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HIV/AIDS Training: A Study of Stigma Reduction

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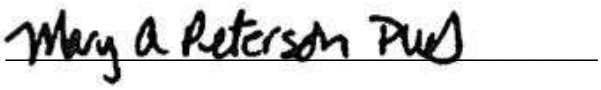

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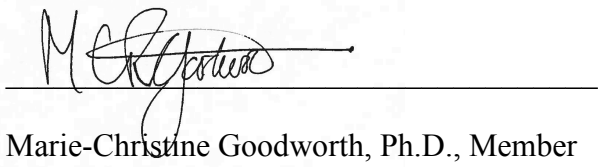

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Abstract

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Disease (AIDS) are complex chronic conditions requiring an equally complex approach to successful treatment. HIV/AIDS affects diagnosed individuals in multiple areas of life, as such, a biopsychosocial approach to treatment is important. Multidisciplinary teams engaging medical, psychology, and social works professionals provide effective support for patients to participate in their care. The intricacy of the disease process in concert with the complexity of treatment require both patients and treatment providers to be fully engaged in care. The patient-provider relationship is of paramount importance to successful outcomes. There are many barriers to successful treatment, amongst them stigma is incredibly impactful. The stigmatization of HIV/AIDS patients has been present since the discovery of the disease in the early 1980s. There are multiple contributing factors to stigmatization, lack of knowledge and understanding of the condition amongst them. Behavioral health consultants are increasingly engaged in multidisciplinary teams providing care to HIV/AIDS patients. This study engaged two first-year cohorts in a PsyD program to determine whether providing comprehensive education regarding HIV/AIDS and stigma to graduate level clinical psychology students increased knowledge and reduced stigma surrounding working with this population. Knowledge and stigma were measured pre and post intervention. It was hypothesized that an increase in knowledge will result in a decrease in stigmatization.

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Chapter 1

Introduction

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Disease (AIDS) are complex medical conditions with wide ranging effects on physical health, mental health, and multiple additional psychosocial factors and as a result, require specialized care (Barroso et al., 2017). When a person is diagnosed with HIV no part of life is left untouched by the time, energy, and effort required to engage in receiving care. Effective treatment must include complex collaboration between patients and clinicians (McCall & Wilson, 2015). HIV/AIDS is a lifelong, potentially fatal condition, however with current treatment options patients can live healthy and full lives, however, patients must possess self-efficacy in multiple domains of life in order to successfully participate in this treatment (Rodríguez & Velázquez, 2017). The complex nature of HIV/AIDS requires a multi-disciplinary, biopsychosocial approach to treatment that not only includes physiological treatment but also addresses the psychological and relational needs of the patient (Mugavero et al., 2013). This holistic approach considers the multiple contributing factors affecting patient's ability to engage in care.

HIV/AIDS

Since the AIDS epidemic was recognized in 1981 more than 700,000 lives have tragically been lost to the disease in the United States. Annually, the U.S. government spends $20 billion in direct health expenditures for HIV prevention and care. There are currently 1.1 million people living with HIV in the United States. While the rates of diagnosis have decreased significantly

since the onset of the epidemic, the current annual new diagnosis rate remains steady from 2012 to 2016 at 40,000 new diagnoses per year. The CDC and other agencies estimate that approximately 15-20% of individuals living with HIV/AIDS have not been diagnosed and likely unaware of the risk of infecting others. The most at risk for being infected with no diagnosis are individuals between the ages of 13 and 24 and estimated 51% of whom have not been medically diagnosed. The impacts of the HIV/AIDS epidemic are large, in loss of life, health implications, and cost to diagnose and treat the disease.

The nature of HIV/AIDS is incredibly complicated requiring high levels of intentionality and engagement on the part of the patient and their medical care team (Blake Helms et al., 2017). The progression of HIV is largely dependent on the time frame within which people are diagnosed and engaged in treatment (Sweeney & Vanable, 2016). HIV/AIDS stems from a virus which attacks the CD4, or T cells, of the immune system. The CD4 cells targeted by the virus help the immune system to fight off various types of infections and infection related cancers. There are three stages of HIV infection acute HIV infection, clinical latency stage, and progression to AIDS.

According to the Centers for Disease Control (CDC) HIV/AIDS occurs in three distinct phases (HIV Basics, 2018). The stage at which a person is diagnosed and engages in care is highly impactful on treatment outcomes and overall health. Acute HIV infection takes place within the first two to four weeks of infection. Often, but not always, this stage is accompanied by flu-like symptoms. Large amounts of the virus are being produced within the body at this stage. The immune system responds by producing large number of CD4 cells to fight the infection, which are destroyed by the virus. This stage carries increased risk of transmission, the virus is present in high amounts and many patients are not yet aware they are infected. If

diagnosed in this stage and treatment begins the virus can be contained and the amount of virus present in the body, also termed the viral load, can be suppressed to scarcely detectable levels.

The virus then progresses to the clinical latency stage, also called asymptomatic or chronic HIV infection. In this stage the virus continues to develop with no symptoms present. During the clinical latency stage, the virus is still replicating in the body and the immune system is increasingly compromised as a result. The virus is still transmittable during this stage which may last up to ten years. Diagnosis and treatment in this stage of infection can lead to viral suppression and increase the immune system's ability to repopulate CD4 cells and fight opportunistic infections.

If left untreated within the clinical latency stage HIV can progress to the point at which the number of CD4 cells destroyed inhibits the body's ability to fight off infection, this level of immunosuppression signals the transition from HIV to AIDs. This transition is indicated by the CD4 count of the patient falling below 200 cells/mm of blood or the presence of two or more opportunistic infections. Opportunistic illnesses include but are not limited to pneumonia, cryptococcosis, salmonella, lymphoma, Herpes Simplex, tuberculosis, and certain forms of cancer.

Transmission and Diagnosis

The virus is carried in bodily fluids including blood, semen, breast milk, vaginal fluid, and anal fluid. Transmission of the virus can occur by transmission of these fluids through sexual intercourse, breastfeeding, sharing of needles, amongst other transmission avenues. Diagnosis occurs by testing of blood to locate the presence of viral cells. Tests can be conducted in multiple treatment settings included by not limited to hospitals, primary care clinics, specialty care clinics, and community health centers. Diagnosis may be communicated by a wide range of individuals

from medical staff to peer counselor volunteers. Unfortunately, there is often a misunderstanding of the transmission process which may complicate necessary medical treatment and psychosocial support.

Current Treatments

As detailed above HIV/AIDs is an incredibly complex disease and as such requires an equally complex response for successful treatment. There is currently no cure for HIV/AIDs, however highly effective treatments are available which slow the progression of the virus, increase the overall health of patients, and lessen the risk of transmission. Pharmaceutical treatments for HIV/AIDs are called Antiretrovirals (ARV's). ARV's are often given in combination at treatment called Antiretroviral Therapy (ART). Successful treatment is heavily reliant on consistent viral load testing and strict adherence to ART medications (Mao et al., 2018). If treatment is not adequately adhered to, the virus can mutate and ARV's can become ineffective. If this process is not carefully monitored viral loads can increase to dangerous levels resulting in further compromised immune-functioning and possible progression to AIDs.

Due to the multifaceted nature of HIV/AIDs, patient outcomes are greatly improved with interprofessional care including medical, behavioral, and social supports (McCall & Wilson, 2015). Integrated care teams providing support for all aspects of the disease medical, social, psychological, and relational allow patients and providers to engage in holistic care. The integrated care team may include multiple medical providers, social workers, case managers, and behavioral health providers.

Patient-Provider Relationship

The complexity of the biopsychosocial factors and the ongoing need to closely monitor the disease process led Dawson-Rose et al., (2016) to describe the relationship between the

patient and medical treatment team as paramount to successful treatment outcomes (Dawson-Rose et al., 2016). Patients and providers must develop and maintain the ability to communicate effectively and openly with one another. Successful treatment relationships are built on a foundation of respect communicated by the provider and perceived by the patient (Dawson-Rose et al., 2016). Only in the presence of a solid patient provider relationship can patients gain the skills and confidence needed to effectively engage in and maintain HIV/AIDs treatment.

While there are many barriers to effective care, a review of the literature related to the broader range of barriers can be found in other research (Barroso et al., 2017) and is beyond the scope of this study.

Stigma

The particularly salient barrier of stigma is the focus of this research. Patient experience of stigma related to assumptions about HIV/AIDS creates a significant barrier to initial engagement in medical treatments (Turan, Budhwani, et al., 2017). Additionally, stigma has been identified as a barrier to creating strong patient-provider relationships, which is required for successful engagement in HIV/AIDs care (Dawson-Rose et al., 2016; Kremer et al., 2013). Regardless of the outcome data supporting interprofessional care, stigma is a barrier that interferes with life-saving diagnosis and treatment (Stockton et al., 2018). The authors suggest the stigma is multi-faceted, it is partially rooted in the nature of HIV/AIDS as an infectious disease transmitted through bodily fluids. Additionally, stigma may stem from both judgement regarding the manner of transmission and from the fear of exposure to the disease in the course of interaction.

> At its core, a stigma is a ‘‘mark’’ or aspect of the self that is socially devalued. Stigma serves to keep some people in a relative position of power because they do not possess

the devalued attribute and others in a relative position of subordination because they possess the devalued attribute (Earnshaw & Chaudoir, 2009).

HIV/AIDs has been stigmatized as a disease since the epidemic first came to light. The stigmatization of HIV/AIDs and people living with HIV/AIDs (PLWHA) continues today in society and in medical and psychological treatment settings. Over multiple studies 26-40% of patients with HIV/AIDs reported experiencing stigma in healthcare setting (Katz et al., 2013). This statistic fails to encompass the individuals who do not to seek diagnosis and treatment as a result of stigmatization. The stigmatization of PLWHA creates barriers to treatment for the population. The U.S. Centers for Disease Control and Prevention estimated that only 37% of PLWH in the United States have been prescribed ART, and only 30% of those have suppressed viral loads (CDC, 2014). Additionally, an estimated 20% of persons living with HIV infection in the United States are unaware of their status, and >50% of those diagnosed with HIV are not engaged in medical care (Mugavero et al., 2013). This lack of seeking testing and adhering to treatment is problematic and leads to further spread of the disease.

Early response and research into the disease was slow due to the initial belief the disease was only present in the gay male community, a highly marginalized community at the time (Rendina et al., 2018). The disease was initially termed Gay Cancer and Gay Related Immunodeficiency Disease as it was believed affect only gay men (Shilts, 1987). As the disease progressed the medical and scientific research community found the disease was not contained to this community and the disease could be contracted by diverse individuals. The early response of the United States government and the Centers for Disease Control was not consistent with their responses with other diseases, such as Legionaries' disease, which received a disproportionate amount of resources and attention with far fewer individuals infected (Shilts, 1987). As a result,

the early spread of the disease was possibly far more severe than it could have been if research, treatment, and education had been made available (Turan, Budhwani, et al., 2017). Fear of the unknown aspects of the disease promoted stigma surrounding the diagnosis within society at large (Rendina et al., 2018).

