Exploring the meaning of underlying client anger was considered essential for understanding litigious intentions:

P6: *"...presumably the client was also at some level choosing to do that [unprotected sex] too and it's as though this business of disclosure kind of crystallises that, was I taken advantage of or am I actually angry with myself for putting myself at risk and I suppose somehow that then becomes unbearable [...] it's like the two go together, don't they? They're flipsides of the same kind of unbearable anxiety.*
P2: *and once you become infected you can shift into that bad category because then you could be liable for prosecution yourself so those roles are completely...*
P1&2 (jointly): *...parallel"*

EXAMPLE 24 (A: 457-472)

Qualification

Participants suggested clinicians could inadvertently collude with clients in ways inhibiting the process of adjustment to HIV-diagnosis.

Participants in the critical strand emphasised the danger of clinicians encouraging blame to be located in the '*Other*' by sympathising with over-simplified conceptualisations of guilty/innocent. Also raised was the possibility of vexatious allegations (influenced by criminal compensation awards) or factors such as mental illness:

P2: *'...everybody who has been diagnosed feels angry and most people have moments when they blame someone and they want to blame the person who infected them and I think what's happening now is that people are being led to channel that through criminal prosecutions and going to the police whereas actually that anger is like a normal part of adjustment and coming to terms with this diagnosis. If people had better support around that time then maybe they could readdress it in a different way"*

EXAMPLE 25 (A: 291-298)

However, (less critical strand) participants emphasised therapists may also collude with clients by not challenging problematic behaviour. The example below illustrates the use of this technique and how clinicians may actively evoke feelings of shame/blame by using threat of prosecution:

P4: *"I always ask people how they might respond if someone sued them [...] some people haven't thought about it [...] and people respond very differently, some people are so petrified they are going to put their heads under the blankets at all costs (pause) other people realise that gosh I wouldn't like to have to stand up there and have my photo in the Metro [newspaper]"*

EXAMPLE 26 (B: 235-242)

Although cited in response to a client discussing newspaper reports (rather than coercive motives), this excerpt is interesting because it explicitly refers to the

use of judgement as a lever to confront the client.

Indicator 2: Lack of empathy & therapeutic strategies

Lack of client empathy was considered to indicate a poor therapeutic alliance or conflict over therapeutic goals:

> P6: *"I think for me the times when I've struggled most with empathy is when I've ended up in a position where I am trying to change their behaviour and it has actually been in a context around somebody not disclosing to a certain client and the more I tried to think about ways she could disclose, the more I lost sight of the fact that actually she doesn't want to, the more irritated and frustrated and less empathic I got and the more judgemental and critical and exasperated..."*
>
> *EXAMPLE 27 (A: 1296-1306)*

The ability to view problematic behaviour within a formulation of a person needing help (rather than attributing '*pathological*' motives) were emphasised as important for managing loss of empathy and avoiding judgemental attitudes. Supervision was considered a useful arena for expressing frustrations and exploring ethical issues, particularly where therapists may attempt to assume responsibility for the client requiring support to recognise their personal limitations and professional role. Therapeutic issues might also be reflected in the therapist/supervisor relationship by clinicians withholding difficulties related to their own underlying feelings of shame in relation to their perceived therapeutic competence.

Qualification

Lack of therapist empathy was associated with interpretations of 'reckless' or 'intentional' behaviour:

Many participants acknowledged their empathic ability could be influenced by an individual's attitude, including their own perceived lack of empathy for others:

> P1: *"but it would colour my view a bit, I would try not to let it but I would find it quite difficult, I might find it harder to empathise with somebody who says "oh well it's their own look out, it's up to them if they want to have unprotected sex" or whatever and that does sometimes happen*
> P4: *I think it's quite a difficult position though as a psychologist because potentially we are identifying the problem that the individual or the patient may not have actually identified themselves*
> P1: *exactly"*
>
> *EXAMPLE 28 (Group C: 152-161)*

The following exchange highlights how clinical interpretations were influenced by how client emphatic difficulties were perceived:

> *P1: ...I do think that for a lot of people it is a source of great shame and guilt and very hard for them to talk about even if it isn't top of their agenda*
> *P4: but I think for a lot of, for an equal amount of people it's not a source of shame and guilt (laughs) [...]*
> *P2: but those people they don't come to see us, I think that group of people who are having unsafe sex and apparently to them it's not problematic [...] often they don't come to consulting rooms and speak to people like us about those issues. I think the people that do come are people that do have a degree of concern about it.*
> *P4: but it might be somebody who presents with something different, say somebody who is depressed [...] or has anxiety and in the course of meeting them for that it becomes apparent...*
>
> *EXAMPLE 29 (Group C: 173-197)*

Noticeably one emotive participant compared not acting to prevent unprotected sex to '*colluding as accomplices to murder*' (C:1170).

Indicator 3: Neutrality & Morality

Concerns expressed that the re-emergence of traditional public health approaches conflicted with notions of therapeutic neutrality:

Many participants expressed difficulties reconciling therapeutic work (perceived as less directive and more person centred) with public health obligations, without appearing overtly moralistic:

> *P1: "...putting that kind of notion of criminality on the therapy agenda seems to further stigmatise it [HIV] in a situation which is supposed to be supportive [...] to bring in the notion of somehow attaching a criminality to an action seems to be a very very uncomfortable way to proceed especially within a psychological session*
> *P2: yes, I think you might end up alienating them"*
>
> *EXAMPLE 30 (B: Lines 409-419)*

However, the critical strand suggested they viewed their professional position within a wider '*political*' context, for example they were concerned to avoid aligning with the notion that all responsibility for HIV-infection resides with persons diagnosed. For example, the following comment reflects the belief that the psychologist's role is <u>not</u> to align with any one position, highlighting that clinicians must be prepared to work with either complainants or defendants:

> *P4: "I don't have a problem being enormously flexible (laughs) it may seem like <u>I am amoral</u> but to a certain extent I think that it is really about the person in front of you and not any of these other people involved [...] so I don't seem to come down quite heavy on either side of the fence, I don't have lots of strong moral feelings frankly"*
>
> *EXAMPLE 31 (B: 251-257)*

<u>Qualification</u>

In addition, the critical strand was also concerned that their ability to form an affirmative therapeutic stance with HIV-clients could be constrained:

Critical participants stressed that their aim was not merely to remain therapeutically neutral but to develop a supportive stance that positively affirmed clients (c.f. A:895 - 908). In contrast, the less critical strand was less likely to consider raising HIV-legal issues identified a moral position, suggesting this reflected the reality that prosecutions were a factual issue.

3.2.3 Domain 3 (Themes 6-8)

DOMAIN 3:	Complexity of new legal & clinical issues
Related THEME 6:	***Access to clinical records & note-taking practice: Supporting people or policing sex?***
Related THEME 7:	***Shifting conceptualisations of HIV-disclosure: Individual or inter-personal responsibility?***
Related THEME 8:	**Crossing the line: Professional liability, confidentiality & duty of care**

This constellation of themes focused on the complexity of the clinical issues emerging from HIV-criminalisation, which were inter-related to wider service developments driven by HIV-science during recent years.

Firstly, participants located HIV-criminalisation to the CPS policy proposing prosecution for the reckless transmission of all STIs. However, technological advancements had facilitated this possibility by providing a means for establishing causality of HIV-infection. Few participants appeared to support the wider application of prosecution policy beyond the current precedents, and there was little consensus surrounding the boundaries or feasibility of such actions (meaning the law was unlikely to be applied to other illnesses). Secondly, discussions identified emerging service changes to the shift towards the '*normalisation*' of HIV, which underpinned its reconstruction as a chronic (rather than fatal) condition. The '*normalisation agenda*' had also followed technological progress, most fundamentally new HIV-medications leading to increased HIV-testing. In response, some services were introducing opt-out HIV-testing within GUM settings or populations (e.g., peri-natal) with counselling no longer available. Consequently, increasing numbers were ill-prepared for HIV-diagnosis impacting upon clients presenting to psychology services.

More interesting perhaps was how participants struggled to synthesis these differing notions of normalisation (i.e. to what extent HIV should be differentiated from other STIs or chronic illnesses). For example, participants raised the case of a female client with genital herpes who considered making a legal complaint. Although herpes can cause infertility (compared to HIV as another type of '*loss of life*': C:1040), there was some difficulty quantifying the concept of harm or qualifying that judgment to the law in this instance:

> P3: *"but you see the whole idea of harm is so relative, sometimes people with genital herpes their quality of life is probably more miserable than an HIV person who is being treated and functioning very well because there is no treatment [...] so in terms of harm, it's so difficult to quantify and qualify [...]*
> P1: *I think that's the point the CPS people in a way are saying, why make a special issue of HIV [...] it's saying everybody has a responsibility not to spread these infections*
> P4: *so it's part of this sort of prejudice thinking in some ways, that's where the law is coming from*
> P1: *yeah, or sort of trying not to be prejudiced in another way, you could say or even handed [...]*
> P2: *so it's not HIV specifically, it's about harm but it's come up in terms of HIV because it's the most serious STI "*
>
> *EXAMPLE 32 (C: 1187-1224)*

Many participants acknowledged that legal considerations were beginning to impact upon how professionals perceived HIV-issues:

> P2: *"definitely I think it's such a good example of a case that we might have thought differently about a few years ago because, you know if somebody says to me they're practising safer sex then I would usually have been focusing more on what are the issues around disclosure for that person, what do they want in terms of disclosure, what would they gain from it in terms of their relationships but I think now we are being forced to think in a different way about risk and responsibility, and I think this is really a good example of that"*
>
> *EXAMPLE 33 (A: 61-67)*

And that 'different ways of thinking about risk and responsibility' were beginning to translate into changes in clinical practice:

> P2: *"...you do, I do, feel a professional responsibility really of being a bit more proactive, don't you?"*
>
> *EXAMPLE 34 (C: 436-437)*

Discussions appeared to describe criminalisation in terms of a paradigm shift altering the tone of health promotion, or in the words of one participant, making it less '*nice and fluffy*' and more '*judgemental*' (A:1065 - 1071), thus impacting upon wider narratives of safer sex as well, to introduce factors related to prosecution:

> P4: *"...I have been doing this for ten years now and in the older days it was just talking about making sex as safe as possible, then it morphed into safety but also issues of disclosure and now it's safety, disclosure and possibly criminalisation issues [...] so safer sex it's got much more specific over the years and that's very anxiety provoking."*
>
> *EXAMPLE 35 (A: 1075-1079)*

Some participants compared the clinician's individualistic concerns (i.e. limiting professional liabilities) as similar to the HIV-clients' concerns to avoid legal culpability; both of which were contrasted to notions of collective (or shared) responsibility espoused by the '*normalisation*' agenda.

The following themes identified the complexity of synthesising these issues into clinical practice.

THEME 6:	***Access to clinical records & note taking practice: How safe is safer-sex advice?***

HIV-criminalisation impacts upon the concept of safer sex which raises uncertainties for professionals providing advice. Access to clinical records may also be used to establish knowledge of HIV-transmission risks (and hence recklessness) during any criminal investigation.

Indicator 1: Supporting people or policing sex?

Safer sex advice does not address what constitutes a reasonable or justifiable level of risk, of which the legal ambiguities remain untested:

The concept of safer sex implicitly acknowledges that HIV-infection risks can be limited, not eliminated; similarly HIV-prevention is based upon risk reduction

strategies. Legal issues were becoming a factor; however, in this regard, the law raised more questions than answers:

> P2: *"it depends on what you mean by safety, I think if you are thinking about the safety of your client then that includes safety from prosecution. In a sense disclosure becomes much more of an issue because what people are saying is I'm using a condom but do I have to disclose as well' [...]*
> P1: *but you can't say at this point you definitely won't be prosecuted if you have safer sex but don't disclose it"*
>
> *EXAMPLE 36 (A: 1059-1067)*

Particular areas of ambiguity highlighted included the necessity for HIV-disclosure for unprotected oral sex or following condom failure (thereby enabling access to post-exposure prophylaxis). Additionally, other sexually transmitted (e.g. Hepatitis C) or communicable diseases (e.g. Tuberculosis), less responsive to medical treatment than HIV-infection were raised.

Qualification

Introducing legal aspects to safer sex messages may deter some clients from volunteering difficulties practicing protected sex:

Participants suggested enquiries might be perceived as policing rather than supporting changes in sexual behaviour:

> P3: *"... and again I suppose it's like anything else when you have conversations about what might be different ways of doing that... I haven't up until this point brought in the legislation around this 'cos it would just feel like a great big hammer (laughs) coming into that conversation – it just wouldn't feel like a helpful thing to do at all*
> P4: *but just because you talk about it doesn't mean you are representing it"*
>
> *EXAMPLE 37 (B: 503-510)*

Some participants offered their experience that difficulties may be overcome by approaching the subject more holistically:

> P2: *"...I think the issue of possible transmission or risk or the need to disclose to other people would be framed around something like what difference are there now that you know you are positive, what will it mean in all kinds of areas in your life? And is it making a difference to your sexual life? [...] How he thinks that this new information about his positive status might then affect his relationships..."*
>
> *EXAMPLE 38 (C: 85-91)*

Indicator 2: Recording safer sex advice

Details of safer sex advice could be used to establish clients' recklessness via establishing knowledge of HIV-risks in any court case:

It was stressed that information pertaining not just to discussions regarding sexual relationships but also safer sex information given could be sought as evidence in court proceedings. Many participants reported reviewing their note-taking practices to document the specifics of advice given, or cautioning clients before the identity of sexual partners became apparent. Only critical participants proposed the possibility of acting as an expert witness for the defence (e.g. by providing information regarding extenuating circumstances).

Qualification

Individual conceptualisations of safer sex may vary according to levels of risk related to particular sexual practices or sexual partners:

Clarifying understandings of what constitutes safer sex was considered important when assessing risk factors, particularly following HIV-diagnosis when the client's practice of '*safe enough*' may have been related to their infection:

> P1: *"there are men who practice penetration but withdraw before ejaculation who believe that's probably safe enough [...] without using condoms*
> P4: *yes but the person would also be thinking in terms of condoms because every time you think safe people tend to think condoms*
> P1: *yes, but not always*
> P4: *so 'safe enough' I think that's key – what does the person really think was safe?*
> P1: *[...] or if one is not comfortable because of the others HIV-status then they would say so or insist on condom use but of course each is (pause) relying on the other in some way for a cue to cement condom use - another very risky strategy"*
>
> *EXAMPLE 39 (B: 96-114)*

THEME 7:	***Shifting conceptualisations of HIV-disclosure: Individual or inter-personal responsibility?***

Psychological conceptualisations view HIV-disclosure as a gradual inter-personal process (contextualised within a relationship) whereas the law views it as an event initiated by one party. Therefore, legal issues impact upon individualistic and shared understandings of risk, particularly regarding expectations of responsibility for safer sex.

Indicator 1: Responsibility & disclosure

Shifting conceptualisations of responsibility impact upon professional perceptions of risk, including the role of HIV-disclosure:

The crucial issue from a legal perspective is informed consent centring upon explicit HIV-disclosure to sexual partners. Yet in reality, disclosure is often implicit (i.e. alluded to verbally or non-verbally). While psychologists broadly assented to their role in promoting greater HIV-disclosure, there were concerns of it being re-framed punitively (rather than personal empowerment). This may encourage others to perceive themselves as absolved from the responsibility of initiating safer sex:

> P2: *"I think that one of the problems with criminalisation of transmission is that it just takes away all the responsibility from people who are untested or negative and seems to place all the responsibility with the [HIV] positive person but I think for me what's concerning about all of that is if you think someone is having safer sex and there is no risk of transmission then that should be enough but because of this criminalisation, the whole thing it's just a regressive step [...] it undermines all the safer sex messages that's taken years to build up"*
>
> *EXAMPLE 40 (A: 83-89)*

Some participants indicated becoming more cautious of clarifying possible (if theoretically unlikely) HIV-infection risks or stressing the importance of disclosure as precautionary safeguards.

Qualification

There is insufficient recognition in law that HIV-disclosure may not always be appropriate or possible for some individuals:

An appreciation of the complexity of HIV-disclosure issues including risk of domestic, sexual or retributive violence were important for understanding client's reluctances. Additionally, for many risk of rejection or having their identity revealed (e.g. through whispering campaigns) was a realistic consequence of disclosing their HIV-status or insisting on condom use. Many considered these factors may encourage anonymous sex, more likely to be unprotected particularly among HIV-positive individuals.

Indicator 2: Responsibility & risk

Another area of confusion related to what extent individuals could consent to risk:

The distinction was made between not disclosing HIV-status and actively deceiving another. Participants discussed some gay men's practice of not insisting on condom use when they were the receptive partner during penetrative sex; perhaps perceiving their role as morally as well as sexually '*passive*'. Although the risk to the insertive (or '*active*') partner are substantially reduced, the absence of (explicit) informed consent raised concerns:

> P3: *"I've seen quite a number of positive men recently who talk about having receptive anal sex but often don't insist on condom use because they say if the guy, that casual partner isn't using a condom then they must be positive already or it's not their responsibility, if they are passive in this role and delegate this [responsibility] to the other as a way of getting round having to really think about it, well it's not that they are not thinking about it but it's a way of kind of justifying what they are doing..."*
>
> *EXAMPLE 41 (B: 497-503)*

Also raised was the possibility of consensual self-harm by individuals actively (i.e., '*bug chasers*') or sub-consciously seeking HIV-infection. In such circumstances, HIV-disclosure alone does not ensure safer sex yet legal liability remains unclear:

> P2: *"...it's still problematic and what I point out to a lot of people is [...] 'but are you taking into account the fact that some men might not be well very informed about HIV, might be young or depressed [...] they might have low self-esteem or a history of sexual abuse'; they might be acting out something that's a bit masochistic and self-harming without them being fully aware [...] you can't just say everyone should take responsibility for their own health because not everyone's in a position to do that are they?"*
>
> *EXAMPLE 42 (C: 229-244)*

Whereas, public health obligations encouraged clinicians to act where risk was known, often HIV-status was unknown either by professionals and/or individuals themselves (e.g. those refusing/avoiding HIV-testing). Although prosecutions could have the effect of deterring HIV-testing for some, it was noted that deliberate avoidance of advice to HIV-test could also infer recklessness.

Qualification

Some participants cautioned on assuming causality of infection and the need for scientific evidence in order to be held legally responsible:

Although some participants were partially aware of the use of HIV-phylogenetic analysis, there was poor understanding regarding the limitations of genetic profiling techniques. However, these participants acknowledged their need for greater familiarity with these matters, which may be a factor upon decisions to pursue prosecution or needed when giving advice to those accused.

THEME 8:	**Complexity and Proximity: Professional liability, confidentiality & duty of care**

Concerns regarding liability related to the complexity of balancing professional responsibilities to the client (e.g. confidentiality) with duty of care obligations. Participants' understandings of their responsibility to third parties included the possibility of civil prosecution for failing to inform another at-risk.

Indicator 1: Proximity & Distance

Whether an individual at-risk was named or known were considered crucial factors in how clinicians' perceived professional risk:

Such knowledge made clinicians apprehensive because the concept of risk became less abstract, and professional liability factors more tangible:

> P5: *"...does knowing a name make the difference [...] so no longer is a person invisible to us, removed from us at some distance but now their proximity is getting nearer to us now that we have a name? But it's exactly the same person so how does that effect our judgement, is it coloured in some way? Do we suddenly become more insecure, do we become more ethically inclined or so on, and that is a huge question because in reality it does have a huge bearing on our perception but we have to be aware of it before we actually act out [...] or self appoint ourselves as being the delivery of law and justice [...] it's impossible not to because he's entering into our psyche, he's becoming more real, he's becoming more real..."*
>
> *EXAMPLE 43 (C: 950-965)*

Other discussions associated attitudes to risk with perceptions of epidemiological distance: For example, participants raised the reluctance of some HIV-positive gay men to recognise casual unprotected sex as problematic. However, the concerns of these (apparently heterosexual and/or married) female participants were related to the risk posed to the wives and children of bisexual men, reflecting how their concerns were heightened when those at risk were closer socio-demographically to themselves.

Qualification

The complexity of such cases warrants that clinical responsibility be located with the multidisciplinary team:

Participants described how feelings of individual responsibility might affect the objectivity of professional judgements:

> P4: *"...this thing can drive you insane, thinking you are responsible for the whole population because you are not and you can't be – I'm just one person sitting here and he's one person sitting there"*
>
> *EXAMPLE 44 (B: 155-157)*

Consequently, the need for exercising emotional distance and pragmatic caution by locating clinical decision making with the wider team:

> P2: *"...at this stage were you presented with it, it would be getting very serious and would be talked about in multidisciplinary mental health or HIV teams so it wouldn't be an individual decision clinically to make*
> P1: *you'd not really be sitting on this, keeping it to yourself, would you?*
> P2: *no way, not with the amount of people involved you wouldn't..."*
>
> *EXAMPLE 45 (C: 533-540)*

One participant reported their service had begun formulating a '*risk register*' of clients repeatedly presenting to GUM services, enabling professionals to document their actions and/or clients' reluctances. Some suggested the purpose of this initiative was an attempt by clinicians to distance themselves from anxieties regarding liability by diluting their individual responsibilities.

Indicator 2: Crossing the line

The possibility of complaints for professional negligence were crucial factors when considering the need for breaking confidentiality:

Knowledge of the identity of persons at-risk was considered pivotal since without such the ability to act was somewhat restricted. At this point, participants considered a fundamental boundary had been crossed:

> P2: *"but I think we've crossed another line in some ways because I think now we know that partner 1 is continuing to have unprotected sex [...] and we've got his [partner's] name so are we going to do anything about that or now is it a legal matter?"*
>
> *EXAMPLE 46 (C: 894-900)*

In reality participants suggested a succession of lines signifying escalating risk, cumulating in the '*need to act*'. However participants cautioned this did not mean initiating police involvement. Important considerations were whether there was continuing exposure risks; and whether the HIV-client was able or willing to engage in protected sex in future. In cases where potential HIV-exposure had already occurred, participants questioned the need for immediate action preferring to consult the client in this process. Participants allowed some negotiation on how or when this could happen (e.g. directly by the HIV-client or anonymously via partner notification). Also suggested was the possibility of facilitating disclosure by another professional (e.g. GP) with client consent; however it was thought unlikely ever to be appropriate for psychologists to do this themselves. Only where the client was steadfastly resolved against any possibilities was there a need to consider acting independently:

> P3: *"...but I would say that for me at that point in time, that would be perhaps the thing that pushes me into having that difficult and awkward conversation with that person whereas before I'd been able to tolerate the ambiguity and anxiety attached to all of this [...] but now it's like the writings on the wall someone's going to have to act"*
>
> *EXAMPLE 47 (A: 591-596)*

Discussions stressed the need to inform clients (even if retrospectively) of decisions to break confidentiality without consent; however most suggested disbelief that a client would still be engaged at this stage.

Qualification

Obtaining legal guidance and consulting with the clinical team were considered integral to protecting the clinician's professional interests:

Outcomes from these scenarios were described pessimistically, recognising that potentially both client and clinician could later be exposed to complaints:

> P5: *"...I've always got in my mind that this might be a no-win situation"*
>
> *EXAMPLE 48 (C: 425)*

However, participants also suggested some relief in sharing legal responsibilities:

P5: *"...the first thing I would do is have a discussion with him [client], and the second thing that might happen is to talk to the Trust risk people and [...] hand it to them and say here's the issue, what do I do? Cos I'm going now to need to protect myself"*

EXAMPLE 49 (C: 931-939)

Two participants experienced in using Trust solicitors implied advice had been extremely cautious regarding ever breaking confidentiality. However, some questioned whether recent precedents would impact this position and whether it sought to protect the liability of the *NHS* Trust to the neglect of the professional. A few clinicians indicated they had or were taking professional liability insurance although it was thought that following best practice was adequate protection.

Indicator 3: Conflicts of responsibility

Participants cautioned that their fundamental responsibility remained to the client except in exceptional circumstances:

Few were able to clearly distinguish between the duty of care for medics (placing ethical obligations to contact parties at-risk) and the professional responsibilities of psychologists to prevent harm where possible. However, many recognised the wider meaning of this concept allowed psychologists to balance their responsibilities with the probable effects of their actions, including the possibility of suicide or violence, which could justify any decision not to act:

P5: *"I don't think it's the same, it's very different, I see there are specific things that are stated within the code of conduct which say that if you either harm yourself or others or plan to do some harm [...] then we have a duty to consider to act or not..."*

EXAMPLE 50 (C: 1693-1696)

Participants indicated that medics often held clinical responsibility within teams, although psychologists were often consulted in complex cases. The dilemma of how much to protect the client's position (by disclosing as minimal details necessary) was described as a conflict of interest in these situations:

P2: *"...I agree about my responsibility to the third party [...] but not to go outside and break confidentiality but I feel I have a responsibility in the room in the conversation with the person in front of me [..] I wouldn't unless it's very very serious circumstances break confidentiality around that'"*

EXAMPLE 51 (B: 681-689)

Discussions also included other conflicts of interest (e.g., where sexual partners attended the same clinic) or where professionals were able to infer associations between clients/sexual partners from case discussions or clinical meetings.

Qualification

Participants stressed that a sub-poena was always necessary for access to psychology notes or before assisting police investigations:

Whereas participants differed in how much information they shared with the wider team, they were clear not to breach confidentiality to non-health professionals unless legally compelled to do so. Most participants signalled they would at least reluctantly cooperate, with only one still having ethical reservations:

P4: *"...I would never dream of that and I think this is a very radical position on client confidentiality and I think that has a lot to do with where I come from as well because [pause] I see that as the most important thing and I think the law might find me a bit too confidential – and I think that if I got into any problems, that's where I would get into trouble..."*
EXAMPLE 52 (B: 547-551)

3.2.4 Summary

It could be concluded that participants opposed to HIV-prosecutions were also '*critical*' in the sense that they were more aware of contextual or social factors. The main objection raised was the failure of the law to recognise the substantial difficulties associated with HIV-disclosure, and the resulting impact upon HIV-stigma/discrimination. Conversely, those '*less critical*' emphasised the issues at an individual level (e.g. by internalising them within the HIV-client), and therefore were more concerned that clinicians may not challenge sexual behaviour considered problematic.

Discussions included how popular discourses and expectations by sexual partners could shape wider changes in conceptualisations of risk, including safer sex narratives and/or practices. Therefore the clinical issues were inter-related to social concepts of responsibility, which in turn impacted on how professionals and clients perceived and approached risk within and outside the therapeutic forum. Therapeutic considerations were mainly concerned with how these changing dynamics may inhibit HIV-clients from expressing difficulties, or clinicians from responding to them. The legal issues impacted directly upon professional responsibilities for preventing harm where possible. This needed to be balanced against safeguarding the client, as well as others potentially at risk; including the possibility of personal liability to the clinician. The ability to tolerate ambiguity and contain anxiety was influenced by how clinicians interpreted the level of engagement and attitude of the client. The vulnerabilities expressed reflected the need for professional re-assurance and the hope that guidelines will clarify clinical and ethical obligations, particularly around confidentiality.

Discussion

Criminalisation for Sexual Transmission of HIV:

Emerging issues and the impact upon clinical psychology practice in the UK

“

because professionally and personally I see it as an important issue and clinical problem, I pick up on it... but I wouldn't say people present it as an issue, they don't

”

Example Quotation 16 (Transcript C: Lines 99-106)

4.0 DISCUSSION

Before evaluating the degree to which the research questions have been answered, it is appropriate to revisit the study's aims to place into context the focus of the issues selected for detailed discussion:

Statement of the Problem

Legal cases concerning the sexual transmission of HIV have raised complex questions for both clinicians and service users about rights, responsibilities and legal obligations to disclose information to others. This research addresses the lack of available information regarding the impact of recent prosecutions upon everyday clinical management by offering a much needed clarification of the clinical implications of these emerging issues. In particular, by offering an understanding of how the psychologists sampled balanced their ethical and legal obligations to protect client confidentiality, with the welfare of third parties potentially at risk of harm from their HIV-clients. Finally, the likely impact upon therapeutic engagement with HIV-clients including the interaction of significant therapist and client factors are investigated.

Rationale for the Selection of Results Discussed

This chapter outlines the clinical implications of HIV-prosecutions giving greater consideration to those factors relevant to the potential confidentiality breaching behaviours of psychologists towards HIV-clients, before concluding with areas of remaining interest for future research. It is noted that because of space limitations, not all of the findings can be reviewed comprehensively. Where this is the case, the discussion seeks to draw together links in the research (or with relevant psychological theory) to summarise how this information can be understood within the context of therapeutic engagement with clients with HIV.

The discussion has been structured to broadly reflect the findings from Maslin's (2003c) study investigating the specific factors enhancing and inhibiting psychologist's self-efficacy when working with asylum seekers (many of whom were HIV-positive), an area where clinical practice also frequently navigates and intersects with complex legal and ethical issues. Similar to the aims of the current study, Maslin sought to further the evidence base informing service policies and clinical practice relevant to a particular and specific client group. Although not directly related to HIV (in the absence of other relevant information in the literature) Maslin's study provides some understanding of which multiplicity of factors are relevant to complex ethical/legal practice issues. Thus, the discussion considers the overlapping range of issues in terms of factors broadly grouped into the following four areas: (1) service issues; (2) professional issues; (3) [therapist] personal ideology; and (4) transcultural issues - with the concept broadened here to include any wider related '*issues of difference*' impacting on the therapeutic alliance.

For the sake of clarity and brevity, the terms '*respondents*' and '*participants*' has been adopted to distinguish references between the survey and focus groups respectively; whereas '*psychologists*' is used when making generalisations across both methodologies.

4.1 *Service Related Issues*

This section examines some of the organisational and service factors impacted

by HIV-legal issues which were identified. The issue of service policies related to working with HIV-clients is relevant for understanding whether psychologists have clear guidance in this area, which obviously affects their ability to work with this client group.

Service Policies

At the time of surveying (2006), only around a third of respondents working in sexual health settings reported specific departmental policies related to HIV-transmission, with the remainder indicating services generally becoming more proactive in ensuring HIV-disclosure to sexual partners. Clearly there is a need for an evidence base to inform the development of services in this area in order to mitigate any unintended effects which may be counterproductive to people accessing and engaging with services; and thus the thrust of health promotion initiatives. Given that the *OAPA* is likely also to encompass other illnesses (e.g. Hepatitis C, Tuberculosis) with reports of similar police complaints (e.g. Herpes transmission), it would appear that the evolving legal context is likely to continue to impact and frame future service provision into the foreseeable future.

In addition, many participants identified recent service changes, at least in part, from the policy shift towards *'normalisation of HIV'* as a chronic managed condition rather than a fatal disease. In response to this trend, routine *'opt out'* HIV-testing has been introduced to a widening range of clinical settings with the aim of targeting specific populations (e.g. peri-natal), especially within high-prevalence areas which now extend to over 20% of the English population – including London, Blackpool, Brighton, Bournemouth, Luton, Crawley, Eastbourne, Harlow, Manchester, Reading, Salford, Slough, Southend and Watford (*NAM*, 2008). Consequently, an increasing number of psychologists in a diversity of clinical settings are likely to encounter newly HIV-diagnosed individuals impacting both their professional role and the type of referrals received. Thus, highlighting the relevance of this issue beyond traditional sexual health services; and the importance that robust policies are in place particularly where professionals are less familiar with HIV-issues.

A particular highlighted difficulty in this regard was that the law remains untested regarding what constitutes a reasonable or justifiable level of risk in terms of sexual behaviour, raising uncertainties not just for professionals providing safer sex advice but also for those formulating policy at a service level. Participants indicated the perceived need for increased caution by professionals when clarifying possible (if theoretically unlikely) HIV-infection risks by stressing the importance of precautionary legal and sexual safeguards in establishing informed consent during sexual encounters. These issues highlight the need for agreement among policy makers regarding the parameters of acceptable safer sex advice in order to provide greater security to professionals while ensuring that the central message from harm minimisation strategies are not obscured by the need to focus upon every eventuality. Having a consistent policy framework for conducting this kind of work would seem therefore to be of key importance.

Generally, participants were concerned that the effect of services responding over-defensively to recent legal developments would provide a disincentive to those at-risk of HIV-infection accessing services and receiving appropriate treatment. Participants with the *'critical'* strand appeared more willing to mitigate these possible effects through their influence upon service policies. It

was felt psychology has an important role in educating the team regarding the complicated and multifaceted personal/social factors relating to HIV-disclosure and by ensuring enough time and appropriate support is provided to meet individual needs. In contrast, the *'less critical'* strand appeared more willing to accept the general direction adopted by the MDT.

Although psychologists stressed that clinical responsibility for contacting sexual partners should be located and shared within the MDT, it was felt important that the profession is not distanced from these issues at a service or policy level. Within services, the responses of medical professionals were often contrasted to psychologists resisting more rigorous practice and urging caution before implementing clinical changes, without undue haste of the wider ethical issues. To a greater extent, the genesis of these differences can be understood within the historical development of each profession in relation to HIV and sexuality issues; as well as the different relationship each profession holds in respect of the law and legal obligations held. These underlying tensions highlight the need for agreement and clarity regarding the role of each profession when developing policies, but also appropriate service user representation to ensure client interests are protected as far as possible. In addition, services need to acknowledge the potential complexity of work with this client group and the impact it may have on the psychologists who undertake it.

In-Service Training Needs

Feeling insufficiently trained will have clear negative implications on the ability of psychologists to undertake their duties effectively. Encouragingly, most psychologists in sexual health settings indicated already having received adequate training directly related to HIV-legal issues (62%), as well as signalling that the issues are beginning to be incorporated into staff induction programmes. However, ongoing need was expressed by many respondents (55%) to be kept informed of relevant legal developments, particularly around the implications for confidentiality and legal liability which was recognised as essential for maintaining best clinical practice. Since this was prioritised or in the process of being organised, it can be assumed that these training needs have since been met. Where psychologists in sexual health settings expressed greatest difficulty was with developing additional clinical skills to address the safer sex and HIV-disclosure issues raised by HIV-prosecutions. Approaches using motivational interviewing techniques were thought to be particularly useful interventions in this regard, both in respect to use in psychologists practice themselves but also in terms of psychologists providing training to other professional disciplines (e.g. health advisors).

In contrast, psychologists from generic settings reported insufficient awareness of HIV-legal issues and requested that further basic training (such as update briefings) be addressed by subsequent qualified *CPD.* This was particularly so among those working with vulnerable populations; such as children and adolescents or the learning disabled; or within particular settings (e.g. forensic) The clinical benchmarking summary (Table 3.5) suggests the confidentiality related practices among this group was inadequate in relation to initiating and recording safer-sex discussions with 60% reporting *'never'* to both these questions. Though this may partly reflect that HIV-clients may not primarily present with sexual or relationship related issues in these environments, the inability to broach or document them adequately suggests a primary training deficit, as well as potentially some anxiety and fear around this topic.

Clinical Psychology Training

A high proportion of participants indicated lacking perceived competence to address safer sex and HIV-disclosure issues. Perhaps this is not surprising given the lack of teaching on clinical training courses and research suggesting trainees come off courses feeling unconfident dealing with sex and sexuality issues (Snowdon-Carr; 2005). Higher priority to these issues which require sensitivity and awareness of social processes and discrimination are recommended by Shaw *et al.* (2008) in order to enable greater effective therapeutic relating when working with issues of difference. A more detailed curriculum which integrates the relevant ethical issues from this research may go some way to improving working confidence and improved practice.

4.2 Professional Related Factors

The prevalence and incidence of psychologist's experiences of HIV-legal issues provide an indication of the extent and range of the professional issues impacting upon clinical practice. This was considered a key element of the study since to date the literature has not provided any empirical data in this regard:

Legal Involvements

Overall, there were restricted cases of psychologists being directly implicated in HIV-legal issues, although it was much more common for them to be impacted indirectly through their contact with the wider team but with many of the cases cited not ultimately leading to prosecution. However, this latter factor could change if trends towards utilising HIV-prosecutions were to continue becoming more frequent.

It is noteworthy that no respondents reported contacting the police pro-actively or releasing patient information inappropriately (since health records are the property of the Secretary of State of Health and therefore may only be released by the Trust Chief Executive). Only one respondent reported having been served a subpoena to provide access to confidential notes although this alone represented a prevalence rate of 3.5% of psychologists from sexual health settings, with two further cases connected to subpoenas received by the wider team suggesting actual incidents are yet higher. Additionally, the possibility of a psychologist acting on behalf of the defence counsel raises voluntary possibilities as an expert witness. Whereas other examples cited where the involvement by psychologists outside of sexual health settings related to exceptional circumstances (e.g. capacity assessment), this nevertheless illustrates the varied implications across diverse clinical settings.

One notable observation during focus group discussions was the difficulty some participants experienced in clarifying their legal/professional responsibilities was distinguishing between '*illegality*' and '*potential harm*'. Those framing behaviours as illegal appeared more likely to initially consider police involvement and had to be cautioned by more experienced clinicians that their professional responsibilities were, in fact, to prevent potential harm where possible; and thus contacting the police to initiate a complaint was (except perhaps in the most extraordinary and exceptional of circumstances) always inappropriate.

Patient Disclosures of Problematic Information

A surprisingly high proportion of respondents (17%) within sexual health settings indicated past experiences of clients disclosing intentional HIV-transmission. Furthermore, a much higher proportion (55% within the overall sample), including the majority of those within sexual health settings (72%), also reported experiences of HIV-client discussions suggestive of '*reckless* [sexual] *behaviour*'. These included four psychologists from generic settings demonstrating these situations are not exclusive to those working directly with sexual health issues. It is however also possible that some of these instances refer to clients describing retrospective behaviour rather than signifying impending intent where a clinician might be expected to take action. Despite these statistics presupposing some subjective evaluation of what constitutes '*recklessness*' or motivates '*intent*' (which may not therefore be consistent with legal definitions of the same concepts), the overall impression is that these situations are relatively common thereby representing the degree to which the professional issues are potentially implicated.

Generally, findings indicated that whether psychologists considered disclosing a patient's HIV-status to sexual partners (24%) or other professionals (44%) was primarily related to whether they were perceived to involve intentional or reckless behaviour respectively. Whereas all disclosures of intentional behaviour were shared with the MDT and discussed with service managers/clinical supervisors, this was less so for reckless behaviour reflecting the perceived less urgency of these situations. As might be expected, almost all of the eleven respondents considering disclosure to sexual partners were sexual health experienced psychologists; the remaining two from generic settings related to exceptional circumstances (e.g. a cognitively impaired client in a forensic secure setting; or involving child protection issues). Although this question's wording did not specify whether these actions were followed through (i.e. not merely considered), they highlight the significant number of cases where professionals were prompted to consider the need for doing so.

Another significant factor was whether individuals potentially at-risk could be named and located which placed practical (as well as professional restraints) in notifying sexual-partners. Additionally, experiences related to such scenarios reported that Trust legal advice stressed such options should not be pursued if they may result in the identity of clients being indirectly compromised. However some participants doubted whether this position unduly reflected institutional caution (to the neglect of a clinician's professional liabilities). In most cases it was felt that disclosure was best facilitated by the process of anonymous partner notification conducted by another member of the team wherever practicable, but this could still prove problematic since it necessitated disclosing particular concerns.

Information Sharing

A particular difficulty in maintaining confidentiality in therapeutic relationships for psychologists is how their practice frequently intersects with other disciplines (Kampf *et al.*, 2006). Consequently, the issue of confidentiality was a central concern, whereby psychologists needed to remain mindful that given the differing professional standards applicable there could be indirect implications arising from their decisions to share information with other professionals (particularly medics).

Findings indicate psychologists frequently share information with other professionals regarding their HIV-clients, although within generic settings this was usually related to legal/immigration and housing/social care issues. The high rate of routine information sharing reported with GPs is surprising given the anonymous status of *GUM* (and some *HIV*) clinics. Within HIV-settings, the drive for greater primary care liaison may account for this anomaly but raises speculation about whether informed consent is always meaningfully obtained. Conversely, other examples related to child-protection issues highlight where consent may not be necessary or appropriate.

Confidentiality Practices

Psychologists attempted to balance their ethical/legal obligations primarily by exercising control over the level of information shared with the wider team. The level and detail of information psychologists shared with teams (either individually or collectively) appeared associated with whether an ongoing and clear risk could be attributed to a sexual partner. Whereas all disclosures of intentional behaviour were shared, this was less so for reckless behaviour reflecting the lesser urgency of these situations. These findings are consistent with Totten *et al.* (1990) who found therapists were more likely to breach confidentiality in situations with potential risk of harm to others, and when considering whether to, therapists considered the degree of dangerousness and identifiableness of the '*victim*'. Additionally, others studies indicate the imminence of the danger (McGuire, 1995) and clinical experience (Botkin & Nietzel, 1987) are also important factors influencing such decisions.

Most respondents (85%) reported clarifying the limits of confidentiality with their HIV-clients with only 62% revisiting these issues when discussions regarding sexual partners arose. Around 80% reported raising safer sex issues and/or HIV-status disclosure to sexual partners, at least on some occasions (with similar levels reporting documentation of these discussions and confidentiality information given to some degree). This aspect was considered particularly important in regard to reckless behaviour where the professional options were considered to be more limited, although respondents appeared discriminating when judging the appropriateness of doing so.

Psychologists faced greater ethical uncertainty where '*conflicts of interest*' arose, such as named individuals being a known patient at the same clinic (or worse, the same clinician); or to a lesser extent where information inadvertently alerted professionals to another's identity. Here, participants preferred to involve the HIV-client in the process of partner notification wherever possible and stressed the need to inform them (even retrospectively) of actions taken without consent. However, it was felt that it was in relation to these very complex scenarios which professional guidance currently failed to address sufficiently.

Changed Clinical Practice

It is perhaps surprising that only 58% of respondents in sexual health settings were yet to change their clinical practice given the high proportion indicating behaviours disclosed by HIV-clients potentially leading to sexual-transmission. In the case of psychologists within sexual health settings, the discrepancy between these statistics for changed clinical practice and client reckless disclosures (43% vs. 72%) supports the assertion that psychologists, although more vigilant, have not responded with a '*knee jerk*' reaction moderating any immediate impact upon clinical practice. However, it is less clear whether this

reflects complacency and confusion about what is required professionally or if they were waiting for further guidance before implementing any changes to their routine clinical practice.

Overall the direction of change adopted did not appear overly punitive or indicate increasingly defensive practice as might be feared. For example, many psychologists (21%) appeared to be using opportunities to safeguard the well-being of their HIV-clients by raising awareness of the implications of HIV-legal issues. This included advocating a more pro-active stance towards HIV-disclosure to sexual partners, or cautioning against disclosing information in clinical contexts which could later be divulged in court; presumably in order to mitigate the personal legal risks to the psychologists themselves, as well as their HIV-clients.

Professional Guidance

Among sexual health experienced psychologists there was some consensus regarding the inadequacy of existing professional guidance although overall these appeared directed towards less experienced clinicians rather than themselves. Qualitative comments from more experienced clinicians described current guidance as *'just about'* sufficient and suggested that there is a danger for misinterpretation, naivety or impulsiveness by less experienced clinicians. Overall, the findings highlight the expressed need for the development of more comprehensive guidelines providing greater clarity and precision in this complex area integrating provision of expert/peer supervision for clarifying the many *'grey'* issues arising in this sensitive and ongoing field of clinical practice. One suggestion was that the guidelines should not just include broad principles but also outline example case scenarios where psychologists might be expected to break confidentiality; as well as illustrating how managing these situations should be managed in accordance to best practice. However, it was acknowledged that such methods could never be exhaustive.

Nevertheless, the majority of respondents reported a lack of concern regarding the possibility of civil litigation suggesting an accurate perception at the time given Chalmers' (2005) report that there have been no UK cases of physicians or psychologists being held liable for failing to prevent onward transmission of an STD. It was noticeable that respondents' ratings of concerns were neither inter-related nor correlated with the self-efficacy index. This is perhaps an unexpected finding since it could be reasonably speculated that psychologists lacking self-efficacy would register higher concerns, and similarly those believing guidance to be lacking would feel more professionally vulnerable. However, psychologists described the various existing professional standards as complex and confusing, and not adequately addressing the complexity of clinical issues and scenarios that can arise. Perhaps, then, it is little wonder therefore that health professionals continue to express anxiety when determining whether to breach or maintain confidentiality (Shapiro, 1990). It must be hoped therefore that the recent publication of the *BPS/DCP* approved Criminalisation of HIV-transmission: Guidelines regarding confidentiality and disclosure, partially informed in light of the preliminary results from this research, meets this urgent need.

4.3 Factors related to Therapist Personal Ideology

This section aims to synthesis the findings from the survey and focus groups

analysis in order to put forward an explanation of how the divergent perspectives towards the issue of HIV-prosecutions which were observed, influenced how they approached the clinical and professional issues. It introduces the philosophical concept of hermeneutics as a useful explanatory framework for demonstrating the relationship between how psychologists understood the wider impact of HIV-criminalisation and how this factor formed the hermeneutical lens – or interpretative prism – through which they approached the clinical and professional issues.

Hermeneutics and Narratives

The central principle of hermeneutics is that it is only possible to grasp the meaning of an action by relating it to the whole discourse from which it originates (Willis & Jost, 2007). This approach is often used for investigating HIV/AIDS (e.g., Ezzy, 1998; Baxen 2008) and exploring the interaction between lived experience and subjective interpretation (Mishler, 1986). Firstly, a hermeneutic (*singular*) represents a particular strand of interpretation. It is used here as a descriptive tool to conceptualise the psychologist's perspectives into two divergent narratives mediated by social and cultural positioning (drawing upon Ricoeur's, 1992 theory of narrative identity). Secondly, hermeneutics (*plural*) is also the art, theory and practice of interpretation; the '*hermeneutic circle*' which relates the whole to the part and the part to the whole (Godamer, 1960). In this sense, it can be considered that the narratives presented did not just project '*ideologically suffused language*' (Faberman, 1992; p.375) but also acted as interpretative scripts or structural devices. These ideas help frame some of the underlying issues pertinent for addressing the ideas and attitudes expressed towards HIV-prosecutions which were identified.

Attitudes Towards HIV-Prosecutions

In one sense, the survey findings indicate the overwhelming majority of respondents (81%) supported HIV-prosecutions to some degree or form. However, within the apparent middle-ground, the evident point of attitudinal disjunction is whether prosecutions should be limited for '*intentional*' transmission only or extended to include '*reckless*' behaviour also (37% vs. 44% respectively). It is not surprising that this the defining characteristic differentiating the position of psychologists in the study since all successful UK prosecutions to date have been for '*reckless*' sexual-transmission; thus reflecting that the issue of prosecution for '*intentional transmission*' is of less immediate consequence

These positions parallel the narratives of the '*critical*' and '*less critical*' camps from the focus groups although it can also be inferred that each reflected wider '*minimising*' ('critical') and '*maximising*' ('less critical') attitudes towards the use of the law in this area. As the literature portrays, both perspectives framed the issues in terms of opposing arguments relating to the policy's public health impact. On the one hand, those critical of using legislative approaches emphasised human rights approaches and the counter-productive effects upon HIV-prevention such as the potential negative effects of increased stigma and discrimination; whereas supporters emphasised the potential deterrent effect of HIV-prosecutions upon modifying risk-taking behaviours. To a greater extent, how psychologists positioned themselves regarding '*reckless*' HIV-prosecutions appeared synonymous with how they prioritised these arguments. However, the literature cautions that these essentially theoretical abstractions are based on distorted oversimplifications (what sociologists term '*ideal types*') which, in

practice, few people would strongly maintain and so presumably these reflect a shifting continuum of perspectives rather than two separate *'hard and fast'* camps of thought and attitude.

Here I would like to attempt to map the characteristics of psychologists within each grouping to suggest how these *'types'* were, at least partly, shaped through personal experience and social representations 'reflecting and communicating identity issues' (Millward, 1995), which Moscovici (1961) conceptualises as occupying the 'space in-between, at the crossroads of the individual and society'.

Sexual Health Experience Factors

The survey findings suggest sexual health experience was an influential variable among those more likely to hold a position against HIV-prosecutions. This is also reflected in the substantive weighting of opposition among focus group participants. However, the degree to which this association relates to the effect of sexual health experience is complicated by the significant demographic factors differentiating psychologists in sexual health settings with those respondents from generic clinical settings among the survey respondents. Generally, this latter group supported HIV-prosecutions *per-se* but somewhat fulfilled the stereotype of psychologists as white British heterosexual females. Additionally, respondents from sexual health settings (who were more likely to be gay/bisexual and/or male) had greater clinical experience of working with HIV-clients. The issue of sexual orientation factors are thus also pertinent to their positioning.

Sexual Orientation Factors

It was noticeable that within the critical strand, many participants expressed their opposition to HIV-prosecutions in terms of the *'political'* with many among this more *'ardent'* subgroup self-identifying as gay/bisexual. This finding is perhaps not surprising as Butler and Byrne (2004, *p*.90) in a paper exploring [sexual-health] institutional systems comment: 'lesbian and gay staff are visible at all levels of service provision' having 'multiple roles as service users, service providers, volunteers and campaigners'.

Although the UK-C sample was not representative of the general population (or perhaps HIV-positive individuals in particular), the *UK-C* study is of interest because of the large number of HIV-positive respondents (71%); among which few (11%) advocated prosecutions for reckless behaviour - suggesting the critical strand's position to be closer aligned to HIV-clients[1] than all other psychologist groupings. This association is interesting in light of Butler and Byrne's assertion that gay/bisexual psychologists interpret their role as 'providing some level of accountability and balanced representation with respect to service provision' particularly in respect of challenging *'heterosexist practice'*.

Sexual Prejudice and Heterosexism

The term *'homophobia'* has been criticised by a number of authors (e.g. Kitzinger, 1997) as depoliticising and individualising anti lesbian/gay discriminatory practices; whereas the wider term *'heterosexism'* includes

[1] Although it might seem reasonable to assume that many of the HIV+ respondents in the UK-C study are likely to have been gay or bisexual, it is not possible to confirm this association as the UK-C survey did not ask respondents to indicate their sexuality. However, the publication also includes many heterosexual readers (often African).

practices pertaining to gender, sexuality and difference - all of which are foregrounded to a greater extent in sexual health services than elsewhere. Butler and Byrne (*2004*) suggest the formulation of sexual prejudice is preferable for broadly social-constructionist formulations as it 'acknowledges the contextual, political and social/cultural influences contributing to the oppression of clients'. Here I wish to link this strand's critical attitude to HIV-prosecutions with the influence of critical psychological approaches, to suggest it was important for them to distance themselves professionally from the legislative policy wherever possible so as not to be seen to collude with discriminatory "systems" surrounding their clients.

Professional Self-Efficacy Factors

A further personal and professional factor of relevance hinges on self-efficacy. In relation to the self-efficacy index only the sexual health experienced and gay/bisexual subgroups reporter higher ratings. However this would be expected since respondents from generic settings reported less experience with HIV-clients (in numerical terms) and the gay/bisexual subgroup were disproportionately represented among those with sexual health experience.

Among those in sexual health settings, the increased self-efficacy collectively reported did not appear to differ significantly. Indeed, in many cases the increased awareness of HIV-prosecutions was itself a cause of general anxiety for psychologists since it brought the resulting clinical issues to the foreground. However the focus of these concerns appeared to differ in relation to psychologists attitudes towards HIV-prosecutions, which broadly aligned with demographic factors. The critical strand's anxieties were mainly directed towards the negative impact of the socio-political aspects (e.g. increased stigma/discrimination). In contrast, the less critical strand appeared less vocal in contesting '*reckless*' HIV-prosecutions and more focused upon their perceived lesser ability to manage these issues within clinical situations; but shared the concerns of the '*critical strand*' regarding the lack of robustness of professional guidance. Although there were significant demographic differences between these two groups, there was some indication that sexual orientation factors influenced psychologist's perceptions, by operating at an individual level between therapists and clients which either mediated or impeded clinical confidence.

Deconstruction of the two strands at this contextual layer allows the discussion to focus upon the usefulness of personal identifiers within each therapeutic encounter which is inherently relational in nature.

4.4 Factors Related to Issues of Difference

This section considers issues related to '*difference*', particularly those potentially impacting upon therapeutic engagement with HIV-clients. As such, it is largely based upon the qualitative findings arising from the focus group analysis.

Incorporating the Findings into Models of the Therapeutic Alliance

The central component of Orlinsky *et al.*'s (1994) model of therapy is the therapeutic alliance, which is considered to be the most robust predictor of therapeutic success (Safran & Muran, 2000). The concept of the therapeutic alliance essentially refers to the relationship established in therapy between

therapist and client, with the components of the alliance conceptualised as consisting of three interdependent components: the bond between client and therapist, the client-therapist agreement on goals and the client-therapist agreement on tasks (Bordin, 1979; 1994; Hovarth & Greenberg, 1986). Identified themes in relation to their impact upon this model are now discussed

Therapeutic Environment

The model's input variables reflect the environment of the therapeutic system before treatment starts. Importantly, all group discussions centred on how HIV-prosecutions had altered the social and cultural environments within which the therapeutic system is located. Although currently participants and respondents did not seem overly concerned about the risk of legal liability, it was clear from the focus groups that sexual transmission issues were now viewed as being higher risk. Noticeably, this was articulated by participants feeling more pressurised to address risk issues earlier following recent HIV-prosecutions, perhaps encouraging less holistic non-contextualised assessments of a situation.

Clinical decision-making regarding risk is considered to be situation-dependent (Orme and Maggs, 1993). This is particularly so in regard to clinical and counselling psychology practice which rely less on the use of actuarial scales that have advanced the prediction of violence and/or sexual in other fields such as forensic psychology (e.g., Tolman & Mullendore, 2003). Garb (2005, *p.*77) discusses the many ways professionals frequently make causal judgments based on clinical lore (e.g., Baumeister *et al.*, 2003) often not supported by the empirical research; with psychologists in general practice, tending to make risk judgments largely reliant upon clinical intuition, with evaluations primarily derived from integrating information (about a person, object or situation - Maule, 2001)

Naturally, where actions have important consequences, clinicians will be more concerned about avoiding negatively perceived outcomes and as Schwartz (1982) argues, become, more risk adverse. However, Hubbard (2009) strongly criticises the perception of professional decision-makers as risk neutral and has proposed a kind of vector quality whereby the magnitude of risk presumes the tolerance of the decision-maker. For example, in terms of the severity of HIV/AIDS, popular perceptions widely hold the virus as being similar to that of a '*dread risk*' equitable with nuclear warfare, whereby threat perceptions are shaped relative to differences in personal susceptibility (Weinstein, 1998). Since cognitive processing frequently occurs outside of one's own awareness (e.g., Kihlstrom, 1999) the danger is that these perceptions may be guided as much to implicit models owing more to everyday experience than to scientific findings (Garb, 2005).

Cognitive heuristics and biases – or '*mental short-cuts*' (Tversky and Kahneman, 1974) - are often used by clinical psychologists to make sense of situations and decide what to do (Garb, 2005), especially when unfamiliar (Thompson & Dowding, 2004). Indeed, experts are commonly classified as such because they are skilled in deploying cognitive reference points, often as a result of considerable clinical experience (Benner & Tanner, 1987). As long as these are good quality and reliable they mostly lead to efficient and effective decision-making. However when addressing high-stake issues, availability and representativeness heuristics (i.e. faulty '*rules of thumb*') can lead to consistent

and serious errors in judgment (Kassirer and Kopelman, 1991) contributing to an *'illusion of control'* from the overestimation of good outcomes (Poses *et al.*, 1991).

Within the therapeutic encounter participants made particular and repeated references to the influence of popular discourses (e.g., most notably from parts of the popular press) which were described as strongly contributing to stereotypes in how HIV-individuals and HIV-infection were perceived. A more subtle, but similar, phenomenon related to clinical decision-making is the way taxonomies invented as conceptual conveniences are reified being seen as representing the way the world is really structured (Nickerson, 1998). Since clinical psychologists frequently categorise clients according to hypothetical prototypes (e.g., Cantor *et al.*, 1980; Garb, 1996) these beliefs, whether real or illusionary, may hold greater salience for, or prime them when making judgments about similar behaviours between those from within and outside these groups (Feldman *et al.*, 1986; Hamilton *et al.*, 1985). Thus the potential danger for expectations and assumptions to influence therapist-client actions in ways which become *'self-fulfilling prophesies'* (Merton, 1948; 1957).

There are inevitable tensions between the client centred empowerment approach underlying counselling and the public health ethos (Cowan et al., 1996). It is interesting that difficulties in the therapeutic role were related to these conceptualisations and were described by participants in terms of the level of judgementalism and morality implicit to each. Singer (1994) considers how the articulation of *'expertise'* in the area of sexual health cannot be separated from its historical associations with morality which have been well documented (e.g., Easton *et al.*, 2002) as contributing to perceptions of HIV/AIDS as a *'moral panic'*. Additionally, Beck (1992) suggests that in modern times we live in a *'risk society'* where risk management has become increasingly individualised (Beck, 1992). These trends have resulted in the association between *'risk'* and *'lifestyle'* encouraging risk to be located within specific *'high risk groups'* perceived as being both uniquely *'at risk'* and also synonymous with, and therefore viewed to be dangerously *'posing'* a risk to others as well (Flowers, 2001). In more recent years, reactions to HIV and resulting stigma/discrimination has developed along two clear forms; towards gay men and *'foreigners'* (Accoroni & Watson, 2006) directly related to historical notions regarding the distribution of both responsibility and blame for managing HIV/AIDS risks (Flowers *et al.*, 2001) – notions which have been repeatedly challenged throughout the history of the epidemic (e.g. Singer, 1994).

These themes can also be observed in the way participants alluded to the professional issues raised for therapists as paralleling the ethical dilemmas experienced by their HIV-clients regarding HIV-disclosure in their personal lives. For example, the clinician's individualistic concerns (i.e. limiting professional liabilities) were compared to the HIV-clients' concerns to avoid legal culpability; both of which were contrasted to societal notions of shared or collective notions for avoiding HIV-transmission in sexual relationships. The *'less critical'* strand was less likely to consider raising HIV-legal issues identified a moral position in relation to HIV-prosecutions, suggesting this reflected the reality that prosecutions were a factual issue; whereas *'critical'* psychologists stressed their aim was not merely to remain therapeutically neutral but to positively affirm clients (e.g. Example extract 31), as well as being related to questioning the ability and power of therapists for policing sexual behaviour.

Therapeutic Relationship

While recognising outside forces upon the therapeutic frame; the concept of the therapeutic alliance essentially refers to the relationship established inside therapy between therapist and client. The development of which is strongly influenced by client-therapist conceptions of how they relate to each other, as well as how they conceptualise difficulties. Similarly, in relation to treatment outcome, these factors are influenced by the therapist's skilfulness in maintaining stability in the therapeutic frame and adherence to the treatment model. It is easy to see how these issues are difficult to balance or could easily be disrupted when negotiating HIV-legal issues, particularly around the area of reaching agreement around goal and task setting.

The ability of therapist and client to collaborate in setting therapeutic objectives was moderately related to their ability to feel sufficiently well equipped and comfortable dealing with issues of difference. Differences in personal values vary according to individual differences in one's own needs, priorities, and preferences; with disjunctions observed to colour the clinician's internal perceptions regarding the desirability and priority of client's actions and choices (Van Wart, 2004). Therefore, how much the therapist is influenced by or engages with the prevalent culture of attitudes towards HIV-prosecutions within society will influence how they relate to the client, as well how client perceptions of the therapist's own politics, prejudices and beliefs about people with HIV interact upon therapeutic dynamics. In particular, race, culture and sexuality factors are considered key components when understanding and working with sexual health issues since social processes are interwoven through any biological and psychological aspects of behaviour (Davidson *et al.*, 2002). Difficulties in these areas have been attributed to increased concerns by patients about the likely attitude of sexual health care professionals, particularly around being '*judged*' (Green, 2002). Fundamentally, Rodgers (1978a) suggests that whether empathy is difficult to achieve due to therapist's views, or other source of prejudicial attitudes, the end result is potentially damaging to the therapeutic relationship.

The ability to view problematic behaviour within a formulation of a person needing help (rather than attributing '*pathological*' motives) was considered crucial for avoiding judgemental attitudes. Many participants acknowledged how lack of empathic ability could result in them inadvertently trying to push for HIV-disclosure where it was inappropriate or untimely. Although whether an individual considered at-risk was named or known were crucial factors in how participants perceived professional risk, other discussions also observed attitudes of '*dangerousness*' and '*potential harm*' to be heightened by socio-demographic proximity to the therapist; and therefore associated with the concept of epidemiological distance. For example, some participants within the '*less critical*' strand appeared especially concerned with the behaviour of some HIV-positive gay men to recognise casual unprotected sex as problematic. However, the concerns of these (apparently heterosexual and/or married) female participants appeared to focus upon the indirect risks of HIV-infection posed to the wives/children of bisexual men, perhaps reflecting how their concerns were heightened when those at-risk were closer socio-demographically to themselves.

In regard to the potential for gender bias among clinicians, Elbogen *et al.* (2001)

suggests that female professionals have been found to view male psychiatric patients as more violent than did male clinicians. It is also of interest that in examining the timing of HIV-prosecutions (in relative historical terms of the HIV-epidemic), Bernard (2005) comments that the law was not invoked as a tool to dissuade people from '*reckless*' sexual behaviour until more recent times. He suggests that HIV-prosecutions have originated during a climate of intensified fear as recent epidemiological trends show that heterosexual transmission has increased significantly compared to other modes. Furthermore, Carter (1995) notes that in the context of technological cultures, '*expert*' risk assessors often police the crossing and connection of the boundaries of '*self and Other*'. These factors may, in part, account for this observation and explain how the gender and sexualities of therapist and client may interact with wider cultural discourses and social processes.

Certainly, participants in the '*less critical*' strand appeared frustrated by the resistance of some gay/male HIV-clients to uniformly adopt protected sex and HIV-disclosure practices, which was more open to interpretation as being considered therapeutically unwilling. To some extent, these legally ambiguous behavioural disclosures were anxiety provoking for the clinician, leading to these psychologists reporting greater difficulty holding back from expressing emotional reactions. In contrast, the approach of the critical strand appeared more tolerant to ideas of negotiated safety and risk minimisation; perhaps influenced by systemic approaches advocating a non-expert stance where the client is the expert on his or her life and experience. Additional considerations included how the altered therapeutic forum may inhibit HIV-clients from expressing difficulties, or clinicians from responding to them. These can be related to what might be termed '*silencing behaviours*' (Foucault, 1989) closing down opportunities for openness and therapeutic exploration and may result in clinicians overlooking the use of alternative safer sex practices adopted by many gay men; such as '*sero-sorting*' which is the selective use of unprotected sex with partners selected because their HIV-status is sero concordant.

Therapeutic Bond

The heart of the therapeutic process is considered a complex and multidimensional process involving affective communication at both conscious and unconscious levels (Safran & Muran, 2000), As such, mutual affect is key to the therapeutic bond (Orlinsky *et al.*, 1994) because trust and being understood are such important components affecting the quality of the therapeutic encounter for the client (Van der Veer, 1998; Stedman, 1999; Harris, 2001). This is particularly so at the input stage where the therapist-client ability to sustain empathy may inhibit or encourage the development of an effective therapeutic relationship.

Issues of power within the therapeutic relationship were described as potentially contributing to the therapist being perceived as authoritarian or persecutory (possibly leading to therapeutic disengagement); as well as how fear of judgement by the therapist may evoke feelings of shame or guilt in the client. Critical strand participants tended to emphasise the danger of clinicians encouraging blame by sympathising with over-simplified conceptualisations of guilty/innocent, whereas many less critical strand participants emphasised the danger of colluding with clients by not challenging problematic behaviour (c.f. Example quotation 26: describing the use of judgement as a lever to confront the client).

Appraisal theory suggests that our emotional responses occur rapidly and automatically (Garb, 2005) and are extracted from our evaluations (appraisals) of people and social factors related to events. Thus how much the therapist is perceived to engage with the prevalent culture of attitudes towards HIV-prosecutions within society will influence how they relate to the client, as well as the clients perceptions of the therapist's own politics, prejudices and beliefs about people with HIV. Although the use of intuition in these matters may positively guide clinical judgment, over-reliance on such feelings have been characterised by Slovic *et al.*, (2002) as the *affect heuristic.* These categories are linked to complex value systems through notions of '*self*' and '*Other*' (*me* and *not me*) where each term implies rejection of the other and where locations of self and Other always operate within a hierarchy (Hodges, 2004). Put another way, we make sense of who we are as much by rejection as acceptance.

4.5 Strength and Limitations of the Research

This study addressed the paucity of the literature examining the impact of HIV-criminalisation policy upon clinical practice. As the first study to approach the topic from a clinical perspective it was appropriate for this research to focus upon exploration. However, one of the drawbacks of exploratory research is the inevitably broad range of issues investigated. Consequently, comprehensive findings from the survey and thematic analysis have been presented to facilitate dissemination and consideration by other sources. The publication and availability of this information is considered integral to the study.

Methodology

One of the noticeable qualities of the project is the considerable interest expressed among psychologists throughout all phases of the research process including encouragement that this was a timely topic of significant concern. The nature of the study lent itself to methodological triangulation where the omission of either quantitative or qualitative components would present a fractured picture. Dey (1993, *p.*28) suggests these methodologies are mutually dependent since 'meanings cannot be ignored when we are dealing with numbers and numbers cannot be ignored when we are dealing with meanings'. The quantitative research paradigm is embedded within an empiricist approach to the study of psychology and has come to be contrasted with the qualitative research paradigm, which is embedded within a constructivist approach (Henwood & Nicholson, 1995). The suggestion here is that "meaning" does not merely reflect the world as it exists but is constructed by people within cultural, social and historical relationships. That is, it is impossible to separate an individual from their interactions with the environment. Certainly it is felt that the survey provided contextual data but the appeal was always to move beyond statistics. The focus groups allowed clearer exploration of the complex interaction of social/cultural and psychological factors impacting on clinician behaviour.

Questionnaire Survey

In retrospect, the modest response rate (22%), although anticipated, partly reflects the questionnaire was overly long covering too broad a range of issues. Although not unusual for studies of this kind (Viljoen & Wolpert, 2000), the response rate is still quite low. People who return questionnaires are not usually representative of the whole target population (Barker *et al.,* 1994). However, the

sampling strategy was successful in obtaining sufficient representation among psychologists from generic settings to allow statistical exploration of the interaction of sexual health experience upon findings, while reflecting greater sexual diversity among respondents. It can only be speculated that perhaps those who completed the questionnaire were more motivated because the subject matter was more pertinent to them in some way. The large number of additional comments received probably reflects some self-interest or previous relevant experiences particularly in regard to those received from psychologists in generic settings (recruited through randomised sampling from BPS/DCP listings). These issues suggest some response bias. Accordingly, considerable attention has been given exploring the sample's composition to assess and make transparent possible demographic influences.

Sampling Bias

A further issue to consider in relation to this study is that of representativeness. The lack of ethnic minority representation (<3%) is disappointing in contrast to Maslin's study (2003) which also used a questionnaire format but obtained a sample including 10% of ethnic minority respondents. Consequently, it was not possible to make inferences regarding the importance of cultural factors relative to the identified findings. Undoubtedly female respondents were predominant in the current survey's sample (79%) thus reflecting wider gender imbalances within the profession; however less visible is the lack of heterosexual male respondents. Even so, although gay males comprised 41% of respondents in sexual health settings, and the gay/bisexual group overall was gender balanced moderating the impact of this factor. Another plausible possibility is that the focus group participation mainly reflected the *HIV&SH Faculty* membership (possibly not reflective of psychologists working in sexual health settings) although in essence the core of each group reflected the hosting team.

Self Efficacy Index

It is always preferable to use existing validated measures when conducting research, but none was available for this study. The construction and analysis of a scale measuring self-efficacy working with HIV-clients was therefore designed to address professional issues specifically in light of HIV-prosecutions. However, although the psychometric scale developed was a reasonable measure, it accounted for only 68.1% of the variance in responses recorded. Lack of sensitivity suggests a number of unidentified variables were not incorporated into the model, perhaps most notably the interaction of sexual orientation and gender characteristics. Furthermore, it was regrettable that it was not possible to identify reliable sub-scale components within the overall scale (and thus allowing further analysis of which particular factors could be attributed to predicting self-efficacy among respondents within sexual health settings), no doubt partly due to the lack of clarity differentiating between many of the scale's items. It is also difficult to interpret the results in relation to self-efficacy given that in reality self-efficacy appears to be situation specific. However, overall the scale was a useful tool for broadly capturing and comparing respondent self-ratings – albeit of moderate effect-sizes – but it is unlikely that such a crude instrument would serve a need beyond this particular study.

Focus Groups

The focus group dynamic stimulated lively interaction and discussion of similar experiences, although generating a large number of themes needing

consolidation. The characteristics of these participants probably reflected demographic omissions within the survey sample, however as information was not formally collected in this regard this observation is anecdotal only. Nevertheless, all the discussions did acknowledge that gender and ethnicity factors are intrinsically interwoven into the nature of HIV-stigma/discrimination, despite the vignette used encouraging focus upon male sexual behaviour. All participants fedback that discussions - although clinically challenging - were immensely helpful for learning from their peers and allowing the psychologists a space for thinking through how they might respond to challenging scenarios; as well as examining their everyday practices. This approach would therefore appear appropriate for training sessions around these clinical/ethical issues although, as always, vignettes need to be carefully selected in order to maximise ecological validity.

Researcher Influence

Another source of influence upon the research process stems from the active role of the researcher – what might be termed his own *'interpretative lens' (c.f. Anderson; 1998)*, perhaps more so with the qualitative component where the analytic process included constant comparison and theoretical sampling in relation to the survey data – described by Bulmer (1979) as a '*flip*-flop' between ideas and research experience. This necessarily involved some subjective interpretative engagement by the researcher (Smith, 1995), particularly in regard to the development and framing of the thematic coding which required 'a delicate balance between possessing a grounding in the discipline and pushing it further' (Charmaz, 1990). However, it is hoped that insight and reflection by the researcher of these challenges; as well as the involvement of various clinicians experienced with working with HIV-clients and of HIV-issues in reviewing both the methodological components and study findings has largely minimised these difficulties.

In part, the researcher's motivation for undertaking the current research stemmed from his experience of working within a metropolitan sexual health clinic during clinical training at a time when the clinical issues from HIV-prosecutions were first emerging. The experience of seeing the team collectively grappling with these complex issues and the divergent opinions and approaches to the topic held by individual clinicians and among professional disciplines convinced him of the need for further research to inform clinical practice in this sensitive and controversial area. A further relevant factor in this decision was the researcher's prior experience of undertaking qualitative research into the perspective of gay men's understanding of responsibility for safer sex behaviours (Rodohan, 2001) which was later used to inform a HIV-prevention campaign by the Terence Higgins Trust (*THT*). The researcher therefore approached the research question, at least partly, from the perspective of the impact of HIV-criminalisation upon its wider health promotion aspects; and an awareness of the potential difficulties in integrating legal approaches to HIV-transmission with the predominant human rights approaches being strongly advocated by, for example, *UN-AIDS*. However in reality, when examining specific examples of HIV-prosecutions it is always possible to identify particular cases where the use and role of the law would seem to be a proportionate and appropriate response to the risks posed by some individuals; and so the researcher would not classify himself as being wholly against legislative provisions in principle. Rather from the researcher's perspective, the issue has always been the appropriate role of psychologists in this process. In

the end, the researcher would agree with the stance taken by the new *BPS/DCP* guidelines not to advocate against HIV-criminalisation in a way which may be perceived as being overly political, not least because this would not be consistent with the culture of the organisation at the current time (and therefore could be counterproductive to the aims of it doing so).

Future Research

It is frustrating that the discussion permits only an over-view of the findings thereby not doing full justice to the richness of the data. Similarly, from a theoretical perspective, the lack of directly comparable research in relation to the legal issues raised by clinical work with this client group is a drawback. Where possible, the relevance of psychological theories and clinical models have been briefly considered to indicate possible lines of future enquiry. Links between the identified obstacles between working with HIV-clients and the role of sexual identity factors impacting upon the development of a positive therapeutic alliance, are to some extent indirect associations. In this regard, further exploration is indicated, as variation in psychologist factors appears to have a moderate influence in how clinician's perceived sexual behaviour. Similarly, greater understanding of how issues of difference contribute to assumptions and attributions made within therapeutic encounters is needed, given that HIV-prosecutions have included a disproportionate number of migrants and ethnic minority individuals for whom the consequences frequently mean deportation (Nyambe & Gaines, 2005). It would also be interesting to examine how the revised *BPS* guidelines have been construed by psychologists and the extent they fulfil the needs of those across varied settings.

Conclusion

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“

in order to really help people

address their emotions about being diagnosed

you have to have some kind of therapeutic space

and it feels like that isn't there now

”

Example Quotation 10 (Transcript A: Lines 532-533)

5.0 CONCLUSION

This study considered HIV-criminalisation from the perspective of UK psychologists concerned with the clinical ramifications of an increase of prosecutions. In time, empirical assessment of the epidemiological impact of the policy at an international level will allow for the detection of any observable differences in national trends, although given the complexity of issues involved it is unlikely any definitive conclusions could ever be made from HIV-transmission rates alone; and neither should consideration of the topic be divorced from the important ethical considerations which are relevant.

The study's 'mixed methods' design was imperative for obtaining the most valuable evidence to maximise the likelihood of influencing service developments and clinical practice. It is of great interest therefore that the Australian Research Council is developing confidentiality guidelines in therapeutic relationships for mental- healthcare professionals (Kampf *et al.*, 2006). This project also encompasses two components utilising a questionnaire (identifying clinical factors leading to the disclosure of information), followed by '*expert*' multi-disciplinary focus groups; including a comparative analysis of confidentiality provisions with Canada and Scotland where it is argued that differences in HIV-legislation and case law may provide an informative background for considering comprehensive law reform. That the current research also closely follows this study's design suggests some methodological merit in the approach taken as well as highlighting the ambitious scope of this project.

Considering the broader historical and political context of the HIV-epidemic, it is likely that the debate on the appropriate focus of the law in HIV-prevention will continue. Echoes of disillusionment with the effectiveness and thrust of current HIV-prevention efforts were expressed by some psychologists sympathetic with members of the criminal justice system who assert that 'sexual behaviour can easily be modified to reduce or eliminate risk' (Spencer; 2004b). Conversely, opponents maintain that HIV-criminalisation laws are 'the product, not of rational public health choices, but of irrational fears, which provide an inveterately poor basis for law-making' (South African Justice Minister, Edward Cameron). Among participants in this study there was limited support among some sexual health experienced participants (and presumably *HIV&SH Faculty* members) for the *BPS* to adopt a more assertive public stance against a policy of HIV-criminalisation. However, given the lack of consensus among psychologists as a whole, it is likely that this could be perceived as a partisan gesture divisive to the wider profession which cannot therefore be recommended, at least until there is further conclusive empirical evidence to underpin such a controversial position. Consequently, the findings from this study indicate current briefings should be restricted to addressing the clinical implications arising for psychologists faced with such scenarios.

The primary means by which HIV is spread are controversial areas within both legal and public health fields since social norms and personal values about sex – and drug use - vary greatly. Not surprisingly, the issue of using the criminal law to punish HIV-exposure is hotly contested. The question that arises, then, is how criminal HIV-transmission laws and public health efforts can work in greater harmony to achieve the best possible outcomes for a given community. However, the difficulty remains that threats to confidentiality posed by criminal

investigations may deter participants (and/or honesty) in sexual-behaviour research, which provides an essential evidence base for HIV-prevention work.

An estimated 22,400 people in the UK have undiagnosed HIV-infection (*HPA*, 2009) with the government prioritising wider HIV-testing among those population groups considered most at-risk (*DoH*, 2001). Crucially the sustainability and success of these measures rely on trust and confidence between patients and healthcare professionals (Donaldson, 2004). However, there was general agreement among the psychologists sampled that defensive responses by services to HIV-prosecutions would provide a disincentive to HIV-clients accessing services, thereby limiting anti-retroviral treatment jeopardising essential public health control efforts. Meanwhile those who do HIV-test may not agree to their partners being notified for fear of legal and personal repercussions. There are already some early indications suggesting unintended consequences resulting from HIV-prosecutions, with clinical audits suggesting a third of newly diagnosed London patients dropping out of care after their first HIV-clinic appointment during 2007 (*BHIVA* Spring Conference cited in *NAM*; 2009).

Awareness of HIV-prosecutions are frequently informed by inaccurate media coverage vilifying defendants and those convicted as '*AIDS assassins*' (The Sun, 15th October 2003), exacerbating the secrecy associated with the disease. Perhaps, then, it is no wonder that those unlucky to become infected often choose to keep their HIV-status secret. Individuals in this situation need support to come to terms with a new diagnosis, to plan how and to whom they will disclose their HIV-status, and finding effective strategies for protecting others. The legal issues arising from HIV-prosecutions highlight a central dilemma for the profession raising questions about exactly what therapeutic work can safely be done with HIV-clients. Many of these tensions described by participants were attributed to the underlying frictions within the dual role of psychologists within sexual health settings, particularly in maintaining therapeutic neutrality while operating (at least partially) within a public-health framework.

Concern over confidentiality breaches have always been an important issue for persons with HIV, and are one of the most cited reasons for HIV-patients not having a GP, which is why HIV-testing has remained sequestered within the '*extra-confidentiality*' boundaries of sexual health services (*NAM*, 2007). The psychologists in this study also shared these concerns; particularly the possibility that changes to the therapeutic frame may discourage those in need of accessing psychological input and appropriate help. Although considered necessary, discussing and clarifying confidentiality limitations was cited by psychologists as a key challenge for establishing engagement and developing an effective therapeutic relationship with their HIV-clients; perhaps because this action symbolically challenges client assumptions that therapy exists within a context where confidentiality will prevail, and that the patient will not be subjected to perilous consequences (Kanfer & Goldstein, 1986). Another consideration in this regard will be the introduction of the *NHS*-wide Electronic Patient Record system changing how patient information is stored and distributed. New data protection guidelines (*BHIVA*, 2008) stress the need for separate and anonymous *GUM* records, particularly in light of documented problems regarding inappropriate disclosure of HIV-status. Psychologists and other health professionals will need to inform patients that session information

will be recorded and ensure this accurately and fairly reflects discussions. Furthermore, the onus is on clinicians to obtain explicit consent before recording HIV-identifying information and to give HIV-patients the option of having HIV-identifying information hidden from view on their care records.

The minority viewpoints from the focus group participants highlight how perceptions of HIV-prosecutions influenced their willingness to share information with the wider team and beyond. For example, the participant who notably described sexual-transmission as '*murder*' appeared more favourable towards enabling police involvement; contrasting another who maintained they would never collaborate with the legal processes of a HIV-prosecution by breaching confidentiality. Both these stances potentially render the clinicians concerned professionally and/or legally vulnerable; and such wide disparities in clinical practice undermine the confidence and expectations of HIV-clients in psychological services. Hence the urgent need for clear professional guidance already highlighted to ensure consistency in clinical practice standards.

Historically, prior to the identification of the HIV-virus, sexual health services focused upon disease control with little role for psychological intervention. In the 1980's, the gay community led initiatives to develop HIV-services which included more holistic approaches which recognised the emotional and political aspects of sexuality and sexual behaviour. Although both medical and psychological discourses have traditionally pathologised homosexuality (Hodges, 2004), its removal as a mental illness (from the DSM in 1973; and later from the ICD-10 in 1992) was mainly led by psychologists and psychotherapists advocating a more affirmative view of sexuality (Cowie & Rivers, 2000). Many of the psychologist-participants more opposed to HIV-prosecutions indicated utilising critical psychological approaches in their practice. Mental health professionals employing a critical approach focus on how power inherent to their positions create and maintain dominant and oppressive discourses (Drewery *et al.*, 2000) whereby their practice becomes a political act challenging inequality (Hare-Mustin & Marecek, 1997). It has been argued that sexual behaviour is best understood in terms of individual interpersonal competencies and the wider social context. These factors inform us of motivations to engage in unprotected sex which are external to the limitations of dominant health/medical conceptions (Flowers *et al.*, 1997).

In conclusion, this research has highlighted how HIV-criminalisation is integrally linked to issues of sexual identity and sexual prejudice thereby interacting at an individual level between therapist and clients. It would be simplistic to assume that these issues solely represent a narrow self-interested perspective determined by sexual orientation alone; but rather reflect limitations in psychologist's ability to empathise and communicate effectively with others outside their own subjective experience and social interactions. In light of these difficulties, perhaps it would be more prudent for the profession to attempt to put aside the difficulties of apportioning blame for who is responsible for HIV-infections, and focus upon the public health implications where there is greater ethical freedom to develop an evidence base regarding the impact of HIV-criminalisation. In the final analysis, surely the essential research question which remains unanswered is, as Lowbury and Kinghorn (2006) suggest, whether the public interest is best served by pursuing justice against the few at the expense of the health of the many?

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Appendices

Criminalisation for Sexual Transmission of HIV:

Emerging issues and the impact upon clinical psychology practice in the UK

Index of Appendices

Relating to Method Section:

Relating to Results Section:

Appendix 2.1
Ethical Approval & Consent Forms

Ethical approval was obtained from the University of Hertfordshire Psychology Department Ethics Committee.

A copy of the letter of approval follows, and also copies of the templates for both questionnaire and focus group consent forms.

Psychology Department Research Project

Student Investigator: Eamonn Rodohan

Supervisor: Barbara Mason

Title: IMPACT OF HIV CRIMINALISATION UPON CLINICAL PSYCHOLOGY PRACTICE

Registration Protocol Number PSY /08/06/ER

The above research project was approved on 31 August 2006 by the Ethics Committee of the Psychology Department under delegated authority from the Ethics Committee of the University of Hertfordshire.

Signed Date: 31 August 2006

Dr. Lia Kvavilashvili
Chair
Ethics Committee, Psychology Department

I confirm that I have followed the ethics protocol approved for this project

Signed (student) E Rodohan

date ~~15th March 2007~~ 18th January 2010

As far as I can ascertain, the above student has followed the ethics protocol approved for this project.

Signed (supervisor) 

date 18/1/10

Division of Clinical Psychology
Faculty of HIV & Sexual Health

The British Psychological Society

30th August 2006

Dear Psychologist,

Survey of Emerging HIV Issues in Clinical Practice Questionnaire

As part of the Doctor of Clinical Psychology Training Course at the University of Hertfordshire, I am conducting my major research project into the experience of psychologists working with emerging HIV issues in clinical practice.

I would be very grateful if you could participate in this valuable piece of research by completing the attached questionnaire which takes approximately 30 minutes to complete. This is an extremely important area of research and as yet no studies have attempted to explore psychologists' experiences of working with these HIV issues in the UK so directly.

The aim of the research is to explore the emerging issues that are arising for practitioners working with clients where HIV may be a factor. It is hoped that the survey will help inform understanding of the professional and ethical issues faced by clinicians working within this context. The survey will also contribute to the development of professional guidelines by the Faculty of HIV & Sexual Health in order to enhance working practice as well as to identify future service development and training needs.

The project is being supervised by Liz Shaw (Chair of the Faculty of HIV & Sexual Health and Consultant Clinical Psychologist, St Ann's Hospital, N15) and Dr Barbara Mason (Academic Project Supervisor, University of Hertfordshire). If you have any questions, please contact either me (contact details below) or Liz Shaw on (020) 8442-6464.

In order to protect confidentiality, I am not asking participants to sign a consent form and completion and return of the questionnaire will be taken as an indication of informed consent. Please read the further information regarding informed consent provided on the reverse of this letter.

If you would be interested in receiving information regarding the results of the study, please contact me separately so as not to your compromise confidentiality and I will forward a summary of the project's results and conclusions at a later date.

Please return the completed questionnaire by 14th October 2006.

Yours sincerely,

Eamonn Rodohan
Trainee Clinical Psychologist
University of Hertfordshire

Telephone: *04138 314333 (extension 3764) or 01707 286322 (via Course Administrator)*
Email: *E.P.Rodohan@herts.ac.uk*
Address: *Doctor of Clinical Psychology Training Course*
University of Hertfordshire (Hatfield Campus)
College Lane, Hatfield, HERTS AL10 9AB

Informed Consent
Emerging HIV Issues and Clinical Practice Research Study

INFORMATION FOR QUESTIONNAIRE SURVEY PARTICIPANTS:

NB: *Completion and return of the questionnaire will be considered as an indication of consent.*

By completing and returning the questionnaire survey as part of the above research study, it will be understood that you agree to participate in the research study being conducted by the named Trainee Clinical Psychologist as part of a research project investigating HIV issues in clinical practice. The research project is being undertaken as part of the Doctor of Clinical Psychology Training Course at the University of Hertfordshire and is supported by the Faculty of HIV & Sexual Health of the Division of Clinical Psychology (British Psychological Society)

By consenting to participate in the study, it is understood that none of the reported data will be attributable to any participants and that all identifying names, addresses or distinguishing material will be removed and/or made anonymous to protect participant identity (and the identity and privacy of their clients). It is understood that the data may be shown by the undersigned Trainee Clinical Psychologist to his research tutors and to the course examiners who will be qualified clinical psychologists.

I understand that even after giving my consent (by completing and returning the questionnaire) that I can withdraw consent at any time and/or can ask for my questionnaire data to be removed from the study prior to publication. I understand that this is in accordance with point 6.1.5 of The British Psychological Society's Division of Clinical Psychology Professional Practice Guidelines.

By providing consent, it will be understood that confidentiality is assured and will be preserved; that all research data and completed questionnaires will be stored totally anonymously in a secure cupboard at the offices of the University of Hertfordshire in accordance with the Data Protection Act. The materials will not be labelled with any identifying information including names, addresses, or any other information that may compromise my identity. The completed questionnaires and data will be destroyed and/or erased after completion of the study (usually a minimum of five years).

This research project has received approval from the University of Hertfordshire Psychology Department Ethics Committee. Participants may request information regarding the findings and results of the study by contacting the Principal Researcher or Research Supervisors (details below).

It is on this basis that participants give consent for participation in this research study. It will be understood that by completing and returning the questionnaire survey that respondents are indicating their informed consent to participate in the research study as detailed above.

Name of Principal Researcher:	EAMONN RODOHAN	
Contact Telephone Number:	01438-314333 (ext. 3764) or 07956-434830	
Email:	E.P.Rodohan@herts.ac.uk	
Project Supervisors:	Dr Barbara Mason	Elizabeth Shaw
Telephone Number:	01707-286322	(020) 8532-6359
Email:	B.L.Mason@herts.ac.uk	Elizabeth.shaw@beh-mht.nhs.uk

University of Hertfordshire
Doctorate in Clinical Psychology

Course Director: Prof David Winter
Telephone: (01707) 286322
Fax: (01707) 285079
E-mail: : j.v.thomas@herts.ac.uk

Consent Form: HIV Issues and Clinical Practice Research Study
FOR FOCUS GROUP PARTICIPANTS:

I agree to participate in the Focus Group facilitated by the undersigned Trainee Clinical Psychologist as part of a research project investigating HIV issues in clinical practice. The research project is being undertaken as part of the Doctor of Clinical Psychology Training Course at the University of Hertfordshire and is supported by the Faculty of HIV & Sexual Health of the Division of Clinical Psychology (British Psychological Society)

I understand that the focus group interview will include audio recording of the group discussion for analysis by the researcher at a later date. The undersigned Trainee Clinical Psychologist has explained to me the purposes of audio recording the research interview. I understand that none of the reported data will be attributable to me and that all identifying names, addresses or distinguishing material will be removed and/or made anonymous to protect my identity (and the identity and privacy of my clients). I understand that the recordings may be shown to/heard by the undersigned Trainee Clinical Psychologist and his research tutors and to the examiners who will be qualified clinical psychologists.

I understand that even after giving my consent to the recoding that I can withdraw consent at any time and/or can ask for all recordings to be erased at any time during or after completion of the interview. I understand that this is in accordance with point 6.1.5 of The British Psychological Society's Division of Clinical Psychology Professional Practice Guidelines.

I have been assured that confidentiality will be preserved. I understand that all research data and interview recordings will be stored totally anonymously in a secure cupboard at the offices of the University of Hertfordshire in accordance with the Data Protection Act. I have been advised that the materials will not be labelled with any identifying information including names, addresses, or any other information that may compromise my identity. The recording will be erased after completion of the study (usually a minimum of five years).

I understand that this research project has received approval from the University of Hertfordshire Psychology Department Ethics Committee. It is on this basis that I give consent for my participation in this research project and the audio recording of my research interview. I confirm that I have received a copy of this consent form.

Participant Name (PRINT) _____

Participant Signature _____

Date _____

Name of Principal Researcher: EAMONN RODOHAN
Contact Telephone Number: 01438-314333 (ext. 3764) or 07956-434830
Email: E.P.Rodohan@herts.ac.uk

Project Supervisors: Dr Barbara Mason Elizabeth Shaw
Telephone Number: 01707 286322 (020) 8532-6359

Appendix 2.2

Focus Group Clinical Vignettes

(Vignette A)

Part 1

Client B is a 35 year old married man who occasionally has anonymous sexual encounters with other gay men.

He has presented to the clinic for treatment of an STI.

As he is new to the area and does not have a previous clinic record.

During treatment he was also tested for HIV and diagnosed positive.

During the discussion with the Health Advisor when he is given his diagnosis, he reveals that he is married but is very reluctant to inform his wife.

He is concerned about the reaction of his wife and extended family and the negative reaction within his culture and community (including possible violence from his wife's family).

He also has a 'mistress' as well as other 'casual' partners, usually anonymous gay men but sometimes also female.

He self-identifies as 'straight' and believes that as he is always the 'active' partner with male sexual partners so that he was not at risk of HIV-infection.

He is referred by the Health advisor to you, the Clinical Psychologist on the team for support coming to terms with his diagnosis.

Client A is concerned that introducing condoms to these relationships may raise suspicions by his partners and he is unwilling to consider the possible implications for either.

Although he is really not keen on telling his wife or 'mistress', he reluctantly agrees to although he is vague about the details and unwilling to discuss the matter in much depth.

WHAT DO YOU THINK ARE THE ISSUES AND WHAT WOULD YOU DO?

- **Invite discussion of the vignette.**
- **Clarify professional and ethical issues**
- **Ask what courses of action could be appropriate.**

Part 2

Client B has attended only a few of your regular appointments and you have had to ring him on his mobile to encourage him to attend.

After a couple of missed appointments, he attends and tells you that he has informed both his wife and 'mistress' separately although both have failed to attend subsequent appointments with the Health Advisor that were made in liaison with him.

You have his address on record where he lives with his wife but do not know the name or address of his 'mistress'.

You suspect that he may continue to be having unprotected sex with the occasional 'casual' partners and both his wife and 'mistress' although he denies this.

You feel that Client B is unwilling to engage with you and at times appears arrogant and generally unwilling to take the issues you raise seriously (for example, he does not reveal the identity of his 'mistress' and declines an offer for the clinic to contact her anonymously).

WHAT DO YOU THINK ARE THE ISSUES AND WHAT WOULD YOU DO?

- **Invite discussion of the vignette.**
- **Clarify professional and ethical issues**
- **Ask what courses of action could be appropriate.**

Part 3

Client B does not attend any further appointments with you and his mobile number has recently been disconnected.

According to your last contact with him, he says he has advised his wife and 'mistress' but neither had yet contacted the clinic or as far as you are aware, been tested for HIV.

WHAT DO YOU THINK ARE THE ISSUES AND WHAT WOULD YOU DO?

- **Invite discussion of the vignette.**
- **Clarify professional and ethical issues**
- **Ask what courses of action could be appropriate.**

Part 4

Despite sending two letters to Client B at his home address, including one registered delivery letter, he still does not contact you as requested.

WHAT DO YOU THINK ARE THE ISSUES AND WHAT WOULD YOU DO?

- **Invite discussion of the vignette.**
- **Clarify professional and ethical issues**
- **Ask what courses of action could be appropriate.**

Part 5

Despite sending two registered delivery letters addressed to Client B's wife, you have still not received any contact with Client B or his wife.

You suspect that he may have intercepted the letters as the signatures for both registered delivery letters may be his and not his wife's.

You have still been unable to find out the identity of his mistress but know that she works with him in the family business.

WHAT DO YOU THINK ARE THE ISSUES AND WHAT WOULD YOU DO?

- **Invite discussion of the vignette.**
- **Clarify professional and ethical issues**
- **Ask what courses of action could be appropriate.**

Focus Group Clinical Vignettes

(Vignette B)

Part 1

The client is a 40 year old single gay man.

He recently diagnosed HIV-positive during a sexual health check-up.

His previous test was a year ago had been negative.

He's shocked by the diagnosis because he thought he had been 'safe enough'.

He asks the Health Advisor for support coming to terms with all this and is referred to see you (team psychologist).

During your sessions, he says he has occasional 'casual' partners and describes 'dropping his guard' occasionally but is unable to contact any of them.

He also has four 'regular' sexual partners:

Partner 1 - single gay man.

Partners 2 and 3 - married.

Partner 4 - gay man in relationship.

Your client is reluctant to inform any of them about his positive status and still has some sexual contact with them all.

He's concerned about any adverse reaction.

He says he now practices safer-sex and uses condoms for penetration.

WHAT DO YOU THINK ARE THE ISSUES AND WHAT WOULD YOU DO?

- **Invite discussion of the vignette.**
- **Clarify professional and ethical issues**
- **Ask what courses of action could be appropriate.**

Part 2

Client A has attended all of your appointments.

Despite lots of discussion and support, he's still unwilling to inform any of his partners.

He believes he most likely contracted HIV from Partner 1 (single gay man)

WHAT DO YOU THINK ARE THE ISSUES AND WHAT WOULD YOU DO?

- **Invite discussion of the vignette.**
- **Clarify professional and ethical issues.**
- **Ask what courses of action could be appropriate.**

Part 3

With support, the client decides to inform Partners 2, 3 and 4.

You provide guidance to assist to him through this difficult task.

Initially he gets a bad reaction but all they all make contact with the Health Advisor and visit the clinic.

Partners 2 and 3 (married) test positive.

Partner 4 (gay man in relationship) tests positive.

Still, the client is reluctant to inform Partner 1.

He says their encounters are mostly uncommunicative and describes difficulty bringing the topic up.

Upon reflection, he believes Partner 1 was most likely source of his infection.

He describes him initiating sex without a condom, particularly when they first met.

He also reports him having many 'casual' partners, using sex clubs and saunas.

He says he's reluctant because he might loose his temper and feels growing resentment toward Partner 1.

After further support and guidance, he decides not to inform him.

WHAT DO YOU THINK ARE THE ISSUES AND WHAT WOULD YOU DO?

- **Invite discussion of the vignette.**
- **Clarify professional and ethical issues.**
- **Ask what courses of action could be appropriate.**

Part 4

Client still hasn't informed Partner 1 and now reports occasional unprotected sex with him.

During your sessions, he names Partner 1 who is also a known client at the clinic.

His records shows he was been treated for 3 infections during the last year but always refuses a HIV test.

He doesn't have a history of attending for regular check-ups unless he has an infection requiring treatment.

WHAT DO YOU THINK ARE THE ISSUES AND WHAT WOULD YOU DO?

- **Invite discussion of the vignette.**
- **Clarify professional and ethical issues.**
- **Ask what courses of action could be appropriate**

ANY SIMILAR EXPERIENCES?

After vignettes, ask if they have had other cases raising similar ethical and professional dilemmas. Ask for brief examples.

Appendix 2.3
Transcript for Focus Group A
(Held on 26/9/2006)

Key:

I	Interviewer (*italic*)
P1-6	Participant 1 – 6
[unclear]	Unable to determine what was said
P?	Unable to identify participant
P?s	Multiple people speaking – unable to identify
same?	Same participant speaking as previously, unable to identify
P1?	Might be participant "P1"
( )	Pauses, laughs, sighs, intonation
Exactly	Emphasised word
Bold	**Quotations appearing in Focus Group Results section**

6 Participants
Total 90 minutes

I: The client is a 40 year old single gay man recently diagnosed HIV-positive during a sexual health check up and his last test was about a year ago which was negative, he's quite shocked by the diagnosis because he thought he'd been safe enough. He asked the health advisor for support coming to terms with all this and he's referred to see you the psychologist in the team. During your sessions he says he has occasional casual partners and describes having dropped his guard occasionally in the past but he is unable to contact any of these partners. He also has 4 regular sexual partners, partner 1 is a single gay man, partners 2 and 3 are married and the fourth partner is a gay man in a relationship. Your client is reluctant to inform any of them about his positive diagnosis and he still has continued sexual contact with all of them to some extent. He says he's concerned about receiving an adverse reaction from them. He says he practices safer sex and uses condoms for penetration. What do you think are the issues here and what would you do?

P1: Can I just clarify? The partners that you said were married, did you mean in a sexual relationship?

I: They're in a sexual relationship, yeah. You can read the prompt sheets if you're a little confused about the details, all the vignette information is there

P5: I'm thinking with that example because part of it is where all the responsibility lies and um if he's saying that he practices safer sex and you have an idea that he that he's doing what might be generally understood as that, then I wouldn't see that, you know there is no sense of risk of transmission here and also these other 4 people you know they would, you know where their responsibilities lie that doesn't stop because his status is now different really

P3: I'd need to get a sense of what he thinks HIV is and what it means to him and just his personal adjustment to it, to start with, because that would obviously influence how he would disclose or who he would, or, so his personal sense at first

P1: hmmm, so I guess at the moment he's not willing to disclose and, to his partners, and they are going to be having other partners as well. So there's that whole duty of care, who's your duty of care to. Do you need to tell their partners, tell their partners, a kind of a chain of events.

P4: I think in the more general sense, you're going to have to keep to, um monitor in an ongoing way this fellow's willingness to talk about this issue their willingness to work with you. There is obviously an agenda here but at this point he says he doesn't want to go there. So I think you have to watch over a few sessions to see if he, he will move towards talking about this more cos it has to be talked about.

P2: Umm, that's interesting. I'd be interested in exploring, I guess this, um, you know safe enough sexual behaviour and the fact that, um, that I think he said, he said that he had some slip ups but that if he's been doing all the right things, yeah and he's said that kind of what's the meaning of having become positive anyway but also if he's continuing with the same kind of safe sex that he had before, um, whether he perceives that you know anything needs to change, that he thinks he's already doing all the right things and, I noticed that to unpick that a little bit, I think that would be kind of quite useful.

P3: I'm sort of thinking kind of concurrently with that and increasingly, I never used to think of it maybe before but I do now and this link to this focus group but who's having safe sex with who and how and what's my role with now that I know that he's positive and he's with people who I'm not sure what and so really I want to find out, but do it in a way where I can not feel that I'm policing him or that it starts to alarm me a bit in my mind and that challenged me as to what, how I perceive him and whilst I'm really free and happy and everything, **these issues we are getting pressured to think about. This is the law and that would be more a feature in my mind. If this was a vignette 4 years ago maybe it would be more he's just sort of not adjusting to his sexuality** and it would be all sort of that **but now it's getting that enmeshed in trying to give him that space yet wanting to know what you're doing this week or and I don't know how I'd do that or say that but it would be in my mind so that would affect my dynamic for sure.**

P2: **definitely I think it's such a good example of a case that we might have thought differently about a few years ago because,** you know **if somebody says to me they're practising safer sex then I would usually be focusing more on** you **know what are the**

issues around disclosure for that person, what do they want in terms of disclosure, what would they gain from it in terms of their relationships but I think now we are being forced to think in a different way about risk and responsibility, and I think this is really a good example of that

P1: and keeping an ongoing agenda I think isn't it? That it's not just exploring it in one session but you actually if they are still saying well I'm not willing well it is still keeping it on the agenda even if they don't want it

P6: **It's interesting because it will evolve**, in the next few months it will evolve more because **a week ago I found out in the clinic somebody went to the police station who was with, two gay men, one didn't want to disclose to the other but the other found out and he went to the police and** he was treated, **the positive man was treated in our clinic** and that was just a week ago, two weeks ago **and now we are losing contact with him so we don't know what's happening but we thought what if someone found out that we knew that their partner was positive and we didn't tell them so we start to get a bit angry in some way. Maybe it's not what will happen 'cos it's only a matter of time but what is going to happen with this when it does?**

P2: **I think that one of the problems with criminalisation of transmission is that it just takes away all the responsibility from people who are untested or negative and seems to place all the responsibility with the positive person but I think for me what's concerning about all of that is if you think someone is having safe-sex and there is no risk of transmission then that should be enough but because of this**, this **criminalisation the whole thing it's just a regressive step** it don't sit well with HIV-prevention I mean **it undermines all the safe-sex messages that's taken years to build up**

P1: You can see the direction things are moving in but I mean it all depends depends on more cases to test the law so its like, it's like public health I mean they don't sit well together it's all on hold now isn't it waiting for lawyers who know nothing really about [HIV] prevention. I mean what about oral sex what happens there I mean it not just about safety from HIV now, it's about safety from the law too

P2: everyone said it would be a bad thing for public-health, stop people coming forward for testing cos of increased stigma and discrimination and all that, more untested people which makes unprotected sex more likely, drive the epidemic underground

P3: It's really annoying because for two years a lot of the perspective has been on dealing with stigma and you know now we know it is a chronic condition, you live with it, be proud and you know tackle disclosure and the next thing you know I get the criminalisation and you think what do you do now?

P?s: [agreement]

P5: The agenda is quite conditioned now and therefore it's the same as diabetes and is really I think being led by the department of health because like they are doing routine testing where you have to opt out now so you will get tested unless you say no

P3: So they don't realise [unclear]

P5: And the reality of it is that um you know actually when I was in Toronto, speaking to a lot of people outside the conference who quite clearly stated that if they knew someone was positive, they wouldn't have sex with them so there is still a lot, I seem to pick up a lot of stigma about it still and I think that um the criminalisation doesn't um, I mean there was an article in the Metro the other week describing someone who was on the run after been convicted, a gay man who had transmitted, and describing him as a public health menace – and it doesn't say anything about why people might not disclose in the first place.