Perceived and actual stigma toward PLWHA can result in multiple derogatory health outcomes (Turan, Budhwani, et al., 2017). Compromised quality of care in medical treatment settings is connected with the experience of stigmatization (Rendina et al., 2018). Additionally, patients are less likely to utilize health services in the face of perceived stigma by health providers (Sweeney & Vanable, 2016). Patients experiencing stigmatization also endorse higher levels of mental health concerns, lower levels of self-efficacy, and higher participation in risky sexual behaviors (Turan, Rogers, et al., 2017). Health literacy refers to a patient's ability to "find, understand, and follow health-related information" (Dawson-Rose et al., 2016). This skill is incredibly salient for PLWHA due to the complex and long-term nature of the condition. Taken together, the combined impact of poor health literacy and stigma creates a barrier that potentially impacts quality of life, longevity and increased incidence of the disease.

Behavioral Health Providers

The presence of behavioral health providers in settings where HIV/AIDS patients receive medical care provides a unique opportunity for increasing both patient engagement and education for medical treatment teams (Belar, 2012). If engaged in care behavioral health providers could provide valuable contributions towards combatting the barriers to treatment caused by stigma and poor health literacy.

Behavioral health providers are increasingly employed in medical treatment settings where patients with HIV/AIDS may be diagnosed and treated (Auxier et al., 2013). Behavioral

health providers are trained to treat patients holistically and consider the biopsychosocial components of patient's presentation (Auxier et al., 2013). This specialized training combined with research supporting a biopsychosocial approach to HIV/AIDS treatment provide an opportunity for increased patient engagement. Additionally, behavioral health providers are uniquely poised to understand stigmatization and the treatment implications associated due to their training in psychological functioning. Specialized training on the effects of stigmatization experienced by patients with HIV/AIDS may provide behavioral health providers the opportunity to engage not only with patients but also with multidisciplinary teams in the medical setting.

Training

As described above, the stigmatization of this highly complex, chronic condition by the healthcare community creates barriers to diagnosis, treatment, and overall positive health outcomes. However, research has shown that an evidenced-based training intervention reduces stigma and increases knowledge (Mak et al., 2017; McCall & Wilson, 2015). Regarding PLWHA, current trainings currently included in many medical schools represent an important first step in working with patients with HIV/AIDs. However, limited time may prevent adequate training in the intersectionality of patient outcomes, patient provider relationship, and perceived and actual stigmatization of HIV/AIDs (Wagner et al., 2014). Providing a more comprehensive understanding of the nuances of HIV/AIDS from a psychosocial perspective would likely enhance providers' abilities to work well with patients and improve overall health outcomes for PLWHA.

Behavioral health providers are increasingly integrated into various healthcare settings (Belar, 2012). Although medical students may not receive sufficient training in biopsychosocial treatment of HIV/AIDS, a review of the required competencies and discipline specific

knowledge for doctoral psychology training programs failed to reference expectations for working with patients with chronic disease, let alone the complexity of HIV/AIDS. However, the presence of behavioral health providers in interdisciplinary teams represents a unique opportunity to provide training that may influence the attitude and behavior of the medical team. Behavioral health providers are already trained to treat patients from a holistic psychosocial approach (Auxier et al., 2013) as such, training in treatment for PLWHA would simply extend the holistic training. Research has shown an interprofessional team of providers integrating psychosocial components into medical treatment for PLWHA increases treatment adherence, self-efficacy, and improve patient relationships in treatment settings and socially (Rodríguez & Velázquez, 2017).

Purpose of the Study and Hypotheses

The goal of this study is to explore the impact of training on students' knowledge and stigma regarding providing treatment for PLWHA.

Hypothesis 1: Doctoral students in clinical psychology participating in training for the psychosocial treatment for patients living with HIV/AIDS (PLWHA) will show an increase in knowledge relevant to patient care.

Hypothesis 2: Doctoral students in clinical psychology participating in training for the psychosocial treatment of patients living with HIV/AIDS (PLWHA) will show decreased stigmatization regarding PLWHA.

Chapter 2

Methods

Participants

The study was conducted at George Fox University, a private faith-based university in Newberg, Oregon, within the Graduate School of Clinical Psychology. Participants included a convenience sample of students from two separate first-year cohorts. The control group (n = 14) and experimental group (n = 18) were randomly assigned. Participants consisted of male (n = 8) and female (n = 24) doctoral students currently enrolled in their first year of training at the Graduate School of Clinical Psychology. The participants ranged in age between 21 and 52, with an average age of 27. Participants race/ethnicity was predominantly white (n = 24), with additional race/ethnicities of Black or African American (n = 3), Asian (n = 2), and Middle Eastern or North African (n = 1). This study was approved by the Human Subjects Review Committee (HSRC) at George Fox University.

Materials

Demographics Survey

A general demographics survey was completed with all participants to gather information. Previous exposure to PLWHA HIV/AIDS patients, presence of and HIV/AIDS patient who is a close friend or relative were included on this questionnaire to control for possible confounding variables. (Appendix A)

HIV/AIDS General Knowledge Questionnaire

A 10-question General Knowledge Questionnaire was compiled based on information gathered from the CDC and other resources (Appendix B).

The Health Care Provider HIV/AIDS Stigma Scale (HPASS)

The HPASS (Appendix C) was utilized pre-training and post-training to measure level of stigma regarding HIV/AIDS patients for study participants (Wagner et al., 2014). This measure was developed by Wagner et al. and underwent initial validation in December 2014. The total scale (N = 30 items) had Cronbach's α = .940. The Prejudice subscale, consisting of 13 items, had Cronbach's α = .913. The Stereotypes subscale, consisting of 11 items, had Cronbach's α = .871. The Discrimination subscale, consisting of six items, had Cronbach's α = .917.

Training

Training was sourced from Three-hour Introductory Workshop for Doctors, *Training Guide for a Stigma-Free Health Facility* (Appendix D; Kidd et al., 2015). Developed by The Health Policy Project, a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. The project's HIV activities are supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). HPP is implemented by Futures Group, in collaboration with Plan International USA, Avenir Health (formerly Futures Institute), Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WRA). Training included the following modules:

A4- Naming Stigma in our Health Facility (Case Studies) (Appendix E)

A3- Effects of Stigma on the HIV epidemic (Appendix F)

A2- How Stigma Feels (Reflection Exercise) (Appendix G)

A6- Analyzing Different Forms of Stigma in Health Facilities (Appendix H)

Post-Intervention Measures:

1. HIV/AIDS General Knowledge Measure (Appendix B)
2. HPASS (Appendix C)

Procedure

Participants in both the intervention and control group completed the demographics survey and the HIV/AIDS General Knowledge Questionnaire (Appendix B) and the HPASS (Appendix C; Time 1). Next, the intervention group participated in a 2-hour training regarding HIV/AIDS and stigma (Appendices D-H) and the control group had class as scheduled with regular course content not related to HIV/AIDS or stigma. Immediately following the training, those receiving the training completed the HIV/AIDS General Knowledge Questionnaire and the HPASS post-test (Time 2 for Intervention Group). Additionally, both the control and intervention groups completed a time-delayed Post Test of HIV/AIDS General Knowledge Questionnaire and HPASS (Time 2 for control group, and Time 3 for Intervention group) to assess the retention of training information.

Chapter 3

Results

A Levine's test confirmed group equivalence between the group for both demographics and pre-test scores. Table 1 shows the demographic information for all participants with a final total sample size of $n = 32$.

The first hypothesis proposed in this study stated that doctoral students in clinical psychology participating in training for the psychosocial treatment for patients living with HIV/AIDS (PLWHA) will show an increase in knowledge as measured by the HIV/AIDS General Knowledge Questionnaire. See Table 2 and Figure 1.

The second hypothesis proposed doctoral students in clinical psychology participating in training for the psychosocial treatment of patients living with HIV/AIDS (PLWHA) will show decreased stigmatization regarding PLWHA.

A repeated measures MANOVA was utilized to analyze between group differences on the pre and post intervention scores between the control and intervention groups for each of the dependent variables. The assumptions were analyzed utilizing Mochley's test of Sphericity, which verified assumptions we met $\chi2(1) = 1$, $p > .001$. The MANOVA showed a significant difference, Wilke's Lambda F (2, 29) = 2.11, $p = .007$ Wilk's $\Lambda = 0.873$, partial $\eta2 = .127$. Following the significant results of the MANOVA, we analyzed the repeated measures univariate results to identify the specific differences.

Table 1

Demographic Information

Baseline Characteristic	Control		Intervention		Full Sample	
	n = 14	%	*n* = 18	%	*n* = 32	%
Gender						
Female	11	79	13	72	24	75
Male	3	21	5	28	8	25
Ethnicity/Race						
Asian	2	14	2	11	4	12.5
Black/African American	0	0	3	16.5	3	6.3
Middle Eastern or North African	1	7	1	5.5	2	6.3
White	11	79	12	67	23	71.9
Training on HIV/AIDS						
Yes	0	0	3	16.5	3	9.4
No	14	100	15	83.5	29	90.6
Average # of hours if yes	0		5.33			
Treatment of HIV/AIDS Patients						
Yes	2	14	7		9	28.1
No	12	86	11		23	71.9
Average # of Patients	3		10.3			
Personal Experience						
Yes	1	7	1	.5	2	6.3
No	13	93	16	99	29	90.6
Prefer not to answer	0	0	1	.5	1	3.1

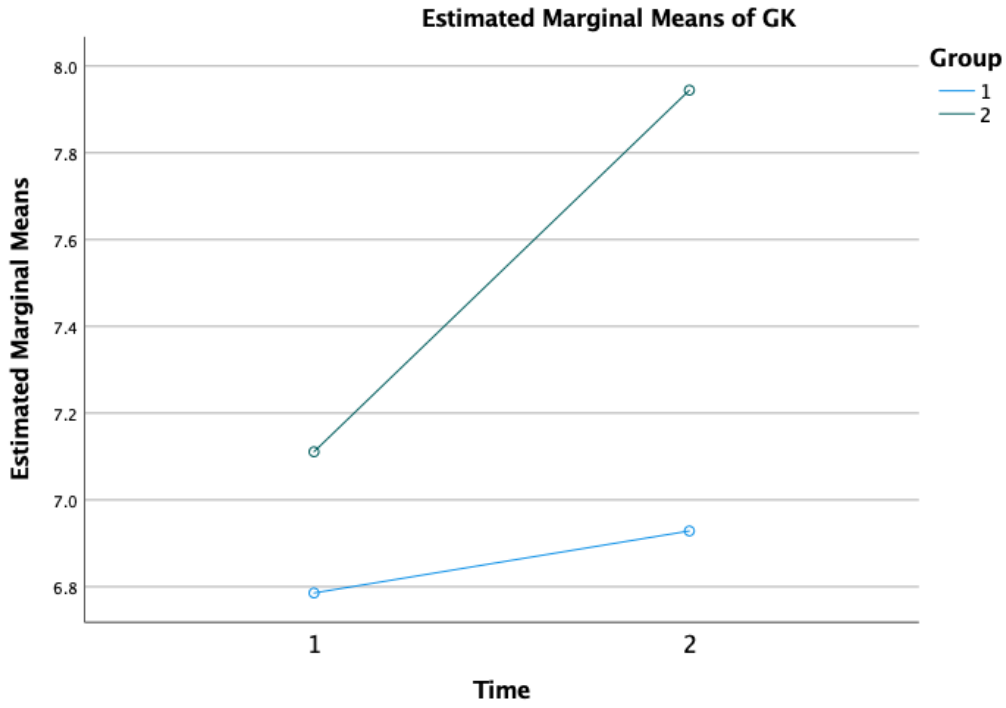
Table 2

HIV/AIDS General Knowledge: Means and Standard Deviations

	Pre-Intervention *M* (*SD*)	Post-Intervention *M* (*SD*)
Intervention	7.11 (1.18)	7.94 (1.16)
Control	6.79 (1.89)	6.93 (1.14)

Figure 1

Estimated Marginal Means of General Knowledge



A univariate test was utilized to analyze how participants performed individually on each of the dependent measures. Results of changes in *knowledge* between Time1 and Time 2 showed no significant difference over time was (F (1, .063) = .155, p = .803, d = .057). No main effect was present for general knowledge measure, this was like due to the use of a non-standardized measure of general knowledge which was developed by the researcher and have not been psychometrically validated. See Table 2 and Figure 1.

However, results showed a significant difference for both groups over time for the HPASS. There was a main effect for time on the HPASS, (F (1, 10.93) = 2783.36, p = .002, d = .89) showing that both the interventions and control groups showing a significant reduction in stigma. See Table 2 and Figure 3.

Table 3

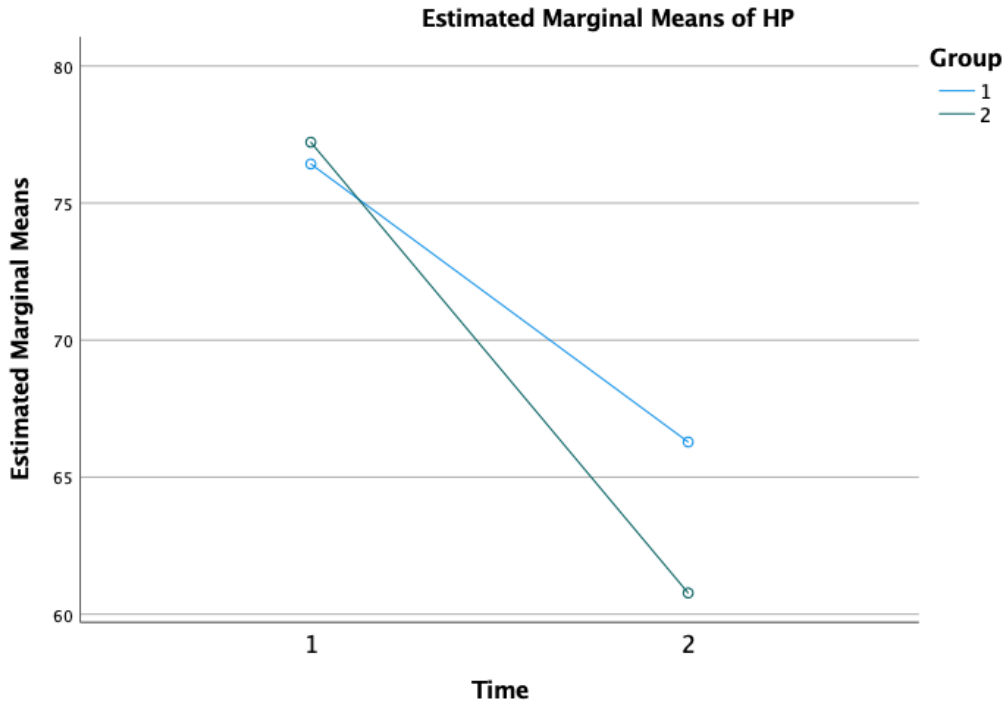
HPASS: Means and Standard Deviations

	Pre-Intervention *M* (*SD*)	Post-Intervention *M* (*SD*)
Intervention	77.22 (19.91)	60.78 (13.36)
Control	76.43 (30.61)	66.29 (13.41)

There was no main effect for group between pre and post intervention scores on the HPASS ($F(1,.614) = 156.36$, $p = .439$). This was likely due to the large standard deviation present in pre-interventions scores on the HPASS. See Table 3 and Figure 2.

Figure 2

Estimated Marginal Means of HPASS



Chapter 4

Discussion

The current study endeavors to determine whether training in HIV/AIDS and specifically in stigma related to treating HIV/AIDS patients, will increase knowledge and decrease stigma in doctoral students in clinical psychology. Hypothesis one was not met, general knowledge did not increase significantly over time or between the two groups. This is likely due to the use of a non-standardized and non-psychometrically validated general knowledge measure.

Hypothesis two, included two components and the results showed mixed findings. First, we found a lack of statistical significance between the intervention and control groups on the HPASS. The lack of significance was likely due to the wide variability between scores as evidenced by the large standard deviation. In exploratory analysis we extended the statistical guidelines in the elimination of outliers and were able to show significance which suggests that there could have been between group differences that were obscured by the response variability.

One explanation of the variability in responses in Time 1 of the HPASS may be related to the lack of a shared definition of stigma. The reduction of stigma evident in the Time 2 responses may suggest participants understanding of stigma was impacted by their overall training experience.

Additional analysis testing hypothesis two showed a significant reduction in stigma for both groups between Time 1 and Time 2. Similar to the suggestion that overall training reducing variability in responses, the overall reduction in stigma may also reflect the general increase in

knowledge over the course of the first year of a doctoral program. This increase in overall awareness and understanding likely impacted participants thoughts surrounding the construct of stigma and influenced their responses on Time 2 completion of the HPASS. Further exploration is necessary to determine the impacts of graduate education in clinical psychology alone on students' understandings of the construct of stigma.

Implications

It is imperative for medical professionals, including health service psychologists, to be aware of the impact of stigma on the patients they are treating. Without the awareness of the construct of stigma providers may not possess the ability to fully appreciate the far-reaching effects of stigma, both conscious and unconscious, on their patient's care (Katz et al., 2013). However, possessing the knowledge is not sufficient to address the prolificity of stigma in healthcare systems (Dawson-Rose et al., 2016). Trainings which educate not only on stigma, but provide evidence-based methods to reduce stigma, are crucial to efforts to increase the quality of patient care (McCall & Wilson, 2015).

Utilizing different training modalities and learning opportunities fosters holistic and deep learning (Mak et al., 2017). Recognizing the role stigma plays in each person's life and the lives of those they care about is imperative to understanding how patients are impacted. This training provided opportunities for individual and group learning, including reflection and application to real-life case vignettes to help solidify concepts and information covers. Future trainings developed for stigma reduction should consider the impacts of these forms of learning on understanding of stigma and ability to enact actions to move towards de-stigmatization.

The training utilized for this study, sourced from Three-hour Introductory Workshop for Doctors, *Training Guide for a Stigma-Free Health Facility* (Appendix D; Kidd et al., 2015), was

originally developed for healthcare providers. This workshop was adapted for use with doctoral students in clinical psychology. Further development of trainings specifically for behavioral health providers could increase efficacy of training and strengthen impacts of interventions.

Effective training for those working on interdisciplinary teams can have long-reaching impacts as providers receiving this training not only experience impacts of training themselves but are also able to impact the teams and systems in which they work with the knowledge and skills gained in training. If providers are given the opportunity to explore this topic early in their training it can have lasting impacts on the way they formulate their approach to practice and interdisciplinary work. This early intervention may serve to cause a ripple effect of increased knowledge and understanding whereby those exposed to training will carry the knowledge gained into the systems and facilities where they complete their clinical work.

Health service psychologist however are only part of the interdisciplinary teams in which crucial health diagnoses, such as HIV, are made. Generalizing this training to all medical staff who may come in contact with stigmatized populations could reap long-lasting impacts on systems and quality of patient care. Additionally, it is notable that stigma is pervasive in medical systems for multiple patient presentations including but not limited to weight and body shape, chronic health conditions (such as HIV/AIDS), mental health diagnoses, and other aspects of patient identities which may be marginalized, such as gender and sexual identity, race, ethnicity, etc. The knowledge that trainings are effective in reducing stigma for one population may lead to adaptation of the present training for different populations who experience disparities in their care as a result of stigmatization.

Limitations

The limitations of the current study include a small sample size, which if increased may further display the efficacy of training. Additionally the training was conducted over the course of 2020, during which the COVID-19 pandemic began. While pre-measures were completed via pen and paper in person, post measures were completed over an online survey. The events of the intervening time between pre- and post-measures along with the different modalities of data collection may have impacted participant scores. Lastly, the absence of a standardized and psychometrically validated measure of general knowledge about HIV/AIDS was a limitation of the study.

Future Research

Areas for future research may include generalizing this training to other clinical psychology doctoral programs which would allow for further validation and development of training for diverse trainee populations. Additionally, generalizing this training for multidisciplinary healthcare workers including doctors, nurses, and other medical staff could create further information regarding impacts on patient care. Finally, adapting this style of training to other marginalized and stigmatized patient populations would allow for exploration into the impacts of general stigma reduction in medical care.

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Appendix A

Demographic Survey

Age in years: _____

Ethnicity/Race:
❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Hispanic, Latino or Spanish Origin
❑ Middle Eastern or North African
❑ Native Hawaiian or Other Pacific Islander
❑ White
❑ Some other race, ethnicity, or origin, please specify: _____
❑ Prefer not to answer.

Gender- with which of the following do you most strongly identify?:
❑ Female
❑ Male
❑ Transgender Female
❑ Transgender Male
❑ Non-Binary
❑ Gender Nonconforming
❑ Other, please specify: _____
❑ Prefer not to answer

Have you had any formal training in working with HIV/AIDs patients?
❑ Yes, approximate hours of training: _____
❑ No

Have you ever worked with HIV/AIDs patients?
❑ Yes, number of patients worked with: _____
❑ No

Have you been impacted by HIV/AIDs in your personal life?
❑ Yes
❑ No
❑ Prefer not to answer

Appendix B

General HIV/AIDS Knowledge Questionnaire

HIV/AIDS General Knowledge (Administered through Survey Monkey)

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1. What does the abbreviation HIV/AIDS stand for?