P3: I suppose like before I was talking about anger, It's more about this issue I'm not anti any behaviour as long as it's consenting, it's fun but it just it's done, because we know about all the issues, it's how do you deal with all the emotions, the police haven't sussed it, the lawyers don't know, they're just dealing with it in the crisis level, we formulate, but we've got that person and how they cope with the stigma triggers, their childhood issues of neglect and, you've got this

real feeling for someone and then you're starting to think – it's just really annoying, that's why I'm glad this focus group is occurring cos it's quite cathartic to – actually this is not um just me, it's not me going through it in my head and the clinic dealing with it it's everywhere but then what, maybe this will lead to what next. But this is it? What would the solution be? It's

P4: yeah, one thing we've started to do at our clinic, well I think we've supposed to doing it um I don't know if everyone is (laughs) but we are supposed when we get into these discussions if this is the scenario um and we get into these discussions on safer sex and disclosure and all that kind of stuff and responsibility and it's shared and in that we are supposed to make sure we communicate to the people that to assess up their knowledge about what's happening recently and to inform them about the criminalisation risks and that and it's amazing since I have started to do that in the last year I would say virtually everyone's been quite ignorant – where the only knowledge they have is on the billboards when they are walking by them so we've found that to be really helpful to start telling people about what's going on out there

P3: Has that helped their behaviour or? Do you help their adjustment or?

P4: I can only assume so, I think it must because you see their eyes widen and so you know they've heard it

P1: It's interesting because I was when you were saying that I was thinking **but is our role as psychologists shifting in some ways you know new skills? because** you know then **I was thinking when I work with clients who are asylum seekers I do a lot of that, informing them about the latest law and what rights do you have and so actually I guess we are doing that already but we haven't been doing it about this issue – you know having to do it about something new**

I: is that something other people are doing too – talking about criminalisation in therapy?

P?: um

P?: no

P2: I think **people bring it as an issue and I have encountered quite a few people recently who come very fearfully, asking about it** and um you know and yeah I think, people have been you know seeing media reports which sort of inaccurately kind of imply that people are being prosecuted um for for things that they are not so maybe they are not understanding what all the things about recklessness and intention and whatever but **what I am picking up from people is a huge anxiety and you know fear of being criminalised just for being positive** you know criminalised **even when they have disclosed**, um and I guess as psychologists you know we can hypothesise and formulate about that person's individual situation but I think **there is a general climate of kind of fear and panic out there** you know **especially for people who have been newly diagnosed**

P4: and that's why it's important to talk about it and so you can clarify cos I think there are a lot of people out there walking around with the misperception that they can be charged if they just have sex and not disclosing but no, it's sex and then transmission so that's the bit that many people are forgetting about so that's one of the reasons why we came up with this guideline at our clinic so to speak to make sure people know what's really going on

P5: I think one thing that I always worry about is like why now really, because it's a new development and it's also one that's um, I mean Canada and Australia and in fact I think Austria – there are three countries, there's Austria as well in the European Union, that account for the majority of prosecutions, it's not just limited to here so I'm kind of wondering why like this move cos I know 150 years ago people were trying to put prostitutes in prison to combat syphilis

P3: It's interesting because that's why I liked sexual health, it's quite atheoretical, it was about death in the 80s and I wouldn't have liked to have worked in it to be honest then, about mass bereavement, chronic grief and what-not, and it became sort of children and then it became adolescent issues and we are all familiar with that and it was like chronic health and what's the difference between a terminal illness, chronic condition and now it's kind of like now you are all living, you all police your behaviour, so this is sort of like the new issue and it kind of whilst it's fascinating theoretically it's irritating because there are all these horrible issues and it might be

because now it's been 10 years, the drugs in this country, it's been enough time, asylum seeking is kind of not the hot issue now and it's

P7: I think that's really part of it I think one of the reasons why now, it's if you look at why it's been prosecuted

P3: like it was with asylum

P7: most of the people who were prosecuted were asylum seekers and I think it's part of that whole hostility towards immigrants were there have been loads of things in the media about you know HIV because there was a big scandal about an HIV positive nurse in [unclear] hospital I think there's, I think it grew out of that kind of, just in my perception of it I don't know if that's actually true and then of course it's become generalised and part of the whole kind of racist um sort of agenda to say oh there are health tourists coming here and people bringing infections into the UK and that kind of discourse has been redeveloped

P1: and then they bring up the African, the African AIDS and there's a discussion because they were talking about data about, there was actually, about the number of HIV positive African people in Britain and they were actually talking about how, what do we do with this data, is it safe to release because what would happen if the media got hold of this and does anyone know of kind of friendly journalists that we can present it in the way we want to present it and it's kind of you know there is research being done, people are finding out things but it's not being disseminated because of this fear of fuelling more racism and I think also if you look at that, it's so interesting the kind of discourses around you know who infects and who has been infected like first few cases were all of heterosexual transmission and these asylum seeker men got presented as these sort of demons, you know, searching out these passive victims who had no way of protecting themselves, you know the women were presented as being entirely without responsibility or agency or ability to protect themselves despite the fact that they were consenting relationships and I think you know it's sort of for me that was part of the whole attitude towards immigrants and asylum seekers

P3: It's scary because where will this go to you know will it become like people having tattoos on their foreheads or something really draconian

P?s: (laughs), yeah

P3: and it scares me really and that's why I like to work in this area to deconstruct these issues and normalise them but it's it just [unclear] worried really

P6: I was thinking about the whole sort of message of disclosure and the whole um you know health promotion to try and encourage people, to destigmatise it and be ok with it and [unclear] almost that kind of you know not having to not be ashamed of it and how that's um, and I suppose also that and it overlaps and coming from a different direction, but kind of ideas of psychology as talking about things as good um and you know communication and honesty are you know a good thing in and of themselves and that's sort of that certainly I've struggled with, you know finding a way through that, and acknowledging that for many people not telling a lot of people is you know, whether partners or not, might be a good thing, the right thing for them but I suppose that this sort of latest, the legal climate sort of hijacks all of that and turns it into not something that you can do as a good thing under its own but kind of takes it over and puts limits around it in a completely kind of shutting down kind of way

P2: and doesn't acknowledge that it's a process cos disclosure isn't just like a one-off event and as psychologists we would be thinking of in terms of the whole process and I think the legal thing sort of makes it the single point it

P1: and it has to be verbal as well

P2: it can't just be that kind of non-verbal negotiation around condoms or whatever

P3: we I suppose where I am, we are trying to create a database and I'm sort of the more we talk about it, the more, it's like the risk register which is what it [sounds like], it's not [that] that's what it is but that's, because we have several clients who, and it's more about the nursing staff can't cope with the idea of having hundreds of clients turn up and not be in control of them but,

the descent is people they want to document who, but this is a thought that people in the clinic are having, but the point is I suppose this is it, it's not just psychologists who are working with it, it's nurses, doctors with very different belief systems around health behaviour but this is what's worrying me, it's what people would go on it, or would they go on it or what would define them going on it and would they know if they were on it or it's just this is where I'm worried this is going in some way.

P2: and what would happen to it – what would be the purpose of it?

P3: I suppose what people have discussed is that it would be to help with the discussion of cases so that those who may be on it could be discussed within the team to think oh how we can help them get off it or help them with why we are concerned about them but then this says a lot about the personalities of the staff, if the physician consultant is too biological and is minimising behaviours and it's not just about the client, it's formulation of the system that the client is seen within and what does that say about why the fact that people are keen on it where I am and yet the reactions here are quite – this is terrible and it's who does what and how do we manage it?

P1: and how much power do maybe as psychologists we do bring skills and stop and think and try and think of the context and different issues and blah blah blah which I think other members of a multidisciplinary team obviously do as well but we kind of in theory this is what we bring, we bring the training we sort of do know and how much power do we have in teams, and how many team meetings do we actually attend and the more of us the better to bring a different voice that's not just a medical voice

P2: And what training do people have as well because I think that's a really important point because one of the things we've found, because we did some work here with nurses in the HIV clinic was that initially they felt very unconfident to address issues such as safe sex and transmission with positive clients

P3: It's because of nurses not being confident. I mean I've read your paper

All: laughs

P3: we did a session on it in the clinic because that's why they are wanting a register, they are getting nervous about it, they want to pin down who do we say what to and [unclear]

P2: exactly! And I think also if you think, I think another thing that happens with this that we need more of is attention to helping people to adjust to their diagnosis, because **everybody who has been diagnosed feels angry and most people have moments when they blame someone and they want to blame the person who infected them and I think what's happening now is that people are being led to channel that anger through criminal prosecutions and going to the police whereas actually that anger is like a normal part of adjustment it's part of** you know **coming to terms with this diagnosis** and I **think if people had better support around that time of diagnosis then people maybe they could readdress it in a different way**

P3: That's interesting – we should formulate more about transmission – it's not just a categorical, you did, you didn't, you're safe, you're unsafe, it's about, it's to do with adjustment fundamentally but, there should be some way of – but then isn't it ironic – we are, we've been working with it for years, but people still don't – they demean it – you know it's like diagnose everyone in the clinic who turns up, it's like what you were saying - the world just treats it in a way that actually deformulates it and colludes with actually the problem that that they are then dealing with and they don't realise that they are feeding it in the first place and then you just go mad as psychologists sometimes

P8: I think going back to that vignette though one of the things I would be wondering about is um if that, if this guy wasn't having safer sex, how easy would he feel able to say that to you? And it um either in terms of his behaviour in the past or anything going on currently because I'm just thinking of some of the people I'm working with, it might be quite a long way down the line that they tell me something that I've had doubts about before and I've had a, once they build up a relationship with you but I think many people are very concerned to actually say something because they are just so concerned that we judge

P4: how many times have you met a brand new client who has recently been diagnosed and they have told you like "oh I must have got it through oral sex" and we know what the real risk of oral sex transmission is (laughs) you know and four months later they tell you "oh yeah I am doing this every once in a while" or whatever. I think for this vignette another thing that needs to be talked about is um the therapist or the health care practitioner or whatever, one's capacity to tolerate ambiguity around anxiety because I think this comes down to and this plays a large role in it, how do you handle disclosure is over a course of time, it's dynamic, you handle it by tolerating your anxiety about this situation and I know that my role, at my clinic is with the SHOs as they come in and the trainees or psychiatric nurses who are coming in for placements, my role is to uh help them identify that this is something that they have to face and address when they meet their first client who has sex with more than one person and might be having sex with someone that's married and it's a whole new world to them and it triggers anxiety

P3: cos one's consultant and we discussed, said to me a few weeks ago "I just don't understand why we need to meet every week to discuss HIV cases, why don't we do this about Chlamydia or" and he just can't see that it's a chronic condition and the process and people evolve over time and there's a treatment issue. This is a lead person and it's like no matter how much you try and tell you are trapped in a sometimes the systems you are in and who's, and I suppose it's frustrating when you are trying to formulate, you've got ideologies that are like not even medieval – I think that's giving it, that's being positive (laughs) but this is a, we do try to speak with staff but it just shows it's where you are located and that's frustrating but then that's, sexual health clinics are very different, a different populations

P8: **I think the criminalisation thing is not to do with public health it's basically a moral position really and** you know **where people sit with regard to retribution** really and you know

I: perhaps this is a good point to move on with the vignette, if we move over to the next part. You've got it? So with support the client decides to inform partners 2, 3 and 4 and you provide guidance to assist them through this difficult task. Initially he gets a bad reaction but all 3 partners make contact with the health advisor and visit the clinic. Partners 2 and 3 the married ones test positive and also the 4th partner, the gay man in the relationship he also tests positive but the client's still reluctant to inform the first partner (1). He says the encounters are mostly uncommunicative and he describes difficulty bringing the topic up. Upon reflection in his sessions, he believes partner 1 was the most likely source of his infection. He describes partner 1 initiating sex without a condom, particularly when they first met and reports him having many casual partners and using sex clubs and saunas. He says he is reluctant to talk to him about the issue because he feels he might lose his temper and he is feeling growing resentment towards partner 1. Even after further support and advice he decides not to inform him.

P6: so the client, he's worried that he will lose his temper with partner 1 or is it that partner 1 will lose his temper?

I: the client will lose his temper himself, but feel free to consider both possibilities if you like. What are the issues here and what would you do?

P4: well not to cut the discussion on this but if you want to follow a very prescriptive method here, the guidelines state that partner 1 who is not a client at this clinic, you have a duty of care to that person and that person's just as important as other person and so you are on the road to disclosing and breaking confidentiality but as a psychotherapist (laughs) it might be a little bit different for me

P6: it's interesting that partner 1 has always refused an HIV test and that kind of adds something quite different to the scenario maybe, it also very clearly demonstrates the complexity of responsibility doesn't it

P3: in some way you just don't really know who had it first to be honest it may be just that our client has been diagnosed first – and this is it

P6: it may be partners 2, 3, or 4

P4: and partner 1 can be told – you can help your client to tell partner 1 or whatever way it shakes down - the person still might refuse the test in the end and that's that person's choice to still refuse it, if the person's been told, look,

P1: yes but there is still this issue of partner 1 losing their temper so I

P4: is it partner 1 losing his temper or the client?

I: the client loosing his temper towards partner 1, but feel free to consider both possibilities

P1: right ah oh ok – cos I was wondering about whether that would become violent and the other risks and then other ways in which you were going to disclose to partner one, you could do it without revealing your source

P5: yeah you could do a contact trace couldn't you

P1: yeah

P3: it just sort of goes back in a way to the point, I just think oh my God it's a sea of like, my God who's doing what and who's, where's it all come from and the point you made saying about responsibility, I was just and the point you were saying about process, you have to just keep calm and think look everyone should know some basic facts we hope, but then they don't and safe sex everyone and you try to just cognitively restructure, stop getting distorted (laugh) you know the world's going to die and this is massive. It's just trying to keep quite focused, a bit of mindfulness before you go to work

P1: [unclear], if I didn't know the latest conviction, a gay man was convicted and there has now been nine convictions

P3: right

P1: and that's nine convictions out of 1000's of people but then

P2: but although it's a small number I don't think it's very comforting in a way to clients because

P1: It could still be you next

P2: it could be you next exactly and because the you know all different types of people have to be convicted in all different types of situation now and I think it is quite difficult for people to be able to say okay that's it I'm safe enough from conviction

P1: do you think – this might be quite tangent – but do you think also as clinicians in the NHS which is changing in directions we don't know as well so, with agenda for change and also just, you know everyone's having to cut jobs and getting frozen and blah blah blah so actually the structure which we knew where we worked in and that we would be backed up and blah blah blah maybe we feel less kind of protected and safe – and that it could be us next as well (laughs) kind of

P?s: yeah (agreement)

P1: whereas you know if we worked in the states where very clearly there are lots of legislation and you kind of you know maybe they would have, we would talk so much more about the policies, and like your clinic where you are like well we have to do this because this is what we need to do whereas we don't have that general culture but the NHS is shifting and changing and maybe it's, that adds to our anxiety as well as the client's anxiety that they are bringing as well

P4: that's why you should have your own professional liability insurance

P2: yeah

P4: I can't believe how many clinicians don't have it

P3: I've got it but it was only in the last year

P6: We haven't and maybe we should

P8: yeah I've got it yeah

P?: I might suggest it

P?s: (laughs)

P?: straight after this

P6: also thinking about the kind of thing, the worry that he will be angry with partner 1 if he informs him, I was just sort of thinking what, how it sort of, I don't know I suppose it is mainly object, relation kind of idea but so there are only two positions, there is poor kind of, wrong done to victim or there's kind of careless, callous, heartless, abusing kind of affecting um and so there's not much space between them and it's interesting that partner 1 initiated unprotected sex but **presumably the client also was at some level choosing to do that too and it's as though this business of disclosure kind of crystallises that,** kind of who was that, **was I taken advantage of or am I actually angry with myself for putting myself at risk and I suppose somehow that then becomes unbearable**

P2: or was this person thinking of prosecuting partner 1 because they are building resentment towards partner 1 and they're thinking well obviously I got it from him and is that going to actually flip and do it that way round rather than the nondisclosure being, being prosecuted

P6: well **it's like the two go together don't they, they're flipsides of the same, the same kind of unbearable anxiety**

P2: **and once you become infected** you know **you can shift into that bad category because then you could be liable for prosecution yourself so those roles are completely**...

P1&2: ...**parallel**

All: yeah

I: is that something you talk to clients about or that they bring up in sessions? about thinking of prosecuting

P1: I've never

P5: I've never had a conversation with anyone who was talking about doing that

P2: I have and I mean you know he decided against doing that in the end but I think it was very much within that sense of anger of you know that how could this person do that to me, which is you know so so common um and I think it was partly you know though sessions and exploring all that that he also began to think well but I am also in the same position because I am having unprotected sex sometimes with other people and to you know maybe deconstruct some of those maybe user kind of discourses but um yeah at least one person felt and maybe another person had had fleeting thoughts of it and wondered and who actually did inform somebody who his partner, who he believed had infected him was, so he kind of took it into his own hands as it were [unclear[

P4: that is one of the questions that we will have to address at our our um thing we are getting together in a couple of weeks because the department of health is getting into this business too and wants to consider it's directive policy which will you know be an umbrella policy for all of us, with all of our professional guidelines and that and they are asking us to consider whether or not it should be a guideline that you should inform people about their legal rights when they get diagnosed with HIV and I would imagine that a lot of us have different opinions about that

P2: yes

P1: yeah so as a pack of people on the faculty committee then having a chat about what the different positions are (laughs)

P4: cos apparently it's best practice guidelines for women who have been sexually assaulted to tell them about their legal rights and so the precedent is set so we do tell people under certain circumstances about their legal rights but it sound's like you know why

P6: but there is a difference between your legal rights for compensation and telling people about their legal obligations I mean they are sort of all being put together

P4: it's a very important distinction isn't it?

P7: yeah it is

P6: yeah exactly

P4: I just don't want to even go there (laughs)

P6: exactly I mean as a psychologist

P4: that's my gut intuition

P5: like with things like sectioning and those sort of responsibilities yeah they happen in the system and somebody has to take responsibility for them but as a psychologist I think that creates a relation, that would create a relationship with clients that I wouldn't want

P4: ummm (agreement)

P2: and that's why I don't think as a psychologist I would ever want to be involved in that process and I feel the same about this because **I think it in order to really help people address their** you know **emotions about being diagnosed you have to have some kind of safe therapeutic space and it feels like that isn't there now**

P1: but maybe it will go the way of sexual assault that we may be expert witnesses to talk about why someone wouldn't disclose and all the reasons why you wouldn't um as a defence and it might be that it's not your client you are doing that for but your

P3: that's interesting

All: umm (agreement)

P5: I think what's easy I don't know, I think on some level what's easy for me to forget because of the setting that I work in is how different uh attitudes in one society are not just around sexual behaviour but a whole host of things and you know but I'm relating this kind of thing to a wider society where everything is becoming much more aggressive and the solutions to problems are you know more and more about controlling or being excessively punitive, you know like invading countries and blowing them up you know as, is seen as an ideal solution sort of thing and I think that trickles down

P2: yeah and this climate of litigation also where someone is always to blame you know there is no risk that can't be prevented, there is no um you know adverse outcome that somebody can't be blamed for and held to account

P5: and you know, precisely, if there is going to be an enquiry into a death or a suicide there's always some senses, that there could have been, that everything is preventable

P2: yeah it's not

P5: and it's usually because somebody didn't do something they were supposed to do

P2: yeah

P5: yeah you know the fact that they've got 100 patients and that they are working you know 200 hours a week is completely ignored

P4: do you work that much?

P?s: (laughs)

P4: oh wow

P5: just at the weekends

P?s: (laughs)

I: shall we move on to the final part of the vignette now? So your client still hasn't informed partner 1 and he is now reporting occasional unprotected sex with him again. During his sessions he names partner 1 who is also a known client at the clinic. The client's record show that partner 1 has been treated for 3 infections from the last year but and that usually he refuses an HIV test. He doesn't have a history of attending for regular health checks unless he has an infection requiring treatment. What are the issues here and what would you do?

P4: I mean as I said before with partner 1, he is a known client to your clinic so that person has a duty to care as well or you have a duty of care to that individual as well and so that to me that's the turning point in this whole process.

P1: but as you were saying you could do it through contact tracing and try and be anonymous about it

P4: yeah you could offer that as an option to the person um **but I would say that for me at that point in time, that would be perhaps the thing that pushes me into having that difficult and awkward conversation with that person whereas before I'd been able to tolerate the ambiguity and anxiety attached to all of this**, and it's going to take weeks maybe even a couple of months **but now it's like** you know **the writings on the wall someone's going to have to act**

P2: and that happened in the [location] outpatient clinic didn't it, when I was, there was a case where they disclosed to the partner and it was exactly this kind of case because the partner was known to the clinic as well and attended the clinic and the person you know flatly refused to disclose and they felt the person was still at risk so you know the doctors took the decision to disclose

P1: it's interesting [unclear] disclosed recently and was in the past six months there was another case where the partner was not a patient of the clinic but the person who was a patient of the clinic was dying on the ward and and it just had, I mean, we were thinking well obviously the partner must know if they go and visit them in an HIV, AIDS ward but there was this, he had never come to the clinic to be tested, he didn't know if he was aware that, and so the doctors decided that well this woman's going to die, we need to let him what she's going to die of so they made the decision and it was very difficult

P4: that's a bit off the mark cos that person's not at risk of future infection

P2: but had they been having sex in you know the last you know 10, 15, 20 years then I suppose they might have been positive and not been accessing treatment that they might have needed and then we had you know the two cases where they did disclose in the time I've been here, in both cases lost contact with the indexed person so they left the clinic and went somewhere else and I think that's an important thing as well, cos that's another risk of harm,

P4: umm, yeah

P2: you know they destroyed the relationship at the clinic

P3: this makes you wonder will there be a point when clinics are liable, you know I've talked about it before but is it just a, who's covering who's backs or but it just

P6: and what becomes a priority? Is it thinking about holding on to our patients and giving the best care or oh no we are going to get sued or

P5: but I think what will, one of the, I mean it will be interesting to look at what the affect of uh you know the risk of prosecution and how it will affect behaviour you know because people will, I mean I wonder if the increased anxiety will mean more people having sex anonymously for example because that's safer for me because I can't be traced you know

P?: yeah

P2: yeah I think so

P3: I just think it's never going to be resolved and sorted out because if we look at 10 average clients and formulate why they are engaging in unsafe sex, there is clearly some people who are married and say are Turkish and if they came out they would rather die, so they are not hardly going to start stamping around on Gay Pride, so they are never going to be out, so there will always be at risk, they will always get frustrated and want to be with men and then there are you could just go on and on, we will never be able to have like a nice neat psychological population where everyone fits in the bubble and because sex is always going to be like this

P1: yeah and that's what I was thinking about different populations and does this encourage people to have anonymous sex and you know I don't know maybe you grew up in a very catholic, heterosexual environment and having anonymous sex is something you would never, you wouldn't know culturally and socially to do that so it's a very different sexual pattern if you like, I mean I'm making assumptions about Catholics (laughs) which I shouldn't do but

P2: if you are a married woman or

P1: yeah

P2: you know like a lot of the clients that we see at, you know, how much are they able to refuse sex, how much are they able to insist on condoms like not at all and

P6: and the responsibilities there you know

P3: and some can't – you spend many sessions with one clients who just won't tell their partners put a condom on and it's because it's not just people are so subjugated or the dynamic of the relationship it's just it will always be, you know it's just a fascinating time in some way, but where will it go.

P2: yeah but also you know **if you look at it on a global level, Britain has a success story at managing HIV** you know **we don't have an epidemic ranging out of control** and the approaches that have worked and **people come to this country to learn about how do we address HIV and that's because** there has always been a harm reduction philosophy here, it worked with drug users you know the idea of you know instead of you know using the law as a blunt instrument to clamp down on people or behaviours **there has always been this harm reduction policy philosophy throughout services here** and it's worked, it's worked really well here and you think **so why are we reversing that, why are we going for a policy that's completely at odds with what's been working well here** you know

All: (agreement)

P3: I suppose you saying that just made me realise because we do see a sort of skewed, we don't see Mr Bloggs referred because when diagnosed with HIV, when.... (tape fades)

END OF SIDE 1 – TAPE CHANGE

P3: My point is that this is a success country and whilst it's quite worrying, this is there are lots of it's so frustrating like it's you know, picking up on what [P8's name} was saying earlier about this now opt out testing that you know I've been doing, working in other countries, with international agencies about ECT voluntary counselling testing and you know what we are there pushing all the time is this idea that mandatory testing is bad and wrong and you know it has to be voluntary and how do you encourage people to want to test, how do you, you know help people make that important decision and all of those sorts of things and what we're doing here, although it's not mandatory testing you know I think is, is a retrograde step you know it's not a high prevalence country, there isn't an urgent need to test the whole population so we can put

people on ARVs and I think all of us have probably seen in our clinical practice women who have been tested in antenatal care with no counselling and just been told you are HIV positive

P5: or no awareness

P2: yeah no awareness that they could have been at risk you know and suddenly they are just told at a time when they are pregnant

P3: to attach to someone

P2: you know that they have got HIV and how difficult that adjustment is, how traumatic and how difficult for them to disclose to their partners

P3: it's interesting because this test everybody will, because clinics, the NHS is a bit naff, I'm increasing believing it's run by politicians who just get on my nerves and please make sure that is written down

P?s: (laughs)

P2: as the title of your project

P?s: (laughs)

P3: because basically you know the problem is no one's got a grip of it because it's loads of you know if someone did get tested in a clinic, they could then if they were positive not go back there but go to another and get their STIs treated somewhere else and then not go and then opt out there, so no one, people can hide and suss the system by doing that it is sort of backward step, it's just nonsense, it's all this reactionary thinking you know that is actually going to collude with the problem and make it worse and you know because so many clients that I see don't live in the area that I work with the Trust that I work with in although they are going to try and change it so that you prove, at least which postcode you live so the Trusts that you live in will be charged for your treatment but then still you still could be seen anywhere and that's not going to be a documentation of what your health is, it's just where you live, just it's a mess really

P2: well you know I think the thing is about that policy is that it's not, it's not there to help people to be devious, it's there because HIV is a condition unlike other conditions in that it's so stigmatised that people are frightened to see somebody who is in their community, or see someone who recognises them they go to the clinic and well STIs generally and I think that's why traditionally STI services have been so,

P3: open

P2: open access ones and that I think you know stigma is the big issue here that you know this is double think, on the one hand, oh yes we want to address stigma against HIV and on the other hand the policies they are putting into place are just totally contradictory as far as I can see and the at odds with that where you have newspaper headlines calling people monsters, you know I saw this on the, I don't know it was like the mail or the express or something, when that woman was prosecuted recently, the headline was monster

P3: shocked (drawing in breath)

P2: you know and a picture of her, a photograph of her you know, I think, how is that going to reduce stigma against people with HIV – how is that going to make them want to go to their GPs?

P3: I suppose it's been this year, it's kicked in, lets see next year the consequence of this, once it embeds more in the population – what will we see clinically? Will, it will be fascinating what the dynamics and behaviours of people we are seeing

P2: I think people will disclose less and they will disclose less to us about

P3: and we will become police figures or because if anyone knows, if you know now then you could do something with this information it's just it will then affect our fundamental, whether it is our fundamental law, but our therapeutic stance from the start

P5: in the Toronto world aids conference I mean basically there was this idea there that the main impediment, or main impediment to the epidemic globally is human rights and also improving them is the main way of reducing the epidemic and um you know and you have these backward steps across the globe, because you have got the president, the US, president Bush's aids fund, the money can only be given to prevention schemes that preach actually, abstinence which is not relevant to the people it's going to be targeted at

P1: or if they are in any way linked to abortion, they don't get anything

P5: yeah and you know I think these moves are political, I think that's where they come from

P2: exactly

P5: (pause) and I think one of the things in terms of how psychologists respond to this is that I think psychologists are reluctant to, or at least some anyway, to be seen to be political and so I think there's a danger that the profession just lets this go quietly on you know I think you have to just speak up very loudly about this really

P2: I think a lot of psychologists who end up in HIV are quite political; I think more than in other disciplines that we can go into

P3: ummm (agreement)

P6: the faculty can address this I suppose

P1: yeah

P3: and uh because this is it where we work, we can have this conversation here because we work within this area and if I was to sit with my friends who are psychologists who do not, they wouldn't know, well so what is HIV then? So it's basic stuff, they are not even aware of, let only the massive existential concepts of barebacking men who then go back to their wives and you know we are dealing with this on a daily level this – it's quite bizarre (laughs)

P?s: yeah

P3: yeah but then something

P2: yeah but then also I think we're, well the faculty is within the BPS which as an organisation is very apolitical

P3: ummm (agreement)

P2: you know and I think that is a difficult place to sit as well you know I don't have any sense that they would necessarily back up very strong political stance

P3: yes because the psychological BPS can't even, sorry I'll get struck off for saying this, can't even get it's act together and have this, are we going to be chartered or not and who's a psychologist and who isn't, and the fact that that occurs proves it's a wet organisation that can't even deal with the issues that the qualified people are there to address and you think what's the point – I am chartered by the way (laughs)

P2: exactly, [unclear] really high degree of homophobia as well, homophobia within the organisation, there is plenty of it

P3: the gay and lesbian section stopped how many times

P2: the gay and lesbian section, you know all this stuff letters into the psychologist you know I mean

P3: I bet if people knew, there was something in the forum a few years ago about gay clinical psychologists going out and getting drunk in Brighton

P2: yes that's right

P3: how people sent letters this is *disgusting* and you know of course wherever you work you need to be aware of where you are going to be, you know if you work with people who have 3 heads that might be quite easy to avoid in the population but that this – but the point it – what is the point (laughs) – but there's such battles within psychology

P1: and there's also racism as well within the profession - there are so few sort of black and ethnic minority psychologists who are getting onto courses, who are getting into management positions, you know it's a really white profession, a really heterosexual profession

P3: so it will end up this issue will be maybe left to the sun and to the mail to sort out and criminalise and then mess up what we are dealing with and I feel often as psychologists we are mopping up epidemiological rubbish, that it's behavioural trends that aren't addressed properly, that are like put in boxes by people who don't know what they're doing, politicians and this that and we are formulating, but no the reason why she was raped isn't because she wore a little dress it's because of this and it's formulation is our skill but it's surprisingly lacking in the population but that can sound quite patronizing but it's true really you know we take for granted how we see things and we think well it's obvious but this is, this is it, this is what we are trained to do

I: so you've kind of touched upon two issues there, one about the therapeutic relationship and one about issues of difference working in this context so that's made me think about how do the two overlap and how does that affect your practice and what concerns would you have talking about criminalisation or thinking about criminalisation?

P4: one thing I know is, well I think I've made the point already is um as a psychologist working in such a vignette like is, I think a large thing that has to be encountered for is how familiar and comfortable are you with people who live lives differently from yours and I can't tell you how many trainees and just even actually colleagues um come from a very heterosexist background and just can't get their head around the fact that someone might be having ongoing you know fuck buddy relationships with 4 different people, like this whole scenario would be honest to god they would just be freaked out and that's what's driving their need to disclose and have these issues

P2: yeah and also I think it's about not you know not understanding other people's contexts but also you know not looking at issues of power in a wider sense and you know who has power in sexual situations you know it's heterosexist but it's also sexist you know it's not um looking at um you know what might prevent somebody from a particular group disclosing you know or you know what would be the constraints on somebody being able to implement safer sex. I've been party to discussion in the virtual clinic which is a client which actually you're seeing where she wasn't disclosing to her partner and she was terrified of violence and I was in the virtual clinic and one of the SPRs said categorically "well I'm sorry if she gets beaten up what is that compared to having HIV and having it for the rest of your life, well you know lets just think about that and think about those two in comparison" and it was just like "what?! Are we making that decision?" oh ok let's just put her at risk for being beaten up because it's not comparable and she said it in all seriousness, "oh well it's to stop the person spreading it around and let's get on with it"

P5: you see that's the you know, that's the devaluing that happens with people who are positive, that they become less entitled to all kinds of things you know

P1: yeah, making decisions (laugh)

P5: you know and

P2: and it's also taking responsibility away from the untested or presumed negative person because it's you know

P1: absolutely

P2: it's also the case where in order for positive people to be able to disclose there's a responsibility and an onus on negative or untested people to make that disclosure ok and to not you know behave in ways you know like that

P?s: yeah

P5: well I don't think, I think it's paradoxical really, because in terms of response you know, you could argue that people who are positive *are* the most responsible because they know you know isn't it but yet they are often regarded as or seen as being the least

P2: yeah and there is evidence I think that people who are untested actually engage in the most risky behaviours or something like that and have the highest level of stigma, something like that I saw in a study well I mean the most negative attitudes towards people who are positive

P6: but it's interesting I suppose in terms of you know how that impacts upon your therapeutic relationship, I would always aim to be creating a, not a neutral you know non-judgemental relationship but a kind of a affirmative, I suppose that would be my aim and so that why this vignette kind of, I mean these kind of these situations I struggle with because how do you take up a position which essentially says whatever you are doing I'm not going to just say well that's wrong or that's bad or that's self destructive but you know it's being interested and understanding what might be keeping it like that what might that be doing for you? What is that about? How can we understand it without having to label it? Um and to then be in a position to need to have that kind of, I appreciate there is a, within this climate there is a need to have a conversation about legal consequences, It just doesn't sit with that at all, how can you say I want to understand how this works for you but also you have to know that kind of actually that this is wrong and I have to do something about it, I mean it's a complete contradiction um and I think um yes I've kind of lost track of how that, it was something you said that made me think of that

P5: It's funny you know that I, I think, when I think of my position of it, but I really do think that the responsibility is on each individual to protect themselves

P2: to the best of their ability

P5: and you know and you know and I think that I would probably put, like it would be difficult for me too so, I would intervene much more if it's the right thing to do and I think often these people are invisible and not known to you but I do think that ultimately everyone has got, if people are very sure about something they need to seek out information everyone is capable, well not everyone, people are capable of making choices here

P3: I wish there were better instead of adverts you know, in terms of accessing people with basic messages you know, someone could, someone could be just given an advert with messages around HIV which were agreed could be really helpful which everybody should be responsible, I can't think off the top of my head now but instead of some *crap* advert where someone masturbates over a car and then you are in a different coffee advert (laughs) and you think how much money went on that

P?: (laughs)

P3: and what did that really achieve?

P5: you're making it up

P3: haven't you seen that one?

P?s: he is! (laughs) exactly

P3: and the amount of money that is spent on the comedic portrayal of health and they are all getting off on the bed of the operating theatre doing the heart surgery and they are all discussing the night out that they had before and then realise it is the father of the husband and then they work in the ward next door and you think how much money went on their wages on, why can't we have some more money in the health service thank you very much so we can

have some more psychologists, more people to do this work that is so central and I really believe that sexual health is more core than adult mental health because in affects identities and how we express them is more than how we react to losing a job or whether we have got OCD and for them formulation won't be about what's going on inside. Sex, sexual health is and sexuality is really the crux and yet it's left to the little STD clinic and we're battling with real lives, what people, who people really are, we find the truth about people, yet they pretend it's not there when they leave, we know what people are getting up to, the fuck buddying and stuff like that is a reality and yet when they leave the clinic they are with their wife or their one partner and it's like there's such a politically, it's as you said maybe political people become sexual health psychologists

P5: if you look at countries that have you know like in Holland which has I think in terms of the average age of teenage pregnancies or like the average age of first intercourse, I think it's something like 17 or 18

P2: yes it's higher

P5: because you know when that's how sexual education is delivered in school

P3: it's normalised yeah

P5: yeah and so actually you know why we have the worse is because it's not delivered in any real sense

P3: well this is it they sexualise people with their poor sex education

P5: well not sexualise but moralise people so they people don't, people learn that there are certain things to be ashamed of and if how people tell people about their sexual desires which means they find it hard to tell people about what they are doing and that kind of thing

P1: and having the spaces to talk about it because I think that sexual education in schools as part of the sexual health education team in [geographic location removed] (laughs) and yeah each year gets an hour

P3: an hour really

P1: and you just go in for an hour to battle through all the STDs and all the rest of it and then you just think how are much are they going to remember of that? If at least they know where the clinic is to come and get a test or whatever then that's what they get but in terms of the more emotional side to it and the kind of social side of it and all those contexts and you aren't given space to explore those

P3: well this is the funny world in which we live where the people who try to stop that are people that are not even married themselves, Ann Widdecombe, Baroness Young – they're women and there's another guy who well I hate his guts, I don't want to know his name anyway but, they're people who stop clause 28 or stop these issues, they are not even married as adults and yet they are purporting these values so we've got leaders who are dictating sexual morals who can't even do it themselves, it's nonsense

P1: you don't have to be married to do (laughs)

P3: it's made me wonder who's setting the laws, and who makes the decisions and the people who are quite unprocessed

P5: well you know with Ann Widdecombe there is something peculiar going on anyway

P?: (laughs)

P1: what, being a Tory?

P3: I've got these hypotheses but I won't say them here

P2: but It's also I think there is that sense of working within sexual health we always live in fear of the Daily Mail and of things being discovered and like we had this situation where again when I worked here where some of the clinic staff had written a paper in um an academic journal about the policy for condoms for under 16 year olds and you know a thoughtful academic piece about how they addressed young people coming into the clinic requesting condoms and what kind of services were being offered and as soon as it was published journalists called and um the one question they wanted to know was who was the youngest person who came to the clinic, the youngest person was 11 I think so there was a headline in the paper, "condoms to 11 years old on the NHS" and there was a sort of implication that we were sort of lurking outside school gates you know trying to give condoms to children

P6: "go on do it, do it"

P2: yeah and also the thing that [P1] was mentioning earlier about that knowledge that you know that African communities are disproportionately affected by HIV and you know wanting to keep that a little bit under wraps somehow in case people get blamed or stigmatised and I think we've always lived with that level of you know awareness that you have to be careful and we have to keep things secret and under wraps just like our clients do about their sexuality (laughs), we have to do that about our work too and I think this adds a whole new dimension to that, it just really exacerbates

P3: you wonder though where will the media go, this morning I heard something "gran of dog baby killed" and I thought who's the dog baby?

P?s: laughs

P3: And it's that poor 5 month year old child who is the dog baby now and I thought that but the gran and what sort of you know "11 year olds murdered by psychologists" story – what will the next ones be – "2 year olds with gonorrhoea"

P1: but as psychologists do we have the power to more global sort of influence social attitudes do you know what I mean, should there be psychologists employed in the department of health

P3: there should be

P1: that do you know what I mean not actually not working with clients but seeing these more wider issues

P5: but one of the you know one of the psychological therapists who have had a very reasonable position in the NHS, because there was Glenys Powell who used to work for the department of health and she was you know was kind of part of the reason why they haven't been sidelined

P3: this is it, there are some, it's not clear how do you then skip up in the guardian and get a job, oh there's pioneering HIV, criminalisation psychology oh that's a good job there (laughs), maybe there is one – but there needs to be

P?s: (laughs)

P1: maybe we should create one

I: I was just wondering about safer sex, how do you talk about safer sex now following criminalisation, has what is safer sex, has the concept shifted at all as a result of recent events?

P2: **it depends on what you mean by safety, I think if you are thinking about the safety of your client then that includes safety from prosecution in a sense** then **disclosure becomes much more of an issue because what people are saying is** I think well **"I'm using a condom but do I have to disclose as well"** um for me that's something that's a bit, I mean of course that has always been an issue but you know I think now there's a sense of what's the safest option, what's the next least worse option and what's you know

P1: **but you can't say at this point you will definitely won't be prosecuted if you have safe-sex but don't disclose it**

P2: that's right

P3: the prosecution thermometer (laughs)

P?: yeah

P4: I know for myself though, you know **I have been doing this for ten years now and in the older days it was just talking about making sex as safe as possible, and then it morphed into safety but also issues of disclosure and now it's safety, disclosure and possibly criminalisation issues** you might want to think about **so safe-sex it's got much more specific I think over the years and that's very anxiety provoking**

P?s: ummm (agreement)

P4: with the risk of sounding judgemental, cos you just talked about safety you know like that would be kind of nice and fluffy and non-judgemental with the health education and now it's health care education and legal warnings so

P2: and I think you know what I have, what I feel is happening with some clients at least is that as we have already mentioned that people are more reluctant to say that they are not safe all the time and um

P4: us and them

P1: (laughs) exactly, what did you think I said?

P4: s and m

P?s: laughs

P3: it's a Freudian slip

P4: it is [unclear]

P4: sorry

P1: no no that's alright

I: so, how do you feel about the current climate of uh encouraging people to disclose?

P2: it's also well no, just sort of connected to the last point maybe but also connected to this it's also where does the disclosure stop because one of these things, just you mentioning S&M (laughs) that brought it to mind about hepatitis C transmission and is that going to be another you know people you know quite recently started thinking more about transmission of Hepatitis C sexually and people who are maybe involved in kind of heavy S& M type practices that there was this idea that there was a greater risk associated there with hepatitis C and you know I've had conversations with clients around that where they said "oh God I've never thought about disclosing my Hep C status" or they have been diagnosed with Hep C and they are like "oh you know I haven't even thought about that" so you know that's kind of another factor I think in the discussion of safety you know that it's kind of

P5: well obviously then you kind of when you think I mean on that and where will it all end in terms of people being prosecuted, if you went into an old people's home and you had a cold could you be prosecuted if one of them caught a cold and got pneumonia and died? You know what I mean I mean it's interesting why this area and not others or people who are overweight are they going to fined?

P3: apparently in America they are all suing tobacco companies now and I just laugh at it but this is it, what next? You looked at someone and you triggered um depression because they were paranoid, could you be done for that you know?

P5: well this is what happens when people are regarded as culpable in that they are stripped of their humanity and people that don't have any empathy for them and this is what is happening here, if people smoke weed and get arrested you know why should you receive any treatment you know you've got cancer now so it's your own fault

P6: in a way there's this whole, it's kind of, it's spreading that further so that if you were able to enforce that everyone were to disclose their HIV positive status before sex then if anybody after that got HIV or contracted it, it will be well you knew the risk, you still contracted it therefore you are equally do you know what I mean, it's almost like you are getting to that situation where everyone should know all the risks and after that it's their fault you know and it's sort of dressed up as protecting people but I think it's actually about transferring more blame onto anybody that develops any more kind of health issues

P1: yeah and actually our clients are making decisions all the time around disclosure, and actually it's not a new thing, it's something they all bring to everything and when we've now got a party line where legally this is what I have to advise you and how effective are they able to be to think about issues of safety and other options.

P2: you know also what [facilitator] was just asking about, you know this encouraging disclosure, like um I don't think it does encourage disclosure because I think there are good reasons to encourage disclosure and it's not all about transmission, it's about the positive person being able to get social support and emotion support from those around them and I think that often there's a lot of evidence that you know people experience positive effects of disclosing their status, or can do um and so I think that is to be encouraged, but beneficial disclosure rather than a kind of punitive disclosure, kind of you must tell or something terrible will happen to you or you yeah or we will tell for you

P3: it makes me wonder you know all this work around disclosure for children, what must children now be thinking that are positive and oh my God are they going to get, going to go to prison when I grow up and you know it's what will that, how will that affect their adult disorders and it's terrible and that's not even discussed and the focus is on the adults getting them told off or this or that so maybe we will have a load of really dis-informed young people who are already fed up with the world and you know it's ridiculous and it's clearly not getting better in some way

P2: um that's a good point

P3: but uh I suppose as you said before this is a good country or is it? But compared to Holland it's not

P1: I never said it was a good country (laughs)

P3: better than some, it's fascinating that

P2: but globally I think yes there is, if you look at you know the countries, even where within countries where there are a lot of resources, you know the United States is the one where there is an epidemic of HIV among drug users for example and that's because they don't have a harm reduction approach which has you know plentiful evidence you know so and I don't know about those countries like Sweden where they do a lot of prosecuting and imprisoning people I don't know what the affect of that is, I don't know whether anyone else does but to me it just seems like you know, we have had a system that has worked really well and now we are doing things to dismantle that

P3: it's interesting cos I was thinking where is there a country where it is working well? Not that prosecution will work well but there will always be a way you can never prove it – it's emphatic each case really in law cos how would you really know

P2: you could look at each case

P3: you could look at how long people are infected before diagnosis, viral loads, legislation

P2: I mean Britain could be a good test case you know, compare the situation

P3: but in terms of like how can someone, you know say in this vignette, who really affected who here, you could say that those with the lower viral loads theoretically would be the less infected therefore someone who's higher but that's nonsense the body could respond differently. So we'll never really, it will never be categorical so what will then it can't become this thing in the future where people can get done, so it will never be that straight forward now that those, does this make sense?

P5: how would you be able to establish source of transmission anyway?

P3: well this is it, how can you?

P6: I mean there's, I guess if any of the people had tested negatively then you negative recently then you could minute that as well

P3: but do have that evidence

P2: what if someone [hadn't been tested]?

P5: yeah there are different strains as well aren't they? there is some kind of like justifiable probability or you can rule it out if you have seen differences strains

P1: apparently that's

I: scientific evidence has been used in past cases but more recently that has been questioned

P2: yeah but it's also interesting I think you know what they're doing by that in laws it sort of mirrors what people often go through when they are first diagnosed, running through in their heads all the people they've slept with, who could it be? Was it, is it him, he had a cold that time and could it have been you know and that kind of search for knowing who's the one who infected you and I think that's something that people bring to therapy and often what you are having to do is help them to adjust to never knowing because that's a fruitless search very often and you know

P3: so in some way there is going to be a point where it can't carry on any further it might end this whole issue, I hope dies on some level because whilst it, whilst I think people should be responsible it's I can't see this becoming a big law thing where people will be getting tattooed or two communities or

P5: what I wonder about is people who are positive who actually didn't seek prosecution of another person and also what's their psychological profile – you know, is it similar or different to other people, you know what's going to happen to them and it just made me think people who you know relatives of murder victims in the states, the murderer is being executed and half of them actually get worse rather than better cos in what way, how is revenge going to help you, you know what I mean?

P4: it's the same with um I'm really going of in tangents here but they have lots of research where people have PTSD type reactions to motor vehicle crashes um you know it gets dragged out if there is litigation, it doesn't resolve until the litigations over

P6: absolutely

P4: so that's why we are process of adjustment to something else that's traumatic potentially

P1: [unclear] well some more ways I would like the law to be used would be to support some of the asylum seeking women I'm seeing who have been infected and who have been raped by the army and the laws of the public aren't

P3: absolutely we've been holding these conversations for years and no one bats an eyelid you know countries should be sued for, it's just nonsense

P1: absolutely well obviously that's not going to happen

P2: but I don't think it's so much of a tangent because I do think that you know one way that it you know it can be that you know as far as I know there hasn't been that much attention to this where people have been infected through rape and getting that taken into account in their criminal injuries compensation or whatever I think

P1: so it's already happening

P2: I don't know, I don't know because I think that you know the emphasis in the law seems to have been on picking out you know guilty people you know

P?s: ummm (agreement)

P1: and making victims

P2: and yeah exactly and um but considering you know that no one gets prosecuted for rape any more the chances of you know

P?: umm (agreement)

I: ok, as we've only got a few minutes left and we've touched a bit on empathy, I was just wondering are there times in therapy where empathy comes easier than other times

P?: yeah

P3: yes absolutely

P?: umm (agreement)

I: or are there cases where it's quite difficult to feel empathy?

P5: no I think there are times when you know I've been, actually around issues like this where this disruption in their lives or you are on a challenging interaction you know, yeah you can feel like you have lost your empathic connection and obviously that you can use as a cue really for you know something is going amiss here

P3: I suppose I always try to stick to the formulation, why is the person engaging in unsafe sex, why are they exposing them, and not if it's because of her and this and that and it just keeps me focused, it's not just some silly behavioural thing and that helps the empathic like, it's there is a logic to this behaviour pattern or what not but sometimes still you know you think how many sessions do you need to change this behaviour and it doesn't you know

P6: **I think for me the times when I've struggled most with empathy is when I've ended up in a position where I am trying to change their behaviour** which you know kind of **and it has actually been in a context around somebody not disclosing to a certain client and the more I tried to think about ways she could disclose, the more I lost sight of the fact that actually she doesn't want to, the more irritated and frustrated and less empathic I got and the more judgemental and critical and exasperated** and I think I think you know it probably touches on difference and that might be where the difference is greater that might mean that lack of empathy is more of a risk **but I think also that the position you take as a clinician affects how empathic you are able to be** you know **how much space there is and what you are trying to do and if you are trying to do health education** you know **there's not so much space for it**, I mean **there just isn't because you have a sense of what's right** um **or necessary and it just feels different**, it's like it's almost a mutually exclusive, for me, almost mutually exclusive

P2: that really connects me with the importance of supervision that you know when you, are in those situations where you are losing empathy or whatever you need the support of the supervisor I think who's also going to be non judgemental to you and help you to you know work with that and I think if you, again if we feel that we are policing clients and we feel like supervisors are policing us and their managers are policing them then it creates a chain you know of difficulty in being able for us to disclose sometimes when we are struggling around these issues

P4: we might have problems in disclosing to our supervisors that we are not dealing with this issue

P2: precisely no that's exactly what I mean, yeah

P4: so then we are both colluding with shame but for very different reasons

I: ok well that's great we'll come to the end. Perhaps to just conclude if I could ask you if you had one thing to say about what we have been talking about today, what thought would you leave us with?

P3: I really feel this has actually helped me a great deal because it's is a really key issue and it's actually helped me to feel more confident in some way but I really valued this because I chat with other people at work but it's just, really it's validating hearing that I am thinking on the right tracks, I don't have to have all the right answers so I found it very validating and helpful

P1: I think for me similar, I think we've all, we've had similar ideas but I know that in terms of disclosure there are different ideas within our psychology team as well as for the multidisciplinary team and it's been really useful to have a really big chunk of time just to thrash what are the issues and how useful would this be if we actually had it within our own team or in our multidisciplinary team and be allowed to have different perspective and different positions and you know how are we going to work with our clients if we are doing this and be explicit about that

P?s: ummm (agreement)

P5: I was thinking how useful it is just to be able to think about the issues and not necessarily all, I know it was useful to have the vignette as well as the talking point, but not you have to kind of "oh what am I going to do next Wednesday when I see this guy", it's something that allows us all to step back from our practice

P?s: ummm (agreement)

P6: and sort of think about in a you know slightly separate from the day to day context, I think that's really important

P5: I suppose I hope that this jump, this criminalisation, doesn't become another unhelpful intrusion into therapeutic space really which there seem to be quite a few of at the moment

P2: I think for me it was just great to be with other psychologists, kind of working in the field who are in comparable positions because I'm not attached to a team of psychologists so um I'm the only psychologist working in this particular setting and I think that's it's just me, it's good to feel connected to other people who are thinking in similar ways about things and I just think it's a really, really important topic of research and I'm really glad you are doing it

P?s: umm (agreement), yeah

I: Ok thank you very much everyone. We've come to the end so you can now have your free sandwich now!