_____

2. When was HIV first recognized in the United States?
   a. 1970
   b. 1975
   c. 1981
   d. 1986

3. A person has AIDS when which of these occurs
   a. Exposure to HIV
   b. HIV Antibodies are found in the blood
   c. The CD4+ count is lower than 200 or opportunistic infections develop in an HIV-infected person
   d. A person has HIV for 5 years

4. What does HIV-positive mean?
   a. Either antibodies against HIV or the virus particles themselves are present in the blood
   b. You have been tested for HIV
   c. Your white blood cell count is high
   d. You have been informed about HIV

5. HIV attacks a certain kind of cell in the body, which is it?
   a. Red blood cells
   b. White blood cells, called T-cells
   c. Platelets
   d. Epithelial cells

6. The risk of contracting HIV is tied to behaviors, which of these behaviors can put you at risk?
   a. Spending time with someone who has AIDS
   b. Not wearing a latex condom during sex
   c. Physical contact such as handshakes and hugs
   d. Injecting drugs
   e. Both B and C
   f. All of the above

7. Why is a combination of drugs used to treat HIV?
   a. The virus changes (mutates) rapidly
   b. Each person responds to medication differently
   c. Combining medications triples their strength
   d. Both A and B

8. How many people are currently living with HIV/AIDS in the United States?
    a. 300,000
    b. 565,000
    c. 1.1 million
    d. 2.2 million

9. HIV is not present in which of the following
    a. Blood
    b. Semen
    c. Sweat
    d. Breastmilk

10. There is no cure for HIV/AIDS
    True
    False

Appendix C

Informed Consent

Consent/Assent

Thank you for your participation in HIV/AIDs Stigma Training, and associated research through George Fox University. We are interested in exploring the effectiveness of the training curriculum related to knowledge surrounding working with HIV/AIDs patients.

INFORMATION

Involvement
Through participation in the HIV/AIDS Stigma Training, you will be asked to complete pre- and post- measures relating to the training and covered materials. Data collected from the surveys will be used to measure the effectiveness and impact of the training.

Foreseeable risks or discomfort
Participation in this study involves no extra time commitment and will be conducted in normal class time. Efforts will be made to protect identifying information, and the confidentiality of research participants.

Benefits
There is no financial compensation for participation in this study. However, the training and participation in this study are of educational benefit and opportunity.

Confidentiality
Confidentiality of personal information and data collected will be protected through use of participant ID numbers on forms collected, and with a separate secure file that contains the links between subject names and ID numbers. All electronic data will be password protected. Physical data (test protocols, forms) will be stored in a locked filing cabinet in a locked office.

Voluntary Involvement
Your agreement to allow this data that is being collected to be used for research purposes is voluntary. Refusal to participate will involve no penalty or loss of program benefits to which the participant is otherwise entitled. You may also discontinue participation at any time up until data analyses are completed.

AGREEMENT

I, the undersigned, agree to participate in HIV/AIDs Stigma Training in the Graduate School of Clinical Psychology at George Fox University. I also agree to complete a series of pre- and post-questionnaires related to the training program.

I understand that this information is being gathered for research purposes, and that the person gathering the information will protect my identity and privacy in any and all ways in which this information is used.

I understand that I may stop my involvement at any point, with no explanation necessary. If I have any questions that the person administering the training and associated measures cannot answer or concerns about the training process, I can contact Dr. Mary Peterson of the George Fox University Graduate Department of Clinical Psychology. Dr. Mary Peterson is available at mpeterso@georgefox.edu or (503) 554-2377.

I understand that I will receive a copy of this consent and by signing indicate that I am at least 18years of age and understand and accept the conditions described above.

Participant Printed Name

_____ _____
Participant Signature *Date*

_____ _____
Researcher's Signature *Date*

Appendix D

The Health Care Provider HIV/AIDS Stigma Scale (HPASS)

Below is a list of ideas about HIV+ patients. Some of the ideas may be true for you, and some of them may not. People hold a wide range of ideas about HIV+ patients, and we are interested in your particular ideas. Please answer the questions honestly – your responses are completely anonymous.

1	2	3	4	5	6
Strongly Disagree	**Disagree**	**Somewhat Disagree**	**Somewhat Agree**	**Agree**	**Strongly Agree**

1. I believe most HIV+ patients acquired the virus through risky behaviour.	1	2	3	4	5	6
2. I think HIV+ patients have engaged in risky activities despite knowing these risks.	1	2	3	4	5	6
3. I believe I have the right to refuse to treat HIV+ patients for the safety of other patients.	1	2	3	4	5	6
4. I think people would not get HIV if they had sex with fewer people.	1	2	3	4	5	6
5. HIV+ patients present a threat to my health.	1	2	3	4	5	6
6. HIV+ patients present a threat to the health of other patients.	1	2	3	4	5	6
7. I believe I have the right to refuse to treat HIV+ patients if other staff members are concerned about safety.	1	2	3	4	5	6
8. I would avoid conducting certain procedures on HIV+ patients.	1	2	3	4	5	6
9. I think if people act responsibly they will not contract HIV.	1	2	3	4	5	6
10. HIV+ patients tend to have numerous sexual partners.	1	2	3	4	5	6
11. I believe I have the right to refuse to treat HIV+ patients if I feel uncomfortable.	1	2	3	4	5	6
12. I would rather not come into physical contact with HIV+ patients.	1	2	3	4	5	6
13. I would want to wear two sets of gloves when examining HIV+ patients.	1	2	3	4	5	6
14. I believe I have the right to refuse to treat HIV+ patients to protect myself.	1	2	3	4	5	6
15. I would be comfortable working alongside another health care provider who has HIV.	1	2	3	4	5	6

16. I think many HIV+ patients likely have substance abuse problems.	1	2	3	4	5	6
17. I believe I have the right to refuse to treat HIV+ patients if I am concerned about legal liability.	1	2	3	4	5	6
18. I would rather see an HIV-negative patient than see an HIV+ patient with non-HIV-related concerns.	1	2	3	4	5	6
19. HIV+ patients should accept responsibility for acquiring the virus.	1	2	3	4	5	6
20. I worry about contracting HIV from HIV+ patients.	1	2	3	4	5	6
21. I often think HIV+ patients have caused their own health problems.	1	2	3	4	5	6
22. HIV+ patients make me uncomfortable.	1	2	3	4	5	6
23. I would be hesitant to send HIV+ patients to get blood work done due to my fear of others' safety.	1	2	3	4	5	6
24. It is a little scary to think I have touched HIV+ patients.	1	2	3	4	5	6
25. I worry that universal precautions are not good enough to protect me from HIV+ patients.	1	2	3	4	5	6
26. I would feel uncomfortable knowing one of my colleagues is HIV+.	1	2	3	4	5	6
27. HIV+ patients who have acquired HIV through injection drug use are more at fault for contracting HIV than HIV+ patients who have acquired HIV through a blood transfusion.	1	2	3	4	5	6
28. I tend to think that HIV+ patients do not share the same values as me.	1	2	3	4	5	6
29. HIV+ patients who have acquired HIV through sex are more at fault for contracting HIV than HIV+ patients who have acquired HIV through a blood transfusion.	1	2	3	4	5	6
30. It would be hard to react calmly if a patient tells me he or she is HIV+.	1	2	3	4	5	6

Appendix E

A4- Naming Stigma in our Health Facility (Case Studies)

G: Three-hour Introductory Workshop for Doctors

Description

This is a mini-workshop for doctors who may not have time for a full workshop. The three hours includes an introduction to stigma in health facilities; a reflection on personalizing stigma; and an opportunity to analyze stigma in health facilities, with a view to suggesting actions for change.

If possible, follow up this workshop with Workshop I, which focuses on key populations.

Target Group

Doctors

Objectives

By the end of the training, the doctors will have accomplished the following:

- Identified some of the most common examples of stigma in their own health facilities
- Discussed the forms, effects, and causes of stigma in health facilities
- Discussed further steps for helping to reduce stigma in their health facilities

Modules

NUMBER	TITLE	TIME
A1 or A4	Naming Stigma in Health Facilities Through Pictures; or Naming Stigma in our Health Facility (Case Studies)	1 hour
A3	Effects of Stigma on the HIV Epidemic	1 hour
A2	How Stigma Feels (Reflection Exercise)	0.75 hour
A6	Analyzing Different Forms of Stigma in Health Facilities	1 hour

Appendix F

A4- Naming Stigma in our Health Facility (Case Studies)

A

A4. Naming Stigma in Our Health Facility

Facilitator's Notes: This exercise helps health workers name the problem of stigma in their own workplace. It includes case studies based on the real experiences of PLHIV and other key populations. Select the case studies suited to your own context.

Objectives: By the end of this session, health workers will be able to accomplish the following: ƒ Identify stigmatizing attitudes and discriminatory practices within the healthcare setting ƒ Explain the causes of those attitudes and practices, and how these affect their clients
ƒ Identify practical things they can do to change the way they relate to their clients

Understanding and Challenging Stigma Toward MSM: Toolkit for Action (Cambodia) – Exercise A13
2 hours
Copies of case studies for participants

Case Study Analysis

Select the case studies most suited to your own context. Divide the participants into groups and give each group a case study to read. Have each group then discuss the following questions:

ƒ What happened in the case study? Is the situation realistic?
ƒ What other forms of stigma have you observed happening in health facilities?

Report Back and Processing

Ask each group to report back on what they have learned from discussing the case study. Then ask the following questions: ƒ What are the effects of stigma on PLHIV and other key populations?
ƒ Why is stigma happening in the health facility?
ƒ What can we do to make our health facilities more user friendly and challenge stigma?

Case Studies – Select Those That Fit Your Situation HIV-positive Client Case Studies
Case Study A: Sarah

Sarah is a 30-year-old woman. She went to a health facility for the delivery of her baby. The nurse looked at her health facility card, which read "PMTCT," and knew immediately that she was HIV positive. While waiting, Sarah saw this nurse and other nurses looking at her and whispering, which made her upset and nervous. She waited a long time for someone to help her; when the baby started to come, she shouted for help, but the nurses kept doing whatever else they were doing, pretending to be busy. One doctor took pity on her and came and assisted with the delivery.

Afterward, she was left all alone. Sarah saw other women being helped, but she was left to do everything on her own.

Case Study B: Victor

Victor is a 40-year-old man. He started to have rashes and diarrhea, which did not respond well to treatment. The health staff bullied him into taking an HIV test and he was diagnosed as HIV positive. He was admitted to a health facility
and his health worsened. He stayed in the health facility for four days without receiving any treatment. During the

Sources Time Handouts

Steps

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ward rounds, he complained to the doctor but the nurses told the doctor not to pay attention to him, saying that he was confused. Victor's condition became so bad that he could no longer get himself to the toilet and started to soil his bed. The nurses would not give him a bed pan no matter how often he requested one and they scolded him for soiling the bed. He finally asked to be discharged so that he could go home and die peacefully.

Case Study C: Mary

Mary is a 35-year-old nurse who is married with two children. After noticing some symptoms of HIV in her husband, she decided to be tested and found out she was HIV positive. Mary accepted the situation. She asked her husband to take a test but he refused and accused her of being unfaithful. He started to drink on a daily basis and each time he came home drunk, he would beat her and call her names. When it became known that Mary was HIV positive, other nurses refused to work with her. She felt excluded and heard the other nurses gossiping about her. Eventually, they assigned her to the ward that deals with HIV-related diseases. Mary started to feel demoralized by her rejection by the other nurses and began to take her anger out on her clients. She often forced them to be tested for HIV, using harsh words to scold them and make them feel guilty.

Case Study D: Sick Child

Two women arrived at a health facility with a nine-year-old boy who looked very sick. The nurse read on his card that the boy was HIV positive and, thinking that there was not much she could do, began to feel angry and said to the women, "Can't you see that this child is almost dead anyway? Are you not aware of your child's condition?" Then she added, saying these words in the middle of a busy waiting room, "Maybe you should take an HIV test yourself!" The mother kept quiet, but her friend said, "Nurse, all we are asking is for you to treat this child." The nurse left the room, returned with a prescription for the pharmacy, and told them to go home, saying there was nothing else she could do.

Case Study E: Judith

Judith is a 35-year-old nurse who has worked for more than 10 years in a health facility. She has not received any training since leaving medical college. When doing her tasks in the facility, including serving food to clients and taking their temperature, she puts on gloves, a gown, and a mask.

Key Population Case Studies

Case Study A: MSM

Juan is a 30-year-old gay man. One day, he began getting painful sores around his anus, so he went to the health facility to be tested and get treatment. Because of his fear of stigma, he told the nurse that he was constipated and it was very painful. The nurse didn't say anything but left the room; a few minutes later, she returned with two other nurses. The nurses looked at Juan, whispered to each other, and then left.

The nurse returned 20 minutes later. Juan said, "I've been waiting a long time. Could you help me?" The nurse laughed and said, "Who are you to tell me what I should do? You'll just have to wait. We know you people...." She said this in the presence of other clients and then left.

After a long delay, a doctor entered and, without even examining him, said, "What have you been doing? How did you get this STI? It must be your disgusting behavior!" He told Juan to remove his pants and examined his bum from a long distance.

He then began to ask Juan a lot of questions about his sex life: "When was the last time you had sex? When was the last time you had sex with a woman? How do you have sex with a man?" Juan told him that he just wanted to be treated, not asked about his sex life. The doctor told him he only treated "real men."

As soon as the doctor went into the next room, Juan got dressed and left the health facility. He told himself he would never go back. "All I wanted was treatment," he said, "but all I got was insults and blame!"

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A

Case Study B: Sex Workers

Sara is a 30-year-old sex worker. One day she went to a health facility for an STI check and a supply of condoms. When she arrived at the health facility, she was kept waiting for a long time. Clients who arrived after her were treated before her. When she asked one nurse for help, the nurse said, "You'll just have to wait. We know you—ladies of the night! You wait all night for men, so why can't you wait a few more minutes?" The nurse said this in the presence of all of the other clients; Sara felt humiliated.

Eventually, Sara was called in to see the doctor. The doctor gave her a funny look and said, "What is your problem?" She explained the symptoms and the doctor said, "I don't know why we are wasting our time on you. You are just a virus collector. I don't care if you die. It's your own fault, sleeping

with all of these men!" Then he told Sara to take off her dress, and made a quick examination of her private parts.

He then began to ask Sara a lot of questions about her sex life: "How often do you have sex? What kind of sex do you enjoy the most? Can I see you some time?" Sara told him she just wanted to be tested and treated, not asked about her sex life. He responded that the health facility did testing only for normal women, not sex workers!

As soon as the doctor left, Sara got dressed and left the health facility—without medicine or condoms. She never went back.

Case Study C: People Who Use Drugs

Nam is a young man who uses drugs. One day, he went to a health facility for an STI check. The nurses watched him closely, observing the scars on his arm. Nam could hear them gossiping about him. "That one looks dangerous! If you are not careful, he might attack you!" He asked one nurse to help him, but she turned around and walked out of the room.

Finally, one nurse called him and told him that he had to take an HIV test. There was no counseling—they simply gave him the test without his consent.

After the test, he was called in to see the doctor. The doctor looked at him and said, "I can tell you are a drug user. You must have HIV. You are ruining your life with drugs and sex workers!" Nam said, "All I want is to get treatment for this STI. Could you please help me?" The doctor got angry and did a rushed examination. Nam left the clinic without getting any medication for his STI. He bought some penicillin from a friend and treated himself.

When Nam got the results of the HIV test, he learned that he was HIV positive. He went to another health facility to register for ART. One nurse scolded him, telling him that he had come on the wrong day. When he returned on the right day he was told, "You don't look reliable enough to adhere to ART. We need someone who is responsible. I'm sorry, we can't help you."

Summarize

Summarize the main points that participants have made during the exercise. In giving your summary, you may use some of the following points if participants have not already mentioned them.

- ƒ Stigma in the health setting takes a number of common forms, including delaying or refusing services, providing differential treatment, verbal abuse, breaking confidentiality, forcing clients to take an HIV test without their consent, isolating clients in separate wards, or excessive use of barrier precautions (e.g., gloves and masks) for routine tasks.
- ƒ Stigma may be based on judgmental attitudes toward clients or fears about getting HIV through casual contact with HIV-positive clients.
- ƒ Stigma toward PLHIV or other key populations defeats our mandate as health workers. PLHIV or key populations may stop using our health services. If so, we are failing in our role as health workers.

- ƒ Health workers' code of conduct requires us to treat all clients without exception. Every client has the right to be free from discrimination and access the highest attainable level of physical and mental healthcare.

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ƒ
Makeyourhealthfacilityawarm,welcoming,andnonjudgmentalenvironmentthatisopentoandrespectfulofall clients—a place where clients can seek services without fearing discrimination from health workers or that community members will learn about their situation. This means establishing systems that ensure client privacy and confidentiality.

Developing a Code of Conduct

Ask participants, based on this discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

Appendix G

A3- Effects of Stigma on the HIV epidemic

NAMING STIGMA & DISCRIMINATION IN HEALTH FACILITIES

A3. Effects of Stigma on the HIV Epidemic

Facilitator's Note: This exercise helps participants understand how stigma toward PLHIV (or those suspected to have HIV) and other key populations fuels the HIV epidemic.

To prepare for the exercise, review the case studies and make any changes needed to adapt to the local context. If these case studies are not applicable, you should create new ones more relevant to the reality and experiences of participants.

Objectives: By the end of the session, health workers will be able to see how stigma or the fear of being stigmatized affects PLHIV and other key populations, including their ability to access health services and practice safe sex.

Understanding and Challenging Stigma Toward MSM: Toolkit for Action (Cambodia) – Exercise A12
1 hour
F1: HIV AND KEY POPULATION STIGMA & DISCRIMINATION

Introduction

Explain the objective of this exercise. Then divide into groups and give each group one of the following case studies. Ask them to read the case study and answer the questions at the end.

Case Studies

Say, "Share your experience with someone with whom you feel comfortable." Give the pairs a few minutes to share their stories with each other.

Case Study A: Effects of stigma on MSM

Kiri started to have sex with men when he was a teenager but managed to hide it from his family. He knew that being a man who has sex with men was natural for him, but he was worried that his family would find out and make his life miserable.

When he grew older, he lived in the same town as his family but lived on his own. His family suspected he might be gay, but they didn't bother him until he was 30, when they started to pressure him to get married. He agreed to marry, feeling that he had no choice.

Soon after getting married, he found out that one of his previous male partners had tested HIV positive, so he started to worry about his own status. What would people think if he was HIV positive? Would his wife find out that he has sex with men? How would he be treated?

He went to the health facility to take an HIV test, but the counselor made him feel very uncomfortable. He asked lots of questions about Kiri's sex life. When Kiri mentioned having had sex with men, the counselor said, "No, you are not one of those! You seem different!" Kiri left the health facility without taking the test and told himself he would never go back.

He was so worried that his wife would find out about his male partner that he just continued to have sex with her without using condoms.

Discussion

ƒ What happened in the story? Why is Kiri behaving this way?
ƒ How does stigma affect disclosure to his partners and his use of health services?

Sources Time Handouts

Steps

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A

Case Study B: Effects of stigma on PLHIV

Mohammed was a migrant laborer. He worked for 10 years in the capital city, returning three times a year to his village to see his wife Ana and his two sons. While he was away, his wife gave birth to a girl and another boy.

After a while Mohammed started to suffer from a constant fever. He went to a clinic where he tested HIV positive. When his employer discovered he was HIV positive, he was fired.

Mohammed found it difficult to get other work, so he returned to his village. When he arrived home, he told no one. He didn't want to face any more shame. Ana asked him what was wrong, but he kept silent.

He survived one more year before dying. During this year, one of his sons started to get sick, too. After he died, Ana went for an HIV test and learned that she was HIV positive.

Discussion

ƒ What happened in the story? Why did Mohammed not tell his wife?
ƒ What are the consequences of Mohammed not disclosing his HIV status to his wife?

Case Study C: Effects of stigma on people who use drugs

Nam finished university and started his own business selling computer equipment. He also got married. After the birth of his first son, he decided to expand his business. He traveled around the country to get customers, and in the evenings he spent a lot of time in bars. In one bar, he met Ly, a sex worker. He fell in love with Ly, began to see her on a regular basis, and stopped using condoms. Ly introduced him to drugs, saying it would make sex more enjoyable—and he agreed. After a

while, he became addicted. He used drugs by injection, sharing needles with Ly and two other sex workers.

One day, Nam started to have a lot of pain when urinating. He went to a health facility to get tested for a sexually transmitted infection (STI). The doctor gave Nam a funny look, asked if he was using drugs, and told him he was ruining his life with drugs. Nam got very upset and left the health facility. He bought some penicillin from a friend and treated himself.

Nam's life started to fall apart. Some of his clients suspected he was using drugs and stopped doing business with him. His wife suspected he was using drugs and refused to sleep with him.

When Nam saw Ly again, he told her about the STI. Ly said they should be more careful, but Nam said he didn't need to use condoms with her. They continued to have sex without using condoms and to use drugs together.

Nam's friend told him to check his HIV status. Nam took the HIV test and found out he was positive. Nam was shocked and confused and didn't know how to tell Ly and his wife. He became very depressed and worried about what to do next.

Discussion

ƒ What happened in the story? Why is Nam behaving this way?
ƒ How does stigma affect his use of injecting drugs, condoms, and health services?

Report Back and Processing

Organize a report back. Ask each group to report on what they discussed. Then discuss the following: ƒ How does stigma result in the continuing spread of HIV?
ƒ What can we do to change this?

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NAMING STIGMA & DISCRIMINATION IN HEALTH FACILITIES

Summarize

Summarize the main points that participants have made during the exercise. In giving your summary you may use some of the following points if participants have not already mentioned them.