P?s: yeah (laughs)

END

Appendix 2.4
Transcript for Focus Group B
(Held on 18/10/2006)

Key:

I	Interviewer (*italic*)
P1-4	Participant 1 – 4
[unclear]	Unable to determine what was said
P?	Unable to identify participant
P?s	Multiple people speaking – unable to identify
same?	Same participant speaking as previously, unable to identify
P1?	Might be participant "P1"
( )	Pauses, laughs, sighs, intonation
Exactly	Emphasised word
Bold	**Quotations appearing in Focus Group Results section**

4 Participants
Total 65 minutes

I: The client's a 40 year old single gay man who has recently been diagnosed HIV positive during a sexual health check up. His previous test was about a year ago which had been negative and that after the diagnosis he says he's quite shocked because he thought he had been safe enough. He asked to see the health advisor for some support coming to terms with all that's happened and he's referred to see you the psychologist in the team and during his sessions he says he has occasional casual partners and describes dropping his guard occasionally with them in the past but he is unable to contact any of them. He also has 4 regular sexual partners. So partner 1 is a single gay man, partners 2 and 3 are married and partner 4 is a gay man in a relationship. Your client's reluctant to inform any of them about his positive diagnosis and still has some sexual contact with all of them and he's concerned about receiving an adverse reaction if he tells them. He says he practices safer sex and uses condoms for penetration. What do you think are the issues here and what would you do?

P?: Um (long pause)

P1: Well I suppose the issues from my point of view would be do his partners know that he has other partners? um has he been - so I suppose I – um I'm I'm avoiding the word honest because that sounds pejorative um– but has he been, has he informed them that they are not the only partner?

P?:um

P1: Obviously the two married men have disclosed their marital status to him so he knows that he's not their only partner um and I suppose if they do know about the other's existence then you know they're all you know cognitively competent men then they all know that there is some risk attached um to their sexual encounters just because of um you know

P?: yes

P1: the more contacts people have the more statistically at risk they are and so the issue would be do they know? – do they know of each other's existence? that would be one thing for me? But obviously he's in some dilemma because he now knows he's positive so he hasn't been safe enough um and if he's had some um some slip ups with casual partners then presumably he's had some slip ups with regular partners so that's an issue

P2: um you know I think for me in terms of initially working with this man and thinking about the initial assessment and what he was coming into psychology for is what's the different sort of agendas were in that referral might be – so he is coming in to deal with did you say it was kind of adjusting to his diagnosis?

I: yes

P2: is that what the referral is for – so he is not necessarily presenting with issues around disclosure but obviously maybe that's the agenda of the referrers

P?: yes

P2: and that he's not, that he's not being comfortable being referred so you've again possibly then got a bit of a conflict in terms of the work that you may be doing because you've kind of got the health promotion hat on in a sense and maybe need to have those conversations but if he's not saying that that's something he wants to think about then it immediately makes it a bit difficult to have those conversations so that would be one thing um so I'd want to kind of get his perception about what he maybe imagines the health advisors thought about the referral, you know if they've mentioned issues around disclosure, what do they think is important and try to get – kind of illicit his ideas about why it might be important to tell your partners and you know what might be the possibilities – trying to kind of elicit some of those things – so that would be something I would be thinking about –I was also thinking about this particularly for partner 3 this married man, partner 2 rather, this married man with children and just thinking about (sigh – drawing in breath) responsibilities I suppose around these 3 partners and what the consequences then might be if he's transmitted HIV to 5 you know if he's transmitted it to 5 others (laughs)

P?: um

P2: um you know I don't know whether you know I suppose I have never been in this situation with a client before where you, where they talk about children, the children of partners and I wonder if that kind of maybe changes or might change it for me really in thinking about this case I don't know (drawing in breath)

P3: Um – I think I would be considering a similar issue – kind of wanting to find out a little bit more about the reason behind the referral – whose idea was it for him to come along to this, how he feels about it and explore a little bit more about why he's reluctant to inform any of the regular partners and what his ideas were around that? – what's making that difficult? Um (pause) and I suppose his ideas about safe sex and ideas about what is safe enough – um (pause) – um (pause) and what's going to happen next?

P2: It says here he "now" practices safer sex

P3: Um (as in agreement)

P2: um so what is, you know?

P4: what did he think was safe?

Ps?: yes

P4: if he wasn't using condoms and it's *highly* unusual to have 40 year old single men – I'll bet you there are not a lot of 40 year old single men walking around thinking that

P?s: ohhh (as in not sure they agree)

P1: oh I bet you there are

P?: yes

P1: **there are men who you know practice penetration but withdraw before ejaculation** um **who believe that's probably safe enough** you know men who um yes well I suppose that's probably safe enough **without using condoms** so that's it

P4: **yes but the person would also be thinking in terms of condoms because every time you think safe people tend to think condoms**

P1: **yes, but not always**

P4: **so safe enough I think that's *key* – is what does the person really think was safe?**

P?: yes

P1: and it's predicated on all sort of things like you know if you're going to have insertive sex without a condom and withdraw before ejaculation that I suppose is predicated on that if there are two people, well of course there are two people involved in this, **or if one is not comfortable because of the others HIV status then they would say so or insist on condom use but of course each is (pause)** you know **relying on the others in some way for a cue to cement condom use – another very risky strategy** – so the other thing that strikes me about this – the married men with children – and I mean I suppose I have always had the view that every every consenting adult is responsible for his or her own health – although I know goodness knows what they practice – but as a general principle – but when it comes to children being involved and married men were having loose sex with men who are also, who have also got children, it sort of it somehow makes it worse and I don't know why but it sort of feels more dangerous and I feel more concerned about the married men then I do feel about the gay men which is slightly and I feel slightly bad for saying it

P2: I know what you mean I felt it saying it

P?: um (agreement)

P1: but it seems worse that there are kids but these kids aren't this man's responsibility they are their father's responsibility and if their father is doing something wrong then that's his responsibility so why should he do it? - but it somehow does feel more incumbent upon the client to say to his married mates look I've got something to tell you and it sort of feels more urgent because there are kids involved.

P?s: (agreement)

P4: I know what you mean, I don't feel and I must admit I also feel bad to say I don't feel so strongly on that

P1: you don't?

P4: no

P1: because you...?

P4: because I've no heart (in jest) it's cos of where I come from. I feel very strongly about the person who's sitting in front of me that (pause) they are really the key to everything that we are going to talk about and I do consciously feel, I feel very strongly about the health promotional side and the public health I think because of where I come from – I come from South Africa so there's a very high rate of people with HIV and so this is why – in South Africa I'm telling you, you wouldn't see a lot of people like this and I mean I can only just say that people can't have had much sex education around here, one wouldn't expect that of a 40 year old thinking that certainly where I come from and I meet a lot of single friends like this all the time so I consciously when I'm talking to a person or when I'm with a person I consciously don't ask myself what is the public health implication of this person because he's my patient or she's my patient and yes of course it's got a *huge* public health thing so when something like that comes at me, I consciously think – because you, **this thing can drive you insane, thinking that you are responsible for the whole population because you are not and you can't be – I'm just one person sitting here and he's one person sitting there** so

P?: um (agree)

P4: and so I feel differently but I agree with you there's *huge* issues but it's not something I think usually of when I see a person and I especially don't cos this can drive you nuts (pause) and it's not going to help the person in front of me because you start becoming anxious about um yeah well you start thinking about why are you especially wanting to know?

P1: my views?

P4: well that's my view, that's sort of the way I would go about it, (pause) I also don't have any, I don't have any strong (pause), I guess I, I guess it's cos I have been in a situation where just everybody has got it, it's like a tidal wave, everybody hasn't got it but it is it's like a tidal wave, you have to make some, you have to make some decisions about how you are going to deal with this now because it's just like coming over you and really you can only just take a part of it at a time, you can only work with the person that's there and what they're prepared to do and what they're not prepared to do. I think the system that we have here of partner notification, I think that if the person *likes* that, you know if I was this guy if I liked that idea, if I realised that a lot of nasty things would come out of that for me as the person I'd go along with it but if I had a patient that thought that sucks I don't want anything to do with it I really, I really do think that it's essential that I – perhaps we could work towards it but if the person doesn't want to and they are gone after that session I just have to go home and say I couldn't do anything about it - that's why I do think that the *state* is so important and what happened to the education because that isn't my responsibility.

I: Is that something other people feel also?

P?s: um (drawing in breath)

P3: Just thinking back to own cases, um I am seeing a man at the moment, a 36 year old man at the moment who whose his ex partner was a married man with children and with a wife and had a very split life who lived outside of London in his married life and he bought a flat in

London for his other life which was mainly to have sex with men um and my client was aware that he was positive whilst he was having sex with his ex-partner and they separated early on this year and now his ex-partner has now been diagnosed positive but that wasn't through my client telling his ex-partner this was what's happening um so at the moment I suppose our sessions are very much, it's he's saying he doesn't want to do anything about it, I know he's still having unprotected sex with his other partners – it's quite similar to this really

P1: male partners?

P3: male partners um but he he feels that this is, this is what makes him feel good, that his social life is very much tied up with going to the pubs, going to the clubs and meeting men um and he says if you take, if you tell me not to do that, if you take that away from me, you are taking away my social life, my, the one way that I feel good about myself – so talking about responsibility and um safer sex is quite difficult with him although I (pause), I want to have it in the conversation, I want to have it on the agenda um but it's really – it's hard, it's really difficult [unclear]

P2: I think working in the setting that we do in this [unclear] NHS health service, there is that sort of conflict with the different hats that we wear

P3: yeah

P2: because **there's sort of psychologists very much working with the agenda that the patient's bringing but then** having that kind of health promotion hat on or having that you know **being referred by the health advisors or whoever to work on these issues so there is that sort of conflict of agendas** and where it's not the person's agenda in front of you but actually [what] everybody else bring in and it is a sort of delicate balance in terms of to bring those things in, and kind of put, bring them into the room um **and a conflict of people saying you are not to go there so it's a difficult one to kind of balance but** I suppose yes **I feel that (pause) it's not my responsibility to tell somebody what to do or to even necessarily force that to be on the agenda**

P3: yeah

P2: because then that's not about rapport building and you can't keep a good relationship, you are not going to keep someone engaged if you you step into that role, but sometimes **I will talk about how I am going to put my health promotion hat on and I wonder if we could have that difficult conversation**, I don't know and there are different ways of which I try and bring it in and try and allow that to happen and maybe to talk to different people about , but I have never found a way that really works (laughs), you know it's just trying to feel that there is and yes **that does feel important particularly in the current climate with all of these** sort of **moves towards criminalisation** of transmission and I suppose that is part of what this focus group is about, **and that is something that we need to be thinking about it but it does pull our professional responsibilities in different ways**

P4: **I always ask people how they might respond if someone sued them** um I do always ask them that question – it's not as though I don't enter those kind of questions I do but um because I'm interested to know how they would respond because **some people haven't thought about it** because most people nowadays have read it in the paper so I will ask them what do you think about that? Um (pause) **and some people respond very differently** um **some people are so petrified they are going to put their heads under the blankets at all costs (pause) other people realise that gosh I wouldn't like to have to stand up there and have my photo in the Metro**,

P?: of course not

P?: um (agreement)

P4:but at the same time I'll never take the position that the person whose (pause), or of the side whose going to say yes you should be sued um (pause) however supposing I had the person's *partner* um and the person said I am going to sue so and so I mean if I got into that horrible position I would go with both of them , **I don't have a problem being enormously flexible (laughs) it may seem like I am amoral but to a certain extent I**

think that it really is about the person in front of you and not any these other people involved and I don't have a lot of problem just focusing on that um because I, I think that's the only way to help the person move on or be where they want to be, or get to where they want to get psychologically **so I seem to come down quite heavy on that side of the fence**, um, **I don't have lots of strong moral feelings frankly**

P1: I suppose though that there are probably very few (pause) medical conditions um that are transmissible in this way that have such consequences, maybe apart from pregnancy which isn't a medical condition as such

P?: uh-huh

P1: you know I mean it is maybe a comparison that you live with something *incredibly* tangible that the consequences are life changing, it can be it can be life *enhancing*, yes but it can be life destroying in some way and I suppose the issue for me of asking somebody how they might feel if somebody sued them is such tangible, public, shameful potentially thing to happen – I mean nobody wants to be sued for anything, sued for transmitting HIV, brings ones – well whatever one's morality is, whatever you think about consenting adults doing whatever they want, brings another dimension of other people's views about what you are doing with your genitals into the relationship in a very very strange way

P?: um (agreement)

P?: absolutely

P1: um and um even though people might be you know sort of very clear about what I do in my sexual relationship in my business and the business of whom I am sharing the sexual encounter but it's not now and maybe it never has been because sex has always been, you know once people get pregnant it's clear, you know unless you are the Virgin Mary, you know, this is a public declaration that you have had sex with someone

P2: well it's the condition that stigmatising really [unclear], it kinds of adds a layer of judgement doesn't it as well, as well as actually having the impact on people's lives, of course having the condition but also the extra levels of stigma kind of makes it very different

P1: but people know what you have been up to

P2: yeah

P1: um and disapprove,

P?: um (agreement)

P1: usually disapprove of it

P4: yeah but most people know that they disapprove of it anyway and that's a problem isn't it? that if you address the issue, what could you think, how would you think if someone did this, it brings the reality into the room of what you actually might face (pause)

P1?: yes

P4: If I, I know now what my HIV status is and if it changed and I'd had sex with one person, I would certainly sit there and consider what took, what advantage it would be to me to sue this person, I would, I would sit there in cold blood and think about it – what could I get out of this now, would this really be to my advantage? Because how would I look in the Metro as the victim, um (pause) because I have sued people and it was very good for me (laughs)

P?s: (laughs)

P4: not because I had sex with them it wasn't

P?s: (laughs)

P3: but isn't there some kind of hidden agenda then maybe for the people that do say look this person has transmitted HIV, I've got it now so I am going to do something about it, almost like revenge

P4: well, shouldn't I have some revenge? I think I have the right

P1: yeah but then it's a bit you know what about the people who say well ok I've got HIV but actually it has transformed my life – I mean that's not coming from that place is it? Is coming from I am now a victim, you have destroyed my life and I *demand* retribution, or justice, justice for the things that actually I participated in, because I hope to god what I participated in wasn't a risky situation you know but what is the justice though this?

P?: yeah

P2: yes I mean it's putting responsibility entirely onto one partner, the partner that had HIV and making and suing that partner or the partner who is suing the other one is very much laying blame isn't it? It's about blame when yes if it was a mutually consensual sexual partner then whose responsibility is it to have discussions about ...

P1: and additionally I think, it's also saying that you knew you had it, you understood that the consequences of having HIV are life destroying, you and you deliberately engaged in sex with me knowing there was a strong possibility, therefore actually you wanted to harm me

P4: and you said no I haven't got it

P2: right well that would change things a bit

P4: I wouldn't dream of suing if I didn't have that kind of evidence

P?s: um (agreement)

P4: I just think that um (pause) everybody is so different, you know I am just sitting here thinking why, there was a book that really changed my thoughts about this, it was a book that I read quite some time ago the author of the book is Johnstone, it was about a group of HIV negative men in Boston, all of whom had really been *a*ffected by HIV and it was on [unclear] about 34 interviews and each of these people had got such a different *take*, on their own sexual life and why they did or didn't engage with people's HIV and how HIV had *affected* their lives and afterwards I thought well this is just not how I thought it was, this is really all up for grabs, every single person thinks completely differently to what everybody else does and then I loosened up all my thoughts *hugely* about it and so I don't (pause) I'm just saying that if it happened to me I would consider it, I might come to the conclusion that it was hopeless and a stupid thing to do. But I think it's important to think through would it be of some advantage, if I'm poor is it going to give me some money?

I: Thank you very much. Perhaps now is a good time to move the discussion on to the next phase in the vignette. The client is reluctant to tell any of his partners but thinks he is most likely to have contracted HIV from partner 1, which is the single gay man.

P1: (pause) it's not something that I have discussed in such formal, concrete, bare boned terms, the discussions are often around what are the difficulties in telling people who need to know are, what are people afraid of, especially for women um who often are very vulnerable and I suppose you know our population in [area of] London tend to be immigrant women, you know tend to be black African who tend to have had very negative experiences in their own country either with their men folk or men in authority, police, the army, you know so there are real understandable difficulties in figuring out who needs to know, how much power do I have in this situation, if he's going to demand sex anyway um you know what am I going to do? will it make any difference if I'm HIV positive? Will it make things worse? Cos you might demand it anyway, or force me to have sex, so you know that's quite a common, I mean I don't know whether that's everybody's...

P2: yeah I have similar conversations usually with the women that I see, usually African women and there is there are different kind of issues around disclosure, you know there are a lot of fears of stigma and you know the fear of rejection and fear of and expectation possibly that a regular partner may have given it to them or fear of their response, or fear that they won't then

go off and get tested so there are a lots and lots of those sort of things and I would say that similar to you [P1 name] those are the kind of conversations I would tend to have with people about disclosure and about how their HIV status for example might affect their sex life and I was thinking about how in this vignette is his sex different? Is he using condoms more now? And has that impacted upon the conversations he would have with people and I think it is those kind of conversations I would have more and **I don't think I have ever brought in issues around legislation with anyone and I think part of that is because I'm not really sure of what to say at this point (laughs)** I just don't know what to say at this point **because I don't know whether I have got my facts straight really and I suppose not really knowing whether this conversation I am having with them could be** you know, could it be **subpoenaed if I write it up?** Those kinds of things You know **what is my responsibility in terms of disclosing this thing? That's why I haven't had these discussions.**

P3: yeah I agree and I think part of being psychologists where we are – I don't know whether that's my *role* because there are senior health advisors who are more public health oriented and who could be a bit more directive where I feel that my role could be a bit more understanding why, it's how they feel now and why they feel so difficult really to disclose and whose idea is it really to disclose cos I have had a few conversations with people recently about well how it's the community nurses idea or it's the health advisors who is kind of pushing the person to tell children, to tell partners friends uh rather than them

P2: yeah I know [unclear] cos often people will come into the room having had, knowing what the message might be from them in the doctor's practice for example, they kind of you know they know that and having discussions about yes yes you should, why shouldn't you and why can't you and it kind of reinforces those things (laughs) and for you to kind of have a different conversation with a psychologist perhaps than you might with perhaps a different health professional there

P3: it's useful to bear in mind though about that..

P1: I also think that you know **putting that kind of notion of criminality on the therapy agenda seems to further stigmatise it in a situation which is supposed to be supportive** and make it you know it somehow I would fear it would make the situation worse, I mean usually people are generally trying to get their head around it you know, generally trying to work a way through this life changing thing that has the potential to really affect their relationships and they they want to find the best way, you know best for themselves and you know often best for their children and um and **to bring in the notion of somehow attaching a criminality to an action seems to be a very very uncomfortable way to proceed especially within a psychological session**

P2: **yes, I think you might end up alienating them**

P4: I think you'll find that people bring it up themselves, they read about it in the Metro and they say did you see what was in the newspaper last week, they are already talking about it, even mentioning it does not mean that *I* think that they are responsible for any kind of criminal act or that they are a victim of some kind of criminal action, I'm just asking them and they can see by my attitude that I'm not criminalizing them – some people find that's precisely what some people are petrified of is that suddenly that might just jump out of the bush like we have a person who has a 3 year old daughter whom he doesn't live with and the 3 year old daughter is with her mother and there is a question mark about whether this child might be infected and he's petrified that this woman might play this child against him so I find that I don't find that it changes my relationship to people at all, they are very aware that a lot of people I work with are in a different country and one of the things they struggle with all the time is what's happening in this system you know what's going on and that's one of the things well in this system, look at Mrs so-and-so who got put in the newspaper last week, she caught it and she sued Mr so-and-so and oh my god that might happen to me so I find that they bring it in the session quite naturally that's why I started to ask people how would you feel– it's not like the person was diagnosed last week and I am seeing them this week and already I am jumping them, it depends a whole lot on how the person acts with it, sometimes they have been diagnosed a long time ago – they can't get over the diagnosis and they are thinking of something else when you are seeing them, that's a very different issue than if they have had their diagnosis last week but I don't find that my relationship with the person changes, I find that that's something they are afraid of

P3: it's interesting, I find that a lot of people that I see, don't actually, they have never mentioned it, I don't think I have ever had anyone mention criminalisation, but I have had people saying that they feel terribly guilty that they might have passed it on to someone else and it is more the guilt rather than worry, I think they wouldn't care if they were arrested I think they would think they deserved it in someway but they haven't – no one's explicitly talked about the legal stuff – I wonder why – don't know

P4: [unclear] I have had many women like that, all of them, always feel strong guilt

P3: oh yeah, yeah

P4: I find it enormously difficult for a woman to think that she wasn't responsible for having, as if she meant, sort of picked it up on the street, or bought it for herself in some way and decided almost as if she feels she made a decision for herself to have it, it's enormously difficult for men to think outside the box, lots of other people out there have got it and I am passing it on

P3: but I suppose I wonder that we think about this, do we think about this differently when we think about you know patients disclosing other things that they are doing which could be classified as criminal, I mean I know there is a change in the law so that's why this is an issue so I do understand this but **I am just thinking of this client I saw yesterday who was asking me lots and lots of questions about confidentiality, what were the limits, what are the *exact* circumstances under which I would have to break confidentiality, he was very anxious about it and it turned out that part of it was around this sort of issue and part of it was around** his recreational drug use and he worried that I would you know need to disclose something about his drug use so I was able to put his mind at ease pretty quickly on that one but this did feel slightly differently **but I don't know why this should feel different to other potential criminal activities that people are disclosing to us in a room** um I don't know

P4: (pause) **because if we know that there's potential harm, we do have limits of confidentiality**

P1: but you know the kind of things that people have told me in the past are you know things around theft now if somebody steals a television, you know televisions are replaceable and I'm not going to get too excited about televisions, if someone is stealing say £50 out of someone's handbag, you know I may not approve of that but I'm not going to get very excited about it but HIV is different – you know if you if the client is saying look I *do* have lots of unprotected sex then I will of course be wondering why? what you are doing, what is that saying about how you are coming to terms with your diagnosis, what do you actually think? are you angry, is this about revenge? Is this about you not actually taking care of yourself in some way, or is it some kind of complete denial about it? Have you not understand something? I mean I wouldn't automatically go into how you are a criminal, now you have told me something, you can't take it back, it's been said, now I am now in a position where I have to do something about this, but at the same time at some point I would you know– well would I – **I have never been in this position – what would I do? Would I tell? And tell whom and tell them what? You know tell the police that somebody may have sex in the future that might not be protected** you know

P?s: **(laughs) what's the police going to do with that information?**

P2: It's a tricky thing

P1: **you know that's when it becomes absurd** you know **you can't police this** um

P4: **well, I mean you don't want to get the police involved, do you**

P3: **I've seen quite a number of men recently who talk about, who are positive who talk about having receptive anal sex but often don't insist on condom use because they say if the guy, that casual partner**, that casual partner **isn't using a condom then they must be positive already or not it's their responsibility, if they are passive in this role and delegate this to the other as a way of getting round having to really think about it, well it's not that they are not thinking about it but it's a way of kind of justifying what they are doing** and uh so that's been coming up for me quite a lot with people **and again it's I suppose it's like anything else when you have conversations about what's you know what might**

be different ways of doing that and what do you think and **I haven't up until this point brought in the legislation around this cos it would just feel like a great big hammer (laughs) coming into that conversation** that's very you know **– it just wouldn't feel like a helpful thing to do at all**

P4: **but,** you know **just because you talk about it doesn't mean you are representing it**

P3: sure

P4: it's like um (pause) just because, people have read about it so they ask what do you think about it I mean as soon as something's appeared in the newspaper you will have a whole string of people coming to ask you and they will all ask you everyone will ask you that - you know did you see that thing in the newspaper, what thing in the newspaper? You know that thing where the lady went to court against so and so? Yes I saw it what do you think about it? And they will say, oh you know I think this and this and this and what if it happens to me? A lot of people think that

P?: sure

P4: and it doesn't mean that I'm a bit defensive about being seen as a big hammer in the conversation

P3: no, no

P4: I don't get the sense that people take it that way simply because a lot of conversations I have with people are about the different systems that they are in and that they feel and see about it and that in many parts of your life is where your money is coming from or where the roof over your head is coming from, about what your doctor's saying about understanding this and about how this works in the UK, about how that works in the UK um (pause) and that's something else

P3: I mean yes you can introduce this is what's going on at the moment and this is what is happening with changes in the law and this doesn't necessarily mean that I endorse that or agree with it but we maybe need to talk about it

P3: yes that's a really useful way of introducing that conversation isn't it?

P4: I mean I have only talked about it in terms of have you seen it in the newspaper? not do you know that this is the law now and did you know that I am going to do this

P?: (laughs)

P4: **I would never dream of it and I think that this is a very radical position on client confidentiality and I think that has a lot to do with where I come from as well because (pause) I see that as *the* most important thing and I think the law might find me a bit too confidential – and I think that if I got into any problems, that's where I would get in trouble** so I would

PI: I think though that's if this were law, I think that possibly, is it case law at the moment? I mean there have been certain people who

I: all the cases to date have been brought by applying the offences against the person act

P5: yeah if it did become law, certainly if there were more precedents established then I would probably tell people you know this is a consequence of, you know there may be consequences if you talk to me about unprotected sexual activities, so you may want to think very carefully about that before you talk to me um so as not to be in the position where I could either be seen as kind of colluding with somebody's behaviour or acting unlawfully or

P2: it's so hard isn't it? Because You might obviously be the second guy that I am seeing at the moment who is talking about these things and it would just make these conversations incredibly hard to have and are you actually going to stop it – having these conversations with people?

P1: yeah – I mean you could have hypothetical conversations with people

P3: yeah and I've done that before, had hypothetical conversations with people (laughs) but it's not very helpful

P1: It's kind of the location of the badness I mean the malign intent that kind of underpins these kind of thoughts and it's about malign intent that I am going to harm you, I am deliberately, cold bloodedly harming you, and I think that's the difficulty, I mean I don't see anybody who is you know [in the ..] I don't get the impression that anybody is deliberately trying to harm anyone, i mean people have sex for all sort of reasons, revenge usually isn't one of them you know making people pay, I mean obviously people have unprotected sex when they're – I mean who hasn't – when they are drunk or tired or they're on drugs or they say oh go on then if you must you know it's or you know we have all made silly decisions around it at certain points but to attribute a malign intent it's such a leap from my experience both personal and

P2: I would agree

P4: yes I don't know anyone that would think like that

I: I would like to develop the vignette a bit again now which is touching upon some of the things you say. So now the client, he tells partners 2, 3 and 4 who all test positive but he is still reluctant not to tell partner 1 who he thinks is the most likely source of his infection. He describes him having a lot of casual sex in sex clubs and saunas and doesn't want to inform him but then in one of your sessions he names client 1 who is also a named client at the clinic, how does that change things. What do you think are the issues here and what would you do?

P4: (drawing in breath) God

P1: well I think this is where it does become really tricky because we as psychologists also work within systems and work with colleagues within the clinic and it is a system and I suppose I would feel that my job is done at that point and if the health advisor takes over at that point and maybe makes contacts, and where client 1 would be contacted to say you may have been contracted with HIV sexually and would you like to come in to discuss the possibilities in the clinic

I: when you say at that point do you mean when someone gets named?

P1: yeah

P4: I mean you realise or a group of you realise that they are in the same clinic but in our situation there is a procedure in place so then that's what I would do fall back on that procedure

P2: yeah and then they have PN, that's what they call the clinical group, I can't remember what they call it where that's not necessarily down to if your client doesn't want to tell his partner that's just what you said, then the clinic can do that, the health advisor can do that so that's just a different way so I know people worry about tracing it back to them but um (pause) yes I suppose what's difficult is to let the health advisors in the system know that this guy's identified which I suppose isn't breaking confidentiality because it's within the clinic setting but would it then, would you then let that information then inform how you were with this client, client one?

P3: yes that's interesting

P2: um (pause) it's difficult

P3: I would be very curious to know what's so difficult for this client to tell this particular partner – how come they managed to do it successfully with the other ones

P2: what are the negative consequences

P3: and they got a bad response but he did it so how come this person is so difficult?

P4: because he thinks he got it from this person

P3: um

P4: it also has a lot to do with the quality of the relationship doesn't it, whether he is more angry with this person [unclear] I think it is more difficult if you know in the clinic that these two people are connected in this way – it wouldn't affect my work with that person no, it wouldn't, I haven't, having been a psychologist all my life I think that precisely these kind of things bother me horribly so before I became a psychologist I would ask myself a lot of these very difficult questions and what I tend to do is keep things separate in my mind so I don't think that it would of course it's something that I know but when you work as a psychologist you have so many different kinds of people are going to come and see you and they are going to tell you so many different kinds of things and I just feel very very strongly that if you haven't got a sense of confidentiality to that person, if it's not there, that person can't come out of the woodwork, that person can't do that whatever you've got as a psychologist, you haven't got *anything* the whole thing's prejudiced from the beginning so I come down very strongly on that side of the fence about it so it's not going to move forward by pushing and pushing it or by saying I know this or whatever, you're just subverting the whole thing and sabotaging it yourself so that's something I just for me that's just like what I found right down to the bottom of my toes about it

I: would you feel you have a professional obligation to the third party?

P4: (drawing in breath) I think that of all the people in the room I would feel that the least, I do think that you do have an obligation but because we have this procedure, it was very different in the previous situation in which I worked and we split, we split the functions as psychologists have never had the same professional responsibilities as doctors but... (unclear)

END OF SIDE 1 – TAPE CHANGE

P4: ...whole partner notification and supposing that you didn't have health advisors and it was just us sitting there having to do these partner notifications there would be hard for me but I would say I chose this job, I let myself in for this and this is the way it goes and I would never let it be down to my kind of arbitrary something or my skills with relationships, I would always have a pro, you have got to have a *procedure* that works and the person knows about the procedure. That would be the only way I could manage it so I would I would find it very hard if we didn't have these health advisors but if we if I had to manipulate the system myself I definitely would

P1: I think as psychologists we know lots of things about people's lives, we know about domestic violence, health and sexual abuse, um, poor parenting behaviours all of which might potentially be criminal, you know potentially and what we do is we really you know instead of running off and saying we have to get the police and saying we have a public duty to protect these people from you um you know we tend to work with people where they are you know working towards goals around you know stopping the behaviour and in some ways I don't see why, I mean of course I see why this is different in some way but I was just thinking let's say domestic violence, I have a couple of clients who are domestically violent but I'm not running off to the police because what's going to happen, they are going to warn the client don't do it again, but the client knows he shouldn't be doing it, it's not going to save anybody that the police being involved, they aren't going to be there 24 hours a day and in the child protection cases, what we do is we work with the parent, you know the carers who are the perpetrators of the neglect, the abuse you know whatever because that's the realistic, that's the most sensible way of dealing with it rather than criminalizing the person who has got the problems

P2: my feeling is, **I agree about my responsibility to the third party** is that i feel do have a responsibility to the third party **but *not* to go outside and break confidentiality but I feel I have a responsibility in the room in the conversation with the person in front of me** I suppose we haven't identified that before (laughs) but that is the principle in which I work on, it's like how I work if someone is telling me some of these things I mean I won't say ok that's fine then I might kind of be curious or think about the kind of questions I would ask in order to make my position clear as you mentioned but so I see that as yes that's my sense of responsibility I can't, **I wouldn't of unless it's very very serious circumstances** I wouldn't **break confidentiality around that**

P1: and that has always been made quite clear you know with severe child sexual abuse, you don't have an option at that point, you know murder, I mean but those are real extremes, but I suppose I'm just wondering, I suppose asking these questions, why is this so different then?

What is this debate about criminalisation then? What's it saying? What does it mean? And it seems to me that it is saying something about society's you know *huge* anxiety about the other and whether that otherness and difference gets located and it gets located you know in a very sexually active population, people are having more sex than we've ever had if you believe the sexual behaviour survey. We're having sex at an earlier age and there are all kind of consequences from that ranging from Chlamydia to relatively high rates of teenage pregnancy, so you know how does that inform something that seems to be an anxiety which is I don't know disproportionate in some ways, I'm not saying for anyone to be diagnosed as HIV positive isn't a big deal – it is a big deal but it's not like there are tens of thousands or you know of people being affected every year or you know I don't want to risk sounding uncaring but also generally it is gay men who are not that valuable and black people and drug users and these are people on the margins of society anyway so I mean what's the big deal, drug users are dying of heroin overdoes I mean we don't really care about that or if it were gay men dying of anorexia because they all want to be beautiful you know I don't think that would be a worry to society, or black people in Africa, you know just look at Rwanda, 1 million people have been killed in 90 days and we weren't running screaming and shouting about that so what is – it's not like you know every life is a valuable life and we must go an – I just don't get it

P2: it does have a very punitive; very controlling kind of flavour to it doesn't it – the whole criminalisation issue?

P1: it's something about keeping it away from me, I'm a respectable person who has a normal sex life, I don't want any of your dirtiness coming anywhere near me and if you are dirty then you have to tell me you're dirty you know it's like that – it's something like that

P?: it's interesting

P4: I feel that the law for being criminalised or in the process of being criminalised (pause) (drawing in breath) actually not so many people have chosen to charge other people have they really or quite a – I think it's because it's *unusual* it hasn't happened before but I think there is something around it that the press has made out of it I think (pause) there is something about the way it's been, sort of, how can I say I mean when you get measles you catch it from somebody too don't you?

P?s: yes

P1: or hepatitis which might be better example in some ways

P2: or TB which is pretty life threatening

P4: so you know I agree with you but I don't think like for instance it's been 2 people at the moment it's been about the 2 or 3 cases that I have read

I: Actually eight or nine cases so far

P4: Ok but it's not something that you see increasing and increasing and increasing and increasing in the press or do you – maybe I don't read enough newspapers – I don't see though, I don't see it, like when you look at the issue of the Muslim veil I mean this has gotten bigger and bigger and on and on and these people have picked up (unclear) and these people you know, I mean that's an issue that has gotten *tremendous* mileage and has gotten bigger every day whereas I don't see this one has I mean maybe I'm just blind I think that it's got more serious if you're a person who has got it and that is passing it on that's why I do like to talk about it but I think it is odd you know this sort of thing you know, why this? it would be interesting to know why this law came about – what is it about and how come HIV suddenly got into this category, why hasn't everything else? I would love to see someone else come forward with something else having someone given them something, it would be great to test the law

P1: I mean drugs are a hazard to health for example you know but I mean drug dealers don't get offence against the person act they get charged with drug dealing even though their drugs can kill someone so why aren't they charged with, you know it's a much more immediate risk to someone's health

P3?: you can transmit HIV as well

P1: yeah why do they, I mean surely yes, I mean if you are taking dirty heroin, you know heroin cut with cement or something it's a much greater health hazard towards life but they don't get charged, they get charged with other offences but not the offences against the person act it's a funny way of conceptualising what happens

P4: when did this action come about was it around in the last century?

I: 1860 or something

P4: 18 something there would have been a lot of people who would have had syphilis at that time

I: I think the legal precedent originally relates to a woman who caught an STI from her husband, I don't think it was syphilis but another sexually transmitted disease but she didn't win because she didn't have the right to say no to her husband but it established that the law could be applied to sexual health. Anyway, the time is up unfortunately, so so thanks very much for everything and for all your contributions.

P2: quite interesting

P3: yeah it has actually been really really interesting

P2: yeah, yeah, there's a lot to think about. These issues really touch upon everyday practice

P3: it really got me thinking about this thing in a new way so it's been very helpful so good luck

END

Appendix 2.5
Transcript for Focus Group C
(Held on 2310/2006)

Key:

/	Interviewer (*italic*)
P1-5	Participant 1 – 5
[unclear]	Unable to determine what was said
P?	Unable to identify participant
P?s	Multiple people speaking – unable to identify
same?	Same participant speaking as previously, unable to identify
P1?	Might be participant "P1"
( )	Pauses, laughs, sighs, intonation
Exactly	Emphasised word
Bold	**Quotations appearing in Focus Group Results section**

5 Participants
Total 75 minutes

I: First is a vignette which is in a few parts, and then afterwards there is a more general discussion. I'd be interested in hearing if you have had similar experiences yourself so please feel free to bring those in and relate it to the discussion. There's prompt cards here just to help you remember the basic information from the vignette. If you start at page A1, that's it. The client's a 40 year old single gay man who was recently diagnosed HIV positive during a sexual health check up. His previous test about a year ago had been negative. He's quite shocked by the diagnosis because he thought he had been safe enough and he asked the health advisor for some support coming to terms with all of this and so he's referred to see you the team psychologist. During his sessions he says he has occasional casual partners and describes dropping his guard occasionally in the past but is reluctant to contact any of these people. He also has 4 regular sexual partners – partner 1 is a single gay man, partners 2 and 3 are both married and partner 4 is a gay man in a relationship. Your client is reluctant to inform any of these partners about his positive status and he still has some sexual contact with all of them. He's concerned about any adverse reaction from them if he was to tell them and he says he now practices safer sex and uses condoms for penetration. What do you think are the issues here and also what would you do if anything?

P1: Um well obviously all the people in relationships are their partners are also at risk so you could say partners of anybody would be at risk but these are regular partners and in the case of the married men, I should think it was very unlikely they would have the faintest idea that they were at risk.

P2: Are they married to woman or married as in gay civil partnership?

I: women, was intended but feel free to consider both possibilities

P2: ok – just checking

P3: the client referred for help with adjustment issues, what are the issues, I suppose psychological adjustment you know in terms of what issues psychologically

I: well, I think the vignette is presenting quite a general view for you to elaborate on

P2: just for support in coming to terms with it – it just says support coming to terms with his diagnosis

I: yes, the referral states for support and advice

P3: with his new adjustment then well adjustment then mmm

P1: now that he knows he's positive and presumably and is still seeing all these partners he's um perhaps um putting himself at risk of prosecution (pause)

P2: well the good news is he's using condoms, now that he knows he's HIV, he's using condoms

P1: he, yeah but he's probably having oral sex as well isn't he?

P2: I don't know (laughs)

P4: I suppose that's the complicating factor in some ways isn't it in that he is still using condoms so perhaps that lessens it to some extent his need to tell them

P2: I don't know if he was using, do we know if he was using condoms before he was diagnosed?

P1: it says he was occasionally dropping his guard

P2: oh yes that's right, is that what that means?

P1: but it says he thought he was safe enough

P2: that's what happens, yes ok

P1: I mean I would I don't know, it's all very um, one has a need to fill in the whole picture, so I'm wondering was he only using condoms. The usual pattern is you use condoms with casual partners, you might not use condoms with your regular partners but you, you always use them with casual partners so

P3: I think in this case I mean I have to be honest I don't make it um a sort of priority for me to discuss the sexual practices and safer sex, I take it that you know I prioritise what is the problem for which the patient is coming for

P1: oh yes

P3: so that is one thing and in this case, in this case, because it is an adjustment because the client is actually quite surprised and somewhat miffed because he got HIV um and he's coming for adjustment, in some way, adjustment difficulties, in some ways I would probably bring the subject around as part of his adjustment, as part of the adjustment difficulties being that it came as a surprise you know that also these things do happen so therefore if he is surprised and as troubled by it then it would be worth addressing this issue on a deeper level in terms of the implications that him having HIV has on other people without informing them so in this case I probably would because it's a clear adjustment issue and clearly he's quite surprised that he got it because he was performing safe sex and it just happened to him but it could happen you know if you leave it to sort of fate so to speak and chance it's quite likely that all these partners may have it or be infected

P2: I think like [P3's name], I'm going to be paying attention to why he's been referred so I'm going to be exploring what the adjustment difficulties are and **I think the issue of possible transmission or risk or the need to disclose to other people would be framed around something like what difference are there now that you know that you are positive, what will it mean in all kinds of areas in your life? And is it making a difference to your sexual life?** And I should think that's where our conversation would come about, the level of risk he's taking now, **how he thinks that this new information about his positive status might then affect his relationships** because you already have a clue that he thinks there's going to be some adverse reaction so I would be quite curious about that

P5: And also to think through with him possibly how he might have um not transmitted it, but contracted it and also thinking about that about as well

P2: I would say that probably most of the people I have worked with, when they're presenting problems to me, **it's easier to present things like I've been diagnosed and I'm really struggling with that and what that means to them but it's much harder for them to talk about, particularly any ongoing unsafe sexual practices that they have now they're positive so men I've worked with that have talked about that they have kind of said it in a small way, not presenting it as a problem but I think they are definitely communicating something very important to me and I suppose because I understand the implications of what they are saying and because I suppose professionally and personally I do see it as an important issue and an important clinical problem, I pick up on it but I wouldn't say people present it, they don't**, they wouldn't be if you gave them a, if they were presenting a list of three problems, I don't think most of them in the way they have told about it said that my third problem is that I'm not using condoms you know as often as I would like or all the time when I'm having sex so because I think there are a lot of difficulties with talking to people about having unprotected sex when you have HIV

P?s: yes

P2: and that's really important but **when they have spoken about it, I've picked up that they felt relieved particularly because they have been concerned about the way we would talk to**

them about it and the way we might be judgemental or in a way not allow the whole topic to be opened up for thinking and understanding rather than come in a rather simplistic way and say that's not acceptable, that's not ok, in a judgemental way and that's really important because I do think there's a lot of shame involved **and** a lot of **guilt involved**

P1?: it's not likely to be the first thing that people feel comfortable about talking about in the first meeting

P3: no

P2: you are going to have to build up quite a good rapport with them to be able to talk about those things and for them to be able to offer up those things

P3: yeah

P1: and they don't necessarily at the time that you are seeing them, see them as you say, as the most important issue, I mean a lot of people are having unsafe sex every now and again and you just regard it as part of life's rich pattern as far as I can see um but I have to confess it if I knew I mean I can't help much as I want the best for my patients, I can't remove my own view of the situation from you know the consulting room and so I do feel that people should take responsibility for telling other people, particularly when there are people who don't live that lifestyle involved, whether or not that's non PC I don't know but for all you know the um married couples might be having more children I mean you don't know so there's a lot of people involved as there are in gay couples as well

P2: are you saying that that might be... because for me that would be a personal opinion that I might hold

P1: yes

P2: but would you want to kind of hold that in initially?

P1: oh yes yes yes of course

P2: then now it's informing you

P1: **but it would colour my view**, it would colour my view **a bit, I would try not to let it but I would find it quite difficult, I might find it harder to empathise with somebody who says "oh well it's their own look out, it's up to them if they want to have unprotected sex"** you know **or whatever and that does sometimes happen**

P4: **I think it's quite a difficult position though as a psychologist isn't it because I think potentially we are identifying the problem that the individual or the patient may not have actually identified themselves** you know

P1: **exactly**

P4: so I know to negotiate that without actually shaming somebody I think it's really hard so to keep it on the agenda but not to be a sort of police person in a way

P?s: umm (agreement)

P4: I think it's incredibly complicated really

P1: um and not to let your aim really, I mean some people are really quite unappealing in these situations and you might feel like saying something like "oh for god's sake, what do you think you're doing" (laughs) but you can't say that and you don't want to but those feelings are there so you have to work with that but **I do think** as [P4's name] was saying I **that for a lot of people it is a**

source of great shame and guilt and very hard for them to talk about even if it isn't top of their agenda

P4: **but I think for a lot of, for an equal amount of people it's not a source of shame and guilt (laughs)**

P1: yeah that's true

P2: **but those people** though I think **they don't come to see us, I think that group of people who are having unsafe sex and apparently to them it's not problematic** although I'm sure it is at some level

P?: yeah

P2: I don't think, **often they don't come to consulting rooms and speak to people like us about those issues. I think the people that do come are people that do have a degree of concern about it.**

P4: **but it might be somebody who presents with something different, say somebody who you know is depressed**

P?: umm (agreement)

P4: **or has anxiety and in the course of meeting them for that it becomes apparent** because that's the

P2: yeah absolutely

P2: um, just to come back to your point about personal view and a professional view, I don't have incompatibility between say my personal view, my personal view is that people should take responsibility for their health status and they should inform people, prospective partners about their HIV in an ideal world, if it's casual sex, if they use condoms I think that's kind of good enough for me at the moment because I think it's complicated, in an ongoing relationship I think definitely that the person that you are having sex with should have the right to know that they are HIV and certainly not to be deceitful or to lie about that I mean I completely disagree with that but I suppose the compatibility between my personal view and my professional view is that even if there was someone saying that they're not apparently concerned that, ok there was one guy in our clinic at the moment who says he's been in a relationship for 4 years, he's telling me he's having unprotected sex with his HIV-negative partner now and again he is concerned about it but I suppose professionally for him, I don't think psychologically it's good for him to pass HIV on to his partner or for anybody to pass HIV on to anybody whether they actually say they are concerned or not, I can't think there would be many people that aren't going to find that problematic at some level to know that they have passed on HIV and the implications, particularly if they are living with the problems, they have a lot of insight into what it means to be HIV so even if they're, does that make sense? Even if they are not saying they don't have to be saying it's a problem, I think from a psychologist's point of view, it is psychologically problematic to pass HIV on to someone else because there are consequences of that

P?: umm (agreement)

P2: we have to live as a human being with those consequences that you've not been caring for someone's else's welfare

P4: do you think even if that person consents?

P2: I think, no absolutely, **it's still problematic and what I do point out to a lot of people is** because they say "well a lot of people are warned about HIV and if they don't want to use condoms then that is their responsibility" but I do say to some of the people that I've worked with "**but are**

you taking into account the fact that some of these men might be, **might not be very well informed about HIV, might be young or depressed** and you know not so well informed that they might be depressed, that **they might have low self-esteem or they might have a history of sexual abuse**", lots of things that can, **they might be acting out something that's a bit masochistic and self-harming without them being fully aware of that** so if you talk to people about those kind of problems and why, in other words why people get into having unsafe sex, that's quite helpful for people I've found because they are suddenly feel like " oh yeah, oh yeah, I hadn't thought about that" so it's a bit simplistic

P?: umm (agreement)

P2: **you can't just say everyone takes responsibility for their own health because not everyone's in a position to do that are they?**

P1: no that's true I suppose what I meant was that sometimes it's hard to be a good psychologist in a situation you know be patient, when you want to say things

P2: it feels uncomfortable doesn't it?

P1: yes it does

P2: because I think you are having to hold in some feelings

P1: you are having to collude in a way, it does feel like that

P2: and maybe feel that sometimes you have to collude or not challenge

P1: exactly, exactly

P2: something you think quite strongly about but you know you're doing that in order to build up a relationship where you even have a chance of potentially [unclear]

P1: I know, I know

P2: and that's just, that's quite hard to manage and contain

P1: it's hard to do it well

P2: and you don't know how long you actually will have with that person [unclear]

P1: no for all you know they are never going to come again

P4: well yes I think if you are going to have a chance to build some you know kind of positive alliance with your clients then, you know, you do that very patiently then if you start off with a very dogmatic, very moralistic um approaches then it's totally counter productive and I agree that there's such a skill in striking a balance between

P?: ummm (agreement)

P4: um you know what you think is ethical and moral to what information you needed to pass on and what is it to with be working with and what are the chances of, what are the likelihood of that patient actually going to be hearing because if there is a sufficient risk for them to become HIV you know then there is something about a difficulty, a real struggle it's an issue, it's not something that it's easy you know, if it was easy they wouldn't have contracted it

P2: has anyone here actually ever been asked by a patient whether if they would tell people? If you've been asked to be put in their shoes and they said would you tell, would you disclose?

P?: um no

P2: because I can say that that's never happened to me

P4 they sometimes ask for advice don't they

P2: do they ever say do you think I should tell them?

P4: yes that kind of thing more or less

P2: because again I don't know if that has happened very often, where people has actually said

P4: what do you think I should do

P2: yeah, well help me, actually sought an opinion out, not explicitly anyway, I mean probably implicitly but not explicitly

P1: what I find quite amazing is that people will tell you things at all I mean here I am a middle aged heterosexual woman and I am completely amazed at the way within a few minutes of meeting them, these gay men will tell me all about their sex lives without the slightest thought apparently that I might not be familiar with it, I am as it happens but you know but that I might not be or that I might disapprove, that's the funny thing, [unclear]

P4: [unclear] in the department they expect that we have the knowledge [unclear]

P1: it's still is amazing to me that they will say things and not expect in a way any kind of censure or shock or surprise – do you find that sometimes? Sometimes I think [unclear]

P5: well I've had the opposite as well where a guy that has just looked really embarrassed and I've tried to understand what and he has tried to tell me and I have said is your relationship open? Have you agreed to be just the two of you have sex within the relationship? He looked really embarrassed and what he's struggling with is what it means to be gay maybe and in his mind, straight people have monogamous relationships and don't have open relationships and he's trying to tell me that this is a different way of having a relationship and it's kind of a gay thing and a gay lifestyle thing which for me is you know nothing new at all, at all but in his mind he's perceiving me as somebody who, just, I suppose, how's he perceiving me? As somebody who's going to be shocked by the possibility of an open gay relationship which is really interesting

P4: I do rarely get that

P2: but it's funny that even [other gay male psychologist within the team not present at focus group], even [he] does have experiences where men will have difficulty about telling him about a particular sexual behaviour and it might be something really for him quite mild like having casual sex in the park or something and you can almost feel with him that he's like "is that it?" obviously he never says that

P?s: (laughs)

P2: you know and even people who look quite similar whereas you are quite other can sometimes have difficulties telling stuff like that

P?: yeah

I: Perhaps this is a good time to move the vignette on a bit

P?s: ok

I: If you want to turn over to page A2. So the client's been attending a few of the appointments and he's coming regularly and despite a lot of discussion and support he's still vague on whether he is going to inform any of his regular partners about his HIV status. He thinks he most likely contracted HIV from partner 1, the single gay man. What are the issues here and what do you think you would do?

P2: I think, I suppose clinically if you say he is very reluctant to disclose I would be clinically working around what his fears about disclosure are and trying to be obviously work through those

P?: so what he thinks the responses might be?

P2: yeah and you know if that were to happen and also, I think, obviously you'd have to be talking about these people's needs as well and their right to know um and also I would be exploring I suppose issues around condom use, whether was he using condoms at all times, were there any slips, if there were slips what were the circumstances around the slips, trying to understand who it was related to, I don't know drug use um or pressures from any of these people not to use condoms um and these people might not want to be using condoms themselves or

P4: or accidents might they happen again

P2: yes so to get a sense of that that would be relevant

P1: I mean one has to assume that his concerns about possible negative responses from partners are very well founded can you imagine what it would be like for some of these people you know well in relationships, they are all in relationships, I mean he's right

P2: but...go on

P1: well nothing really he has to dwell on that and how it's going to feel for them and how they've got to know. He's got to think about that

P4: but they are still consenting to have sex with him outside those relationships as well?

P1: they have, they have but I wouldn't be surprised if they were conversations about how often do you test you know all that kind of stuff maybe they don't know about each other either

P2: I mean I suppose the patient himself, you don't know how informed he is about HIV issues and about transmission of HIV so you do, you'd need to assess all of that but there's no reason why he couldn't have got HIV from any of those 4 partners obviously including the married people

P1: exactly

P2: so who knows what the patient himself is presuming um but I suppose it is, I'm just thinking about some of the people that we've had, who have been referred to, who have been married, who have had children, who have found themselves to be HIV positive, who have been absolutely devastated and, not to generalise but maybe there is contradictions, maybe there are some generalisation about men who are having sex with men and are married and their wives don't know and psychologically how they manage their identities, their sexual identities, how they manage those lifestyles and how there's um, psychologically there's complicated things going on in their minds that are relevant to what they do sexually and being cut off from things and responsibilities and information and, not having I think with, a lot of the gay men we work with are very um up to date with all things to do with HIV, they are very well informed, they are very responsible um and like I wonder like say some of the people who are not in groups where they can be so open about all the HIV related issues and learn and to discuss things and explore things and get advice, it's some of those people are in much more difficult situations and that what we have seen clinically is some devastating family situations with suicides

P5: I was going to say I can't think of many times when it's gone well

P2: no (laughs)

P5: I would have that in my mind, I cannot think of many times when someone in a situation similar this who's contracted HIV who's then gone and told everybody [unclear]

P2: oh where they have disclosed their status?

P5: oh yeah

P2: well that's when the married men have HIV haven't they?

P?: yeah

P5: you are talking about the end of a family

P2: and there have been people that have killed themselves, there have been wives that have killed themselves, husbands that have killed themselves

P5?: it's not good, I mean clearly nor is it for everybody to contract HIV but I think perhaps in my mind **I've always got in my mind this might be a no win situation** in mind

P2: I suppose that's why preventative work is so important isn't it, if you can, if you can have a role in that, I mean if they are HIV that's one thing, if they are not and then that's why I think because some of them like this one guy I was seeing, he's kind of, he has presumed without even realising that he's presumed that his partner is positive already so even in the case of having not using condoms and he's kind of thinking that his partners already positive and I've said "you know your partner might not be positive" and in a way that's quite surprising that it's only just dawning on him that yeah actually, that might be the situation in which case there is a reason to carry on using condoms because if you presume your partner's positive you might think there's no point but I think say clinically, I don't know if you've come across these cases where there have been, devastating impact of HIV being diagnosed... **you do, I do feel a professional responsibility really of being a bit more proactive, don't you?**

P?: umm (agreement)

P2: I mean a lot of gay men that have been diagnosed I haven't come across anyone that's killed themselves, you see a lot of gay men that have been diagnosed and just move on with their lives

P5: not unless they've got some pre-existing mental health problems

P2: yeah

P5: they might be unstable or have a suicidal tendency, so it might be a tipper

P4: I suppose you know that's because they are familiar with it, it's part of their lives but just as you say the result on a heterosexual family is never good, at the same, the reason for it is because, well part of the reason is because it's not part of their lives in many ways, it's not part of the way they live, mostly, I don't like to, it's just horrific for them to contemplate apart from the personal you know being deceived

P3: but it's also, this is, slightly different, the sole presentation is [unclear] I'm HIV positive and my 4 partners it's not different but it's the um, the issues being raised here are different to what typically happens in reality, you know

P?: yeah but not impossible

P3: after a patient, in terms of adjustment, it's very very rare that the transmission, further transmission of HIV is ever the focus so we are already dealing with 2 different perspectives, from the psychologists' perspective and from this after what it says here "after regular attendance, discussions and support he's still very reluctant to inform, this assumes that actually the focus has actually been on transmission when in fact it's very rarely like that if you because if it was, it's a little bit of a tradition here because in reality if the focus had been on transmission and safer sex, then you would have lost the client. He came for adjustment difficulties

P2: not necessarily

P3: well mostly with the adjustment difficulties that they have in presentation that you have [unclear] people coming to terms with it, there's a lot of anger, there's a lot of frustration there's um you know, it talks about limitations, a lot of anger especially if he think he's actually used condoms and lo and behold he gets this, there are issues to do with him personally, very rarely about his concern about transmission

P4: but isn't that an issue in itself and the fact that that gets lost and

P3: it gets lost but

P4: but now in some ways

P3: sure, but

P4: it's more our responsibility to make sure it's on the agenda

P3: but it's a fine balance

P4: yeah exactly

P3: between me bringing my judgement "but do you realise that if you pass it on to that duh, duh duh duh", it's potentially quite a difficult, a very technical

P4: it's easy to get lost

P3: it's very easy to get lost um and the if if if he's still reluctant, then he's still reluctant to inform others and you did say the focus has been on that issue, very very yes number one, number two. I would probably not insist, not insist but to try to explore even more psychodynamic ways, what is, what are his feelings, what is, because it's essentially quite an aggressive gesture to not do it, to do actually withhold information that would be placing people at risk, it's actually quite aggressive, not that he's doing consciously but it might be something that inside he is you know, I've got it then why can't everyone, you know he normalises it so it's a very easy to normalise you know after you contract HIV, there is a life after HIV [unclear] still having sex with lots of people you know nobody is harmed but actually I would probably try to explore that side of it, you know what does it actually entail, what is it, what is it about, you caught it from a sort of ad hoc chance like thinking this well there's a chance that you might, someone else might be on the receiving end, what if this person, is not going to be as subdued as you and as accepting and what ever is going to actually make enquiries into it so I would probably try to see, you know, try to help and encourage, take someone else's perspective in my time, any difficulties they may have to adjust you know and maybe be more curious to find out who they the person who transmitted it was so I would encourage that kind of more explorative in terms of making other people's perspectives as well

P1: it is interesting actually because very very few gay men in my experience anyway are interested in where they got it from they might say oh yeah I think I got it from da, da, da and you know the rarest person, you know, is entirely focussed on who they got it from and stories about being raped and all those kind of, it might have been often fantasy stuff but the other issue is, the practical one, is that health advisors take the role of talking to people about the range of partners that might be at risk and that kind of thing so it's less of a responsibility and they spend a lot of time

P5: I think it's very interesting that he still thinks the source of infection might be partner 1 if he now knows that there are 3 other people who are positive

P3?: definitely

P2: but isn't that I mean, isn't [researcher's name] possibly setting something else for us to think along the lines of prejudiced thinking or stereotypical thinking, isn't that part of... I mean it's not a question – isn't that, what you can do with vignettes is set them up in such a way so everyone goes "oh yes he did it, he did it" and then you go "da daaa!".

P1: this would be extremely unusual let's face it, HIV isn't all that easy to translate

P3: I was going to say that's one virulent strain they've got

P1: yeah absolutely

P2: well he could have got HIV from number 1 and

P4: infected all the others?

P2: or well the others could all have been infected from independent sources

P1: affected anyway

P?: they could all be with number 1 as well

P?s: (laughs)

P?: yes

P?: you don't know it – it's so dark in those back roads

P2: I suppose just information that number 1 has initiated unsafe sex with this client you'd, it would be a bit surprising if he only initiated unsafe sex with that one man that he didn't have much a relationship with and you might think that that is something that first person is doing so he is definitely placing himself at a lot of a risk if he is doing that on a regular basis

P5: I'm definitely going to want to explore where this anger's coming from and why towards him [unclear]

P2: yeah what's going on there?

P?: yeah

P5: there's something going on, don't know what

P2: but if he said that 2, 3 and 4 were all tested 3 months ago and they were all negative and they've only had only sex with me and their wives have all been tested and duh duh duh that's not what he's saying

P5: that's not what's he's saying?

P2: no no no but you would explore yeah all of that

P1: but again, I wouldn't be able to assume, that necessarily the next patient had then infected them

P2: no, no absolutely

with people who are newly diagnosed so one would assume that they only refer them if there's some issue so that may make a difference to us I don't know

P?s: ummm (agreement)

P1: you know, I think if we're the ones, I don't even know what the policy is in the clinics in situations like this, you know contact tracing and all that, I don't know what the policy is now, does anybody else?

P2: I think they try and do it through people's consent don't they?

P1: yes

P2: educate people to take responsibility for themselves but I think in I mean **at this stage were you presented it, it would be getting very serious and would be talked about in a multidisciplinary mental health or HIV teams so it wouldn't be an individual decision clinically to make**

P1: **you'd not really be sitting on this, keeping it to yourself, would you?**

P2: no way, **no way not with the amount of involve you wouldn't**, especially with this level of resistance to wanting to tell people, no, you wouldn't

P1: but is it because there are heterosexual families involved or is it because, I get lots of HIV positive men um who don't bat an eyelid to say

P2: I think that definitely weights it yes

P1: you know "oh I never tell anybody" and I have sort of thought "ooohh" [unclear] I usually try to tell them that I have as many people come and say "I usually tell everybody" so

P?: umm (agreement)

P1: what's going on, so you don't really react to that very much, I don't, I must admit, you know obviously I might talk about it but

I: so maybe we can stir things up a little bit more again now!

P?: thought you might! (laughs)

I: If you turn over to page A3. With support the client decides he's going to tell partners 2, 3 and 4 and you provide some guidance and assistance through this difficult task. Initially he gets a bad reaction but they all make contact with the health advisor. Partners 2 and 3 which are the married ones test positive as well as partner 4 the gay man in the relationship also tests but your client is still very reluctant to inform partner 1. He says that their encounters are mostly uncommunicative and he has difficulty bringing the topic up in your sessions, reflecting on his past experiences he believes that partner 1 was the most likely source of his infection. He describes him initiating sex sometimes without a condom, particularly when they first met and he describes him as having many casual sexual partners and using sex clubs and saunas. He says he is reluctant to tell partner one because he is frightened that he might lose his temper and he is feeling very resentful towards him but still after some thought in the sessions he decides not to tell him.

P2: Who might be violent, the client or his partner?

I: he's worried he might lose his temper to partner 1 but again feel free to consider both possibilities

P2: ok so he might be

P?: no

P4: but I think regardless of who's infected who, I think he's now crossed a bit of a line hasn't he?

P?s: yes

P4: cos he's now having unprotected sex with somebody where he doesn't know their status

P?: um

P2: and he's presuming he's positive

P4: yeah

P2: and he's angry with him

P5: are they still having sex without a condom?

P2: yeah

P4: occasional unprotected sex

P1: I mean he is definitely if he is worried about that, he's definitely acting potentially illegally

P?s: yes

P1: but I haven't met anybody who's concerned about that I have to say

P2: concerned about?

P1: about the legal aspects of having, and being positive

P4: no I haven't

P2: no I haven't met anyone who is concerned about the fact that they might get charged, no, but I do think there's anxiety generally around about catching it

P4: I saw one person recently who was anxious about it and therefore wasn't having sex because he was so scared

P?: oh really

P?: oh

P4: yeah – that's the first time

P1: I think it is because of what I said earlier or part of the reason that most gay men accept that it's or seem to accept that it's a risk if you have sex, you might get gonorrhoea or HIV and you hope you won't but that seems to be

P?s: yes

P1: and they are not that bothered about where they got it from

P3: it's normalising it

P1: so they wouldn't, well no but they don't, have you come across people that

P3: no no but it's part of the normalisation of uh transmission, there are risks involved and that um people know about them, the risks and their responsibilities lies with those

P1: yeah

P3: and there is a common response or um I don't know response or a way of getting round is by saying to someone, you know, you know there are risks so are you sure you don't want to use a condom and the other person says yes I know there are risks so it's ok and then what they, the HIV positive person says that they should acknowledge that I am informing them

P?: yeah

P3: so by reminding them of the risks is you know is enough and removes responsibility from so that's quite a, I hear that quite a lot and it's a firm belief you know when I test for the conviction in this and we have done actual tests just a question of a reminder they say yes absolutely, they don't see the responsibility

P2: I don't think I want to get into side tracked that now we have got 3 of the 4 informed we have to go onto the fourth, I think what I would be focusing on now is the issues of his anger and why he's frightened to let this out and what does it all mean but also now I've got the information that he's continuing to put himself at risk even though he knows he is positive I'm going to have to talk about you know possible

P3: resistance

P2: resistance factors not only with potential partner 1 but with the other bloke as well, I can't remember partner 2 but there's going to continue to be a relationship there. I think my focus would be on, not necessarily shift but be on the patient's safety and their health and how people think about those things.

P3: and we're we assuming that there are people looking after the people who have just been diagnosed?

P1: you know [unclear] they're visiting the health advisor and visiting the clinic

P2: do we need to think about their needs or not?

P4: no

I: please feel free to think about whatever issues you'd like to

P4: I would be a bit worried about partner 1 here though

P?: yeah

P4: what's going to happen to him, I think he would be in my mind but I wouldn't be quite sure how to negotiate that actually knowing he was at risk and he might need an HIV test

P?: yeah

P2: but that's, I would say that's a really really common scenario, that we work with gay men who have been diagnosed as positive and they are having sex with a number of casual partners or regular but still a bit casual but yeah I think that's our number 1 most common scenario, isn't it, it's the most common.

P4: but I think it's trickier in this scenario isn't it because we have some extra information about Partner 1 as well, we know that he's never been tested but we know that he is part of this clinic so that sort of brings it a bit closer to home in a way

P5: the other thing that's a good test for confidentiality is that we might be able to find out about partners 2, 3, and 4 by the health advisors but you wouldn't be able to have contact in any other way would you?

P4: you wouldn't want to would you

P5: I mean from the point of view of being concerned whether they are linked in to the clinic

P2: and their partners, have their partner's been told cos that's another disclosure issue there isn't there

P5: yes

P2: have all of those 3 partners been told?

I: ok, if we could move onto the final part of the vignette now. The client still hasn't informed partner 1 and he's now reporting some occasional unprotected sex with him and during one of his sessions he names partner 1 who is also a known client at the clinic. His records show that he's been treated for various infections from the last year but always refuses an HIV test. He doesn't have a history of attending regular check ups unless he has an infection requiring treatment. What do you think are the issues here and what would you do?

P5: I can see that happening

P?: um

P2: I suppose with people like that there's only so much you can do isn't there?

P4: I suppose I'm just thinking about confidentiality though and I think that we always say I won't break confidentiality unless I think you're going to harm yourself or somebody else and he's doing that really, isn't he?

P1: I was just thinking there is no way I would ever look up somebody that a patient had named

P2: if you can imagine that we've discussed them in ward round care, or even that they've been referred by the health advisors or a colleague

P1: But this is a GUM patient, he's not an HIV patient, and they're supposed to be protected by

P2: yeah but he could easily have been referred by the health advisors

P1: he could have for having unsafe sex but it doesn't sound like he would have wanted to come

P2: might just say yes to the health advisors but not actually come

P1: yes, well that's possible, but we could have found out by chance

P3: by chance yes that does happen

P1: he was in our referral file and you happened to see it, you happened to see a connection with client A

P3: doesn't it seem that in the most unlikely situation and I think it very unlikely for me to know of this other patient, that would be a huge dilemma, your question is nothing about that, it's about the outcome but would be

P1: in a way it's nothing to do with that but he looks like quite typical of quite a large group of gay men, that's nothing to do with it, the fact is his partner I mean you know if you are looking at the transmission

P2: I'd definitely be talking about it in the psychology meeting

P1: sorry [P3's name] I interrupted you

P3: no that's ok, no that would be because I'm thinking about it like, I've never had this kind of situation where I know the partner who doesn't know that there's HIV or something and I know this other bloke, it would be a huge dilemma and I would probably have to explore it with my patient, I would probably have to probably communicate the dilemma I'm finding myself in and try to get around it with, with him

P2: what do you mean?

P2: what's the dilemma? What that clinically we are working with two people?

P3: no, to know that he's actually infecting someone (tape fades)

END OF SIDE 1 – TAPE CHANGE

P2: but you can't, it's a matter of professional confidentiality

P3: it's a yes I know in that sense it's a, yes it's not about telling names or anything like that

P2: it is! Even if you don't name him, you would be compromising his confidentiality

P3: well no because it would be the way I would probably do it is that this patient is actually known in the department, you would have to

P2?: how?!

P2: Can I, I don't understand what you are talking about, who are you thinking is infecting who because

P3: no neither do i

P2: if you've got, say this person 1 who's having, who's initiating unsafe sex with our patient who's HIV

P3: yes

P2: but also he's known at the clinic because of it, is this the right way round to do it, he's a regular presenter at the GU clinic and gets GU infections?

P?: umm (agreement)

P2: right, obviously him as a gay men who has regular infections and goes to GU doesn't particularly do anything about it, doesn't want to have an HIV test, keeps going for treatments for when he gets an acute infection, that is a particular group of patients

P?: uh huh

P2: who you know just having, obviously having unsafe sex and putting themselves at risk, don't want to face it, well lots of things, but I'll say don't want to face HIV issues, don't want to know they're positive, he's one of a group of people and what we do with those and the way they try and manage them at GU is to try to, they try to intervene but if they are not letting us in they are not letting us in and as human beings they are allowed

P3: sure

P2: to carry on living their lives in the way they choose to

P3: but if I knew the patient I'm seeing

P2: which patient?!

P3: his partner, number 1, partner, if I knew him

P2: if you were working with him?

P3: yes, if I as I said I would find

P1: I would find it unbearable

P3: yes unbearable, there would be a huge dilemma and you know obviously I would have to discuss it

P2: but you, in that case you are working with someone who says I am not protecting myself and we do that work anyway don't we, we work with people who have current infections and they are referred to us because the health advisors or the GU staff are concerned about these regular presenters and we work with them in the same way

P4: **but I think we've crossed another line in some ways because I think now we know that partner 1 is continuing to have unprotected sex,**

P?: yes?

P4: so client A is continuing to have unprotected sex with partner 1 **and we've got his name so are we are going to do anything about that or now is it a legal matter** isn't it?

P1: it is, is it?

P4: which I think is different to

P2: why is it a legal matter now?

P4: because we know that he's continued to have unprotected sex, knowing that he is HIV positive and hasn't disclosed his HIV status

P3: yeah but we knew that before so nothing, he would actually have done nothing has changed

P4: yes so it's the same, yeah but it's still crossed the line of

I: what's changed is that you know about the name or does that make a difference? Is that right?

P4: it's slightly different, I don't know what (laughs)

P?s: yeah

P1: well I suppose it would make a difference wouldn't it if the person was saying instead I want to have sex with partner 1, unprotected sex and I'm not going to tell him, if he said I'm going to, I'm so angry, I'm going to go round there and I'm going to ambush him and stick a knife into him, you might, you might very well have to do something then so it does change things when you know of a threat to a named person

P?: yes

P1: I suppose

P5: I think then what we might, or **the first thing I would do is have a discussion with him, the second thing that might happen is to talk to the trust risk people and**

P?: yeah

P?: the legal people

P5: **hand it out to them and say here's the issue, what do I do? Cos I'm going to now need to protect myself**

P?: umm (agreement)

P4: cos all of the process would have had to have been documented and

P?s: ummm

P4: if you had been telling him to disclose or whatever

P3: if the question, not that it's explicitly formulated in that way or, but if the question underneath this is **does knowing a name make the difference** and does it judge our, does it inform our approach, does it make a difference, you know who that partner number 1 is exactly that partner number 1, **so no longer is a person invisible to us**, a person **removed from us at some distance and now their proximity is getting nearer to us now that we have a name** and uh **but it's exactly the same person**, you know **so how does that effect our judgement** then **is it coloured in some way, do we suddenly become more insecure, do we become more ethically inclined or so on and that is a huge question because in reality it does have a huge bearing**, in reality we know that proximity has a huge bearing **on our perception** whether we like it or not **but we have to be aware of it and work with it before we actually act out** or before we take any actions you know in terms of going by our you know gut feeling or whatever you want to call it or instinctively, acting instinctively because of judgement now we know this person and we can feel responsible towards, we need to actually set aside and think of the implications that actually yes it is a new issue then not appoint ourselves, or self appoint as making you know sort of being the delivery of law and justice because it is a problem, the point I'm making is that yes making, having a name and actually knowing about this person does, and **it's impossible not to because it, he's entering in our psyche, he's becoming more real**, he's becoming more real

P5: I don't think it's that, I think it's that you now have an ability to potentially be able to protect someone cos you now

P4: you can access

P5: now you have the ability to act whereas before you did not

P?: yes

P5: before you knew that there were potentially these people who may be at risk now you know somebody is at risk, you know where they live, you know their name

P4: so your responsibility increases

P2: yes and I think that

P3: your responsibility increases without a doubt but we also have to be careful in that when it is our job you know we are not administering the system you know we are not making judgements

P5: no and it's not very likely to be our job is it?

P3: no

P5: and that's why I think you get to the end of your area of expertise so you say right you lot over there you're paid to make these decisions and what happens next

P2: I suppose the two main things that need to be done, one is before you would break anyone's confidentiality about their HIV status by telling them that the person that you are having sex with over here is HIV positive, that's obviously that but before that I suppose there's one thing which we haven't said explicitly which is that **as psychologists what we are in a position to do and what we do have a responsibility for is to give information about the legal issues and saying if you have sex with this person being HIV as you now know you are and you don't tell them and you don't practice safe sex then there is a risk that um you might be charged with reckless behaviour and inflicting grievous bodily harm on that person**

P5: And in fact all of those 3 people who are now positive who get, who do now have that choice

P2: but they don't know, you don't know where the source is though

P5: no you don't

P1: and that's what the trouble is that there's [lots]

P5: but you do have an ability to do that

P2: but as psychologists that's what we can say to people

P3: but the client already knows that because he is at the receiving end and he's saying well in fact he's

P2: but he might not know about the legal issues

P1: no he might not know that

P?: we have, I said that earlier

P1: he might not know that there have been successful prosecutions

P2: no

P1: that's the main thing I think I would

P2: but I think that's the main thing we can see we definitely can say that to people whether or not that influences their practice is, who knows what will happen after that but at least for us we are in a position as a health professional to give them that information

P?s: yes

P3: but then would you say the same for people with herpes, would you keep that, would you give them that information [unclear]?

P1: well that's very interesting [P3's name]

P3: because that's for me you know, people become infertile and you can see it as a loss of life?

P2: yeah well it might move in that direction that they might be charged

P1: but the crown prosecution service have got a consultation document out, you can find it on their website, proposing exactly that, the reckless transmission of all STIs, they think should be subject to prosecution, I know

P5: the thing is how are we ever going to prove it with herpes because how are you ever going to know when you've shared it or are you saying that no one with herpes is ever allowed to have sex again?

P1: and it's interesting that they, that the prosecutions that have succeeded have all been between about um men, male to female

P?: oh no they haven't

P?: no

P1: female and heterosexual anyway, heterosexual transmissions, I mean I just can't imagine now it will be possible to demonstrate

P2: no there have been male to male ones, I remember seeing on the news not that long ago

I: only the most recent cases were male homosexuals, he was found not guilty, well it was dropped actually because the pathologist at the royal free gave evidence that the scientific evidence wasn't entirely certain

P2: was this the guy I saw, where there was a mugshot and it said this guy was on the run and

P4: wanted

I: I think he's still missing actually, yes

P2: yeah but they are hoping to have the prosecution against

P?: and he's a gay man

P2: he's a gay man

P2: the link between the

P3: but it cannot be proven, even with HIV how can they prove

P5: they can they can [unclear]

P2: well you can prove it in some cases, but what they can do is [unclear]

P1: especially with needlestick injuries you can kind of prove that

P2: you can match the dna

P3: oh can you?

P1: can you?

P2: umm (agreement)

P1: but is the dna sort of exclusive to the virus that belongs to, I mean aren't there loads of people with that dna type virus out there?

P4: cos I thought you could almost attach little maps or cross stickers but I guess that's not going to show causality

P1: actually I'm too ignorant but I would just thought in London particularly, say if you took a sample in Earl's court, there would be too much similarity between amples surely, anyway, it I think it's a mad one myself, I think it's completely insane

P?: what to charge someone?

P1: I do really, I thought that about that patient, you know that woman that had herpes, who saw her?

P2: yes, me

P1: I thought it was complete insanity and it will, and can you see the kind of people, I shouldn't generalise but you can easily see there are going to be people who haven't got much in their lives making big issue out of these people with all kinds of disturbed ideas and disturbed functioning, it's very worrying

P3: what I want to know about it is it's, I don't even see the legal aspects of it, first of all because I am not aware that there are any laws as such, or that they have been enforced, I actually you know trying to tap into the patient's understanding his situation in life, maybe trying to explore his views about self belief and you know how much he, if he respects others in his life and go onto that category is tapping into something that maybe, although having safe sex is very novel and we need to normalise that I think cos that what's happens, you know it's an instinctive thing isn't it?

P1: well we all know that, take unwanted pregnancies

P3: we all know about that, we don't need to, exactly, so it's much more of a, if it's by degree then it's getting to know your patient and see what does it, if it occasionally or what does it say schematically about their life, and patterns, is it a self-destruct, in some cases is it and each case and I don't think we can just make one huge generalisation and say that you are wrong for doing

P2: we are not trying to generalise it

P3: no I am not saying that but if you mention that a legal aspect, we are saying you know you will be prosecuted and you know

P1: but just giving information

P2: and not in that tone of voice

P1: but I think it's information that you need to make sure they have it

P3: yeah and if there is such a law, I was not aware that actually there is a law like that

P1: yes but there's precedents aren't there, people have been successful in, it's a bit the same that if somebody, if, that you might be in a position to have to say to a patient if you tell me things about harming other people, I will not be able to respect confidentiality and you know you need to tell them, that's information

P2: well that's the law and you can harm other people so it's how that's related to mental health, health problems

P4: it's taking it a step forward I think just from a sort of slightly defensive point of view, and the impact on us, would there be a case in the future if we do know somebody who's been transmitting HIV and affecting other people and we don't do anything about it, are we not then partly responsible for

P?: umm (agreement)

P4: that in terms of being

P3: accomplices

P4: yeah

P3: to murder (pause)

P3: or colluding as accomplices to murder

I: have you or anyone had any similar experiences where this has come up?

P4: not in that dramatic way

P?: (laughs)

P1: it happens all the time that patients tell you they are having unsafe sex

P?: yeah

P?: all the time

P1: all the time, HIV positive ones, some of them seem to be quite proud of it almost you know sort of badge of honour to come back from Florida with another STI – I think I've been a bit naughty!

P3: **but you see again the whole idea of harm is so relative** you know um **sometimes people with** herpes, **genital herpes their quality of life is probably more miserable than an HIV person who is being treated and functioning very well because there is no treatment**

P1: yeah

P3: **so in terms of harm, it's so difficult to quantify and qualify**

P1: oh it is!

P3: it's not a dimension I mean and what it before, where HIV was heading, probably you would inflict death upon others and maybe this law would carry a lot more weight but harm as a you know domestic violence is harm and people don't end up in prison

P2: they do

P3: not

P2: they do, of course they do

P1: **I think that's the point the CPS people in a way are saying why make a special issue of HIV**

P3: yeah, yeah

P1: after all you know why make that the most, the only, **it's saying everybody else has a responsibility to not spread these infections**

P4: **so it's part of this sort of prejudice thinking in some ways that that's where that law is coming from**

P1: **yeah or sort of trying not to be prejudiced in another way you could say or even handed**

P3: I would say that there is a lot more HIV you know that should be more the other sexual transmitted

P2: **so it's not HIV specifically, it's about harm but it's come up in terms of HIV because it's the most serious STI**

P?s: yeah

P2: but I do think that society and I don't want to use that general term for people and the way they should be encouraged to treat and respect other people but it is important that **some of the things that are in law, they are** messages, **hopefully good messages for society and I think one of those** good messages **is that you do think about other people**, you think **about their health and you take responsibility for that yourself when you are in relation to for example disclosing your HIV status, I mean that is a good message and if that has to be backed up in law and kind of publicised then that's not a bad thing by itself**

P3: I agree with you

P2: but I would say in a general way but I do think that it's very very complicated with HIV, there are so many issues

P?s: yeah

P2: and even one small one would be if you tell someone you know that you're positive, what might their reaction be, how might that put yourself in danger, that would be just one small example but in general I think it's a good idea that people are informed and tell other people and are encouraged to tell other people

P1: it is so so complicated because when do people keep that to themselves and who's to know, I mean they might not know their casual partners but this casual partner might know them, they might you know, they might tell people, you do wonder

P3: I think, I agree with you about the message, the overall message about caring for other people and taking responsibility for other people welfare, I think it's a crucial message in any, at any level, it should permeate from domestic violence

P2: yeah

P3: to sexual practices and so on, I definitely think that should be, how it's enforced and how, you know, where do we delineate between something that is potentially harmful and what isn't harmful, that is a very complex issue but the message should somehow be, because actually yes, I have to be honest, I have difficulties sometimes dealing with patients sometimes who say, who disown any responsibility by saying, by yes by displacing the responsibility and projecting it onto the others, "I told them you know you do realise the risks that you are taking", you know it's so generic and so you know It's one way of getting round it and they firmly believe that they are actually taking all of the measures that are you know safety measures by saying you know the risks

P1: [unclear] I don't get people saying that

P3: [unclear]

P1: it's interesting mostly they say well you know they were willing to so you know they know the risks, they don't, no conversation occurs as far as I can make out so that's rather unusual to have a conversation (laughs) but I agree with you you know whatever goes on, I mean it must be so horrible to have HIV infection and to feel you know that you can't just live your life because after all you know everyone has sex

P3: let's not forget about the group of people who actually stop having sex when they are HIV positive

P1: yes there are some

P3: they discriminate against themselves

P?: yeah

P3: a lot of adjustment issues that we have here are [unclear]

P1: exactly

P3: compared with the limitations they have on themselves and the anger they stand against themselves and that's another thing, the extreme you know actually not wanting to harm someone actually ends up causing huge harm to oneself

P?s: yeah

P5: I think the other thing that needs to be acknowledged is that it is incredibly hard to disclose your HIV status

P?: oh of course!

P5: because you lose so much control, I mean what happens to that information and there are many more

P2: well it's stigmatised isn't it?

P5: absolutely, I mean things have moved on a lot in terms of years but they haven't moved on that far, I think they haven't moved on that far enough so you can kind of turn round to someone and say "well why didn't you tell everyone" as if it's kind of an easy thing to say

P?: exactly

P5: and that's where one of the big problems with the law is, because you are really asking people to put themselves at risk by disclosing their status

P?s: ummm (agreement)

P?: absolutely, yeah absolutely

P5: that's why it's hard starting that conversation and I think the other thing to acknowledge is that possibly we have all seen is when it doesn't go well when people disclose their HIV and get sacked, or get dumped or

P?s: yeah

P5: beaten up or have to leave their homes or and then there's a big whispering campaign within their community and it can be awful, that can be almost more devastating than the infection itself cos you can get drugs for that

P1: and it's amazing the level of ignorance amongst some gay men that I get referred you know they don't know, they still think that people with HIV infection go round looking like you know they have just come out of Belsen sort of thing so if that's the case amongst gay men sexually active gay men can you imagine what it would be like in wider society, it's very, we do forget because we are in this world and it's very familiar to us but um we've strayed a long way from the ethical [unclear]

I: how do you feel about the trend of encouraging people to disclose their status? Do you feel comfortable with that in your practice?

P?: I think

P2: have you noticed a trend in it?

P3: no

P2: cos I have to say I haven't

P5: that's right, we've, I suppose always encouraged it anyway if we have understood certain situations but I suppose you know when you are talking about the legal issues and the recent court cases over the past I don't know 6, 7 years, how they've influenced our practice, or what that means for the

I: I mean in relation to the overall government strategy, that is supportive of encouraging disclosure

P5: what's that then?

P2: yeah I was going to say I don't think it's necessarily trickling down to us

P?: yeah

P5?: what policies is that, can you tell us, we might know what you are talking about, but we might not

P1: I can't say I've noticed any difference

P?: no

P1: more recently, not particularly

P2: but I think what I, what we were talking about before, the reasons people don't disclose, I struggle with that because I think it's outside of my control working within the clinical room because if you've got a woman who's telling me you know how worried she is about, her GP knows that she has HIV but the reception staff don't know and she is in a generally white community in one of the home counties, I really understand her difficulties around not wanting people to find out in her community and her being a real target

P?: absolutely

P2: of prejudice, of violence, of hostility, which I think gay men in London get as well if it gets found out that, you know

P4: I think we need to be able to work with the rest of society

P2: absolutely and you know even I suppose the hostility directed at gay men as a group is a massive massive problem within our society and then on top of that HIV related problems

P1: still as I said before it is interesting that some people will say I have always told all my partners and it has never been a problem

P2: yeah!

P1: whereas others say exactly the opposite naturally you say well what experience have you had of telling people and they will say well I only did it or I did it once or twice and they told me to forget it or whatever so it's strange isn't it, I mean that gives me some hope that

P2: yeah

P1: it is possible to do that and to cope with it

P2: yeah I find it really helpful to work clinically with those people that say, I'm very upfront, I tell everyone that I have sex with, it's quite good for us to work with those people because we can then report that in another way back to other people

P1: exactly and also you can forget about that issue

P2: yeah

P1: with those people but actually maybe you shouldn't because they tell people and then they probably still have unsafe sex with them

P?: umm

P5: I think what's interesting though is that you will probably have 2 people go to that same person and say I'm positive and the same reaction which would happen which is I don't want to sleep with you, one person will think well I don't want to sleep with you either and walk away and that will be them saying well I've never had a problem and the other person will find that absolutely devastating

P?: yeah, exactly

P?: that's exactly what I was going to say

P4: perhaps it' s about self esteem

P?: yeah

P5: I think it's about the attitude when they go into saying to somebody [unclear] and timing and, you know and if you are just about in the middle of things and it's the last thing you say before da da da da they maybe the turn down then would maybe be more catastrophic then when you meet them for coffee and oh by the way I'm positive, is that going to be a problem, no? ok let's go on with it

P?s: yeah

P5: I think it's

P4: maybe in a way it's depends on how you sort of integrated it into your identity

P5: absolutely!

P4: whether you've acknowledge that you are HIV positive yourself you know and that's that

P5: yeah I really agree with that

P3: do you think the question is also about should we be more aware, if this is a sort of legal issue what role do we play in this as psychologists, that's going to be, for me personally that's going to present a problem because I'm a psychologist not as a you know my job I don't see my job to be moralistic, to inform to remind people of safety issues, I do it if it's in the context of my job [unclear] as a kind of a routine procedure, tick another box have you actually reminded him that he will be in prison if he, you know he will be prosecuted if he doesn't, I would have problems with that and I do think therefore

P2: I do think your job is to be moralistic, you are moralistic

P3: but it's not, in my, in my

P2: but in a helpful way

P3: I think to answer your question, have we noticed a change in the trend in our practice, in our practice psychologists sense there is more awareness in terms of the consequences the legal consequences well first of all I haven't, I'm not aware that there is a trend as everybody else says here and secondly I would actually have a problem if there was a trend in terms of making this like, ticking a box business, making it I've got my in I have to say that these issues are very rarely mentioned, when people come with HIV, all our patients who are HIV positive, I don't volunteer to ask, I don't volunteer to ask, do you um in your practice, in your sexual practices do you actually inform your patients, if it's particularly relevant from the problem that it just doesn't fit

P?: no

P1: no they often tell you though don't they?

P3: yes and no

P1: and you think to yourself oh phew, he always has safe sex I don't need to ask him anything else it's a bit like that

P3: no well

P2: I think you would, you have **to have it on your radar as part of your agenda**

P1: yeah

P3: it is a, definitely but I don't want to make it like, it might be when you say moralistic yes but it, you can't, you know they don't have to be moralistic because there are heterosexual people as well who practice safe sex

P2: yes of course, no you don't do it in that way; you don't do it in that way but you

P3: no I know, I'm not putting it so crudely in context of a therapy session but the point I'm making is that it's not, maybe it should be, I'm not saying that it shouldn't be but I'm saying that it is a subject that only raises it's head when it is in the context of either safe sex, transmission, you know, the patient has struggled in having, in continuing sexual activities since HIV positive um you know just and then it's more a self generated issue rather than the psychologist coming and saying you know I'm going to explore this issue and [unclear]

P1: **but I'd be surprised** [P3's name] **if you didn't, I was just trying to think about any patients where this hasn't been relevant, I think if you picked up the last 20 gay men that you saw, I bet you it would come up because it comes up in the context of you know have you got a partner, what do you do for sex?**

P?s: yeah

P2: **is your partner HIV positive or negative?**

P1: yeah I would be surprised if it hadn't come up

P3: it does come up, it comes up but in a sort of not the focus

P1: no not the focus unless it is and you would probably do it without even being aware, you know most of your gay patients

P3: yeah of course it's part of a yes but if you kind of think to a face value it's not an issue that you

P1: yeah, yeah, yeah

P3: go on talking about and have you thought

P1: no

P3: about the implications and if you don't you know, there's kind of a face value to discuss you know

P1: well I don't know though, you see, **but that's the thing I feel I've got to, I can't help it, it makes me cross to be honest if people just go "oh well, you know, you know".** I feel a bit bad about feeling cross

P3: but what can you do more than that I don't think [unclear] face value

P1: well you can speak to them about it, how would you feel if you know, some of them will say, well you know it's just part of life's risks or whatever but some people will stop and think about it, I like [P2's name] saying you've got to be moralistic because I can't help it, **I'm sure we all feel the same and I feel a bit bad for feeling cross and thinking it (laughs) and hope that it isn't going to colour the way that I speak to the patient but see quickly I'm thinking, what are you doing spreading HIV all round the place**, however difficult it is to tell people which [unclear] obviously acknowledge, I mean it's not easy is it, it's not easy at all

I: how do you deal with things like that, how does it affect your empathy with the client when personal feelings like that come up?

P1: well I try to recognise when I'm feeling a bit cross or whatever and try to you know think of the person as needing help to see that there is something there that is probably going to make them unhappy, I mean it's a very vague answer, I mean I try as with any feelings I have when the patient shouts at me, my natural response is if you are going to talk to me like that you can just go now (laughs) but I try not to think that and um I think we all struggle with some of those feelings

P?s: yes

P2: um absolutely, I think it comes up in a lot of different ways I mean HIV is kind of one obvious ways it comes up, I mean at the moment I'm working with a woman who has HIV and that's part of why she is depressed and suicidal, she's, well she's known for 3 or 4 years but she is really struggling to come to terms with her diagnosis and kind of so much shame linked up to it and she's suicidal at the moment, she says to me, she's got 3 children, she says to me I you know I want to kill myself at the moment, she's written us a list of why she should and why she shouldn't and she said in terms of the list about her children, she thinks that they would be better of without her because they won't have to worry about her, they won't have to deal with HIV related problems and I would say that's a kind of similar thing, I have very powerful feelings about you know obviously about her killing herself and also about her belief that it wouldn't bother her children, she says it wouldn't bother my children they will be better of without me and it that's so delusional and so I

work with that but in the same way that say people who go around who might not have, who don't express any concerns about the fact that they are having unprotected sex with other people, that's also delusional and I would work with that even though it does stir up powerful feelings

P?s: ummm (agreement)

P2: cos I think actually she does, at one level she does know that her children would be devastated and I think um HIV positive people they do know at one level, even though they might not be articulating that, it's problematic for them to give HIV to other people, of course it is, how can it not be, unless you know most people are not psychopaths so we are just working with that, [unclear] some people are

P?s: ummm (agreement)

P3: I don't think we need to be psychopaths, to actually be negligent, you know not care about, and be hedonistic you know a lot of not telling you know, and we don't actually know why people don't tell but one of the reasons is from a pure hedonistic

P?: yeah, yeah

P3: um angle that you know um in the heat of the moment, I was so interested in my pleasure that I forgot you know, I was more interested in my pleasure my satisfaction that I forgot to be more interested in much more than the safety of this person

P2: yes which you can work with, that's the reason that I'm mentioning, I mentioned the term psychopathic as in to refer to a very small minority of human beings who you can't really work with and influence

P?: you don't have much [unclear]

P2: yeah absolutely yeah

P1: I thought the negative responses in the vignette meant, automatically it came into my head, oh they're not going to want to have sex with him anymore because that is a very very common common thought and uh you know when you're HIV positive you might, if you're client A you might have trouble finding partners

I: and do these issues affect the therapeutic encounter?

P2: I think in some ways it leaves you carrying things certainly because I am working with a man who works in HIV prevention, he's very articulate, middle class, very well informed and he's the one who's having, he's not using condoms with his boyfriend, his boyfriend knows he is positive, his boyfriend's negative and he comes to me we talk about it and I don't see any sort of behavioural change, he is concerned about it, he doesn't want to pass HIV onto his boyfriend and I just carry it in a way that is quite painful, in a way, it's, you [unclear] feel frustrated and

P4: [unclear]

P2: yeah I do! And I feel involved with it, I'm trying to work with him in dealing with it but I suppose one of the ways I cope is that I think there are lots of things that we, you know in human nature that are conflicts internally for individuals that partly this man doesn't want to pass HIV on and yet he finds himself not using condoms, people want to loose weight, they find themselves eating, there are lots of I think problems in human kind

P?: sure

P2: that I think professionally we haven't got the answers to, people learn about HIV and they are still not using condoms because it's one of those – there is a real conflict

P5: I was going to say the solution is quite simple, you just don't eat or you tell someone

P2: yeah

P5: but then it's the incentive to act and if that doesn't happen it's in a sense why

P2: yeah and I suppose when I hear that HIV prevention work over the years is not having good results I mean what

P?: it's depressing isn't it?

P2: I mean what, it's really

P?: umm

P3: I think it's a, you know in terms of the moralistic um, well what is moralistic you know? I mean informing people needn't be defined as moralistic but sometimes it's experienced as that and I remember one time I was a little bit more straightforward and direct about um the patient said I don't care and I told them you know that they should be using a condom and about you know this but basically not taking any responsibility and I was a little bit more direct in terms of uh just making them aware of the risks and [unclear] what else um I can't remember it was some time ago but anyway I was just making them aware of things but he didn't come the next time, he just didn't, he felt so persecuted by my interest in his sexual practices and success and I think he feared that [unclear] might be the focus of my attention for the remaining sessions so he didn't come back and at one time I was more [unclear], so I'm just thinking that's why it's such a fine line

P?s: yes

P2: the way you express it yes

P3: the way we describe it, but it's not didactic and it's not moralistic, it's not experience as a persecution or is an opportunity for a representative for authority

P?s: ummm (agreement)

P4: I think if you express it in terms of concern though

P3: yes

P2: that's what I do

P3: yes yes of course,

P4: if you approach it in a, people will be more receptive to that but it's a bit of a tricky balance

P2: I would say let's try and understand, that's what I do a lot, I say, you know I feel very concerned about this situation that you're telling me, I feel concern for you, I feel concern for your partner

P?s: yes

P5: I think sometimes the way I put it, not necessarily for HIV but other issues when people tell me about things that come under that cluster of whether I should say something or not, is a sort of almost state that you would not be doing your professional duty, say with HIV I would not be doing my professional duty if I did not say to you right now that I'm concerned about this, this and this because of these reasons

P2: yes

P5: **and I need to say that to you and then backing away, almost like you are stepping out of role, one role and into another one**

P3: you see I don't know, it's a different subject I know, I'm not going to digress too much, but in terms of you know people who will overtly talk about not paying taxes and also you know trying to get welfares and everything, it's really in a way illegal what they are doing and you are talking about an illegal act, do we then have a responsibility, what do we do to actually take some action you know this is where I don't know, it's such a difficult one because many times you know I can't say that I have, I have very difficult feelings around people who are open with me, not talking about HIV positive, I'm just talking about general you know who's using mental health as a way of avoiding paying taxes, being on the welfare, getting housing benefit and it's part of my, 90% of my working day? Is about writing letters to what do we, what is the role we play and how do people experience us and it's almost the same dilemma, this is illegal, it's illegal

P1: it is

P3: it's an illegal act

P5: **I don't think it's the same,** I think **it's very different, I see that there are specific things that are stated within the code of conduct which say that if you either harm yourself or others or plan to do some harm** and I take that to mean physical or emotional pain, **then we have a duty to consider to act or not**, other things about illegal acts, I might then for example in a situation where I am being asked to write a letter, I might say I'm not able to provide that letter because I don't feel that you meet these criteria but then I don't think I would, it would even, I would even consider then talking to them about illegalities or issues or shopping them to the council or whatever I see them as very very different issues

P3: yes but that is if you know that, I'm talking about if you know the person is uh you know feigning an illness and clearly is not diagnosed then that's

P5: yes but there's no risk onto self or others within my duty of care under my professional ethics and if they are asking me to provide a report I'm not going to lie

P3: but it's stealing, they are stealing from us, from the people, the tax payers

P?: it's not the same

P5: I think it's completely different and I have no way to act on that

P3: no I take your point they are different, I'm just uhh the point I was trying to make is that actually we are placed in a very difficult role, this is where, where having to give where there is a risk to others or legal matters or fraud you know where does, you know what is within our remit, you know who do we protect

P?: the patient

P3: do we protect the community, do we protect the patient, who is doing harm to whom and are we in a position to judge who is doing harm to whom

P1: ah well that's the difficult bit isn't it cos with an HIV patient you know they're moonlighting you think oh well, I think it's difficult for them to get employment you know they can't get by day to day, the whole thing, a patient phoned last week cos he was angry because in a letter, he got a copy of a letter from uh [P2's name] in which it said something about him working 2 days a week and he was absolutely furious because he didn't want that to be sent to his GP uh

I: ok, thank you very much, so we are just coming up to the end of our time, we have a few minutes left, so perhaps if I can ask to conclude things, if you had one thing each to say um what would it be?

P3: to say to the government?

P?s: (laughs)

I: no in general, no just the discussion

P3: sorry

P5: I think until there is a situation in society where there is such a stigma around being HIV positive, I think it's going to remain incredibly difficult for people to disclose their status [unclear] and that's going to make criminalisation of HIV transmission incredibly difficult to prosecute, that's going to make it [unclear]

P4: actually I'm just concerned about the impact of this on therapy and trying to strike that balance between holding people to open up about their difficulties but not becoming a policing person as well and how you actually negotiate that

P3: I agree with you in this, could my viewpoint be

P?s: (laughs)

P3: glued on to yours, they're my concerns too

P1: I can't think of anything else sorry

I: that's ok, thank you anyway

P2: I guess probably, I don't know, I know this, **I'm not sitting on the fence but I do agree that legally people should be held responsible for if you want to use the legal term reckless behaviour where they do harm people even if there are psychological explanations for why they do that**, I do agree with that **but I also agree with the other side that because HIV's stigmatised and the groups affected by HIV are hugely marginalised that it's hugely complicated** and you'd have to take, pay full attention to both in order to properly understand the issue and in a way there aren't any kind of quick answers to this um but both sides are important really, that people need to take responsibility and um the issues that they are dealing with and the difficulties that they are coping with need to be understood as well and taken into consideration in terms of understanding their behaviour

P5: yes, it would be nice to have clear guidelines

I: that's a good place to end, thank you everyone

P?s: (laughs)

END

Appendix 2.6
Transcript for Pilot Focus Group
(Held on 19/9/2006)

Key:

I	Interviewer (*italic*)
P1-5	Participant 1 – 4
[unclear]	Unable to determine what was said
P?	Unable to identify participant
P?s	Multiple people speaking – unable to identify
same?	Same participant speaking as previously, unable to identify
P1?	Might be participant "P1"
( )	Pauses, laughs, sighs, intonation
Exactly	Emphasised word
Bold	**Quotations appearing in Focus Group Results section**

4 Participants
Total 65 minutes

I: *Client B is a thirty five year old married man who occasionally has anonymous sexual encounters with other gay men, he presents to the G.U.M clinic for treatment of a sexually transmitted infection, he is new to the area and doesn't have a previous clinic record. During treatment he is routinely tested for HIV and is diagnosed positive. During a discussion with the health advisor when he was given his diagnosis, he reveals that he is married but is very reluctant to inform his wife. He is concerned about the reaction of his wife and his extended family and the negative reaction within the culture and the community including possibly violence from his wife's family. He also has a mistress as well as some other casual partners usually anonymous gay men but sometimes also female. He self identifies as straight and says that as he is always the active partner with his male sexual partners so he thought he was not as risk for HIV. infection. He is referred by the health advisor to see you, the Clinical Psychologist on the team. Client B is concerned that introducing condoms into these relationships may raise suspicions of his partners and he is unwilling to consider the possible implications for his partners. Although he is really not keen on telling his wife or mistress, he reluctantly agrees to although he is vague about the details and unwilling to discuss the matter in much depth. What do you think are the issues here and what would you do?*

P1: when you say what would we do, Do you mean what information would we want or how would we manage the information we've got so far?

I: *both but feel free either possibilities (long pause)*

P2: I think I would probably want to explore a bit more. Obviously the main concern would be the wife and you know reluctantly he has agreed to inform her, so I would want to explore that a bit more and find out a bit more about her reaction to that and so I would anticipate it might be negative and she might be distressed and perhaps following on from that [unclear] perhaps look at the possibility of inviting her to come along as well which I think would be quite interesting not least to explore how she feels about what has happened but I doubt whether they would agree to that somehow, I don't know, I think I would be quite interested to see how that conversation might go down

I: *how do other people think about that suggestion?*

P3: usually by the time someone comes to me in the individual sessions, this would have come up in the discussion with the other staff and I wouldn't be the first person to respond to this and if I feel like I share the responsibility with the rest of the team, how do they handle it [unclear], it's raising lots of issues of confidentiality and [unclear] the problems faced when you are dealing with this all the time and what's their usual practice, what influences them to make a decision

P4: I would be wanting to think about what were the reasons for the referral, is this man in distress? Whose idea is it to refer him? Is this a concerned staff that is wanting my help in order to address these issues or is he in shock, never thought it could be, that he would be at risk so that would be my first, I would be thinking about that first and if the referral is about these concerns, how has that been fed back to him, does he know he is coming to see me to discuss these concerns?

P1: It feels like the problem is how to engage him in something doesn't it?

Ps: umm (agreement)

P2: cos there's almost like a missing link in that he's gone from perceiving himself not to be at risk to suddenly now being conceptualised as someone who is very risky to other people but what's actually happening for him in this, because obviously how he's managing, you know as {P4 name) was saying, managing his own distress, well obviously from however he is, to begin to think through these strategies for talking to other people and the potential. so yes what is the referral? Is it oh my god here's this man with multiple sexual partners and he's very risky and we need to do something about it or is it actually here's a man who's very distressed, who's having to adjust to, you know, an enormous piece of news and needs some support around how he's managing that?

P1: but it's hard to do that whilst as you were saying, well [I think that was what you were saying] it's hard to do that whilst you're sort of thinking there's someone here who is obviously not engaging

P2: yes and actually he may be having more sex with his mistress than his wife and may actually be having less sex with his wife than anyone else that he has sex with so yeah but it's very

P3: in terms of these issues it's interesting for me to know how, how much colleagues would get, how much you would get directly involved in these kinds of discussions cos I tend to try and keep everything at arms length but it might not be that that's the right attitude to take but that's what I try to do, I try to take the line, it's not really my responsibility here, I'm here to discuss the issues but in practice I wouldn't take too much responsibility [unclear] I'd be thinking more about like, what people have said, what's the reason why in the clinic to see this person, what's going on psychologically?