Stigma or the fear of stigma stops PLHIV and key populations from the following:

- ƒ **Accessing health services**—getting tested for HIV and STIs, getting information on how to avoid HIV transmission, and getting condoms and lubricant
- ƒ **Openlydiscussingtheirsexualitywithhealthworkers**andprovidingcompleteinformation abouttheirsexualpractices
- ƒ **Accessing treatment** (antiretroviral therapy [ART] or treatment of opportunistic infections [OIs])

- ƒ **Using other services**—for example, a pregnant woman living with HIV is discouraged from HIV testing and making use of the prevention of mother-to-child transmission (PMTCT) program
- ƒ **Disclosing to their partners**
- ƒ **Protecting their own health and the health of their sexual partners**—for example, by insisting on condom use with

  partners, using clean needles and syringes for drug use, and accessing treatment to reduce viral load

- ƒ **DisclosingtheirHIVstatusandgettingcounselingcareandsupport**.Becauseofstigma,PLHIVandotherkeypopu- lations are afraid to tell others about their HIV status. As a result, they may have difficulty in negotiating condom use; ac- cessing services, support, and treatment for HIV; and so may be at increased risk for transmitting HIV to their partners.

  Developing a Code of Conduct

  Ask participants, based on this discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

Appendix H

A2- How Stigma Feels (Reflection Exercise)

NAMING STIGMA & DISCRIMINATION IN HEALTH FACILITIES

A2. How Stigma Feels (Reflection Exercise)

Facilitator's Note: This is one of the most important exercises in the toolkit because it draws on personal experiences to bring out the feelings of being stigmatized. The exercise asks health workers to think about a time in their lives when they felt stigmatized and use this experience to help them empathize with stigmatized groups.

The exercise looks at stigma in general, not stigma toward PLHIV or key populations. This is why the instructions are to "Think of a time in your life when you felt isolated or rejected for being seen as different from other people."

Emphasize that the sharing is voluntary—no one is forced to give their story—and emphasize the importance of confidentiality. Remind participants about the ground rules—"What is shared should stay in the room." Encourage group members to listen carefully to each other's stories.

Objectives: By the end of this session, health workers will be able to do the following: ƒ Describe some of their own personal experiences concerning stigma
ƒ Identify some of the feelings associated with being stigmatized

Understanding and Challenging HIV Stigma: Toolkit for Action (A2) 45 minutes
F1: HIV AND KEY POPULATION STIGMA & DISCRIMINATION

Individual Reflection

Ask participants to sit on their own. Then say, "Think about a time in your life when you felt lonely or rejected for being seen as different from others." Explain that this does not need to be an example of stigma toward PLHIV or other marginalized groups; it could be any form of stigmatization for being seen as different.

Sharing in pairs

Say, "Share your experience with someone with whom you feel comfortable." Give the pairs a few minutes to share their stories with each other.

Sharing in plenary

Invite participants to share their stories in the large group. This is voluntary; no one should be forced to give his/her story. People will share if they feel comfortable. If it helps, tell your own story to get things started. As the stories are presented, ask, "How did you feel? How did this affect your life?"

Processing:

Ask:
ƒ What did you learn from the exercise about stigma? ƒ What feelings are associated with stigma?

Sources Time Handouts

Steps

43

A

Summarize:

Summarize the main points that participants have made during the exercise. In giving your summary you may use some of the following points if participants have not already mentioned them.

ƒ This exercise helps us get an inside understanding of how it feels to be stigmatized—shamed or rejected. It helps put us into the shoes of PLHIV or marginalized groups. It helps us understand how painful it is to be stigmatized.

ƒ Everybody has felt ostracized or treated like a minority at different times in their lives. We have all experienced a sense of social exclusion.

Appendix I

A6- Analyzing Different Forms of Stigma in Health Facilities

A

A6. Analyzing Different Forms of Stigma in Health Facilities

Facilitator's Note: In this session, health workers analyze different forms of stigma that occur in health facilities, including health workers' stigma toward HIV-positive clients, clients' stigma toward other clients, and health workers' stigma toward other health workers living with HIV. The aim is to examine the root causes and effects, and then look at what they can do to solve these problems.

This exercise uses a PROBLEM TREE ANALYSIS—a method for analyzing the effects and root causes of a problem. Each group will analyze a different type of stigma. Explain the technique before splitting into groups.

The technique uses the following steps:

- ƒ Draw a picture of a tree on a flipchart paper.
- ƒ On the trunk, write the name of the problem—e.g., "Stigma toward clients by health workers."
- ƒ Then, on the trunk, using cards, add more details on the FORMS of stigma, e.g., "shouting and scolding the client, making the client wait, using gloves to do non-invasive tasks, etc."
- ƒ Then, at the roots at the bottom of the picture, write the CAUSES, e.g., "fear of getting HIV through casual contact, judgmental attitudes, heavy workloads and stress, etc." Ask participants to dig deeper—to look for the causes of some of the causes they list.
- ƒ Then, on the branches of the tree, write the EFFECTS on cards, e.g., "feeling isolated and ashamed, feeling angry and depressed, self-blame, wanting to leave the health facility, etc."
- ƒ Then, underneath the flipchart paper, write POSSIBLE SOLUTIONS on cards, e.g., "remind health workers of their code of conduct, improve health workers' knowledge about HIV transmission so they no longer fear getting HIV through contact with HIV-positive clients."

Objectives: By the end of this session, health workers will be able to identify the following:
ƒ Different aspects of stigma in health facilities and how it affects different people
ƒ Some of the root causes of stigma
ƒ Practical things they can do to stop or reduce stigma in their health facility

Draft exercises from Alliance Regional Stigma Team (#4)
1 hour
F1: HIV AND KEY POPULATION STIGMA & DISCRIMINATION

Analyzing Different Forms of Stigma (Task Groups)

On cards, write down the different categories of stigma that occur in health settings. (Select those that apply.)

1. Stigma toward HIV-positive clients by health workers
2. Stigma toward people who use drugs by other clients
3. Stigma toward HIV-positive health workers by other health workers
4. Stigma toward women living with HIV who get pregnant
5. Stigma toward sex workers by health workers
6. Stigma toward adolescent clients living with HIV by health workers

Sources Time

Handouts

Steps

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NAMING STIGMA & DISCRIMINATION IN HEALTH FACILITIES

Then divide into groups and assign one category to each group. Ask each group to do a problem tree analysis of their problem, using the following steps:

ƒ Clarify the problem—what are the FORMS of stigma; what actually happens?
ƒ Identify the CAUSES (roots) and EFFECTS (branches), and work out POSSIBLE SOLUTIONS (write on cards)

Hand out flipchart paper, cards, markers, and tape to each group, and ask them to prepare their analysis as a problem tree on the wall.

EXAMPLE RESPONSES

A: Stigma Toward HIV-Positive Clients by Health Workers
Forms: Shaming and blaming clients for getting HIV; making clients wait; using gloves for non-invasive tasks; moving

away from clients assumed to be HIV positive.
Causes: Fear of getting HIV through casual contact; judgmental, moralizing attitudes; heavy workloads and stress.

Effects: Feeling isolated, ashamed, angry, and depressed; self-blame; some may transfer to another health facility or stop treatment.

Solutions: Remind health workers of their code of conduct; improve health workers' knowledge about HIV transmission so they no longer fear getting HIV through casual contact with clients; orient new health staff on how to treat/interact with clients.

Report Back (Gallery Walk)

Organize a gallery walk; moving around the room and having each group present its report. Other groups can make additions to each report.

Summarize

Summarize the main points that participants have made during the exercise. In giving your summary, you may use some of the following points if participants have not already mentioned them.

- ƒ ThethreemaincausesordriversofHIV-relatedstigmaare(1)lackofawarenessthattheyarestigmatizing,(2)inade- quate knowledge of HIV transmission and fear of getting HIV through casual contact, and (3) judgmental attitudes.
- ƒ Judgmental attitudes toward other key populations bring up some of the following issues:

  ƒ Gender (e.g., the common perception that "MSM and transgender people are not real men")

  ƒ Culture (e.g., the perception that "homosexuality, sex work, or use of drugs is 'abnormal,' breaking social norms")

  ƒ Religion (e.g., the perception that "same-sex relationships, sex work, or use of drugs is immoral, against the teachings of our faith")

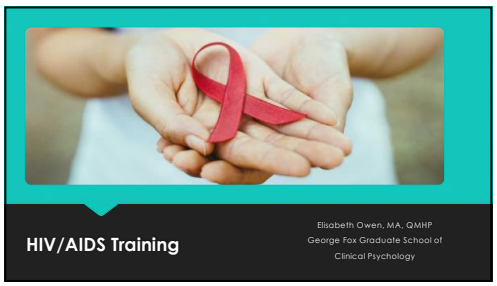
- ƒ Health workers alone cannot solve many of the root causes of stigma. However, general awareness of the root causes will help health workers better understand the needs and concerns of PLHIV and marginalized groups so health workers can provide better services and refer PLHIV to other appropriate services.
- ƒ StigmaleadstolowuptakeofhealthservicesbyPLHIV.Reducingstigmaiskeytoincreasingtheup takeofHIVpreven- tion and services; improving HIV disclosure; and improving client follow-up for treatment, care, and support services.

  Developing a Code of Conduct

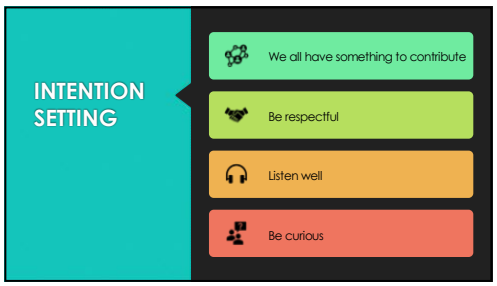
Ask participants, based on this discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

Appendix J

Training Slideshow


HIV/AIDS Training
Elisabeth Owen, MA, QMHP
George Fox Graduate School of
Clinical Psychology

1


INTENTION SETTING
We all have something to contribute
Be respectful
Listen well
Be curious

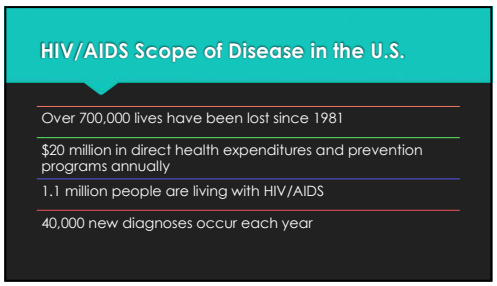
2


What do you know about HIV/AIDS?
We all come in with our own:
Experiences
Knowledge
Preconceptions

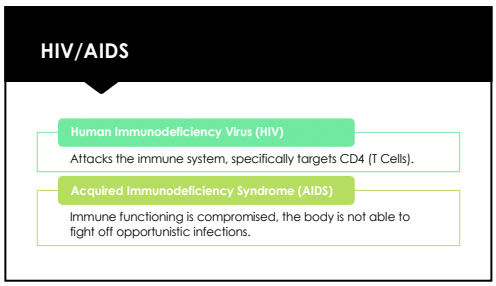
3


AIDS Epidemic (1981)
Believed to only impact gay males
Response to the disease slow
Thousands dying per year
Initially termed:
GRID- Gay Related Immune Deficiency
Gay Cancer
4H Disease
Fight AIDS
NOT GAYS

4


HIV/AIDS Scope of Disease in the U.S.
Over 700,000 lives have been lost since 1981
$20 million in direct health expenditures and prevention programs annually
1.1 million people are living with HIV/AIDS
40,000 new diagnoses occur each year

5


HIV/AIDS
Human Immunodeficiency Virus (HIV)
Attacks the immune system, specifically targets CD4 (T Cells).
Acquired Immunodeficiency Syndrome (AIDS)
Immune functioning is compromised, the body is not able to fight off opportunistic infections.