P1: It depends, if someone is referred specifically cos they are concerned, you know they actually want some help with aspects [unclear] but if like a lot of people I see as you were saying they've already discussed issues with their health advisors who are very concerned obviously and have said you know they've got these issues [unclear] so it does depend

P3: just reading what's there, it seems as though he's, that he didn't think he was at risk at first, it might be, he might be quite shattered at getting this test result but other than that there isn't too much about this is why he needs some help from a clinical psychologist is there?

P1: but we do have professional practice guidelines don't we? If someone is at risk of harm, if a patient is at risk of harm, of harming themselves or others we do have a professional responsibility don't we and duty to act potentially?

I: *would that be a concern at this stage? or is that a concern at this stage?*

P3: probably

P1: I think it potentially is but I also think our role is different from the rest of the team and if they've been, our role is not to have the same conversation with the patient as the rest of the team, you know I think if someone is dangerous then the, you know how are we going to help him to become less dangerous and I think if others are you know setting down the limitations and the need to breach confidentiality and inform and all that, I don't think it's our role to do that, in addition to others doing it, I think we have a different role which is about trying to engage the participant in looking at it and trying to understand it and explore the obstacles to changing but

P3: I read through your questionnaire, I didn't complete it yet but I read through it and I had this uncomfortable feeling we would be homing in on these issues and it got me thinking am I doing enough? Am I well informed enough of these issues, do I have a good view of what my professional responsibilities are? It made me think about it, which is something I've been putting off for some time so thank you for that

I: *and thank you for coming today and I hope you don't forget to complete the questionnaire (laughs), perhaps now would be a good point to move onto the next stage of the vignette?*

P1: yes

I: *Client B has only attended a few of your regular appointments and you've had to ring him on his mobile to encourage him to attend those, after a couple of missed appointments he attends and he tells you that he has informed both his wife and his mistress separately although both have failed to attend subsequent appointments at the clinic which were made in liaison with the health advisor. You have his address on record where he lives with his wife but you don't know the name or address of his mistress. You suspect that he may continue to be having unprotected sex with the occasional casual partners that he has and both his wife and mistress, although he denies this. You feel that Client B is unwilling to engage with you and at times appears arrogant and generally*

unwilling to take the issues you raise seriously for example he doesn't reveal the identity of his mistress and declines an offer for the clinic to contact her anonymously. What are the issues here and what would you do?

P1: I think the Health Advisors would be the ones who would be dealing with this um

P4: I think I would probably liaise with the health advisors and make sure that they were very aware of the situation but I agree, I don't see it as my responsibility in so far as doing anything about this except making sure that the team were aware of my concerns about this particular person and the difficulties I was having engaging them in psychological work [unclear]

P3: it's calling me to question whether with my clients, these issues of confidentiality, what would I do? I've been wondering do I tell them, what you tell me is confidential, the same as anything else you've said to people in this clinic but I think I should say I need to discuss things with colleagues and that might include things about the risk to yourself and others, I'd try and do that cos I think with things like this you probably should, people need to know where they stand don't they? I just feel that this is not ideal [unclear] and what people say to me is not understood by set confidentiality but I [unclear]

P1: I suppose for me one of the things that I might want to do is actually sit down with other professionals involved in the care of this person because um the sense I get and you know obviously this is a fictitious vignette is that this man is being backed into a corner almost you know, [unclear] and encouraged to attend so I think one of the things that I might do is actually sit down with the professionals and try and distinguish you know what you were saying between roles and who is actually doing what and obviously there's a public health issue here and potentially a medical, legal issue but I suppose for me, I would actually want to step away from this, and wouldn't we all, cos the nice bit, you know the nice warm fluffy bit and try and you know, try and take a different tack and if I felt that the public issues were being dealt with and try and engage him you know perhaps more empathetically or whatever and just try and get a sense of what some of his difficulties were um and to try and acknowledge that he is in a terrible place, he is in between a rock and a hard place isn't he, you know? He's made it very clear that he is potentially at risk from violence, you know so he's vulnerable as well as having other potentially vulnerable people at risk so I suppose that's what, that's what I would want to do, not completely you know um avoid all these difficult issues but really just try and say look let's you know, let's try and take a different tack cos otherwise we are all, my sense is that there would be various professionals involved in the GU clinic, all banging their heads against the same brick wall and at the end of the day he has a right not to attend you know psychological appointments, you know that

P4: [unclear] and if he didn't turn up for an appointment I might send him a letter asking him to comply but if he's turning up and still doing all these things then I need to really sort of focus with him on what he wants

P1: yeah what does he want?

P4: from coming you know, maybe he wants to understand himself better, maybe [unclear] I know it sounds, there is anger here, you know if I have been diagnosed HIV positive, you know fuck the world, I want everyone to have it, is this the background?

P1: well maybe he does genuinely want to tell these people who are important to him and in his life and really doesn't know how to but because you know, because he's you know, he's got himself into a oh yes, I've told them and it's fine, that's another piece of work isn't it, that you could productively do, how, you know, run some strategies and you know think about what he might want to do, how exactly as you were saying, how he might become less of a risk to people but this sort of like chasing him is, it feels sort of counter productive really in that sense

P4: yeah on the other hand he seems addicted to danger because he's done quite a lot of deceiving before you know, [not wanting A to know B is involved, or about C] so I'm not sure that is an issue,

but I'm not sure, you could be right, there might be some looking at what happened before and the smaller issue of being addicted to dangerous things and wanting to understand

P2: I think of cases where there has been risk and danger [unclear] and in a way it seems, I suppose the way I would try and engage him is out of expressing concern about his dangers and the consequences of that for him

Ps?: [yes]

P2: and not just for those that he is putting at risk and in a way, sometimes it's worked well when the patient has responded to that, you know but it's not his, you're not seeing him as the bad guy and concerned about protecting others so it's not good for him to be going out and doing things is it, potentially having that on his conscience or being charged you know and I have said to a patient before you know that's potentially grievous bodily harm, you could go to prison for that, but expressing concern for him being, affecting, someone and

P3: well maybe if somebody else tests positive anyway and comes back and blames him of it, one of his partners could do that, um but the difference about speculating about his personality and what might cause somebody like him to choose to act more responsibly and how much would he try to engineer that happening or take more responsibility for that, you know giving him warning and hoping that he will respond

I: *so on a practical level would you leave it there and wait to see if he contacts you again or do you think you'd you be more proactive?*

P4: if, you know, what I would usually do is that people don't come to a meeting, then I send them a letter saying please contact and if after say a month or two they haven't contacted then I send another letter saying if I don't here from you in two weeks you are discharged so I suppose yes another letter would come eventually, I wouldn't contact them by phone unless there is no other way to contact them

P1: I might not, I'd certainly write, what we would do is we send a letter and we don't close the file for months, or maybe it's less time, but certainly I would be communicating very closely with the clinic

Ps?: Yes, yes

P1: so that they knew that he wasn't attending and that we were no longer involved in ongoing work so I would be very clear about that but yes send a letter inviting him, again but like you were saying, there is no way I would be phoning him encouraging him to attend

P2: particularly since you might intimidate them if you've got someone that's engaged really well and then dropped off then I think I'd feel differently and encourage them and tell them I was having concerns not only for them but for others but I think with somebody who for whatever reason is finding it difficult to engage [unclear]

P3: In, I think where I work most, nearly always contacting the client it is done by the clinic staff rather than me directly, if, I wouldn't contact the client or chase them up, I would give further written feedback to the clinic, he hasn't engaged, I have these concerns, I hear you do as well, please when is he next due in or when are you next likely to see him again, to put it [responsibility] back on the clinic

P?: oh yeah

P3: I wouldn't, so that's just not, that's just practice in my department, I wouldn't contact him directly

I: *is this a good time to move on for everyone?*

P?: yes

I: *client B doesn't attend any further appointments with you and his mobile number has recently been disconnected, according to your last contact with him, he says he has advised his wife and mistress but neither have yet contacted the clinic and as far as you are aware haven't been tested for HIV. Despite sending two letters from the clinic to the client at his home address including one registered delivery letter, he's still not contacted you as requested. What do you think are the issues here and would you do?*

P4: [unclear]{laughs} there doesn't sound like there is anything you could do

P3: never there when he delivered the letter, he was out {laughs}

P1: not in this age of course I wouldn't, get involved in that sense

P2: if the clinic had done that, lets say the clinics had done that and he's not contacting and you had all the information, lets say he had said well if I've got it [unclear] {laughs} there is a sense in which he is either angrily infecting people, what I suppose it's what responsibility do you have? You know, what might you do in relation to the clinic staff and the health advisor.

P1: but even if he hadn't been so angry but you'd known, his sex is around you know a compulsive cycle of behaviour so it's not that he's like stuff the world but this is a thing that actually he has very little control over so he may not be so, he may not be benevolent but still not be able to control how potentially risky he is

P4: I would talk to the clinic, I would certainly have a meeting about this man, sort of see what other people think and I don't know {laughs}

P2: it seems to be about responsibility for known people, you can't contact not known people can you but it's like you'd imagine his wife, I don't know, if he hasn't given her name she's not a named person to contact and there is no one to contact is there, if there are named people and should they be informed, might be an issue for the clinic

P4: and I think the health advisors in our clinic might do that if they had been, or they usually talk to people and you know and they say well lets say if you had told them we will see you in two weeks time and in the meantime you take precautions and if they have reasons to think that they haven't done that then they will tell him we are going to contact others

P1: cos the public health registration is quite, it's got quite strong teeth hasn't it you know? You, so I presume that they could act on that to make sure that their partner was notified, you know the partners that they did know the names and address perhaps

I: *so do you think that there's a difference between a named person and an unidentifiable person?*

P1: and if so the wife may be identifiable cos she has the same name

P2: I think you would have to know who was at risk, be clear, be sure that you are writing to the right person um (pause) so in a sense if she wasn't identified, but you had an address for example, you might find that, there's still a risk for example that you might speak to an adult but you don't know who that person is, it's not the right person

P3: I do think there could be mix ups [unclear]

P1: but through contact tracing you wouldn't, you contact anonymously don't you so, you know, we, it's our belief that you may have come into contact, blah, blah, blah so you wouldn't necessarily say we have been trying to see your husband for the last few weeks and he has refused to come to any appointments so

P2: how would you check without her knowing though that you were talking to the wife, if he's not given the wife's name

P1: I know, I know

P2: you can't say are you the wife of

P4: you can say are you Mrs B if he is Mr B but still, I don't know

P3: I mean I would imagine it isn't something that psychologists would probably get involved in

P2: I have never got involved with this at all, never

P3: no I'm not too clear about what my colleagues are doing, it's part of sexual health work but it's not something I have ever

P4: yeah, partner notification etc, I mean I occasionally hear vignettes of people who are having difficulties in contacting partners or that they think the person is saying yes I told her but they don't think they have told the person

P3: this example illustrated the tension doesn't it and the dilemma if you do reveal and someone takes retribution on this chap then you're, you and your employees are liable for litigation but if you don't and somebody discovers they're positive then you're caught again and people could be sued

P2: cos if you contact the wife and she has been named and you contact her anonymously you suspect that she's been exposed to an infection, the only person she has had sex with is her husband and comes into the clinic and gets tested and is HIV positive then in a sense you've breached his confidentiality haven't you unwittingly that he's got HIV. His confidentiality's no longer in place.

P1: but then if she develops HIV and it's known that a medical team knew she was at risk and hadn't informed her then I think you're in quite a very difficult position as well

P2: I think with our trust's solicitor, the patient was a vulnerable young adult girl, knowingly being exposed to an older male HIV positive person and I felt that he should be stopped and she knew so it wasn't about notification, well my feeling was or my inclination was that this man was targeting sixteen year old vulnerable women and having unprotected sex and you know that felt to me like he should be stopped but the trust's solicitors turned round and said on no account must confidentiality be breached around HIV. It felt like and it seemed like that was the priority, his confidentiality.

P4: so he was HIV positive and she wasn't and she didn't know he was HIV positive?

P2: she had been tested and was repeatedly tested and wasn't showing up yet but was still having unprotected sex with him so it was, I mean

P4: she didn't know that he was positive?

P2: she hadn't initially but she does now but she still wasn't protecting herself but it was an abusive dynamic, the relationship so she was vulnerable anyway

I: *going back to the vignette, about your client, Client B? – are you willing to let contact slip away?*

P1: yeah

P2: yep

P3: uh huh

P4: yeah

I: *that seems quite unanimous, a definite yes*

Ps?: (laughs) {unclear}

I: *in this example the clinic decided to send two registered delivery letters which were sent to Client B's wife and they still haven't heard back from either the client or his wife, they suspect that he may have intercepted the letters as the signatures from both letters are not clear, it's not clear whose signature it is. You have still not been able to find out the identity of his mistress but you know that she works with him in the family business. What are the issues here and what would you do?*

P3: this wouldn't arise for me, I mean I wouldn't, I would be off before we got to this stage, I mean I'm sure initially at times the clinic team before but I wouldn't, I would not be in this situation, it's not my job

P2: I think the trust has to take a position on this as well; it's not just for the clinic team to decide

P1: yeah

P3: uh huh and need to take legal advice from the team

P1: yeah you'd need a legal department wouldn't you?

P3: yeah

I: *so it would it be right in saying that you feel that it's something that is kind of out of your hands, that needs to be dealt with at a higher level? You wouldn't be, or you wouldn't want to be, you wouldn't have sole responsibility in this situation*

P3: no, but it's kind of a decision for the team to go down this road, for the team to decide to seek to legal advice

P1: I suppose so, um we've, here we've got quite a lot of information that we know, we know his wife, we know his mistress's address, we know his wife, we may know her name, we may not, we know the mistress works in the family business. I suppose the other thing is how have we had this information? If it's come through from clinical sessions with the psychologist rather than just a general registration then you know, in a sense you would be, you would continue to be involved, but not, my feeling is not in terms of making any more direct contact with him but to go to you know your manager and you know go through the trust and the legal team and actually find out what you know what the trust's position is then, I think, um and certainly you know when I see clients, I do say that, I explain that, I say that confidentiality you know but there are always, you know there is no such thing as absolute confidentiality and explain that right at the beginning so you would have hopefully made that very clear at the beginning you know about the confidentiality so that's what I would do, but I certainly wouldn't make any more contact with him, I'd take it to the trust

P4: Yes I think if he has disengaged from psychological therapy then you know I'm doing so much in the sense that I am sending letters, if he then doesn't contact us, but that is not to say that the clinical people don't do it because they are checking his HIV, do you know what I mean, they are checking his viral load, you know maybe this is a man that needs to come in every three months to be checked so they will have all sorts of reasons to have contact and it's in his interest if he is getting treatment there to be, to be coming so I think they will have more opportunities to try and contact him again but you see they would have more reasons to meet him than I would since he has disengaged from me but I think I would be available if they wanted to talk to me about this and some type of discussion on the motives and for the team, all in psychology and health advisors and consultants and specialists

P2: as a psychologist I wouldn't have written to his wife who I hadn't met, I would not have done that, the health advisors maybe but I certainly wouldn't, rather like you were saying you know I would maybe be involved at some stage earlier than this, be indirectly through discussions with the clinical team, that not a lot is being done about this type of [unclear]

P?: but I think [unclear] to get proof of what he's said he is going to do, that he will get it done, it isn't, it isn't

P4: I mean yes he could be a compulsive liar who actually is saying he is having all these affairs and hasn't got any or we don't know, he could be rubbish

P1: what you would have to do absolutely is record things very carefully so that you know, so that when he did say that he told his wife that that is recorded very carefully and then I think that hopefully

P3: a record of all the discussions that you had had

P1: yeah

P3: is probably the right thing to do

P1: but you know we're not here to prove that people are telling us the truth or otherwise are we really?

I: *If I can mention, if you had found out that for example his mistress worked in the family business and other tit bits of information like that which were revealed in a psychology session but not known to the team, how would you decide what information to share with the team?*

P4: if I've warned him in the beginning which I normally do that I can be, you know it's confidential but you know there are limits and if I believe that someone will be harmed etc etc etc] I can breach this confidentiality then I would let these people in the multidisciplinary team know that I am very concerned about this person but no actually I think I would discuss it within supervision first, I would be inclined to be thinking like that

P1: how would you notify him that you've done that?

P4: umm, well I'm assuming that he's disengaged but if he's still engaged and coming then I think I would be notifying him first

I: *you would notify him first would you say?*

P4: yeah

P1: and that's generally accepted as good practice isn't it that you say you know I can't keep what you've told me today, whatever constitutes [blah blah blah] and I'm going to have to discuss this with the wider team so yes if you were still engaged in therapy he would know

P3: it highlights how important it is that you do say, you have this discussion when you first meet someone, you lay out that this is how it is and make sure that they understand that and even give examples

I: *would anyone else like to add anything else before we move on?*

P1: I suppose my feeling is that given you know the recent sort of legal case, I think that we as you know, we're the psychologists working in the health service, hoping to work therapeutically with people you know the worse case scenario is that it becomes a disincentive either to test or to seek psychological support because it's feared that you know we are almost policing them so that's my thought on the end, finishing up this

P2: I think it just depends I think on how much I'm worried

P3: yeah

P2: because it is a supposition, well not a supposition but in there I mean what's the evidence that his mistress cos there are risks of breaching confidentiality from future therapeutic relationships and also weighing up how strongly you feel, people are at risk and you need to actively protect them, him being someone who might be able to help and protect the relationship and potential future relationships

P3: these tensions aren't unusual though are they, it's made me realize how often you know, you're kind of expected to keep your fingers crossed and hope for the best, you don't ignore these questions, it's very rare that it's really clear what's happening, it's much more much a grey area and difficult alternatives

P1: I mean I was called up to see somebody last week and one of the issues for the ward was she was absolutely adamant, newly diagnosed, that she wasn't going to tell her partner and then I, when I got there the partner was in the room and he'd just been told and I can't tell you how relieved I was to see him there and you know he'd just been having his blood taken there and then so you know we didn't and so that wasn't an issue but we had to work on you know, her feelings about potentially affecting her partner and all the fear and guilt you know about what would happen to the relationship, then we were able to work through all of that, after you know, look at that and not having to sort of get into this type of thing

I: *I think now is probably a good time for us to move onto the general part of the discussion now if that's ok with everyone. Can you describe any professional issues related to your models of working or, your own role that may impact upon your ability to work with clients, described in the vignette, or rather the kinds of client described in the vignette?*

P3: confidentiality issues, you not only have a duty to him but to protect others, it kept coming back to that, you know how do you assess the risk and how do you respond to it, or kind of indicate that the primary duty was to the client

END OF SIDE ONE – TAPE CHANGE

P3: one of the areas that comes to mind is there is a really strong ethical dimension in all of this [unclear]

I: *how do you view your role as a psychologist working in a difficult or complex, case like this?*

P4: I think it's full of contradictions and some of it can get you in really quite a pickle inside like for me and I think for others the work here is very important and sometimes you've got to put your concerns about how dangerous he is to other people in brackets and knowing that other people are dealing with that and you are concentrating on coming to understand this man more than you know what kind of, what kind of sense does this kind of behavior, that he is you know going from person to person and [others] about what he is doing [you know lying a lot to his wife and his casual partners] you know what friction is it, what kind of defense is that, how does that help him and then trying to sort of convey this understanding to him so putting all this awareness of danger in brackets sometimes and that's difficult as you know you want to be thinking about that too but I think we need to think about that

P3: yeah you used the word contradictions and I think that's absolutely right, as psychologists you try to understand why but there's a different responsibility to treat and take more action to trace partners and sort of think of the public health and um understand, that tends to be where we come from as psychologists

I: *what do you think your professional duties and obligations as a psychologist are in this kind of scenario then?*

P3: one of them is to offer appropriate psychological help and support for people who have been affected by HIV so that's the client or others but that's, I think the discussion shows that other things can easily hinge on that in a GU setting

P1: and as an employee of the NHS you also have a responsibility in terms of um you know the trust's procedural guidelines around confidentiality and risk to others and that type of thing. I think it's sometimes easy to think that because we're not, you know we're not mental health, you know social workers or psychiatrists who have the power to section that we can, but we have to be mindful of the larger picture as well and as you were saying it's that contradiction, it's balancing that, it's you know privileging that therapeutic relationship whilst being mindful of the other stuff as well

I: *so how do you understand your professional duties of confidentiality? You said that its' not a strict one hundred percent confidentiality?*

P2: I think it's like we already discussed at the beginning basically, risk to one selves or others that we take outside the session but [unclear]

I: *how does that impact upon the therapeutic relationship?*

P?s: [conversation]

P1: it's a bit like we were saying, you know ideally you would um in terms of good practice you would be able to discuss that with that person but I think it can be inherently it can be problematic but also it can be managed I think um

P2: [unclear]

P1: so I think you know sometimes that's the end you know and other times you can work from that, certainly I think that in the past, I think about child protection issues that you know yeah the therapeutic relationship has staggered but yes we've got, we've managed to work through it so I think there's no hard and fast, there's no general thing that says this is always a catastrophe and that's the end but it's, but in this particular situation I never really got any sense that there was a working relationship between client B and the psychologist

P4: yes

P1: there really wasn't you know, that was my sense

P3: yes some how you got the feeling that this person keeps everyone at arms length, maybe that's how he deals with it I don't know

P4: for me it reminds me of the fact that I mean a year ago I went to a conference about criminalisation in Leeds it was wonderful and I was really thinking of this therapist don gilvano who had a thousand partners and there were many psychoanalysts analyzing him so I was just thinking about that you know, how they said about a weak sense of self and they actually analysed the music that everybody sings at the opera and everybody has got to sing and everybody has got a theme of music so whatever [unclear] there is a song but don gilvano hasn't got any, he just sings along with other people, so it's like a weak sense of self you know needing to be with other people as if, as if to kind of be a part of them because he hasn't got an individuality and maybe that's how it is here but that's you know pure speculation but you know thinking about music etc whatever you make it, you know maybe thinking about that you know thinking about these things within these problems of confidentiality etc, all lead to a sort of a working alliance you know to be able to make theories about why he does all this and it's to distance himself from these other little things that he may have

P1: yeah cos from the vignette the only thing that we actually really knew that he told us was that he was frightened didn't we so actually what hopefully what we would have been doing is working with that and the rest of it was all you know

P3: I would imagine that, I think the question was how would this affect working relationships and how would we manage that but what [P4 name] said, I guess all of us at times when we are discussing clients and all of these risks and worries with clients we probably put some of those psychological thoughts into a plan and we can say this is how it seems to me how this person functions or this is how they react or this is why they act in this way and this is helpful to the team cos they can take it into account when they make decisions, should they pursue this person, how should they handle them when they do come in and we can, even if we are not working with this person directly try to inform everyone and support colleagues

I: *What difficulties have you had in trying to engage clients who might be similar to the one in the vignette? And what helps you in these instances?*

P2: I had difficulty engaging the young girl that I was talking about earlier who actually went on having unprotected sex with the other so she was almost, she didn't pay attention to the potential risks actually and that was a bit, I felt that actually I was trying to tow that line between expressing concern about her and what her vulnerabilities in her taking risks with her own health to exposure to HIV was about, and linking that to having been abused and it] was difficult, whilst at the same time thinking, there was a panic in the clinic about her cos she was really vulnerable and this man was known to the clinic, he'd done it to others and there was this pressure all the time, this has got to be stopped quickly yet the process of forming a relationship and trying to engage her was going to take time and it was kind of the difficulty with containing panic and I felt pressure to do something about it quickly whilst trying to work with her and I was trying, I was talking to her about the parallels of being abused as a child, were very much she was in an abusive relationship now and I was talking to her about questioning whether this man should be stopped and trying to explore that outside of the therapy whilst still trying to work with her and the meanings of it and it felt like she was engaging and but what happened was a doctor in the clinic, I suppose she felt that she couldn't wait and had to do something in that she took another course of action that back fired not for further risk of what happened but back fired and we lost both him and the girl and it's, I suppose with anybody involved in multidisciplinary working it's like you might be working with containing excitement knowing it takes time you know you know others think differently

P1: because of that mindful detox about ethics that obviously one of the primary ethical considerations of working with client autonomy is that mindfulness of actually there are some things that impinge on autonomy like a history of traumatic, you know a childhood history and so you hope that the work that you do can almost help them put some of those building blocks to have a stronger sense of self and, so they can become autonomous but yet it is slow and I think sometimes we ask people to assume personal autonomy but that you know through various sort of social and personal history but actually they don't have and perhaps some of our role is to help them and you know put some of that back

P3: I find engagement and tenure are big issues, you so often feel kind of helpless and you can't do a lot about that but on the other hand I think a strength of being a psychologist and being more person centered and not having the priorities that the rest of the team do means that when it works, it's going to work better because you're there to think about them as opposed to them as a patient [unclear] getting infected or spreading infection, you are the one person on the team who your job is to see them as a person, what concerns them, what's important to them, what affects them emotionally

I: *what psychological models do you use when formulating difficulties with clients? particularly with hard to engage clients?*

P4: it's difficult {laughs}

P3: if you can get through the barrier of a clinic hopefully you will have a positive experience, if you have left the clinic the further you are away you maybe don't have an incentive to come back, there becomes a barrier again, it's easier to avoid it, [unclear]

I: *any other thoughts?*

P4: I think it depends a little bit but I mean the example that I was giving before when I talked about Don Gilvani's psychodynamic, I do tend to think because I have been mainly trained in that modality, I do tend to think of not necessarily all the time, I think in certain cases it's much easier to make a formulation when I see parallels between perhaps childhood events and the way the person is acting now, it's easier or because it's not easy to see a connection so you know

P3: I think I kind of see social psychology and the shame and stigma of HIV, conflicting acknowledgments of infecting people, first hand

P2: I suppose I'm fairly cognitive behavioral. I suppose the beliefs driving the behavior and trying to explore them, stages of change and realizing that people are at different stages of change and not ready to change and that's why they don't engage or they don't whatever [unclear]

P3: I mean the people coming into the mental health services, the majority of them have identified they have a psychological or mental health problem and they have come along with some idea of this is my problem and they are asking for help whereas HIV it is much more, this has happened to me and they haven't sort of identified within themselves as having psychological issues they just don't see themselves as, they have to change their perspective, it's a huge change and accepting what's happened and how it affects them

P1: and then I'm thinking of somebody I'm seeing here where HIV is almost like the latest thing in a complete catalogue of abuse and violence and dislocation and um in that sense you know working with actual trauma and looking at you know trauma issues around which is difficult to engage and you know I suppose attachment stuff so it really depends on what you know. My sense is you never really know, especially you know you sometimes get referral letters from like two or three, my feeling is you can look through them first but you never really know what you're going to get, you just sit there with them and see what comes and two people with identical referral letters you know, people who are very difficult to engage and are working in different ways with each of them

I: *thank you, if I could move onto the next question, can you describe the ways in which your current department structure and philosophy impacts upon your work with clients similar to the vignette?*

P5?: I sort of have no idea, I will have to check with the department, but the consultant there will inform partners won't it? but I don't know what our, what my individual department where I work, what their stance is on this [unclear]

P3: I'm not sure who, I don't know whether there would be a sort of designated person or whether they would share it, depending on who has the most contact with the person

P4: In the clinic where I work, it's the Health Advisors

P1: yeah

P4: it's their role within the department, notification and discuss it with them

P1: yeah, I feel the structure here, the impact it would have on client B, we would probably never get client B cos actually they wouldn't consider it an appropriate referral unless you had specifically stated

P4: psychological distress

P1: yes unless

P2: not sure what the reasons for referral would be otherwise

P1: yes that's right, so it may very well be that we would never see him so that would be the impact cos they would manage all of the partner notification and all of that, we'd never get involved in that

P2: I think I would be part of it don't you

P3: yes it depends how you position yourself, that you say you will say yes to anyone that says they have distress around a recent diagnosis or you are worried about the person or

P2: well we do get people that who have been [unclear]

P1: yes but very often they have said I'm very distressed cos I don't feel I am in control

P3: I don't feel in control, yes

P1: yes so it's very much driven by the patient rather than the clinic though isn't it

P3: yes

P2: and you're working with that person whereas you don't really know [unclear]

I: *and are there policies around working with clients that are considered potentially risky?*

P1: um presumably (laughs)

P3: I mean these are all question that put you on the spot really, I mean I kind of position myself as kind of a weekly add on in the department and not an integral part of all this but that varies and I have this uncomfortable feeling that I think I need to check this out a bit more (laughs), I think I'm practicing safely and competently but

P2: You don't certainly in the psychology department here have a clear policy

P3: no

P1: except for all professional groups, they are all writing guidelines aren't they and the faculty are trying to say this, this and this so they are waiting to

P2: and the department of health and

P1: yeah

P2: process think over this oooh it's a bit early

P3: [unclear] there had been some prosecutions but to me it seems to be, it isn't a theoretical risk but it isn't very little more than that, whether it could be a prosecution or whether you could be liable for failure to act, that's my sense of it, we need more explicit guidelines, we need a framework

P1: but I suspect that if anything went pear shaped that wouldn't be a good defense but you know, cos you know, I've just finished my training this year and I know that that was really taken hard, you know saying oh I wasn't sure what the guidelines were or I didn't know there were are absolutely no [unclear]

P3: no

P1: and I think it's about personal responsibility isn't it? Making sure you are, as informed as you can be about you know the BPS guidelines and your trust guidelines

I: *what do you feel is the role of supervision in cases like this?*

P1: I see it as absolutely crucial that you don't see yourself as working in isolation, I don't think you can be able to so I would see that as essential to working

P3: it's a way of monitoring too [unclear] rather than keeping practices to yourself it's somewhere you can take all these issues and discuss them rather than just rolling them over as a practitioner alone

I: *are there any other sources of support available to you that you can use?*

P3: well this group for one, um though it's beyond the GU sphere

P4: multi disciplinary team meetings where we discuss things like that, it's about working on what can be [unclear]

P2: I think in some trusts, some trusts sometimes have a, I know the doctors in our GU, there is like this, I think it's nationwide, where I think they share with others on the web, their colleagues and get a response. I know our trust used to have a very senior group, well a group of senior practitioners you could take ethical dilemmas to and to mull over and consult with

P1: I think there is one in [name of location] actually; I think there is one

P2: these are these kind of issues though and not just around HIV but there are also these things like multi agency public protection panels and I've contacted them before where there is risk of violence and I wonder if they do a group as well, so it's probation and health and social services so they will have a view as well so you can present the case dilemma and the issues and with solicitors as well as you said

I: *do you think that issues of sexuality and culture impact upon your ability to work with clients?*

P3: I think they do yeah, you try to, you try to maintain an awareness of that and could that be affecting you and the reactions behind, could that be affecting the way your team reacts to a certain client really and what determines a client's actions so I would say yes to that one

P1: and certainly working through, if you're working through interpreters there are obviously issues around confidentiality there, I think it changes the whole dynamic of this kind of work anyway

I: *and finally um can you describe how you personally feel about working with the Client described in the vignette, what are your personal feelings towards him?*

P2: a mixture of concern and anger

P4: yeah

P3: yeah on the basis of the facts there, I'm not positive but you would want to kind of think oh it's only one facet; we have a limited amount of information

P2: yeah, I would be curious

P3: a question mark

P4: and sad, not for me but for him, I would be curious to know more but I think my main concern is about his potential victims actually, the way he treats people is not a lovely place but I don't feel a lot of empathy at the moment on this description

P3: no not just on one description, if you find you might possibly find he is quite psychopathic and a perpetrator

P1: cos I feel quite concerned for him, I think he's got a bit of a raw deal really (laughs) in that I wonder where his central concerns were addressed, I suppose that's my feeling that there was lots of concerns about others as there should be but again just from the vignette there is a sense that his central concerns, where were they sort of addressed, so I would feel concerned about him

P2: and he did kind of

P1: but you see I'm new in the job (laughs)

P2: but he did come to the sessions at first so that makes me think was there a potential and what happened

P4: what is he about? We don't know

P5?: it's two coloured for me, [unclear] he is both very very vulnerable and very very dangerous and, you know this scenario just makes me think of my patients so I can't be objective about it really, you know my patients, I feel alarmed and also very concerned about it

I: *does anyone else have anything to add before we finish?*

P2: I do feel concerned just I would like to know more

Ps: yeah

I: *thank you very much everyone...*

END

Appendix 2.7
Survey Questionnaire & Covering Letters

Questionnaires for the survey were distributed by the British Psychological Society faculty support staff.

A copy of the templates for the covering letter and questionnaire distributed follows, as well as a copy of the reminder letter sent approximately two weeks following the original:

Division of Clinical Psychology
Faculty of HIV & Sexual Health

The British Psychological Society

30th August 2006

Dear Psychologist,

Survey of Emerging HIV Issues in Clinical Practice Questionnaire

As part of the Doctor of Clinical Psychology Training Course at the University of Hertfordshire, I am conducting my major research project into the experience of psychologists working with emerging HIV issues in clinical practice.

I would be very grateful if you could participate in this valuable piece of research by completing the attached questionnaire which takes approximately 30 minutes to complete. This is an extremely important area of research and as yet no studies have attempted to explore psychologists' experiences of working with these HIV issues in the UK so directly.

The aim of the research is to explore the emerging issues that are arising for practitioners working with clients where HIV may be a factor. It is hoped that the survey will help inform understanding of the professional and ethical issues faced by clinicians working within this context. The survey will also contribute to the development of professional guidelines by the Faculty of HIV & Sexual Health in order to enhance working practice as well as to identify future service development and training needs.

The project is being supervised by Liz Shaw (Chair of the Faculty of HIV & Sexual Health and Consultant Clinical Psychologist, St Ann's Hospital, N15) and Dr Barbara Mason (Academic Project Supervisor, University of Hertfordshire). If you have any questions, please contact either me (contact details below) or Liz Shaw on (020) 8442-6464.

In order to protect confidentiality, I am not asking participants to sign a consent form and completion and return of the questionnaire will be taken as an indication of informed consent. Please read the further information regarding informed consent provided on the reverse of this letter.

If you would be interested in receiving information regarding the results of the study, please contact me separately so as not to your compromise confidentiality and I will forward a summary of the project's results and conclusions at a later date.

Please return the completed questionnaire by 14th October 2006.

Yours sincerely,

Eamonn Rodohan
Trainee Clinical Psychologist
University of Hertfordshire

Telephone: *04138 314333 (extension 3764) or 01707 286322 (via Course Administrator)*
Email: *E.P.Rodohan@herts.ac.uk*
Address: *Doctor of Clinical Psychology Training Course*
University of Hertfordshire (Hatfield Campus)
College Lane, Hatfield, HERTS AL10 9AB

Division of Clinical Psychology
Faculty of HIV & Sexual Health

The British Psychological Society

Survey of Clinical Practice & Emerging HIV Issues

29th September 2006

Dear Psychologist,

Survey of Emerging HIV Issues in Clinical Practice Questionnaire

Recently you should have received a research questionnaire sent to you through the British Psychological Society.

If you have already returned the questionnaire, may I thank you very much for your help and time.

Please could I also give a gentle reminder if you have not managed to complete it yet. The limited size of the survey sample means that your input is very important to the outcome of the study.

If you have misplaced the questionnaire or would like another copy, please email me with your details and I can post or email you another copy.

Please return the completed questionnaire by Friday 14th October 2006 either in the reply paid envelope provided or to me at the address below.

Yours faithfully,

Eamonn Rodohan
Trainee Clinical Psychologist
University of Hertfordshire

Telephone: *07956-434830 or 01707 286322 (via Course Administrator)*

Email: *E.P.Rodohan@herts.ac.uk*

Address: *Doctor of Clinical Psychology Training Course*
University of Hertfordshire (Hatfield Campus)
College Lane
Hatfield, HERTS AL10 9AB

Division of Clinical Psychology
Faculty of HIV & Sexual Health

The British Psychological Society

Survey of Clinical Practice & Emerging HIV Issues

Thank you for participating in this research project investigating emerging HIV issues in clinical practice.

This questionnaire should take approx. 30 mins. to complete.

Please return by 14th October 2006

Please read the following background information before completing the survey:

Background information:

The *Offences Against the Persons Act, 1861* defines the situations in which a person may be held criminally liable for harming other people in England, Wales and Northern Ireland.

Sections 18 and 20 of the Act can apply to the situation where it is established that one person has infected another with HIV.

- Section 18: where a person intentionally causes wounds or any grievous bodily harm on another person (**intentional** provision)

The offence of intentionally causing grievous bodily harm under Section 18 would be extremely difficult to prove in relation to the transmission of serious disease (unless HIV was used as a weapon – in a syringe of blood, for example).

- Section 20: where grievous bodily harm is inflicted '(...) with or without weapon' (**reckless** injury provision)

The law says that a person is reckless if they consciously take an unjustifiable risk – which in this context would mean being aware of the risk of causing harm to the person they infected with HIV.

At the time of printing, eight convictions in relation to the sexual transmission of HIV have been successful under Section 20 (i.e. for the reckless transmission of HIV).

In Scotland different legislation is used, but similarly to the practice in England, it is the 'recklessness' (deliberate and persistent) in transmission which is considered criminal.

Questionnaire

Part A:

Please circle one response to each question where a multiple answer option is provided or enter the appropriate response where indicated by 'Answer: _____'

1. Are you male or female?

(A) Male

(B) Female

2. What is your age? Answer: _____ years

Part A continued on next page >

3. How would you describe your ethnic background?

White:	(A1)	British
	(A2)	Irish
	(A3)	Other white background, please describe: _____
Mixed:	(B1)	White & Black Caribbean
	(B2)	White & Black African
	(B3)	White & Asian
	(B4)	Other Mixed background, please describe: _____
Asian or	(C1)	Indian
Asian British	(C2)	Pakistani
	(C3)	Bangladeshi
	(C4)	Other Asian background, please describe: _____
Black or	(D1)	Caribbean
Black British	(D2)	African
	(D3)	Other Black background, please describe: _____
Chinese or	(E1)	Chinese
Other group	(E2)	Other ethnic group, please describe: _____

4. Which profession do you belong to:

(A) Counselling psychologist

(B) Clinical psychologist

(C) Other psychologist, please describe: _____
(*e.g. Health psychologist etc*)

(D) Other profession, please describe: _____
(*e.g. Counsellor, Health Advisor etc*)

5. How many years have you been qualified? Answer: _____ years

NB: *Participants may choose <u>not</u> to answer questions 6 & 7 if they prefer*

6. How would you describe your HIV status?

(A) HIV-positive

(B) HIV-negative

(C) HIV-unknown or HIV-untested

(C) Prefer not to say

7. How would you describe your sexuality?

(A) Heterosexual or 'straight'

(B) Homosexual or 'gay'

(C) Bi-sexual

(D) Other, please describe: _____

(E) Prefer not to say

8. Roughly how many clients in total have you worked with since completing your professional training?

(A) 1 – 100

(B) 101 – 250

(C) 251 – 500

(D) 501 – 1000

(E) More than 1000

Part A continued on next page >

9. What is the primary theoretical orientation used in your clinical practice?

(A) CBT (including Cognitive or Behavioural)
(B) Psychodynamic or Psychoanalytic
(C) Systemic
(D) Humanistic (including Person-centred)
(E) Other, please describe: _____
(*Note: If 'eclectic' or 'integrated', please describe which.* e.g. CAT)

10. How many years experience do you have working within HIV or Sexual Health services?

(A) 0 years
(B) up to 1 year
(C) 1 – 3 years
(D) 3 – 5 years
(E) More than 5 years, please describe how many – Answer: _____

11. Please describe the type of service you currently work in.

Answer: _____

12. Roughly how many HIV-positive clients have you worked with since completing your training?

(A) 0 (*Please go to Q.13*)
(B) 1- 10 (*Please answer Q.12a to Q.12f below*)
(C) 11 – 50 (*Please answer Q.12a to Q.12f below*)
(D) 50 – 100 (*Please answer Q.12a to Q.12f below*)
(E) More than 100 (*Please answer Q.12a to Q.12f below*)

12a. If you have experience working with HIV-positive clients, how often (in your recent practice) do you have <u>discussions regarding safer sex</u> with them?

(A) Never
(B) Sometimes
(C) Usually
(D) Often
(E) Always

12b. If you have experience working with HIV-positive clients, **how often (in your recent practice) do you <u>record in your notes details regarding any safer sex discussions</u> you have with them?**

(A) Never
(B) Sometimes
(C) Usually
(D) Often
(E) Always

Part A continued on next page >

12c. If you have experience working with HIV-positive clients, **how often (in your recent practice) do you include specific details relating to your professional duty to disclose confidential information as part of any discussion regarding confidentiality issues you have with them?**

(A) Never
(B) Sometimes
(C) Usually
(D) Often
(E) Always

12d. If you have experience working with HIV-positive clients, **how often (in your recent practice) have you discussed disclosure of HIV status to sexual partners with them?**

(A) Never
(B) Sometimes
(C) Usually
(D) Often
(E) Always

12e. If you have experience working with HIV-positive clients, **do you (in your recent practice) provide additional information regarding confidentiality issues when specifically discussing sex or sexual partners with them?**
[i.e. Do you outline, or clarify that there may be limits to professional confidentiality which could apply to information disclosed by the client within this particular context?]

(A) Never
(B) Sometimes
(C) Usually
(D) Often
(E) Always

12f. If you have experience working with HIV-positive clients, **how do you (in your recent practice) record in your notes details of any discussions regarding confidentiality issues that you have with them?**

(A) Do not record information provided regarding confidentiality
(B) Record any confidentiality discussion in general terms only
(C) Record any information given relating to the limits of professional confidentiality in general terms only
(D) Record any information given relating to the limits of professional confidentiality including specific details of the information given

12g. If you have experience working with HIV-positive clients, **have you changed any aspects of your clinical practice in recent years?**

(A) No (Please go to Q.13)
(B) Yes, please briefly describe what has changed and why below:

_____

_____

_____

(*Please provide further information overleaf if needed*)

Part A continued on next page >

13. How many recent cases have you been involved with where you have considered the possible need to disclose a client's HIV status without their consent to <u>actual or potential sexual partners</u> (including seeking guidance on the need to do so)?

(A) 0 (*Please go to Q.14*)
(B) 1 – 5 (*Please answer Q.13a below*)
(C) 6- 10 (*Please answer Q.13a below*)
(D) 10 – 25 (*Please answer Q.13a below*)
(E) More than 25 (*Please answer Q.13a below*)

13a. If you answered (B) to (E) to Q.13 above, please <u>briefly</u> describe to whom and the circumstances:
[*If multiple cases, please describe your more complex or contentious cases if you prefer*]

Answer: _____
_____
_____
(*Please provide further information overleaf if needed*)

14. How many recent cases have you been involved with where you have considered the possible need to disclose a client's HIV status to <u>other professionals</u> (including seeking guidance on the need to do so)?

(A) 0 (*Please go to Q.15*)
(B) 1 – 5 (*Please answer Q.14a below*)
(C) 6- 10 (*Please answer Q.14a below*)
(D) 10 – 25 (*Please answer Q.14a below*)
(E) More than 25 (*Please answer Q.14a below*)

14a. If yes to Q14, please <u>briefly</u> describe to whom and/or the circumstances:
[*If multiple cases, please describe your more complex or contentious cases if you prefer*]

Answer: _____
_____
_____
(*Please provide further information overleaf if needed*)

15. Have you ever been asked informally or formally to provide information regarding a HIV-positive client to the police?

(A) No
(B) Yes, please describe on how many occasions – Answer: _____
Please provide <u>brief</u> information of your course of action_____
_____
_____
_____
(*Please provide further information overleaf if needed*)

Part A continued on next page >

16. Have you ever been required by sub-poena (court order) to provide psychology notes or confidential information relating to a HIV-positive client?

(A) No

(B) Yes, please describe on how many occasions – Answer: _____

17. Has a HIV-positive client ever disclosed information to you of behaviour which you feel could potentially be considered as the criminal transmission of HIV <u>with intent?</u>

(A) No (*Please go to Q. 18)*

(B) Yes (*Please answer Q.17a below*)

17a. If yes to Q.17, please indicate what course of action, if any, you took after receiving this information: [*Please circle <u>all</u> answers that apply*]

(A) Kept it to myself

(B) Discussed with my supervisor

(C) Discussed with my manager

(D) Discussed with my team

(E) Discussed with the police

(F) Other, please <u>briefly</u> describe: _____

_____

18. Has a client with HIV ever disclosed information to you of behaviour which could potentially be considered as the <u>reckless</u> transmission of HIV and criminal?

(A) No (*Please go to Q. 19)*

(B) Yes (*Please answer Q.18a below*)

18a. If yes to Q.18, please indicate what course of action you took after receiving this information: [*Please circle <u>all</u> answers that apply*]

(A) Kept it to myself

(B) Discussed with my supervisor

(C) Discussed with my manager

(D) Discussed with my team

(E) Discussed with the police

(F) Other, please describe: _____

19. When deliberating over confidentiality issues, what documents do you refer to when deciding what course of action to follow? [*Please circle <u>all</u> answers that apply*]

(A) I do <u>not</u> usually refer to documents

(B) *BPS* Code of Conduct

(C) *DCP* Professional Practice Guidelines

(D) *Faculty of HIV & Sexual Health* Guidelines

(E) *NHS* Trust policy guidelines

(F) Departmental policy guidelines

Please continue with Part B on next page >

Part B:

Please indicate to what extent you agree or disagree with each of the following statements related to aspects of clinical practice with HIV-positive clients:

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1. I feel *competent* to deal with any confidentiality issues related to potential or actual HIV-transmission	5	4	3	2	1
2. I feel *competent* to deal with any legal issues related to potential or actual HIV transmission	5	4	3	2	1
3. I feel *competent* to deal with any note-taking and record-keeping issues related to potential or actual HIV transmission	5	4	3	2	1
4. I would feel *confident* discussing any confidentiality issues related to potential or actual HIV transmission	5	4	3	2	1
5. I would feel *confident* discussing any legal issues related to potential or actual HIV transmission	5	4	3	2	1
6. I would feel *confident* to know what to write in my clinical notes related to potential or actual HIV transmission	5	4	3	2	1
7. I feel *confident* to initiate safer sex discussions	5	4	3	2	1
8. I feel *confident* that I know what safer sex advice to give in relation to criminal HIV transmission	5	4	3	2	1
9. I feel *competent* to provide advice regarding disclosure of HIV status to sexual partners	5	4	3	2	1
10. I would feel *confident* providing guidance regarding situations involving condom failure	5	4	3	2	1
11. I would feel *confident* discussing ethical dilemmas relating to HIV transmission with my supervisor or team	5	4	3	2	1
12. I feel *competent* making clinical judgements relating to responsibility in relation to HIV transmission	5	4	3	2	1
13. I am *willing* to promote disclosure of HIV status with sexual partners	5	4	3	2	1
14. I have concerns regarding litigation or that I may be prosecuted if I do not encourage clients to disclose their HIV status to sexual partners	5	4	3	2	1
15. When outlining confidentiality issues in my clinical practice, I take into considerations recent law cases (for criminal transmission of HIV)	5	4	3	2	1
16. When note-taking and record-keeping in my clinical practice, I take into consideration recent law cases (for criminal transmission of HIV)	5	4	3	2	1
17. When providing safer sex advice in my clinical practice, I take into consideration recent law cases (for criminal transmission of HIV)	5	4	3	2	1
18. I feel current DCP confidentiality guidance is adequate to cover HIV criminalisation and related confidentiality issues	5	4	3	2	1

Please continue with Part C on next page >

Part C:

Please circle one response to each question

1. In your view should the Crown prosecute:

(A) Both intentional & reckless HIV transmission

(B) Intentional HIV transmission only

(C) Not prosecute at all for either reckless or intentional HIV transmission

(D) Do something else – please specify: _____

2. Should the government change the law which has been used to criminalise HIV transmission (i.e. *Offences Against the Persons Act, 1861*)?

(A) Don't change it

(B) Create a specific law for intentional transmission only

(C) Create specific laws for both intentional and reckless transmission

(D) Do something else – please specify: _____

3. What do you think will be the impact of recent criminal convictions on HIV transmission rates?

(A) Reduce HIV transmission

(B) Increase HIV transmission

(C) Have a neutral effect upon HIV transmission

(D) Don't know

4. What do you think will be the impact of recent convictions on HIV stigma and discrimination?

(A) Increase HIV stigma and discrimination

(B) Reduce HIV stigma and discrimination

(C) Have a neutral effect on HIV stigma and discrimination

(D) Don't know

5. What impact will recent convictions have on discussions by service users with health professionals?

(A) More likely to be frank about their sexual relations and partners

(B) Less likely to be frank about their sexual relations and partners

(C) Have a neutral effect

(D) Don't know

6. What impact will the recent criminal convictions for sexual transmission of HIV have on altering disclosure of HIV status with new sexual partners by HIV-positive individuals?

(A) HIV-positive individuals will be more likely to disclose their HIV status

(B) HIV-positive individuals will be less likely to disclose their HIV status

(C) Have a neutral effect upon disclosure of HIV status by HIV-positive individuals

(D) Don't know

Part C continued on next page >

7. What impact will the recent criminal convictions have on altering the likelihood of discussions about HIV status with new sexual partners by individuals who consider themselves HIV-negative?

(A) HIV-negative individuals will be more likely to disclose their HIV status

(B) HIV-negative individuals will be less likely to disclose their HIV status

(C) Have a neutral effect upon disclosure of HIV status by HIV-negative individuals

(D) Don't know

8. What impact will the recent criminal convictions have on altering disclosure of HIV status with new sexual partners by people with an unknown HIV status?

(A) HIV-unknown individuals will be more likely to disclose their HIV status

(B) HIV-unknown individuals will be less likely to disclose their HIV status

(C) Have a neutral effect upon disclosure of HIV status by HIV- unknown individuals

(D) Don't know

Part D:

We would be very grateful if you could briefly answer the following 3 qualitative questions. However, if you are unable to, please don't forget to return the questionnaire anyway.

1. Have you received any formal training regarding sexual transmission of HIV or any associated issues related to clinical practice?

(A) No (*Please go to Q. 2*) (B) Yes, *please describe below*:

2. Do you feel you have any training needs related to dealing with sexual transmission of HIV issues in your clinical practice?

(A) No (*Please go to Q. 3*) (B) Yes, *please describe below*:

Last page of Questionnaire on next page >

3. Please briefly outline below the principles of any policy regarding clinical practice and HIV transmission issues within your service?
[*Please attach a copy of your department policy if you prefer*]

Thank you for completing the questionnaire.

Please return in the enclosed reply paid addressed envelope or post to:

Eamonn Rodohan
Trainee Clinical Psychologist
Doctor of Clinical Psychology Training Course
University of Hertfordshire (Hatfield Campus)
College Lane
Hatfield
HERTS AL10 9AB

Please contact me if you would like to discuss the questionnaire:

Telephone: 01438-314333 (extension 3764) or
via Jean Thomas (Course Administrator): 01707-286322
Email: E.P.Rodohan@herts.ac.uk

If you would like to receive results of the research project please contact me separately to avoid compromising participant confidentiality.

Please return by 14th October 2006

This research project is supervised by:

Liz Shaw, Clinical Psychologist
Psychology Dept., St Ann's Hospital, St Ann's Road, Haringey, London N15 3TH
Telephone: 020 8532 6359

Dr Barbara Mason, Research Supervisor
Doctor of Clinical Psychology Training Course, Univ. of Hertfordshire (address above)
Telephone: 01707-286322

This research study has received approval by the
University of Hertfordshire (Psychology Department) Ethics Committee
Registration Protocol Number: PSY/08/06/ER

Appendix 3.1
SPSS & RESULTS TABLES for SURVEY FINDINGS

Part A: Clinical Practice Descriptors (Section 3.1.1)

Tables providing the full statistical findings reported in section 3.1.1 are given below. Median responses have been highlighted in bold to enable subgroup comparisons.

Table A3.1: Responses to Question A12a (Safer-sex discussions)

Question A12a	Generic Clinical (Subgroup)		SH-Experienced (Subgroup)		HIV-Experienced (Main Group)	
If you have experience of HIV-positive clients, how often (in your recent practice) do you have discussions regarding safer-sex with them?						
Category/Scoring:	**N**	**Cum %**	**N**	**Cum %**	**N (%)**	**Cum N (%)**
(4) Always	3	20%	9	23%	12 (22%)	12 (22%)
(3) Often	0	-	10	48%	10 (18%)	22 (40%)
(2) Usually	0	-	**8**	**68%**	**8 (15%)**	**30 (55%)**
(1) Sometimes	3	40%	11	95%	14 (26%)	44 (80%)
(0) Never	**9**	**60%**	2	5%	11 (20%)	11 (20%)
Total	15	100%	40	100%	55	100%

Responses 1-4 and corresponding cumulative percentages have been presented in reverse order to allow consideration of the proportion reporting best practice (i.e. '*always*' response).

Table A3.2: Q.A12b responses (Note-taking/safer-sex discussions)

Question A12b	Generic Clinical (Subgroup)		SH-Experienced (Subgroup)		HIV-Experienced (Main Group)	
...how often (in your recent practice) do you record in your notes details regarding safer-sex with them [HIV-clients] **?**						
Category:	**N**	**Cum %**	**N**	**Cum %**	**N (%)**	**Cum N (%)**
(4) Always	4	27%	8	20%	12 (22%)	12 (22%)
(3) Often	0	-	9	43%	9 (16%)	21 (38%)
(2) Usually	1	34%	**10**	**68%**	**11 (20%)**	**32 (58%)**
(1) Sometimes	1	40%	11	95%	12 (22%)	44 (80%)
(0) Never	**9**	**60%**	2	5%	11 (20%)	11 (20%)
Total	15	100%	40	100%	55	100%

Table A3.3: Q.A12d responses (HIV-disclosure discussions)

Question A12d	Generic Clinical (Subgroup)		SH-Experienced (Subgroup)		HIV-Experienced (Main Group)	
...have you discussed disclosure of HIV-status to sexual-partners with them ?						
Category:	**N**	**Cum %**	**N**	**Cum %**	**N (%)**	**Cum N (%)**
(4) Always	5	33%	6	15%	11 (20%)	11 (20%)
(3) Often	0	-	12	45%	12 (22%)	23 (42%)
(2) Usually	**1**	**40%**	**10**	**70%**	**11 (20%)**	**34 (62%)**
(1) Sometimes	2	53%	9	92%	11 (20%)	45 (82%)
(0) Never	7	47%	3	8%	10 (18%)	10 (18%)
Total	15	100%	40	100%	55	100%

Table A3.4: Q.A12c (Discussing confidentiality limits)

Question A12c	Generic Clinical (Subgroup)		SH-Experienced (Subgroup)		HIV-Experienced (Main Group)	
...do you include specific details relating to your professional duty to disclose confidential information as part of any discussion regarding confidentiality issues you have with them?						
Category:	**N**	**Cum %**	**N**	**Cum %**	**N (%)**	**Cum N (%)**
(4) Always	**8**	**53%**	17	43%	25 (46%)	25 (45%)
(3) Often	0	-	**7**	**60%**	**7 (13%)**	**32 (58%)**
(2) Usually	0	-	2	65%	2 (4%)	34 (62%)
(1) Sometimes	3	73%	10	90%	13 (23%)	47 (85%)
(0) Never	4	27%	4	10%	8 (15%)	8 (15%)
Total	15	100%	40	100%	55	100%

Table A3.5: Q.A12e (Confidentiality limits/sexual discussions)

Question A12e	Generic Clinical (Subgroup)		SH-Experienced (Subgroup)		HIV-Experienced (Main Group)	
...do you provide additional information regarding confidentiality issues when specifically discussing sex or sexual-partners with them? (i.e. Do you outline, or clarify that there may be limits to professional confidentiality which could apply to information disclosed by the client within this particular context?).						
Category:	**N**	**Cum %**	**N**	**Cum %**	**N (%)**	**Cum N (%)**
(4) Always	5	33%	2	5%	7 (13%)	7 (13%)
(3) Often	0	-	2	10%	2 (4%)	9 (16%)
(2) Usually	1	40%	4	20%	5 (9%)	14 (25%)
(1) Sometimes	**2**	**53%**	**18**	**65%**	**20 (36%)**	**34 (62%)**
(0) Never	7	47%	14	35%	21 (38%)	21 (38%)
Total	15	100%	40	100%	55	100%

Table A3.6: Q.A12f (Note-taking/confidentiality discussions)

Question A12f	Generic Clinical (Subgroup)		SH-Exp'd (Subgroup)		HIV-Experienced (Main Group)	
...do you record in your notes details of any discussions regarding confidentiality issues that you have with them?						
Category:	N	Cum %	N	Cum %	**N (%)**	**Cum N (%)**
(3) Record specific details confidentiality limits	2	13%	4	10%	6 (11%)	6 (11%)
(2) Record confidentiality limits/general terms only	5	47%	13	43%	18 (33%)	24 (44%)
(1) Record confidentiality discussions/generally	**7**	**93%**	**15**	**80%**	**22 (40%)**	**46 (84%)**
(0) Do not record info re confidentiality discussions	1	7%	8	20%	9 (16%)	9 (16%)
Total	15	100%	40	100%	55	100%

Table A3.7: Q.A12g (Changed clinical practice)

Question A12g	Generic Clinical (Subgroup)		SH-Experienced (Subgroup)		HIV-Experienced (Main Group)	
...have you changed any aspects of your clinical practice in recent years?						
Category:	**N**	**%**	**N**	**%**	**N**	**%**
(0) No	**13**	**87%**	**23**	**58%**	**36**	**66%**
(1) Yes	2	13%	17	43%	19	34%
Total	15	100%	40	100%	55	100%

Table A3.8: Q.A13 (HIV-disclosure to sexual-partners by psychologists)

Question A13	Generic Clinical (Subgroup)		SH-Experienced (Subgroup)		HIV-Experienced (Main Group)		Overall Sample
How many recent cases have you been involved with where you considered the possible need to disclose a client's HIV-status without their consent to actual or potential sexual-partners (including seeking guidance on the need to do so)?							
Category:	N	Cum. (%)	N	Cum. (%)	**N**	**Cum. (%)**	(Cum. %)
(2) 6-10	0	-	1	3%	1	1 (2%)	(1%)
(1) 1–5	2	13%	10	28%	12	13 (24%)	(12%)
(0) Nil	**13**	**87%**	**29**	**72%**	42	**42 (76%)**	(39%)
Total	15	100%	40	100%	55	100%	

Table A3.9: Q.A14 (HIV-disclosure to other professionals)

Question A14	Generic Clinical (Subgroup)		SH-Experienced (Subgroup)		HIV-Experienced (Main Group)		Overall Sample
How many recent cases have you been involved with where you have considered the need to disclose a client's HIV-status to other professionals (including guidance on the need to do so)?							
Category:	N	Cum. (%)	N	Cum. (%)	**N**	**Cum. (%)**	(Cum. %)
(4) More than 25	0	-	1	3%	1	1 (2%)	(1%)
(3) 10-25	0	-	1	5%	1	2 (4%)	(2%)
(2) 6-10	0	-	2	10%	2	4 (7%)	(4%)
(1) 1-5	9	60%	11	38%	20	24 (44%)	(22%)
(0) Nil	**6**	**40%**	**25**	**63%**	**31**	**31 (56%)**	(29%)
Total	15	100%	40	100%	55	100%	(51%)

Table A3.10: Q.A.18 (Disclosure of criminal HIV-transmission/reckless behaviour)

Question A18	Generic Subgroup	SH-Exp Subgroup	HIV-Experienced (Main Group)		Overall Sample
Has a HIV-positive client ever disclosed information to you of behaviour that could potentially be considered as the reckless transmission of HIV and criminal?					
Category:	N	N	**N**	**%**	(%)
(1) Yes	4	26	30	55%	(38%)
(0) No (incl. missing)	0	14	**25**	**45%**	(24%)
Total	15	40	55	100%	

Due to practical restraints, SPSS output relating to statistically significant results for major analyses (e.g., correlations, regression etc.) are presented. Consequently, outputs relating to descriptive data or t'tests are not included; however values have already been reported within the relevant Table presented within the Results Section. Page numbers are stated for ease of reference.

Section 3.1.2 PART B: Professional Self-Efficacy Scale

Self-efficacy & Clinical/Demographic Variables

SPSS tables for Table 3.7: Pearson's correlation co-efficients for self-efficacy ratings by HIV-experienced subgroup membership

HIVEXP1 = 1 (FILTER) = Selected

Correlations[a]

		sexhealthexp_yesno	SUM_SELF_EFFICACY
sexhealthexp_yesno	Pearson Correlation	1	.374**
	Sig. (1-tailed)		.002
	N	55	55
SUM_SELF_EFFICACY	Pearson Correlation	.374**	1
	Sig. (1-tailed)	.002	
	N	55	55

**. Correlation is significant at the 0.01 level (1-tailed).

a. HIVEXP1 = 1 (FILTER) = Selected

Sexual-Orientation (subgroup)

Correlations[a]

		SUM_SELF_EFFICACY	hetero/homo_gps
SUM_SELF_EFFICACY	Pearson Correlation	1	.258*
	Sig. (1-tailed)		.029
	N	55	55
hetero/homo_gps	Pearson Correlation	.258*	1
	Sig. (1-tailed)	.029	
	N	55	55

*. Correlation is significant at the 0.05 level (1-tailed).

Section 3.1.3 - PART C: Attitudes towards HIV-Criminalisation

Attitudes towards HIV-Prosecutions (Psychologist Groupings)

Table 3.11: Cross-tabulations, including effect-sizes of ratings by psychologist subgroups – Question C1

Sexual-Health Experience (Grouping Variable)

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
C1_test_combined0 * sexhealthexp_yesno	101	94.4%	6	5.6%	107	100.0%

C1_test_combined0 * sexhealthexp_yesno Crosstabulation

Count

		sexhealthexp_yesno		Total
		no experience	experience	
C1_test_combined0	.00	4	10	14
	1.00	21	19	40
	2.00	38	9	47
Total		63	38	101

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	15.315[a]	2	.000
Likelihood Ratio	15.752	2	.000
Linear-by-Linear Association	15.121	1	.000
N of Valid Cases	101		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.27.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.389	.000
	Cramer's V	.389	.000
N of Valid Cases		101	

Sexual-Orientation (Grouping Variable)

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
C1_test_combined0 * hetero/homo_gps	101	94.4%	6	5.6%	107	100.0%

C1_test_combined0 * hetero/homo_gps Crosstabulation

Count

		hetero/homo_gps		Total
		heterosexual	non-heterosexual	
C1_test_combined0	.00	9	5	14
	1.00	28	12	40
	2.00	45	2	47
Total		82	19	101

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.418[a]	2	.002
Likelihood Ratio	14.004	2	.001
Linear-by-Linear Association	10.945	1	.001
N of Valid Cases	101		

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is 2.63.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.351	.002
	Cramer's V	.351	.002
N of Valid Cases		101	

Service-Setting (Grouping Variable)

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
C1_test_combined0 * sexhealthservice_yesno	101	94.4%	6	5.6%	107	100.0%

C1_test_combined0 * sexhealthservice_yesno Crosstabulation

Count

		sexhealthservice_yesno		Total
		non sexual-health service	sexual-health service	
C1_test_combined0	.00	7	7	14
	1.00	27	13	40
	2.00	41	6	47
Total		75	26	101

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.405[a]	2	.009
Likelihood Ratio	9.456	2	.009
Linear-by-Linear Association	9.299	1	.002
N of Valid Cases	101		

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is 3.60.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.305	.009
	Cramer's V	.305	.009
N of Valid Cases		101	

HIV-Experience (Grouping Variable)

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
C1_test_combined0 * non-hivexp/hivexp	101	94.4%	6	5.6%	107	100.0%

C1_test_combined0 * non-hivexp/hivexp Crosstabulation

Count

		non-hivexp/hivexp		Total
		no hiv exp	hiv exp	
C1_test_combined0	.00	3	11	14
	1.00	18	22	40
	2.00	29	18	47
Total		50	51	101

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.537[a]	2	.023
Likelihood Ratio	7.849	2	.020
Linear-by-Linear Association	7.365	1	.007
N of Valid Cases	101		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.93.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.273	.023
	Cramer's V	.273	.023
N of Valid Cases		101	

Attitudes towards Changing the Law (Psychologist Groupings)

Table 3.12: Cross-tabulations, including effect-sizes for ratings per psychologist subgroups – Question C2

Sexual-Orientation (Grouping Variable)

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
C2_test_combined0 * hetero/homo_gps	89	83.2%	18	16.8%	107	100.0%

C2_test_combined0 * hetero/homo_gps Crosstabulation

Count

		hetero/homo_gps		Total
		heterosexual	non-heterosexual	
C2_test_combined0	.00	22	6	28
	1.00	19	9	28
	2.00	31	2	33
Total		72	17	89

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.812[a]	2	.002
Likelihood Ratio	7.457	2	.001
Linear-by-Linear Association	2.587	1	.001
N of Valid Cases	89		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.35.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.277	.002
	Cramer's V	.277	.002
N of Valid Cases		89	

Impact of HIV-Prosecutions on HIV-Transmission (Psychologist Groupings)

Table 3.13: Cross-tabulations, including effect-sizes for ratings per psychologist subgroups – Question C3

Service-Setting (Grouping Variable)

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
C3_test * sexhealthservice_yesno	57	53.3%	50	46.7%	107	100.0%

C3_test * sexhealthservice_yesno Crosstabulation

Count

		sexhealthservice_yesno		Total
		non sexual-health service	sexual-health service	
C3_test	-1.00	15	1	16
	.00	18	9	27
	1.00	4	10	14
Total		37	20	57

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.996[a]	2	.001
Likelihood Ratio	15.266	2	.000
Linear-by-Linear Association	13.565	1	.000
N of Valid Cases	57		

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is 4.91.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.496	.001
	Cramer's V	.496	.001
N of Valid Cases		57	

Sexual-Health Experience (Grouping Variable)

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
C3_test * sexhealthexp_yesno	57	53.3%	50	46.7%	107	100.0%

C3_test * sexhealthexp_yesno Crosstabulation

Count

		sexhealthexp_yesno		Total
		no experience	experience	
C3_test	-1.00	13	3	16
	.00	14	13	27
	1.00	2	12	14
Total		29	28	57

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.416[a]	2	.001
Likelihood Ratio	14.683	2	.001
Linear-by-Linear Association	13.088	1	.000
N of Valid Cases	57		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.88.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.485	.001
	Cramer's V	.485	.001
N of Valid Cases		57	

HIV-Experience (Grouping Variable)

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
C3_test * non-hivexp/hivexp	57	53.3%	50	46.7%	107	100.0%

C3_test * non-hivexp/hivexp Crosstabulation

Count

		non-hivexp/hivexp		Total
		no hiv exp	hiv exp	
C3_test	-1.00	10	6	16
	.00	9	18	27
	1.00	1	13	14
Total		20	37	57

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.115[a]	2	.004
Likelihood Ratio	11.124	2	.002
Linear-by-Linear Association	9.924	1	.001
N of Valid Cases	57		

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is 4.91.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.421	.004
	Cramer's V	.421	.004
N of Valid Cases		57	

Sexual-Orientation (Grouping Variable)

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
C3_test * hetero/homo_gps	57	53.3%	50	46.7%	107	100.0%

C3_test * hetero/homo_gps Crosstabulation

Count

		hetero/homo_gps		Total
		heterosexual	non-heterosexual	
C3_test	-1.00	15	1	16
	.00	21	6	27
	1.00	8	6	14
Total		44	13	57

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.693[a]	2	.003
Likelihood Ratio	6.004	2	.002
Linear-by-Linear Association	5.551	1	.018
N of Valid Cases	57		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 3.19.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.316	.003
	Cramer's V	.316	.003
N of Valid Cases		57	

Professional Self-Efficacy Scale (Reliability Analyses)

Reliability Analysis (Overall scale)

Case Processing Summary

		N	%
Cases	Valid	107	100.0
	Excluded[a]	0	.0
	Total	107	100.0

a. Listwise deletion based on all variables in the procedure.

Case Processing Summary

		N	%
Cases	Valid	107	100.0
	Excluded[a]	0	.0
	Total	107	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.930	.929	16

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
48.7839	130.446	11.42129	16

Appendix 3.2
UK-Coalition Survey Findings
(Published Results)

The following are the preliminary results (published online) for the UK-Coalition survey:

UKC UK Coalition of People Living With HIV & AIDS

250 Kennington Lane
London SE11 5RD
Tel: 020 7564 2180
Fax: 020 7564 2140
August 2005

Criminalisation of HIV Transmission

Results of online and postal questionnaire survey

The questionnaire was introduced in the May edition of Positive Nation, with top of page advertising on both the PN and UKC websites. Responses were elicited either by post or on line via the UKC website (those received by post were transcribed to the website by PN staff). 233 responses were recorded and with publication of some interim results in the August edition of Positive Nation, the questionnaire was closed in case the editorial coverage biased further responses.

The questionnaire did not ask respondents to define themselves by age, ethnicity, sex, marital status or lifestyle – as such the answers may represent a snapshot of how people with HIV see their position on the questions asked, but the number of respondents is not sufficiently high to form a representative sample. The survey targeted people with HIV, but The anonymous nature of responses makes it possible, particularly on line, that the same person could respond more than once.

Six main questions were asked, plus one on HIV status of the respondent.

Overview of responses

Total number of respondents =233, total from people identified as HIV Positive = 165, and those that did not identify as HIV positive = 68.

1 In your view should the Crown prosecute

	%age responses identified as HIV+	%age responses not identifying as HIV+	%age of all the responses
Intentional and reckless transmission	11%	24%	22%
Intentional transmission only	47%	28%	42%
No prosecutions at all	35%	32%	34%
Do something else	7%	7%	7%
No answer	1%	9%	3%

2 Should the Government change the law …

	%age responses identified as HIV+	%age responses not identifying as HIV+	%age of all the responses
Don't change it	27%	13%	22%
Specific law for intentional transmission	42%	34%	39%
Specific law for intentional and reckless	11%	24%	15%
Do something else	18%	19%	18%
No answer	3%	10	5%

3 Impact of convictions on HIV transmission rates

	%age responses identified as HIV+	%age responses not identifying as HIV+	%age of all the responses
Reduce HIV transmission	8%	15%	9%
Increase HIV transmission	35%	24%	31%
Make no difference	48%	38%	45%
Don't know	8%	13%	10%
No answer	0%	3%	3%

4 Impact of convictions on Stigma and Discrimination

	%age responses identified as HIV+	%age responses not identifying as HIV+	%age of all the responses
Increase stigma	84%	62%	76%
Reduce stigma	2%	4%	3%
Make no difference	10%	15%	11%
Don't know	1%	6%	3%
No answer	3%	13%	3%

5 **Will convictions make people more frank in their discussions of sex with health professionals or HIV organisations**

	%age responses identified as HIV+	%age responses not identifying as HIV+	%age of all the responses
More frank	15%	18%	15%
Less frank	47%	38%	45%
Make no difference	36%	28%	33%
Don't know	2%	4%	3%
No answer	0%	12%	3%

6 **Likelihood of altering disclosure decisions with new sexual partners**

	%age responses identified as HIV+	%age responses not identifying as HIV+	%age of all the responses
More likely	21%	21%	21%
Less likely	21%	16%	19%
Make no difference	48%	43%	46%
Don't know	7%	7%	7%
No answer	4%	24%	7%

7 **HIV status of respondents**

HIV positive	165	71%
HIV negative	31	13%
Untested	16	7%
Prefer not to say	11	5%
Not answered	10	4%
	233	

Recommendations

1 *Position on prosecutions*

Despite the low level of responses, the answer to the question "should the Crown prosecute intentional transmission only", at **47%** of the people living with HIV is 12% higher than the next most popular answer (no prosecutions at all = 35%).

UKC's previously held position that people who intentionally transmit HIV, as in using HIV as a weapon, should be prosecuted is reinforced by the responses to the question. We should continue to oppose prosecution of reckless transmission on the basis of the potential damage to public health.

2 *Call for a change in the law*

42% of plwha responding have called for a specific law to be created that covers intentional transmission of HIV. A further **11%** of respondents wanted a specific law to cover intentional and reckless transmission.

There is no indication that, in the view of respondents, criminalising HIV transmission will reduce transmission rates (**83%** of plwha responding thought it would either increase transmission rates or make no difference).

UKC should adopt the position that the law needs to be changed. However, what we should seek to ensure is that a law change doesn't result in introduction of an HIV specific law because this would reinforce rather than reduce the stigmatisation of HIV infection above all other serious communicable diseases. Our position is that the aim of any legislation should be to help eliminate or reduce the spread of HIV in the population based on public health principles, not those that inform the criminal law. Additionally a further aim should be to protect and empower people with HIV infection.

An acceptable law change might be to introduce an offence of intentional transmission of serious disease, as was proposed in 1998; an alternative might be a restriction on use of the existing law to put back the precedent set in 1888 in R v Clarence (transmission of an STI not to be considered as an assault) which the appeal court swept away in R v Dica. Additionally, with the courts' modern day interpretation of "reckless" and the new concept of "informed consent to the risk of HIV infection", transmission of HIV could still fit within the draft Offences Against the Person Bill of 1998, thus creation of an acceptable new law is incredibly complex.

Law change can be achieved through the parliamentary process. A restriction in the application of the existing law might be achieved if one of those convicted were to appeal to the House of Lords : the appeal court is only interested in the correct application of the law and the criminal process, whereas the Law Lords are able to look also at whether the application of the law to the broader circumstances of society was appropriate.

UKC should continue to work with lawyers, the Home Office, CPS, All Party Parliamentary Group on AIDS, and other HIV organisations to move towards a satisfactory outcome.

3 Positive Prevention

84% of plwha respondents thought criminalisation would increase stigma and discrimination. **48%** of plwha respondents said that they are likely to be less frank in discussing sex with health professionals and HIV organisations.

47% of plwha thought that criminalisation would make no difference in their disclosure behaviour with new sexual partners, but respondents were not asked what their current behaviour was. Seen against the overwhelming number thinking that stigma and discrimination will increase, the indication may be that plwha will increasingly **not** disclose their status to new sexual partners.

Our view is that sex between two (or more) consenting adults should not be the ultimate responsibility of one person alone. Individuals should be responsible for their own behaviour and not duck responsibility for their choices or actions. Everyone should assume that anyone that they sleep with COULD be HIV positive. Ignorance of safer sex should not be an excuse for either party. The notion of 'informed consent' to the risk of HIV infection needs to be carefully and clearly addressed.

More investment is needed in primary HIV prevention activity that directly targets people living with HIV rather than targeting the broader population. The judgement in the Court of Appeal (R v. Konzani) is clear that the issue of disclosure, i.e. concealment of HIV status, almost inevitably equals deception, thus work in this area should prioritise plwha dealing with disclosure.

Legal precedent has failed to deal with the issue of safer sex and whether the use of condoms negates "recklessness" as regards criminal liability for HIV transmission. In the "spanner" trial, (R v Brown) the Law Lords implied that (ineffective) use of condoms may not absolve the plwha of liability. However, other research suggests that many plwha are incredibly skilled at risk assessment given the appropriate information on which to base decision making. In the interests of public health, investment should be made in assisting plwha to make safer sex decisions through provision of information that assists them in assessing risk and supports them in adopting personal strategies to reduce the risk of HIV transmission alongside strategies to deal with disclosure as a separate but inter-related issue.

4 Combating Stigma and Discrimination

The high percentage of respondents thinking that criminalisation will increase stigmatisation is perhaps also an indicator of the number that already feel stigmatised (anecdotally we know this, but we did not seek an answer to a question that ranked how stigmatised plwha already felt). Coupled with other evidence of discrimination in practice, this reinforces the need for more work that focuses on (i) the broader community in an attempt to reduce the levels of discrimination and (ii) those that are HIV positive to reduce internalised stigma over this and other issues.

On the matter of prosecutions, the Crown Prosecution Service have in each case thus far displayed a particularly tabloid attitude to successful prosecutions – the defendants are all portrayed as "evil monsters", akin to serial sex abusers, who took advantage of "innocent victims". The portrayal of non disclosure as now equating to deception which thus negates consent to an intimate, and in each of these cases long term, sexual relationship which is far from the "monster/innocent virgin" scenarios played out in court. Convictions in England thus far have all been against immigrant males where race and asylum seeker discrimination has also played a part in whipping up public hysteria, despite one of those convicted being a European national.

The salacious headlining of these cases by the CPS both in court and in their published annual reports should be challenged. As well as challenging individual discriminatory cases, UKC will work with CPS and others on the broader national policy context.

Bernard Forbes
Chairman
22 August 2005

The following pages contain the tabular data and additional comments where people were asked to suggest another action to those identified in the questionnaire. Percentages expressed in red relate to the proportion as a percentage of those that identified themselves as HIV positive, those in the totals column in **black** relate to all respondents, those in green to those who did not identify as HIV positive, including those who chose not to answer the question on HIV status (for clarity, the green answers are to the right of the rest of the tables).

1 In Your view should the Crown ...

		r	%	totals	not +ve
Prosecute both intentional and reckless transmission					
	HIV positive	18	8%	11%	
	HIV negative	9	4%		
	Untested	4	2%	**21%**	24%
	Prefer not to say	3	1%		
Prosecute intentional transmission only					
	HIV positive	78	33%	47%	
	HIV negative	13	6%		
	Untested	5	2%	**42%**	
	Prefer not to say	1	0%		28%
No prosecutions at all					
	HIV positive	57	24%	35%	
	HIV negative	9	4%		
	Untested	6	3%	**34%**	
	Prefer not to say	4	2%		
	Not answered	3	1%		32%
Do something else					
	HIV positive	11	5%	7%	
	HIV negative		0%		
	Untested	1	0%	**7%**	
	Prefer not to say	3	1%		
	Not answered	1	0%		7%
Question not answered					
	HIV positive	1	0%	1%	
	HIV negative		0%		
	Untested		0%		
	Prefer not to say	0	0%	**3%**	
	Not answered	6	3%		9%
		233	100%		

Do Something Else suggestions included the following (spelling has been corrected where required, otherwise these are the words used by respondents):

From people with HIV

- When someone meets person they are fond of and that other person is fond of them, the chemistry between them is right, it can be very hard to explain to that person what is wrong with you. You have the fear of rejection maybe humiliation from the other person. Maybe the other person will accept at the beginning but have doubts later. If you viral load is undetectable you are as good as negative anyway the risk to the other person is highly unlikely. i am a classic example of this none of my 2 children are positive. But if the sex was rape then and only then should there be a law of transmission.
- All parties need to prove in a court with a special medical people and psychologists then it should go to a court of law, and what about other viruses - will they be included, eg .influenza virus, TB, herpes. Will these people will be prosecuted to give these viruses to people with HIV for their protection, whilst travelling in the underground and buses.
- Current legislation should cover rape and non consensual sex and be implemented with more force and more severe penalties. If a rapist transmits Hepatitis, Herpes, HPV other STIs are they dealt with differently than if no STI is transmitted? Including transmission of HIV stigmatises HIV infection. It will be a deterrent to taking an HIV test because if you do not know you cannot be blamed.
- Establish clearer rules of evidence and legislate to protect those suffering from an HIV or AIDS "diagnosis" from vexatious prosecution and persecution at the hands of a prejudicial judiciary.
- Not prosecute 'intentional' until a change in the law can protect plwh from the prosecution down scaling the 'perceived offence' to 'reckless'. Only when this change in the law currently used should support be given to 'intentional transmission' and this should exclude sex between two consenting adults.
- Only prosecute cases where there is malice of forethought. An individual should be responsible for their own behaviour. Ignorance of safer sex should not be an excuse for either party.
- Prosecute intentional transmission, but not with the option of downgrading to reckless
- Prosecute intentional transmissions of serious infection/illness (which might include HIV among others)
- The 1861 law needs to be revised and updated or a new law created which addresses the correct complexities of HIV
- The court should not influence what happens in bedroom. This is just like teenage pregnancies. Are they prosecuted in court? It really is a shame. And why now?

From an untested respondent:

- Prosecute only where the 'victim' has specifically and directly asked the partner about HIV status and has been lied to.

And from people who preferred not to answer the HIV status question:

- Empower the society to feel free to talk about their status with others the way gay people do
- Everybody is aware of risk of HIV. Prosecution of reckless/intentional transmission should only be applied on cases of rape, sex with minors or sex with people of unsound mind, otherwise people who knowingly made their conscious and sober decision to have sex should be left, how about somebody with hepatitis sitting next to you and may be you catch infection, should they be prosecuted? how about other known contagious disease, should patients be prosecuted incase of transmissions if not why HIV alone. disclosing your status now can lead to malicious allegations, hence most people will refrain from disclosing for fear of victimisation, after a failed relationship
- Not get involved unless GUM services feel it appropriate.

A number of other respondents made comments on this question even though they answered one of the other options which did not call for comment

Comment	HIV Status
A) - But only if actual evidence of DNA checks have also been established	Positive
No action should be taken against transmission except in cases of rape	Positive
But how do you prove this? You certainly can't definitely prove someone was or wasn't 'reckless' : people define this term in different ways anyway and the infected party has to take some responsibility. I suppose if it were fairly certain that the infection was intentional then that person should be punished in some way, but would their mental state be taken into account? Many people who behave in this way are not acting rationally and need counseling and help to deal with their status/other issues- locking them up is not going to solve anything- and the transmission of HIV inside prisons is a serious problem in itself. Ultimately perhaps there needs to be some kind of deterrent to deter a malicious tiny minority but disclosure should not, in my opinion, be obligatory. Everyone should assume anyone you sleep with could be positive and act accordingly- that way you will stay safe- or safer.	Positive
If someone intentionally infects others they should be prosecuted. Full stop.	Positive
must be very clear of intention	Positive
only if t is non-consensual (rape). Consenting adults are equally responsible for protecting their health.	Positive
reckless is too hard to prove. not everyone does know they are HIV+, and this is too easy a defense to use.	Negative
I do feel that there is evil people out there who would	Positive

infect a partner to get back at them for something. So in this respect this person should be made to pay too.	
If people don't want to use condoms they know the risk and shouldn't complain if then infected	Positive
It only adds to the old saying of HIV = Death	Positive
Prosecution of H.I.V when casual sex it's hilarious. Everyone should be aware of the risk of this behaviour and condoms protect from transmission (at least is what science says, and my H.I.V diagnosis is based on Science, so we can follow both or none of the theories). A guy H.I.V+, that uses condoms for casual sex can go to jail, but a brainless that is having unprotected sex even knowing that have sex with someone H.I.V can not be prosecuted for his actions until he decides to take a test??? Nice. Are doctors going to jail by transmitting M.R.S.A at U.K hospitals? Has anybody went to jail for passing Hep B or A, tuberculosis, or flu?? All those could kill and H.I.V person as me, with a CD4 of 40.	Positive
This is discrimination hiding behind fear and homophobia. When having consensual sex, one must take responsibility for one's own actions. We know the difference between "safe" and "unsafe" don't we? Should we ask if the Crown should prosecute cigarette companies? Alcohol producers?	Untested

The fact that so many people with HIV made additional comments may indicate strength of feeling by the individual respondent even though they answered the question in favour of one of the other options.

2 Should the Government change the law ...

Don't Change it					
	HIV positive	44	19%	27%	
	HIV negative	6	3%		
	Untested	1	0%	**22%**	
	Prefer not to say	1	0%		
	Not answered	1	0%		13%
Specific law for intentional transmission					
	HIV positive	69	30%	42%	
	HIV negative	15	6%		
	Untested	5	2%	**39%**	
	Prefer not to say	2	1%		
	Not answered	1	0%		34%
Specific law for intentional and reckless					
	HIV positive	18	8%	11%	
	HIV negative	7	3%		
	Untested	3	1%	**15%**	
	Prefer not to say	6	3%		24%
Something else					
	HIV positive	29	12%	18%	
	HIV negative	3	1%		
	Untested	6	3%	**18%**	
	Prefer not to say	3	1%		
	Not answered	1	0%		19%
Question not answered					
	HIV positive	5	2%	3%	
	HIV negative		0%		
	Untested	1	0%	**5%**	
	Prefer not to say	6	3%		10%
		233			

Comments under "Something Else" include:

From people with HIV

- Transmission of any disease, by consensual acts between adults, should not be criminalised. However, I do think the notion of "consent" would then need to be clarified.
- To take into account accidental transmission (eg condom failure) and to put the burden of proof as to the true source of infection [identity] onto the prosecution

side. Unless the accuser was a virgin, you cannot assume the accused was the first, or only, source of their infection.

- Tighten up the law so that normal transmission of infections is not prosecutable - we do not prosecute Hep C, Leprosy, TB, Syphilis and many others, why start now. It's the compensation culture breaking out in a different way so that people can duck responsibility for their own choices.
- The law should not be interfering at all in the dynamics of a pandemic. Tens of millions of people have been infected one way or another. Governments can't prosecute all these people who are also infected through some human contact anyway. The distinction between reckless and intentional is too fine if we are to take into account psychological states and belief and information systems. It will be a disaster for prevention efforts if any prosecution is allowed.
- The law should be changed to specifically exclude from prosecution HIV transmission through sex; to do otherwise both encourages people to abdicate responsibility for their own sexual health, and creates a high probability of conviction on the basis of probability, or prejudice and fear in the jury. It is virtually impossible to prove what happened in a bedroom where two people were present - for instance, whether disclosure occurred and whether the person infected accepted the risk of transmission.
- The Law should be changed to provide clarity and to prevent prosecutions being brought against positive people. Is the CPS to prosecute people for transmitting Influenza - it kills more people than HIV these days?
- The law should be changed so that it is NOT an offence to pass on HIV. After all it is not an offence to pass on a cold, herpes, or syphilis virus. its insane to further marginalise a section of the community who are already victimised and weak. the reason the men who have already been convicted of these offences probably were passing on the virus because they couldn't express their anger and fear in another way the law should focus on positive things it can do to protect people with HIV not criminalise us and marginalise us further
- the law presently used dates back to about 1861?, I realise that it is presently being reformed but if the law stands regarding "reckless and intentional transmission" will the government and the people decide to "brand" or by some other method make it mandatory that all people with HIV should be publicly identifiable, will HIV testing be made compulsory also as no knowledge of a persons status is no defence
- The law ought to be sensibly updated otherwise The Crown will pursue its own path and set the law of the land using the precedence of previous case law. I think circumstances in the world have sufficiently changed enough to merit an update in the law to provide the Crown and everyone living in the UK with better guidance.
- The law needs to be clarified for judges, probably by some sort of legislative change. Currently judges are flying in the face of Government policy, which is to prosecute intentional transmission only. If reckless transmission of HIV remains a prosecutable offence, then so should transmission of EVERY sexually transmitted infection. Why is this discrimination against HIV+ people allowed to continue just because of the views of ill-informed courts?
- step up information, if sex is consensual both parties should take responsibility for their actions. The portrayal of the 'innocent victim' is also an ignorant victim.... outdated and misleading. Emphasis should be on personal

responsibility. How can effective prosecutions be reliable -when so few rapists are convicted. Another form of discrimination aimed at poz people.

- Should be more voluntary and adults need to be adults !!.otherwise the problem will go underground and people will become fat cats to claim from the injuries board and safe sex will go out of the window and people will assume the other person to be responsible to play safe and use condoms (male and female)
- no more law; clarification of what exists; no further opportunity for complications.
- Make it a new law - only if can be sure someone WANTED to pass on HIV eg by injecting them with a fresh syringe of blood - not sex as no guarantee will transmit.
- Law should be made clear - can you take someone to court for passive smoking if you believe they have directly caused you to develop lung cancer. Or someone who gives you a cold virus.
- Law should be based on consultation with target groups to identify possible scenarios
- Keep laws, politicians, the courts et al out of the individual inter-personal interactions between adults (who must take responsibility for their own actions and not blame other when they fail to protect themselves) and stick to health education and services. OR: tattoo every person with a transmittable disease, sexual or otherwise, with an appropriately coloured Nazi logo and number.
- Introduce a law establishing, clearly, the responsibility of the individual to protect his or herself from infection and placing the onus on the individual to take precautions.
- Intentional transmission of serious infection/illness/symptoms
- If I need to disclose, why those with flu are allow to travel in the same bus as me???. Should they wear a T shirt disclosing it or stay Isolated to another planet for a while. Do I ask a casual partner if he has been test for thee kind of hep, HPV, another strain of H.I.V etc, etc,???? NO!, so why I should tell????
- I am a woman who was infected with HIV through rape. If I thought a change in law would reduce the incidence of rape, decrease HIV transmission and increase support and understanding for people with HIV I would support it. It may be possible to improve the law without providing a deterrent to HIV testing and reinforcing all the negative stereotypes about HIV and people infected with HIV. However what is more important is changes in the way rape cases are supported and dealt with; sex education for all young people which emphasises communication about sex and self esteem; support and counselling (which does not simply say use a condom) for people diagnosed with HIV infection. Looking at other countries which criminalised HIV transmission the main scapegoats became prostitutes (usually women). Unprotected, and particularly non consensual, sex between a positive man and a negative woman often results in HIV transmission (depending on the man's viral load, other STIs etc..) However unprotected sex between a positive woman and a negative man is much less likely to result in transmission of HIV (again high viral load and other STIs are key co factors). There are issues of gender which need to be thought through which have not come up in the discussions.
- HIV should not be singled out. If other diseases get prosecuted as well intentional transmission could be looked at (like poking someone with a syringe of blood at a robbery)
- Fight stigma and discrimination through training for all.

- Everyone has an obligation to look after their own sexual health. Why should the burden rely mostly on HIV people. If being HIV is an offence then people should be prosecuted for other sexually transmitted diseases e.g syphillis, gonorrhoea, Chlamydia, etc.
- Change to law to give more protection to people living with HIV, and set up processes to prevent discrimination against people living with HIV
- All HIV negative should be responsible for they sexual health in terms of HIV. People who are HIV will have to live with fear of prosecution and in my own opinion it simply does nothing to reduce transmission. People would rather stay not knowing their HIV status for fear of prosecution because you cannot disclose something you do not know.
- Add a clause to the law that states that anyone who consents to sex, consents to the risk of catching HIV or any other STI. Therefore, prosecution would still be possible in cases of rape (as defined by the law ie. even within marriage).

From HIV negative respondents:

- To establish sexual transmission is not a criminal offence.
- Make it unlawful to discriminate against HIV/AIDS as opposed to any other dangerous, crippling, debilitating or potentially fatal illness which is communicable.

From untested respondents:

- The law is not fine as it is - it needs to be changed so that it cannot be used in relation to any STI. If the law was fine as it is we would not be having this debate. The offences against the person act needs to be revised.
- The Government should recognise that the aim of any legislation should be to help eliminate or reduce the spread of HIV in the population. It should audit existing legislation to determine the extent to which it furthers, or impedes this aim. If there is to be coercive legislation it should be based on public health principles, not on those that inform the criminal law (i.e. retribution, deterrence). If criminal liability remains there should be no possibility of prosecution or conviction where a person is unaware of his/her HIV positive status, or where the person infected was aware of the risk of transmission (whether on the basis of disclosure OR general knowledge).
- Not really sure as don't know enough about the law as it stands although if not prosecuting for intentional or reckless HIV transmission law may or may not need to be changed
- Duty on both parties to ask each other about status
- Don't know what the existing law says

From people who chose not to answer the HIV status question:

- Introduce Euthanasia.
- In regards to HIV no law should be introduced, instead we should help the one's dying from HIV and find a cure

- Everyone should accept responsibility for their sexual activities. Providing a special law just for HIV will do more harm than good. The real culprits are the ones responsible for the creation of HIV.

Again, a number of people chose to make comments even though they answered the overall question with one of the direct choices provided when no further comment was expected:

Comment	HIV Status
it is not a crime to be HIV	Positive
to protect the rights of positive people negative and untested people should be aware of their own risks and should expect the consequences of unprotected sex we all have a right to look after ourselves before others	Positive
it is not a crime to be HIV people should get tested in new relationships	Positive
Do not criminalise HIV - it's a disease for goodness sake	Positive
With malice intent ?	Positive
Anybody who is positive and doesn't disclose their status to a prospective partner is an idiot.	Positive
I don't agree with any criminalisation of people with HIV	Positive
Appeals should go to High Court Lords and European Court of Human Rights	Positive

3 In your opinion will recent convictions for reckless transmission of HIV ...

Reduce onward transmission of HIV				
	HIV positive	13	6%	8%
	HIV negative	5	2%	
	Untested	3	1%	**9%**
	Prefer not to say	1	0%	
	Not answered	1	0%	15%
Increase onward transmission of HIV				
	HIV positive	57	24%	35%
	HIV negative	9	4%	
	Untested	4	2%	**31%**
	Prefer not to say	2	1%	
	Not answered	1	0%	24%
Make no difference to HIV transmission rates				
	HIV positive	80	34%	48%
	HIV negative	8	3%	
	Untested	9	4%	**45%**
	Prefer not to say	8	3%	
	Not answered	1	0%	38%
Don't know				
	HIV positive	14	6%	8%
	HIV negative	9	4%	
	Untested		0%	**10%**
	Prefer not to say		0%	13%
Question not answered				
	HIV positive	1	0%	**3%**
	Not answered	7	3%	3%
		233		

4 With regard to stigma in your opinion will recent convictions

Increase stigma					
	HIV positive	139	60%	3?	
	HIV negative	19	8%		
	Untested	10	4%	**76%**	
	Prefer not to say	10	4%		
	Not answered	3	1%		62%
Reduce stigma					
	HIV positive	3	1%	2%	
	HIV negative		0%		
	Untested	3	1%	**3%**	
	Prefer not to say		0%		4%
Make no difference	HIV positive	16	7%	10%	
	HIV negative	8	3%		
	Untested	2	1%	**11%**	
	Prefer not to say		0%		15%
Don't know					
	HIV positive	2	1%	1%	
	HIV negative	3	1%		
	Untested		0%	**3%**	
	Prefer not to say	1	0%		6%
Not answered	HIV positive	5	2%	3%	
	HIV negative	1	0%		
	Untested	1	0%	**3%**	
	Prefer not to say		0%		
	Not answered	7	3%		13%
		233			

5 Will the recent convictions ...

make you more frank when talking about sex with health professionals and HIV organisations

HIV positive	24	10%	15%		
HIV negative	6	3%			
Untested	4	2%	**15%**		
Prefer not to say	1	0%			
Not answered	1	0%		18%	

make you less frank when talking about sex with the above

HIV positive	78	33%	47%	
HIV negative	10	4%		
Untested	7	3%	**45%**	
Prefer not to say	8	3%		
Not answered	1	0%		38%

make no difference

HIV positive	59	25%	36%	
HIV negative	12	5%		
Untested	5	2%	**33%**	
Prefer not to say	2	1%		28%

don't know

HIV positive	4	2%	2%	
HIV negative	2	1%		
Untested		0%	**3%**	
Prefer not to say		0%		
Not answered	1	0%		4%

question not answered

HIV positive		0%	0%	
HIV negative	1	0%		
Untested		0%	**3%**	
Prefer not to say		0%		
Not answered	7	3%		12%
	233			

6 In the light of recent prosecutions will you ...

be more likely to disclose HIV status to new sexual partners

HIV positive	34	15%	21%	
HIV negative	8	3%		
Untested	4	2%	**21%**	
Prefer not to say	1	0%		
Not answered	1	0%		21%

be less likely to disclose HIV status to new sexual partners

HIV positive	34	15%	21%	
HIV negative	3	1%		
Untested	4	2%	**19%**	
Prefer not to say	3	1%		
Not answered	1	0%		16%

not change disclosure decisions in a sexual context

HIV positive	79	34%	48%	
HIV negative	16	7%		
Untested	6	3%	**46%**	
Prefer not to say	6	3%		
Not answered	1	0%		43%

don't know what I will do about disclosure in a sexual context

HIV positive	11	5%	7%	
HIV negative	3	1%		
Untested	1	0%	**7%**	
Prefer not to say	1	0%		7%

Question not answered

HIV positive	7	3%	4%	
HIV negative	1	0%		
Untested	1	0%	**7%**	
Prefer not to say		0%		
Not answered	7	3%		24%
	233			

7 HIV Status of respondents

HIV positive	165	71%	
HIV negative	31	13%	
Untested	16	7%	
Prefer not to say	11	5%	
Not answered	10	4%	29%
	233		

Figures above in green relate to the respondents who did not identify as HIV positive.

The Quesionnaire – online version

Now you've heard from the experts on the criminalisation of HIV transmission, we would like to know what you think

Have your say by completing this short questionnaire online

after

The questionnaire is designed for people from the U.K. only.

In your view, should the Crown

something else - please tell us what below

if you chose "something else" -

please tell us what here

Should the government change the law

click to select answer

if you chose "something else" -

please tell us what here

In your opinion will recent convictions for reckless transmission of HIV

click to select answer

In your opinion, will the recent convictions

click to select answer

Will the recent convictions

click to select answer

In the light of the recent prosecutions will you

click to select answer

Your HIV status

click to select answer

That's it!

Appendix 3.3
UK-Coalition/BPS Survey Findings
(UK-C overall sample)

The following tables are referred to within the statistical findings presented within Results section 3.1.3:

Question C1

Table A3.11: Cross-tabulations, including effect-sizes of ratings by psychologist subgroups – Question C1

Question C1	Pearson's chi-square Cross-tabulation		Effect-size
Grouping Variable Total N=101/107	x^2 (*df=2*)	**Exact *p*** (one-sided)	**Cramers'*V*** (% variations in frequencies)
SH-Experience Exp'd (N=38) Non-Exp'd (N=63)	15.315	0.001**	**0.389** (15%)
Sexual-Orientation Gay/bisexual (N=19) Heterosexual (N=82)	12.418	0.001**	**0.351** (12%)
Service-Setting SH-setting (N=26) Non SH (N=75)	9.405	0.009*	**0.305** (9%)
HIV-Experience Exp'd (N=51) Non-Exp'd (N=50)	7.537	0.023*	**0.273** (7.5%)

** Highly significant at p<0.001 level *Significant at P<0.05 level

Question C2

Table 3.12: Cross-tabulations, including effect-sizes for ratings per psychologist subgroups – Question C2

Question C2	Pearson's chi-square Cross-tabulation		Effect-size
Grouping Variable Total N=89/107	x^2 (*df=2*)	**Exact *p*** (one-sided)	**Cramers'*V*** (% variations in frequencies)
Sexual Orientation Gay/Bisexual (N=17) Heterosexual (N=72)	6.812	0.02*	**0.277** (8%)

* Significant at P<0.05 level

Question C3

Table 3.13: Cross-tabulations, including effect-sizes for ratings per psychologist subgroups – Question C.3

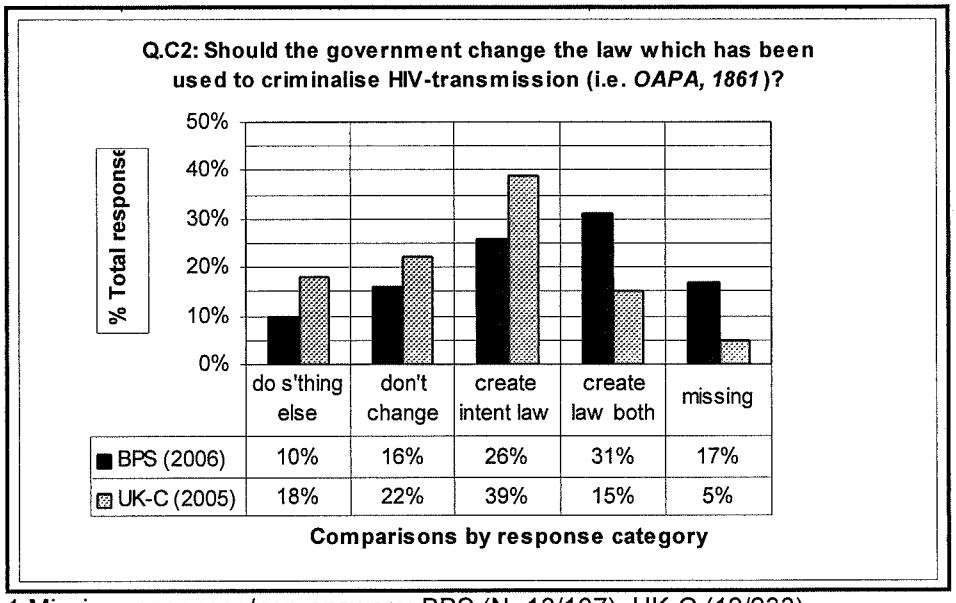
Question C3	Pearson's chi-square Cross-tabulation		Effect-size
Grouping Variable Total N=57/107	x^2 (*df=2)*	**Exact *p*** (one-sided)	**Cramers'*V*** (% variations in frequencies)
Service-Setting SH-setting (N=20) Non SH (N=37)	13.996	0.001**	**0.496** (25%)
SH-Experience Exp'd (N=28) Non-Exp'd (N=29)	13.416	0.001**	**0.485** (24%)
HIV-Experience Exp'd (N=37) Non-Exp'd (N=20)	10.115	0.004*	**0.421** (18%)
Sexual-Orientation Gay/bisexual (N=13) Heterosexual (N=44)	5.693	0.03*	**0.316** (10%)

** Highly significant at p<0.01 level *Significant at P<0.05 level

In general, analyses of psychologist responses with the UK-C survey using comparisons of the non-HIV/HIV+ sub-groups showed more differentiated (although smaller) findings. Therefore, these only were reported in the results section (3.3) for Questions C2 – C5. The following, outlines the response frequencies relating to these questions for the whole of the UK-C sample not separated by HIV-status group, which have not been previously presented:

Attitudes Towards Changing the Law for HIV-Prosecutions

A summary of %-total respondents relating to Question C2 for both surveys appears overleaf in Figure A1:



1.Missing responses/non-answers: BPS (N=18/107), UK-C (12/233).