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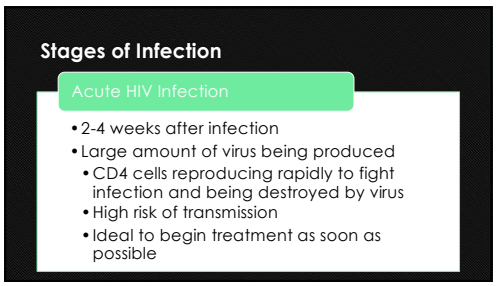
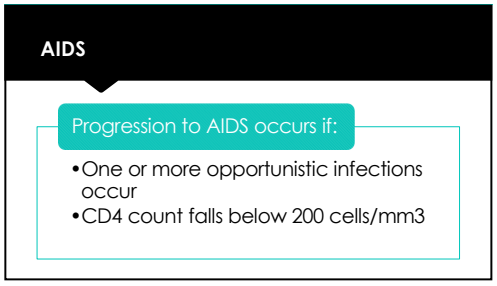

Stages of Infection
Acute HIV Infection
•2-4 weeks after infection
•Large amount of virus being produced
•CD4 cells reproducing rapidly to fight infection and being destroyed by virus
•High risk of transmission
•Ideal to begin treatment as soon as possible

7


Clinical Latency
Virus developing no symptoms present
Virus is highly transmittable

8


AIDS
Progression to AIDS occurs if:
•One or more opportunistic infections occur
•CD4 count falls below 200 cells/mm3

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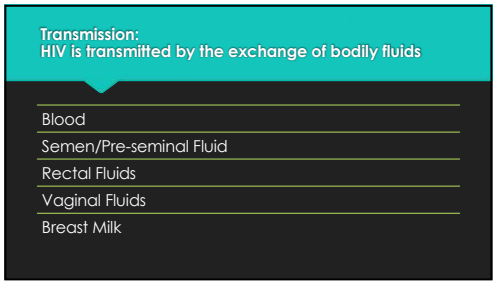
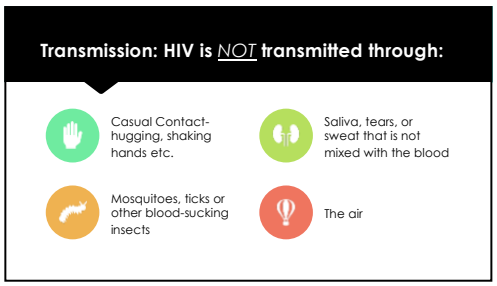
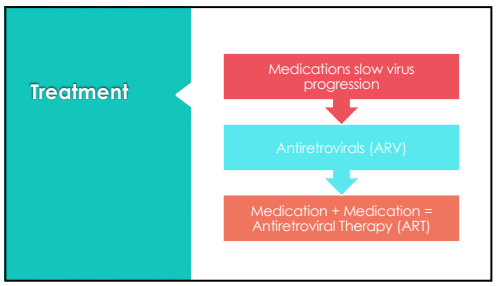

Transmission:
HIV is transmitted by the exchange of bodily fluids
Blood
Semen/Pre-seminal Fluid
Rectal Fluids
Vaginal Fluids
Breast Milk

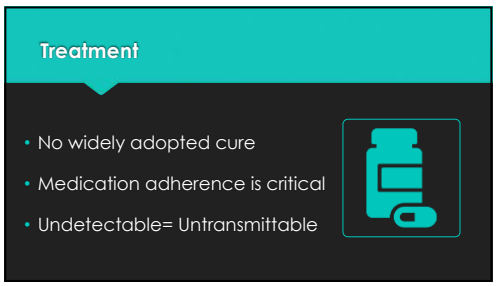
10


Transmission: HIV is NOT transmitted through:
Casual Contact- hugging, shaking hands etc.
Saliva, tears, or sweat that is not mixed with the blood
Mosquitoes, ticks or other blood-sucking insects
The air

11


Treatment
Medications slow virus progression
Antiretrovirals (ARV)
Medication + Medication = Antiretroviral Therapy (ART)

12



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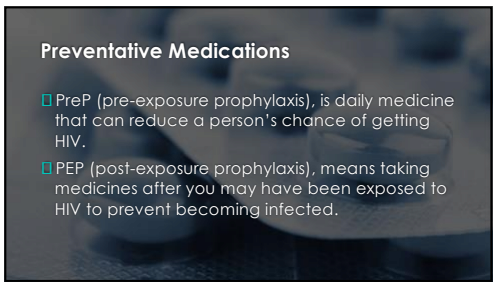

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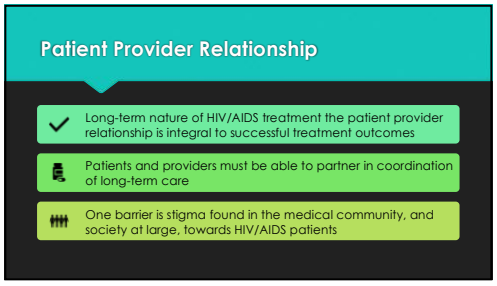

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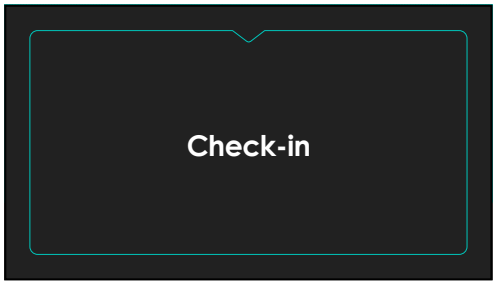

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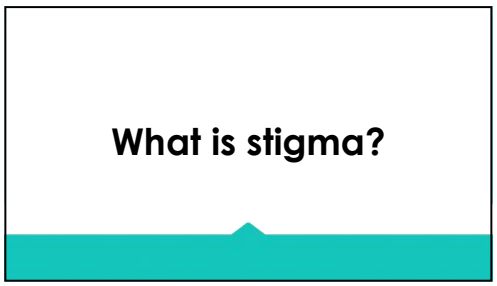

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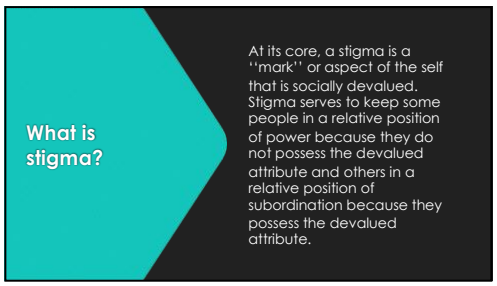

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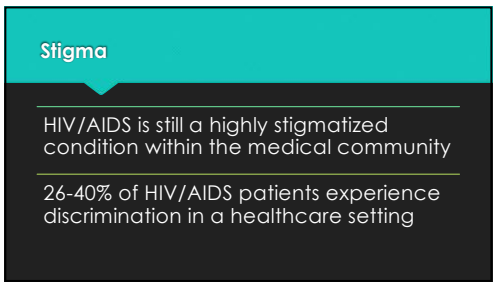

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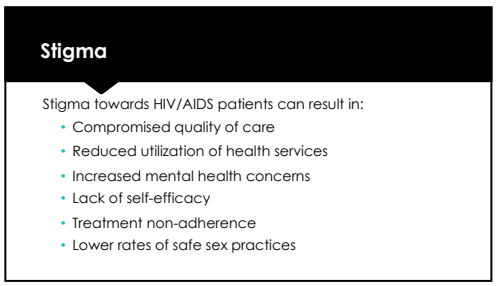

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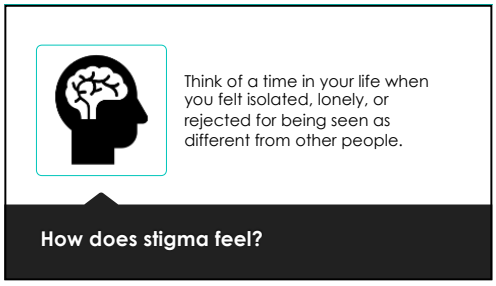

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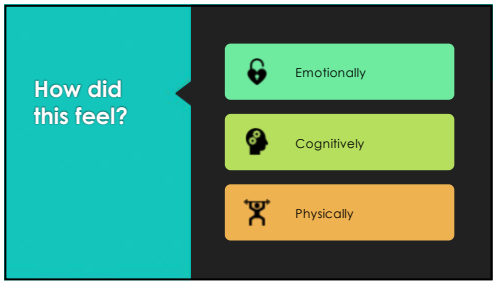

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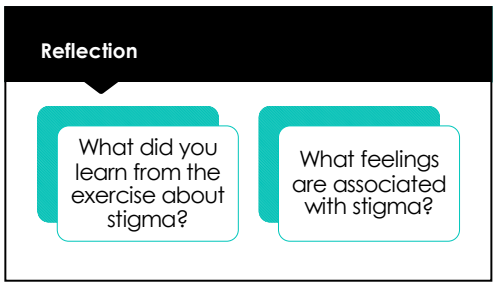

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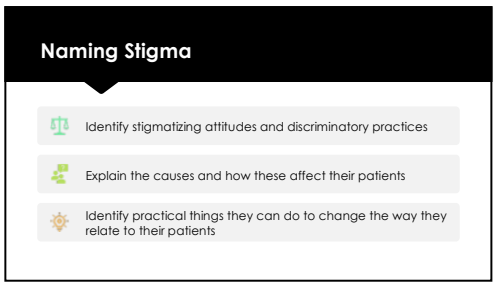

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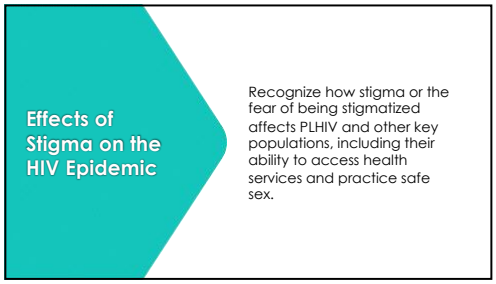

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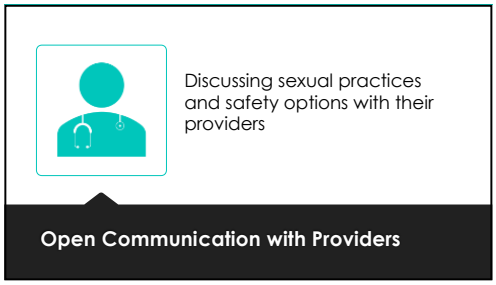