Figure A1: Comparison of response totals by category for BPS & UK-Coalition surveys – Question C2

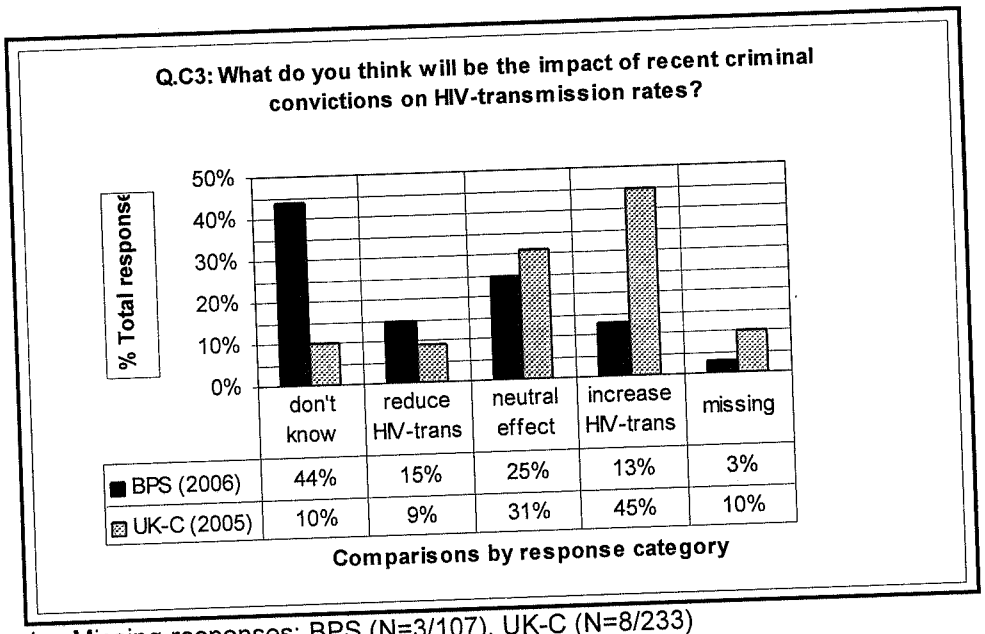
Of the 11 BPS-respondents who stated '*do something else*': 2 cited '*public-health initiatives*' (2%) and 3 '*exclude sexual-issues/STIs*' (3%) – remaining 6 did not comment.

Overall, similar proportions from both surveys were supportive of changes to the law to create offences for either 'intentional' and/or 'reckless' transmission (57% v. 54%):

The largest percentages-point difference between both samples was in support for the creation of a law for '*both intentional/reckless transmission*' (31% v. 15%), with psychologists more favourable.

Impact of Prosecutions on HIV-Transmission Rates

A summary of %-total respondents per response category relating to Q.C3 (both surveys) appears overleaf in Figure A2:



1. Missing responses: BPS (N=3/107), UK-C (N=8/233)

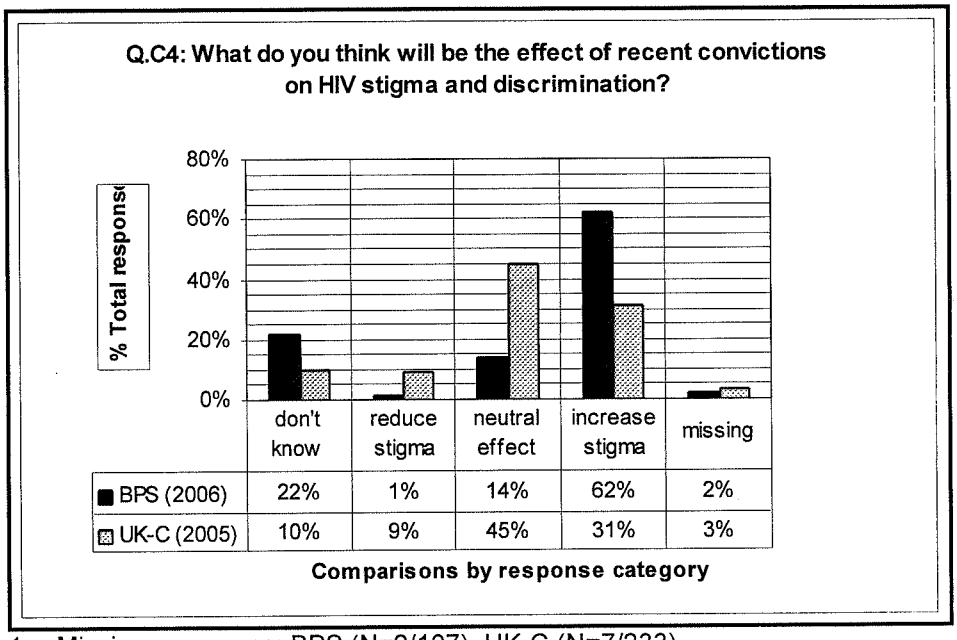
Figure A2: Comparison of response totals by category for BPS & UK-C surveys – Question 3

Overall, 44% of BPS-respondents stated '*don't know*' perhaps reflecting lack of knowledge or interest in HIV-issues. However, among the remaining psychologists who expressed a preference, most (25%) stated prosecutions would have a neutral effect.

Overall, psychologists were more likely to believe that prosecutions would result in increased HIV-transmissions (13% v. 45%; 32% difference) than the UK-C survey.

Impact of Prosecutions on HIV-Stigma & Discrimination

A summary of %-total respondents per response category relating to Q.C4 for both surveys appears overleaf in Figure A3:



1. Missing responses: BPS (N=2/107), UK-C (N=7/233)

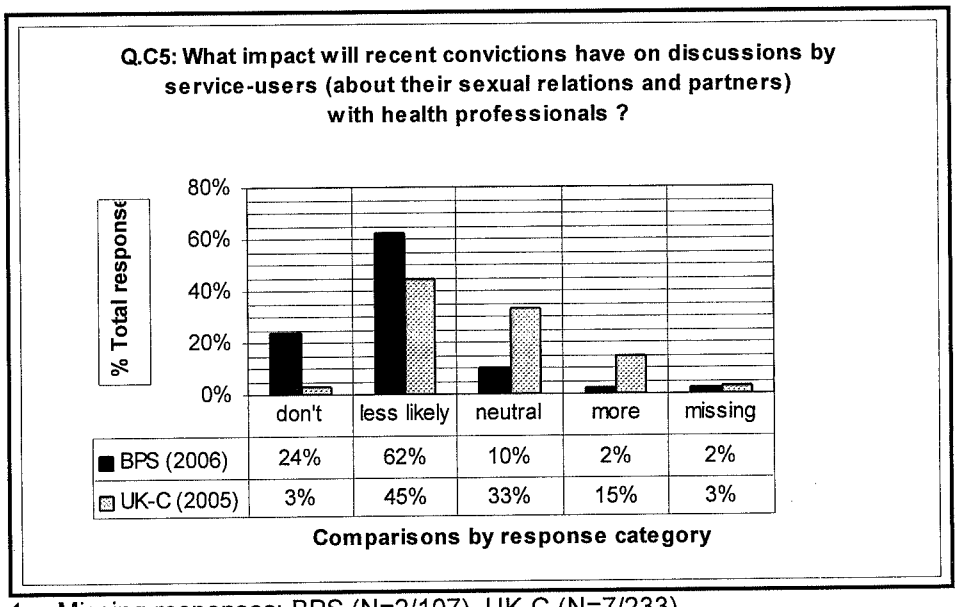
Figure A3: Comparison by response totals – Question C4

Overall, psychologists were more likely to rate the effect of HIV-prosecutions as 'increased stigma and discrimination', compared to the UK-C sample overall who rated 'neutral-effect' more frequently:

The percentages-point difference for both these response-categories was 31%.

Impact upon Discussions with Health Professionals

A summary of %-total respondents to Q.C4 for both surveys appears below in Figure A4:



1. Missing responses: BPS (N=2/107), UK-C (N=7/233)

Figure A4: Comparisons by response totals – Question 5

Overall, psychologists and UK-C respondents were more likely to believe that prosecutions would result in decreased discussions with health professionals (62% & 45%; 17%-point difference):

The greatest contrast (%-totals) from each response category can be observed in the relative higher levels of belief among non-psychologists for a neutral-effect (33% v. 10%). Whereas psychologists were more likely to believe that prosecutions would result in discussions becoming '*less likely*' (62% v. 45%; 17%-difference).

Appendix 3.4

Questionnaire Part D: Training Needs/Service Policy

(Qualitative Responses)

Training Received

Table A3.14: Q.D1 - Psychologists' training received relating to HIV-issues by HIV-experience groups

Question D1 (HIV-Exp'd)	Non HIV-Exp		HIV-Experienced		Overall Sample	
	N	%	N	%	N	%
Have you received any formal training regarding sexual transmission of HIV or any associated issues related to clinical practice?						
No	38	69%	24	44%	62	58%
Yes	**14**	**27%**	**28**	**51%**	**42**	**39%**
Missing	0	-	3	5%	3	3%
Total	52	100%	55	100%	107	100%

Table A3.15 Q.D1 - Psychologists' training received relating to HIV-issues by SH-experienced subgroups

Question D1 (SH-Exp'd)	SH-Setting		SH-Experienced		Overall Sample	
	N	%	N	%	N	%
Have you received any formal training regarding sexual transmission of HIV or any associated issues related to clinical practice?						
No	8	28%	12	29%	62	58%
Yes	**18**	**62%**	**26**	**64%**	**42**	**39%**
Missing	3	10%	0	-	3	3%
Total	29	100%	41	100%	107	100%

Training Needs

Table A3.16: Q.D2 - Psychologists' training needs relating to HIV-issues by HIV-experience groups

Question D2 (HIV-Exp'd)	Non HIV-Exp		HIV-Experienced		Overall Sample	
	N	%	N	%	N	%
Do you feel you have any training needs related to dealing with sexual transmission of HIV issues in your clinical practice?						
No	16	31%	12	22%	28	26%
Yes	**33**	**64%**	**40**	**73%**	**73**	**68%**
Maybe	**1**	**1%**	**0**	**-**	**1**	**1%**
Missing	2	-	3	5%	5	5%
Total	52	100%	55	100%	107	100%

[1] This figure includes one response indicating 'maybe'.

Table A3.17: Q.D2 - Psychologists' training needs relating to HIV-issues by SH-experienced subgroups

Question D2 (SH-Exp'd)	SH-Setting		SH-Experienced		Overall Sample	
	N	%	N	%	N	%
Do you feel you have any training needs related to dealing with sexual transmission of HIV issues in your clinical practice?						
No	8	28%	11	27%	28	26%
Yes	**16**	**55%**	**25**	**61%**	**73**	**68%**
Maybe	**0**	**-**	**0**	**-**	**1**	**1%**
Missing	5	17%	5	12%	5	5%
Total	29	100%	41	100%	107	100%

Service Policy

Table A3.18: Q.D3 - Service policy principles relating to HIV-transmission issues by HIV-experience groups

Question D3 (HIV-Exp'd)	Non HIV-Exp		HIV-Experienced		Overall Sample	
	N	%	N	%	N	%
Please briefly outline below the principles of any policy regarding clinical practice and HIV transmission issues within your service.						
No policy	27	52%	21	38%	48	45%
Not aware	12	23%	4	7%	16	15%
Under review	**0**	**-**	**4**	**7%**	**4**	**4%**
Policy detailed	**3**	**6%**	**12**	**21%**	**15**	**15%**
Missing	10	19%	14	25%	24	22%
Total	52	100%	55	100%	107	100%

Table 3.19: Q.D3 - Service policy principles relating to HIV-transmission issues by SH-experienced subgroups

Question D3 (SH-Exp'd)	SH-Setting		SH-Experienced		Overall Sample	
	N	%	N	%	N	%
Please briefly outline below the principles of any policy regarding clinical practice and HIV transmission issues within your service.						
No policy	11	38%	12	29%	48	45%
Not aware	2	7%	3	7%	16	15%
Under review	**4**	**14%**	**4**	**10%**	**4**	**4%**
Policy detailed	**9**	**31%**	**12**	**29%**	**15**	**15%**
Missing	3	10%	10	24%	24	22%
Total	29	100%	41	100%	107	100%

Comments from Part D are listed below, separated by response category and non/HIV-experience/non groups (with some interesting comments emboldened):

Have you received any formal training regarding sexual transmission of HIV or any associated issues related to clinical practice? **If *yes*, please describe briefly:**

D.1 Comments from HIV-experienced psychologists - with former training:

All my Training was done within this context since we were faced with a national emergency
Yes. Involved in health education since [year], numerous conversations via statutory and NGOs (THT). Updated via reading and discussion with colleagues. I [...] make every effort to keep up with evidence based knowledge on transmission
Yes – I am a provider of training. **Have had some training by a Trust solicitor – this was clearly a disaster! He was clearly homophobic and sexually prudish!!**
Yes. I work in a medical-setting and our weekly teaching has regularly covered this area, from all angles – bio-psycho-social
Attended a couple of conferences/workshops/prosecutions. **Has been a topic of discussion at staff meetings at work.** Have kept abreast of issues on internet based HIV-treatment/prevention websites
This is a fundamental part of our health-advisors' job descriptions. Extensive training and discussion of the issues are constantly being addressed, revised, revisited, implemented etc.
Regular CPD and in-house training within MDT. Attendance at HIV&SH-Faculty days. Motivational interviewing.
Only some – written the post-graduate diploma on psychosexual therapy
Workshops and training led by specialist lawyers – implications for clinical practice to professional duties under the law
Attended recent HIV&SH-Faculty conference – but no specific training as such.
Attended Faculty conference in May 2006. No in-service training although I work in an HIV/sexual-health clinic.
I attended a one day workshop at [venue] which addressed some of the implications for clinicians/clinical services in 2006
At work-place, specialist workshop
Yes. 1-day course in my Trust.
1-day course by 'health first' on HIV-transmission – 5-years ago
[Specified courses at] HIV Project
One day lecture covering transmission of some clinical issues
Yes – Home Office
Yes Faculty day conference
Have attended BPS one-day conference on disclosure and HIV
Yes – in-house awareness training
Not in my role as a clinical psychologist but when I practiced as a general nurse in a HIV/Vascular surgery unit
Many lectures and seminars when first working with people with HIV [venues]
VERY basic info during basic training. Since qualifying, self-directed learning in response to particular cases
Physiology of transmission/psychological impact
Yes, received training at GUM clinic, mostly by specialist nurses. Also attended 2-day workshop on HIV, addressed GPs, health-advisors, psychologists, and other staff that work in this area. Both trainings in 2003 when I started working in this field
Part of my induction training a few years ago when I started my post. This took place at [venue] and it covered most aspects of HIV including transmission issues

Have you received any formal training regarding sexual transmission of HIV or any associated issues related to clinical practice? **If *yes*, please describe briefly:**

D.1 Comments from HIV-experienced psychologists - no former training:

Lots of conversations but no formal training
I have asked the clinic in which I work to ask a solicitor to visit/talk to us to enhance our perception of the law and the team effort in HIV prevention and management – not happened
In process of developing with the service
No. I know the faculty organised a one-day conference but unfortunately I was unable to attend
Only during clinical training!
No formal training but discussions, workshop/conference by Faculty, presentations and peer supervision sessions

Have you received any formal training regarding sexual transmission of HIV or any associated issues related to clinical practice? **If *yes*, please describe briefly:**

D.1 Comments from generic psychologists - with former training:

Safe practice in acute medical-settings and in day-to-day contact within residential care-settings
I went to several training courses on HIV in my NHS hospital trust and run by THT when AIDS was in the press in the 1990s
Trust training and updates
A workshop about 15-years ago
A day's workshop – a long time ago. Can't recall which
I think this was briefly alluded to as part of broader training around sex/couples therapy as part of my D.Clin.Psy. However, too long ago to remember with any certainty. I have not attended any training since. Did have some training from GUM service as a youth worker about 10-years ago – very practical around transmission, safer-sex etc
Only specialist placements during D.Clin.Psy
Only one lecture during clinical psychology training of all HIV-issues and how the psychologist worked in the service
Probably as a trainee but not sure
Hard to remember 2-3 hours as part of basic training. Vague memories re: transmission routes, the course of the virus, symptoms of a AIDS incl. neurological changes, issues re: managing panic, stigmatisation
Awareness HIV training is updated every 3-years
In early '90s. HIV course at [venue] for 2 days
But a long time ago in the 1990s
I had a formal one day training session by a psychologist in HIV-services probably [many] years ago
[Many] years ago but nothing since!

Do you feel you have any training needs related to dealing with sexual transmission of HIV issues in your clinical practice? **If *yes*, please describe briefly:**

D.2 Comments from HIV-exp'd psychologists - identified training needs:

Definitely, especially the changing nature of litigation in these circumstances and the responsibilities of clinicians
Not me personally, but I know colleagues who are desperate for training/supervision. I also worry about colleagues who think they DON'T need training/discussions on this topic
Need clarity as a service about recommendations for practice
Clear guidance on best clinical practice and legal aspects
Yes. My responsibilities for discussing criminal transmission with clients, note-taking and how (if at all) our rules of confidentiality need to be altered. **NB – Also addressing client fears and increased stigma due to prosecutions and media coverage of this issue**
If this issue emerges in routine clinical work, what is my responsibility as a clinician to address this?
Fundamentally – as a psychologist what is our RESPONSIBILITY LEGALLY!? **We can know too much about clients and what do we do with that information!?**
There needs to be continual updating of a fast moving situation – events/ court cases can quickly change case law and this has implications for our clinical practice/confidentiality/responsibilities as clinicians
I think our team would benefit from some training on recent issues relating to clinical practice with HIV+ individuals
Yes, it's to do with the subject you cover in your questionnaire, re policies on clinical practice, i.e. the limitations of confidentiality in my clinical practice
To talk though ethical practice dilemmas in a multi-disciplinary setting
Helpful to have some forum to discuss these issues with other clinical psychologists working in the area and agree on clear guidelines for good practice
I'd be interested to know what other practitioners have to say about the criminalisation issue
Ongoing updates re: changes in law, details of recent convictions etc
Many of the aspects detailed in this questionnaire: 1) Legal stance; 2) Working with clients who are discussing whether or not to disclose
It would be helpful to know more about the law surrounding these issues
Yes – to feel more confident actually discussing sexual transmission
Would like to improve knowledge of legal aspects of HIV-transmission
Legislation
Law issues/medical issues
a) Better understanding of current legislation; b) legal obligations re: disclosure; c) sexual health training
Codes of good practice
A basic description of legal/confidentiality issues would be useful.
Update re: legal responsibilities re: confidentiality issues
Yes – on legal issues, confidentiality and disclosure
As described above – formal training on the law, NHS guidelines, BPS guidelines etc
A day's course detailing all the relevant issues, that you have noted above would be useful
Need to increase knowledge and implications of HIV-issues
Confidentiality in particular, unless my patient is putting him/herself at risk – or puts another person at risk. In such cases, I seek advice and consultation from my supervisor/line manager
Yes but I know where to go if I need specialist supervised training – so it's not a real problem
Unsure – this questionnaire is making me re-think this issue! I usually ask the health advisors in the clinic to discuss safer-sex issues with clients as their knowledge is much more up-to-date than nine. Probably need some training on legal/confidentiality issues re: transmission of HIV.
Particularly related to Scottish law which is different

Do you feel you have any training needs related to dealing with sexual transmission of HIV issues in your clinical practice? **If *yes*, please describe briefly:**

D.2 Comments from HIV-experienced psychologists – no training needs:

However I would welcome all my colleagues getting training on the law and having a chance to discuss cases. This is an emotive topic and people can misinterpret the law as meaning that professionals have to make people disclose
No – but the legal issues and responsibilities have been unclear. Good guidelines for practice have been missing: BASHH are in the process of publishing guidelines much needed in a very challenging area of work
No, but I believe all clinicians need regular and ongoing briefings on current status of the law, and to have a say in how to maintain best practice consistently
Not until any further changes to the law made – feel guidelines are sufficient (just about) at the moment
I have been to a number of presentations on the criminalisation of HIV-transmission as well as those of a more general nature
None – I have directed clinical psychologists to BPS and DCP documents
Not after [many] years in GUM clinic
Not currently working in a sexual-health service

Do you feel you have any training needs related to dealing with sexual transmission of HIV issues in your clinical practice? **If *yes*, please describe briefly:**

D.2 Comments from generic psychologists - identified training needs:

I hadn't really considered it prior to receiving this questionnaire – but it has made me realise that I do have training needs around ethical issues, confidentiality with this specific are [sic]
I would if I worked with anyone who was HIV-positive. I would need an update on current knowledge about transmission and safe practices, likelihood of transmission through different practices etc
Training on all of the issues identified here would be very valuable
How to discuss with clients with a learning disability, particularly since many have had little or no basic sex education, but are keen to develop sexual relationships
Yes, especially in regard to young people
Useful to have specific training about issues that are related to HIV-issues
Specific update would be appreciated
Clear guidance on our liability and implications for practice
After this questionnaire I think I probably do! Because it doesn't come up very often (in my work), probably not given it enough thought
Could do with an update but don't really face these issues in my practice on regular basis (not faced at all in 3 years post doctoral training).
Clarification of the current law
Your questions make me think I do, yes, although it is not an issue that I have encountered to date in my clinical work with older people (but I am aware it could!). Would like training on law and recent convictions, also update on what is understood about transmission, treatment etc
Info on recent criminal cases – training and discussion about trust/dept. specific policies
Further informations and clear policy at local level
Yes, regarding note-taking.
Confidentiality issues, disclosure, law
Guidance on clinical practice including confidentiality and clinical practice
All of the above issues, implications of the law for therapists
Yes – need to become familiar with the issues involved, legal and ethical implications and how to deal with these in clinical practice
Any training would be beneficial, as had no training to date
Ongoing updating. Possibly consider when/whether to ask about HIV-status

Yes – General update/info about all aspects would be helpful – training legal issues
Awareness re: DCP guidelines or legal/ethical procedures beyond what is under the general 'harm to others' risk category
It's obvious from my responses that I need educating! The client group with whom I work is overwhelmingly young and female and currently not sexually active. But terrifyingly vulnerable, therefore HIV-awareness should be something I feel confident about
I think it would be useful but not essential
I would need to look at current research and evidence available or look at sexual health as a social issue and legal issue if it was a significant part of my current practice
What to do if patient discloses they are HIV-positive [from psychologist in assisted fertility clinic]
If my post involved working with adolescents probably yes but not a priority training need currently
Filling in this questionnaire has made me realise I know very little about this area. However, the issue has never come up so far. I think the main thing is I would need to seek specialist advice from an appropriate service
This questionnaire has alerted me to gaps in my knowledge regarding confidentiality etc
Yes. I am unaware of anyone in our service for adults with a LD who is diagnosed HIV-positive although with changing lifestyles time would probably change – in which case I would need basic and in-depth training around issues relating to HIV and transmission to be competent – but would also see our clients accessing mainstream clinics for this.
Probably technically as we do have some clients that could be HIV+ and having sex and due to learning disability might not be making informed decisions around consenting to sex in a HIV-context. However, it's never been raised by a client that they are HIV yet
Working within CAMHS I have not come across HIV-positive individuals. However, do work with sexually active population so should be considering. My thoughts are, the issues would be dealt with by counsellors trained in the field
Very minimal – because HIV-status does not generally arise as relevant issue, need only to know where to look for update if need does arise
Yes but wouldn't be a priority
Yes although I work with a young and mainly sexually avoidant population. I would welcome training on issues related to transmission and confidentiality
In the event of HIV being an issue, I would consult with a more experienced colleague before taking on a clinical commitment or more likely would refer the person on to someone more competent in dealing with these issues
Could do with an update but as yet it is still quite rare in older adult population

Do you feel you have any training needs related to dealing with sexual transmission of HIV issues in your clinical practice? **If *yes*, please describe briefly:**

D.2 Comments from generic psychologists - no training needs:

Not as things stand – if my circumstances changed – working in sexual-health or it began to be an issue, then yes
In [many] years, I have never had a single patient who was HIV-positive. One of my gay patients has a partner who is HIV+ and has been in a long-term relationship with this man. I have never met this man though my patient has been scrupulous to protect his identity
Not required currently, covered by our STD service as no client get in my service diagnosed HIV-positive
Perhaps naively working in paediatrics I haven't felt it necessary

Please briefly outline below the principles of any policy regarding clinical practice and HIV transmission issues within tour service:

D.3 Comments from HIV-experienced psychologists - policies:

If another client of the service is being put at risk of HIV-transmission by a client of our service, the HIV-positive person is encouraged within a time frame to disclose their HIV-status. If they fail to do this, their consultant doctor will take it upon himself to disclose the client's status and offer their sexual-partner an HIV-test
There has been a move in the last few years for the clinic to move towards disclosing to known partners of positive patients – which is a change as in the past this wasn't addressed as much with patients
We are reviewing policy in light of convictions and will comply with BHIVA guidelines in this as we work as part of a multidisciplinary team that is clinician led. It's important that professionals do not overreact to this and think of best practice for the welfare of our patients and contacts. Notes have always been potentially subject to court proceedings. I think staff should contact their legal department if notes are requested by the police.
Being developed
That we advise clients re: disclosure and safer-sex, that we document these discussions. That we consult with senior clinical staff regarding any cases where we are concerned about client risk to others
Encourage discussion of legal implications of patients. Facilitate skills to aid disclosure and sexual negotiation. Such as advice from colleagues re: breach of confidentiality, public-health risk, seek advice from professional bodies i.e. BPS, BMA. Note in clinical record all discussions re: safer-sex etc.
We have discussed BHIVA guidelines and are waiting for BPS guidelines to help us improve our services
My job is a clinical-health job focussed on HIV. I didn't get the sense that we have a special 'policy'. We work to understand the law and how we can best serve clients within that in a multidisciplinary (medical) team.
Criminalisation of the sexual behaviour of HIV+ people is unjust and scape-goating. It places the entire responsibility for the safety of the encounter upon the HIV-positive person. Issues of coercions, lack of power are not addressed in making the HIV+ person solely responsible for 'safety'
Hmmm. No written policy. HIV-transmission is a sub-set of sexual-health problems of people with/without HIV. Certain sub-pops more vulnerable to HIV than others. We work to help all manage any barriers to disclosure and transmission reduction. We acknowledge that actual stigma and discrimination increase anxiety, sex and relationship problems and transmission reduction. Criminalisation should stop now
We always discuss such concerns with clinical director and wider MDT. No single clinician makes a decision
Would welcome further information on where PCT and Trust stands on this issue
To support clients to disclose status to current and potential partners where possible. However to act in our clients' best clinical interests – no professional obligations towards partners who are not patients of clinic. If there is a conflict of interest, policy is not to make decisions without discussion with senior colleagues
In my current post, I do not work with HIV-clients (as part of routine practice). However, the Trust refers to statutory restrictions regarding the disclosure of HIV. There are no specific documents on this subject that I can find. Trust recommends 'seeking legal advice'.
Not aware of any specific policy. Have asked for a team policy. Maybe as this issue increases we will get/make one. **Thank you for this questionnaire and raising awareness about this important issue and the implications for clinical practice. Criminalisation will enhance stigma and not disclosure – time will tell. Many clients have unsafe sex with non-disclosure for many reasons** – we maintain open case discussion around this issue with the team (weekly HIV meeting). A document may not help a difficult situation. This is a really complex knowledge – psychologists are not police!
There are guidelines for the health-advisors (SSHA Code of Practice ethics), and code of conduct for partner notification, BASHH guidelines. DOH guidelines on partner-notification for HIV
I'm not aware of a formal departmental policy other than the application of guidelines regarding safer-sex as point of clinical work with clients

Use BHIVA and BASH. No other local, specific policies
Follow DoH and BHIVA guidance
Same as HIV-Faculty
No written policies as such – one is to be discussed and developed. Most such decisions would be discussed and referred to legal department for advice when required.
As far as I'm aware, there are not clear policies in the service, although there is a focus on risk-taking behaviour, which recently has been addressed via motivational interviewing training. General public-health initiatives
No formal policy but I wouldn't expect there to be one for this specific issue
No policy – yet!
No departmental policy
I am not aware of any policies in this service
No written policy exists
Not aware whether one exists (terrible thing to admit!).
We do not have one that is specific to our service, but are guided by professional/national policies. P.S. Interesting survey – it's clear that I know very little about these issues, I am wondering what has happened to all our HIV-positive people in this area of Wales in which I work, are they being discouraged from accessing service. There is a counselling service attached to our service attached to our sexual health clinics, where I know people are offered support.

Please briefly outline below the principles of any policy regarding clinical practice and HIV transmission issues within your service:

D.3 Comments from generic psychologists - policies:

We have no specific policies as a department but I would see this as a matter for professional and Trust & NHS guidelines
We ask about HIV/AIDS testing if people are infecting drug users
Confidentiality and need to know basis
Not known
I am not aware of any
Not aware of one [from psychologist in assisted fertility clinic]
Don't know of any
There are none
Only aware of this in relation to needle stick injuries received by staff. However, I believe there is a Trust-wise policy but am aware of it's contexts
None specific to this service. There are however policies re: cuts, wounds and contact etc
Don't believe we have a specific policy
Don't know them as have never arisen in my clinical practice. I would find out immediately if the situation demanded it.
Not aware of any specific policies
None available in this Trust
I'm not aware there is one
Not policy known to me

Please briefly outline below the principles of any policy regarding clinical practice and HIV transmission issues within tour service:

D.3 Comments from generic psychologists - policies:

Not aware of any
I'm not sure if we have a specific policy on this. I am not aware of one.
I do not believe there is a specific policy
No, definite guidance is available in the department. Draw on the SIG and BPS guidance mainly.
Our department has never discussed this issue to my knowledge, We do discuss sexual issues and relationships with clients but I'm not aware that HIV has ever come up as an issue.
Don't think there is a policy in CAMHS
We have none specific to this LD service as far as I am aware
I am not aware that any such policy exists even in my Trust
I am not aware of any policies that doesn't mean there aren't any
I am not aware of the policy in our department at the moment
Confidentiality unless a named person is at risk
Would ask for a copy if it should be required
General confidentiality principles attached
As far as I know, my contract of employment requires me to be willing to work with people who are HIV-positive
Not aware of any service as a whole. However, there is a psychologist within the service who works specifically with children with HIV
I am not aware of any policy. This is really a minority interest for those of us working in mental health. I would suggest it is more salient for psychologists working in substance misuse, health psychology or especially GU medicine
No policy within our specific service

Appendix 3.5
Survey Sampling Factors
(Further Information)

The following appendix presents information referred to in Results 3.1.5 (Assessing Sampling Bias within the Survey) where it was stated that the apparent demographic imbalances observed within the sample could be considered an artefact of both the comparatively higher proportion of sexual-orientation minority groups working in sexual-health settings, as well as the increased interest among this group towards the research topic. The following presents findings (but not previously detailed within the main text) to underpin the assertion that the modest size of these subgroups did not appear to over-dominate the survey:

Rationale
It was expected that there would be an over-representation of gay/bisexual respondents within the survey. It was also predicted that there would be a positive association between SH-experience and experience of working with HIV-positive clients, and that these groups would be less inclined to support prosecution for reckless HIV-transmission. However, the impact upon clinical practice of these factors was not formally hypothesised and the purpose of the study in this regard was exploratory.

Exploration Process
To assess the extent to which demographic factors may have influenced findings, analyses (guided by the sampling exploration process outlined in McCormick & Hill, 1997) investigated the composition of these sub-groups within the sample including associations with specific clinical variables, as outlined below:

1. **General clinical experience** (A3.5.1):
   Initial analyses explored differences in general clinical experience (which may have confounded/skewed results) between respondent groups;
2. **Demographic factors** (A3.5.2):
   Secondly, the proportion of sexual-orientation, gender and ethnic minority respondents were explored to identify their representation within the sample, as well as explore any relevant clinical differences between these and other sub-groups;
3. **Experience with HIV-clients** (A3.5.3):
   Lastly, inter-related clinical variables associated among respondents with experience of working with HIV-clients were investigated, focusing upon SH-experience, service-setting, and sexual-orientation;

Again, significant results only are outlined with full statistical output including SPSS tables presented towards the end of Appendix 3.1 (*blue paper*).

A3.5.1 General Clinical-Experience

To assess relationships between pertinent demographic and clinical variables, analyses were performed, with the following results:

As expected, there was a highly-positive correlation between number of years post-qualified and the number of clients for all participants (Spearman's

rho=+0.731 [N=103], $p<0.001$, one-tailed) suggesting good reliability and validity for using these measures to assess relative clinical-experience between sub-groups within the sample.

No significant differences in post-qualification experience with sexual-orientation, HIV-experience or other clinical variables were observed. However, although there was no significant difference (p=0.x) in the number of years qualified between genders (t-test), there was a difference in the number of clients seen (Mann-Whitney U=483.0 [N_1=22, N_2=84], z=-3.518, $p<0.001$ two-tailed) – presumably reflecting gender differences in employment (i.e. female career interruptions and/or more likely to work part-time). The male median of 1000+ clients (ranged 1-5 across all response options) was greater compared to the female group (median=1-500, range 1-5). However, this moderate correlation (Pearson's x^2=17.034 [df=4], p-0.001 one-sided) accounted for only 12% of the variation in the frequencies (Cramer's V=0.401) of clinical-experience between gender groups.

Subsequently, it is concluded that any statistically significant findings are unlikely to be primarily an artefact of differences in levels of relative general clinical-experience between sub-groups.

A3.5.2 Demographic Factors

Gender/Sexual-Orientation

To investigate the potential over-representation of gay/bisexual respondents, inspection of descriptive and frequency data explored their composition within the sample, as summarised in Table A3.19:

Table A3.20: Sexual-orientation & gender of respondents

Sexual-Orientation/Gender	Male (N=22)	Female (N=84)	Total (N=106)
Heterosexual (% of gender group) Count % valid of sexual-orientation group % valid of total sample indicating gender	**54.5%** (N=12) (14%) (11%)	**89%** (N=75) (86%) (71%)	**82%** (N=87) (100%)
Gay/Bisexual (% of gender group) Count % valid of sexual-orientation group % valid of total sample indicating gender	**45.5%** (N=10) (53%) (9%)	**11%** (N=9) (47%) (9%)	**17%** (N=19) (100%)
Total % valid of total sample indicating gender	100% (21%)	100% (79%)	(100%)

1. Percentages relate to 106/107 valid responses only one respondent did not indicate gender.

The proportion of each gender/sexual-orientation sub-group is now considered (in order of magnitude) in relation to their composition within the sample:

Heterosexual Female Sub-group (71% of sample)
The large proportion of female respondents reported previously is likely to reflect their predominance within the profession. Similarly, unsurprisingly the majority of all female respondents (89%) were also heterosexual.

Heterosexual Male Sub-group (11% of sample)
For the same reasons, the comparatively low proportion of male respondents

(21%) is likely to be a reasonable reflection of gender imbalances within the profession. Although male respondents were statistically as probable to be heterosexual as not (55% v. 45%), the proportion of gay/bisexual males within the overall sample (9%) is probably over-represented compared to the general population. Despite this, the heterosexual male sub-group formed the second largest sub-group.

Gay/Bisexual (Male & Female) Sub-groups (9% each)
Within the gay/bisexual sub-group, both genders were equally represented (male/female: 53%/47%). Although the proportion of gay/bisexual females and males within the overall sample (both 9%) is likely to be over-represented compared to the general population (particularly the number of gay/bisexual female respondents observed), the modest size of these sub-groups did not appear to overly dominate the sample.

Ethnicity

Perhaps surprisingly, the under-representation of ethnic minorities within the sample population (<3%) was unexpected. Although this may reflect under-representation within the profession generally, regrettably no ethnic minorities among the gay/bisexual sub-group were observed and so their perspective is not represented in this study[1].

It was considered likely that the apparent demographic imbalance was an artefact of both the comparatively higher proportion of sexual-orientation minority groups working in sexual-health settings, as well as the increased interest among this group towards the research topic. However, the lack of ethnic minority representation within the sample can only be considered a limitation of the study.

Assessing Sampling Limitations

To investigate the influence of potential sampling bias upon the survey findings and any further demographic differences among respondent groups, associations between these variables (sexual-orientation and gender) with the sexual-health experience of respondents were explored further:

Sexual-Health Setting
Gay/Bisexual respondents were more likely to work in sexual-health settings (41% of all working among this group):

The proportion of respondents working in both settings is outlined in Table A3.21 overleaf:

[1] This is noticeable comparative to Maslin's study (with 10% ethnic-minorities) investigating psychologists in relation to asylum-seekers (where HIV-issues are also common clinically).

Table A3.21: Respondents working in sexual-health settings by sexual-orientation

Sexual-Orientation/Service-Setting	Sexual Health	Non Sexual-Health	Total
Heterosexual (of total sample) Count % of total heterosexuals % of sexual-health/non-SH group	**16%** (N=17) (19%) (59%)	**66%** (N=71) (81%) (91%)	82% (N=88) (100%) -
Gay/Bisexual (of total sample) Count % of total non-heterosexuals % of sexual-health/non-SH group	**11%** (N=12) (63%) (41%)	**7%** (N=7) (42%) (9%)	18% (N=19) (100%) -
Total (Count) % of total sample	(N=29) (27%)	(N=79) (73%)	(N=107) (100%)

1. Two respondents failed to provide service details were re-classified as non SH-setting

Further analyses using Mann Whitney tests of independence and (Chi-square) cross-tabulations were performed in order to evaluate the probable effect-sizes of sub-group imbalances upon findings, with the following results:

The over-representation of the gay/bisexual group among the sample was mirrored in their prevalence among respondents from SH-settings and was highly significant (Mann-Whitney U=469.5 [N_1=88, N_2=10], Z=-3.881, p<0.001 one-tailed).

Additionally, Pearson's (chi-square) cross-tabulation confirmed the tendency for this particular sub-group to work in SH-settings among within the sample (x^2=15.201 [*df*=1], p<0.001, one-sided) and although demonstrating a moderate effect size (Cramer's V=0.377) nevertheless accounted for **14% of the variation** in frequencies of all working in SH-settings.

Although few gay/bisexual respondents reported working in non sexual-health settings (only 7% of sample), heterosexuals were well represented within this non sexual-health group (66% of all respondents). Although the relative scarcity of this sub-group among respondents from SH-settings (16% of sample) is evident, heterosexuals nevertheless comprised the largest proportions within both sexual-health (59%) and non SH-settings (91%).

Sexual-Health Setting & Sexual-Orientation/Gender

Although heterosexual respondents were frequently more likely to be female within both SH and non SH-setting, this also probably reflects the reality of these settings (at least within the London & South-East region where the majority of the HIV&SH Faculty membership practice).

However, the relatively few gay/bisexual females from non SH-settings (3.8%) although proportionately low in number within the sample, may reflect their increased presence within these settings. Similarly, although unsurprisingly heterosexual respondents not in SH-settings were more likely to be male (69% vs. 31%), this also may reflect possible under-representation of heterosexual males within these.

Despite the relative (gay/bisexual-male) over-representation within the sample, both genders were equally represented (50%) within the gay/bisexual group (i.e., both lesbian and gay-males). Therefore, although the gay/bisexual male

sub-group were probably disproportionate, again this association did not appear to unduly dominate the survey.

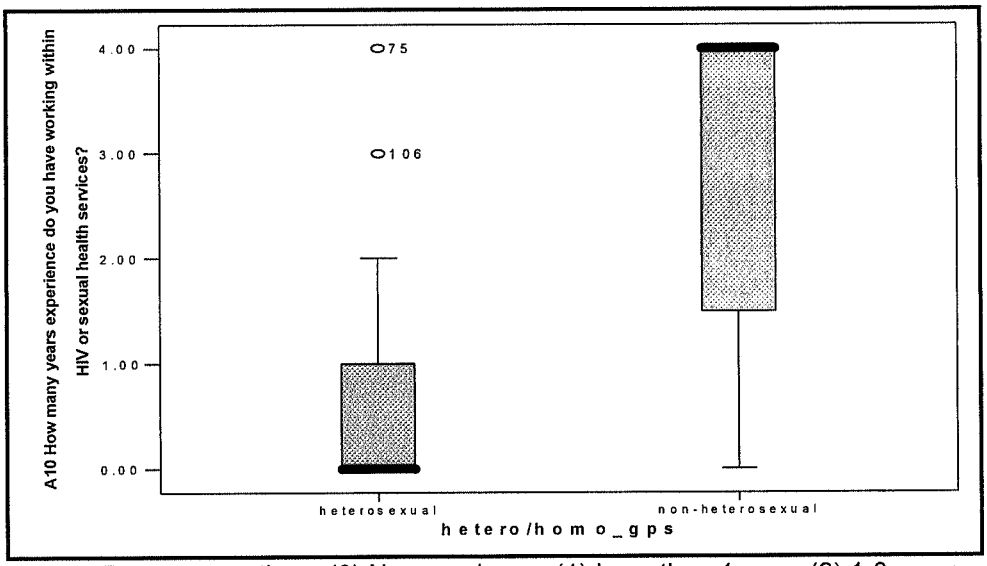
Therefore, it is concluded that the proportion of the sexual-orientation (sub-) groups within SH-settings (& similarly, among the whole sample) is an adequate measure reflecting the diversity of sexual-orientations among psychologists working in SH-settings. Additionally, the composition of the sample (in relation to sexual-orientation) allows the opportunity to explore the interaction of sexual-orientation factors within the sample.

Level of Sexual-Health Experience

As male and female respondents were as likely to work in SH-settings, or have SH-experience as not, analysis focused upon the levels of SH-experience between and within the sexual-orientation sub-groups:

Within the overall sample, gay/bisexual respondents generally had greater sexual-health experience than their heterosexual counterparts *(with the exception of two)*:

Differences in the relative levels of years SH-experience reported by these sub-groups are illustrated in Figure A5 below:



1. Response options: (0) No experience, (1) Less than 1-year, (2) 1-3 years, (3) 3-5-years, (4) 5+ years
2. Median: Heterosexual=0; and Gay/bisexual group=4 (both ranges 0-4)
3. Skewness: Heterosexual (+1.390); Gay/bisexual (-0.808)

Figure A5 Box-plot for level of sexual-health experience (no. years) by sexual-orientation

Overall, the gay/bisexual group was more likely to be have greater SH-experience (Mann-Whitney U=369.5 [N_1=88, N_2=10], z+-4.516, p<0.001 one-tailed) compared to the heterosexual group. The association was highly significant and this tendency (Pearson x^2=20.587 [df=1], p<0.001, one-sided) demonstrated a fairly strong effect size (Cramer's V=0.439) accounting for **19% of the variance** in frequencies of SH-experience between these groups

However further exploration within the SH-experienced sub-group alone (N=55/107), showed non-significant differences in the level of SH-experience between sexual-orientation (p=0.x) or gender (*p*=0.x) sub-

groups (median 3.5 vs. 4; ranges1-3) suggesting similarity among respondents within the SH-experienced sub-group overall.

A3.5.3 Experience of Working with HIV-Clients

The following illustrates the composition of survey respondents with HIV-experience using correlations and (Chi-square) cross-tabulations to assess associations between the HIV-experienced group with other clinical/demographic variables[2]:

HIV-Experience & SH-Experience

As expected, having SH-experience was significantly correlated with the number of HIV-clients seen confirming these were largely overlapping groups (Spearman's *rho*=+0.872 [N=107], $p<0.001$, one-tailed):

Although all but one of the SH-experienced group had HIV-experience, 23% of those working in generic clinical settings (N=15/66) also had seen HIV-clients. Nevertheless, the association was highly significant ($x^2=56.694$ [*df*=1], $p<0.001$, one-tailed) and demonstrated a strong effect size (Cramers $V=0.728$) accounting for **53% of the variation** in frequencies of those with experience of working with HIV-clients.

HIV-Experience & Sexual-Orientation

Only 16% (N=3/19) of the gay/bisexual group did not have experience of HIV-clients:

The association between gay/bisexual-orientation and tendency with HIV-experience was highly significant (Pearson $x^2=9.955$ [*df*=1], $p<0.001$, one-tailed), although only demonstrating a moderate effect size (Cramer's $V=0.305$) accounting for **9% variance** in the response frequencies within the HIV-experienced group. Although the gay/bisexual group were more likely to have HIV-experience, their effect within the HIV-experienced group was moderate.

HIV-Experience & Gender

Within the overall sample, males were significantly more likely to have HIV-experience (Mann-Whitney $U=617.0$ [$N_1=22$, $N_2=84$], $z=-2.762$, $p=0.003$ one-tailed):

However, overall the tendency with gender was moderate (Pearson $x^2=7.701$ [*df*=1], p=0.003 one-sided) accounting for only **7% variation** (Cramer's $V=0.270$) of the frequency of respondents within the HIV-experienced group.

HIV-Experience & Gender/Sexual-Orientation

All 10-gay/bisexual males and six (of nine) female gay/bisexual respondents had experienced HIV-clients:

As expected the association between the male gay/bisexual sub-group and tendency with HIV-experience was highly significant (Pearson $x^2=10.142$ [*df*=1], $p<0.001$, one-tailed) demonstrating a fairly strong effect size (Cramer's $V=0.433$) accounting for **19% variance** in the frequencies of the gay/bisexual group with HIV-experience.

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[2] HIV-Experience has been measured according to respondents answering positively to experience with HIV-clients (i.e. exposure):

However although 84% of the gay/bisexual group (N=16/19) had HIV-experience, this only represented 30% of the overall group (N=16/55). Within (the sample overall) those in the heterosexual group were as likely to have HIV-experience as not (44% vs. 56%) and neither were differences found between levels of HIV-experience (i.e. the number of HIV-clients seen) within the sexual-orientation sub-groups (p=0.x).

It is concluded that the findings suggest a strong interest in the research topic for the gay/bisexual group (as most participating had HIV-experience), although this sub-group did not appear to dominate this group overall within the sample.

Summary of Sampling Factors

While the observed over-representation (gay/bisexual SH-experienced respondents) potentially skews statistical results (particularly the findings of psychologist' attitudes towards HIV-prosecutions); it must be remembered that this sampling method was required to achieve a reasonable sized group of sexual-health experienced respondents to compare differences between the interaction of psychologist's attitudes and clinical-experiences hypothesised with the generic group. The limitations of the selected sample are that indications from the findings cannot be over-generalised (to psychologists as a homogenous population). However despite the relative (gay/bisexual-male) over-representation within the sample (and ethnic minority under-representation), both genders were equally represented (c.50%) within the gay/bisexual group (i.e., both lesbian and gay-males).

Therefore, it was concluded that the proportion of the sexual-orientation (sub-) groups within the sample was an adequate reflection of the diversity of sexual-orientations among psychologists working in these settings. Additionally, the composition of the sample allowed the opportunity to explore the interaction of these factors upon survey findings.

Demographic Summary

This synopsis indicates the general characteristics attributed to significant groups participating in the survey identified from the analysis. These characteristics typify the majority of respondents[3]:

All groups were comparable in terms of relative general clinical experience, however, respondents typically shared the following similarities:

- White/British, 40-year old,
- HIV-negative, female heterosexual,
- Clinical psychologist (8-years qualified; 1000+ clients),
- Not working in a sexual-health setting or any SH-experience.

However, although half-the-sample had experience with HIV-clients, those respondents with HIV-experience were more likely to share the following characteristics:

[3] Typical refers to the dominant characteristics within the groups based on reported findings.

- Gay/bisexual (either male/female),
- Working in a sexual-health setting with SH-experience (19-years),
- Moderately greater experience with HIV-clients (100+ vs. 50-100).

This group formed a sizeable sub-group within the sample but did not appear to dominate the survey's findings.

Appendix 3.6

List of Actual Clinical Cases

(Referred to during Focus Group Discussions)

Focus group	Brief synopsis
Pilot Group (#322 & 594)	Client (vulnerable 16-year old female with history of sexual abuse) knowingly being exposed by an older HIV-positive male (known to same GUM-clinic with past history of similar behaviours) thought to be targeting her for unprotected sex. Trust legal department advised that 'on no account must his confidentiality be breached around HIV' – 'it seemed that the priority was his confidentiality'. Later a medic in the team decided to inform her and the clinic lost contact with both of them.
Pilot Group (#479)	Newly diagnosed female client dying with AIDS related illness on HIV ward adamant not to tell male partner. It was unclear whether her partner was aware of her diagnosis and/or had been exposed to HIV-infection. In the end, the psychologist provided emotional support as the medics requested him to undertake an HIV-test.
Group A (#73)	Example described in Focus Group Results (introduction to Domain 1) – two gay male clients at same clinic, first (newly diagnosed) client reluctant to inform other whom also tested HIV-positive. Second partner went to police but further details and outcome of complaint unknown as clinic lost contact with index patient.
Group A (#483)	Male client who had considering making a police complaint approached the person he believed had infected him – 'so he took it into his own hands as it were'.
Group A (#483)	Male client considering prosecution in anger following diagnosis but decided against after reflection as he was also having unprotected sex on occasions.
Group A (#598)	Situation described as very similar to the vignette presented – i.e. two individuals at the same clinic but first (newly diagnosed) partner was adamant not to disclose to the other (sexual partner) but medics decided to disclose.
Group A (#604)	Female client dying on HIV ward from AIDS related illness and it was not clear if her male partner was aware of diagnosis. The partner was not a client at the same HIV-clinic so it was not clear if he had been tested (or if so, was receiving HIV-treatment).
Group A (#616)	Two cases discussed (no details given) but in both examples, the indexed partners left the clinic and went elsewhere
Group B (#187)	Situation described as similar to the vignette presented – Male client whose ex-partner was a bisexual married male with 'split life'. His wife was later diagnosed (not through the intervention of the psychologist) and they separated. There were some concerns that the male client was continuing to have unprotected sex with other male partners but saying 'he doesn't want to do anything about it'.
Group B	Male (?African) client with 3-year old daughter living with

(#426)	mother, both of whom may be infected but client was reluctant to inform mother of potential risk since she may use the fact to prevent him from parental access.
Group B (#986)	Client agreed for contact to be made with sexual partner through partner notification procedures following identity of partner being requested and named.
Group B (#210)	Gay (HIV-positive) male in 4-year relationship having occasional unprotected sex with (HIV-negative) partner and was concerned about it.
Group C (#389)	Generic reference made to various case scenarios - Newly diagnosed married males with children – resulting in 'devastating family situations with suicides' of either client/wife.
Group C (#428)	Male gay client in new relationship having unprotected sex with partner whom he assumed was also HIV-positive.
Group B (#1102)	Example described in Focus Group Results (introduction to Domain 3) – female with genital herpes considering making a legal complaint.
Group C (#1587)	Middle class well informed HIV-positive male client working in HIV-prevention occasionally having unprotected sex with HIV-negative boyfriend (who was aware of his partner's HIV-status) described as concerned but not initiating behavioural change.