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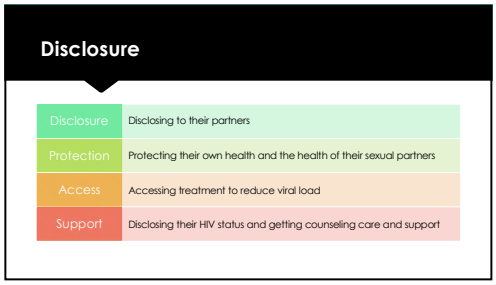

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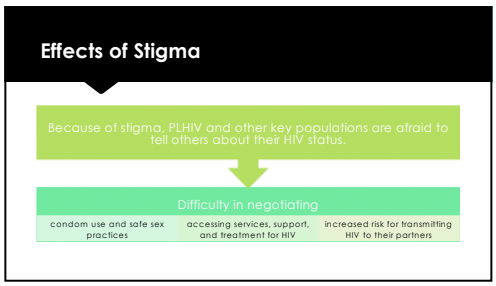

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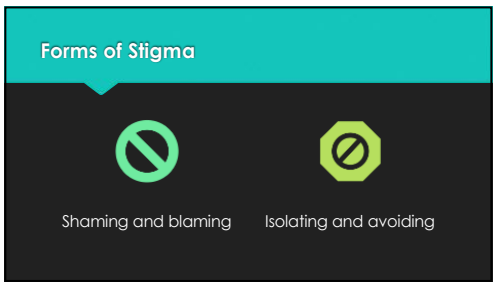

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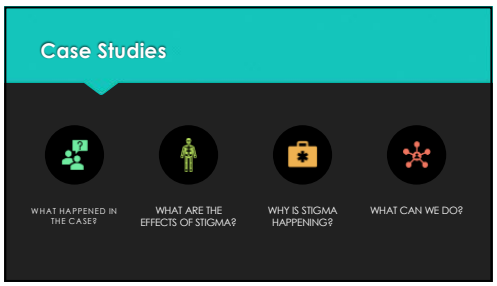

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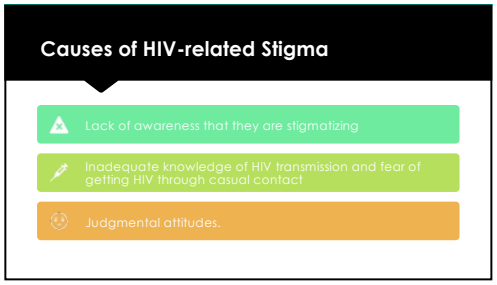

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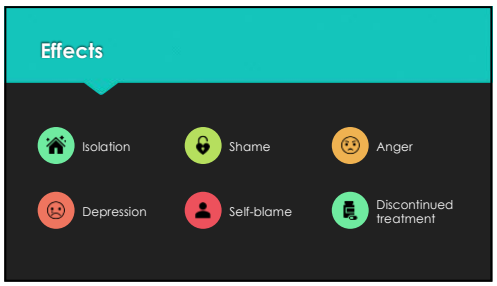

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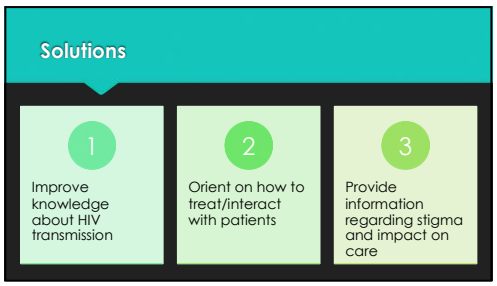

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Reflection
What is something new you learned today?
What is something you would like to learn more about?
How can you see this impacting your clinical work and interdisciplinary collaboration?

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Resources for further learning
HIV.gov
HUMAN RIGHTS CAMPAIGN
AND THE BAND PLAYED ON
RANDY SHILTS
WHEN WE RISE
CLEVE JONES
HRSA
Ryan White & Global HIV/AIDS Programs

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THANK YOU!
EOWEN17@georgefox.edu

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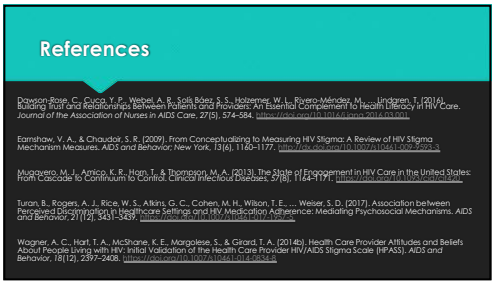
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Turan, B., Rogers, A. J., Rice, W. S., Atkins, G. C., Cohen, M. H., Wilson, T. E., ... Weiser, S. D. (2017). Association between Perceived Discrimination in Healthcare Settings and HIV Medication Adherence: Mediating Psychosocial Mechanisms. AIDS and Behavior, 21(12), 3431–3439.
Wagner, A. C., Hart, T. A., McShane, K. E., Margolese, S., & Girard, T. A. (2014b). Health Care Provider Attitudes and Beliefs About People Living with HIV: Initial Validation of the Health Care Provider HIV/AIDS Stigma Scale (HPASS). AIDS and Behavior, 18(12), 2397–2408.

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Appendix K

Curriculum Vitae

ELISABETH OWEN

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Pronouns: she/her

EDUCATION

Present	**PsyD Clinical Psychology** *(APA Accredited)* George Fox University, Newberg, OR *Anticipated Graduation May 2022* Dissertation: "HIV/AIDS Training: A Study of Stigma Reduction" Committee: Mary Peterson, PhD, ABPP (chair), Marie-Christine Goodworth, PhD, Elisa Rudd, PsyD
2019	**MA Clinical Psychology** *(APA Accredited)* George Fox University, Newberg, OR
2017	**BS Clinical Psychology,** *Summa Cum Laude* Corban University, Salem, OR

SUPERVISED CLINCIAL EXPERIENCE

5/2020- Current

Pre-Intern: Behavioral Health Provider
Providence Medical Group, Newberg, OR
Supervisor: Jeri Turgesen, PsyD, MSCP
Description:

- Primary care behavioral health consultation in integrated primary care medical home including family medicine and internal medicine clinics supporting presentations including: mental health, health behaviors, medical presentations, substance use, and co-occurring presentations
- Completion of warm handoffs as requested by interdisciplinary team members for emergent patient concerns
- Provision of tele-behavioral health services via phone and Zoom due to COVID-19 restrictions
- Collaboration with large interdisciplinary team
- Training and mentoring of incoming Practicum-II providers including initial shadowing and ongoing mentoring and support
- Intake, assessment, and treatment planning
- Determination of appropriate referrals to outpatient services
- Administration of memory testing and determination of appropriate care coordination or additional referrals

- Completion of ADHD screenings including clinical interviews, collateral interviews, and administration of ADHD screeners for diagnostic clarification
- Attend weekly individual and group supervisions with licensed psychologist and supplemental group supervision with Addiction Psychiatrist
- Concurrent charting directly into electronic medical record utilizing EPIC

8/2020- Present

Fourth Year Mentor
Graduate School of Clinical Psychology, George Fox University

- Provide weekly supplemental oversight and mentorship to a 2nd year clinical psychology student
- Oversee clinical work with an emphasis on case conceptualization and intervention
- Cultivate professional development and clinical psychology competencies

5/2019-5/2020

Practicum-II: Behavioral Health Provider
Providence Medical Group, Newberg, OR
Supervisor: Jeri Turgesen, PsyD, MSCP
Description:

- Provide individual behavioral health sessions in integrated medical setting
- Conduct initial consults and follow up appointments
- Coordinate care with medical treatment team and consult with primary care providers and medical staff
- Treatment planning and progress tracking for physical and behavioral health and overall well-being
- Psychoeducation for patients and their support systems
- Medication adherence and disease self-management counseling
- Motivational Interviewing to develop behavioral strategies aimed at symptom reduction
- Brief problem-solving cognitive intervention aimed at modifying negative thinking and promoting self-efficacy
- Self-Care Plan development and skills training to facilitate disease self- management, improved coping, distress tolerance, stress reduction, and relaxation
- Substance use/abuse evaluation, identification of maladaptive coping strategies, and development of harm reduction strategies

1/2019- Present

Supplemental Practicum and Professional Experience: QMHP/Behavioral Health Crisis Consultant
Behavioral Health Crisis Consultation Team, Yamhill County, OR

Supervisors: Luann Foster, PsyD; Mary Peterson, PhD, ABPP; William Buhrow, PsyD

Description

- Provide crisis consultation at emergency departments in local hospitals
- Perform risk assessments regarding suicide/homicide, psychosis, and other behavioral health evaluations
- Consult and collaborate with medical staff and other integrated health professionals
- Attend weekly group supervision and didactics
- Collaborate with other team members and supervisors
- Aid in training for new crisis consultants

8/2018-5/2019 *Practicum-I: Behavioral Health Provider*

Santiam Hospital Clinics, Stayton, OR

Supervisors: Carilyn Ellis, PsyD, MSCP, Tanni Swisher MSW

Description:

- Behavioral health consultation in integrated primary care clinic
- Intake, assessment, and treatment planning
- Provision of brief solution-focused interventions for varied mental and physical health condition
- Completion of warm handoffs as requested by interdisciplinary team members for emergent patient concerns

9/2017-5/2018 *Pre-Practicum: Student Therapist*

George Fox University, Newberg, OR

Supervisors: Glena Andrews, PhD, MSCP, ABPP; Andrew Summerer, MA

Description:

- Provide outpatient, individual, client-centered psychotherapy services to volunteer undergraduate students
- Conduct intake interviews, write treatment plans, make diagnoses, write professional reports, and make case presentations
- Consult with supervisors and members of clinical team
- All sessions recorded, reviewed extensively, and discussed in individual and group supervision

11/2017-5/2018 *Group Facilitator*

Friendsview Retirement Community, Newberg, OR

Supervisors: Glena Andrews, PhD, ABPP; Lynsey Fringer, MA

Description:

- Facilitate group discussion curriculum on life transitions, stress management, and additional topics
- Provide therapeutic support to group members as they shared

their experiences of transitional experiences and struggles
- Answer questions regarding curriculum and provide additional psychoeducation
- Follow up with participants on weekly tasks and progress throughout program

9/2017-12/2017 *Group Facilitator*
Depression and Anxiety Group, Newberg, OR
Supervisors: Glena Andrews, PhD, ABPP; Courtney Chapin, MA
Description:
- View psychoeducational DVD series about anxiety and depression with participants
- Facilitate group discussion regarding video content and workbook activities
- Provide therapeutic support to group members as they shared their experiences of depression and anxiety
- Answer questions regarding DVD content and provide additional psychoeducation
- Follow up with participants on weekly tasks and progress throughout program

RELATED PROFESSIONAL EXPERIENCE

2016 *Intern*
Mid-Willamette Valley Community Action Agency, Arches Program, Salem, OR
Supervisor: Linda Strike, MSW, LMSW, Arches Program Coordinator.
Description:
Arches Project provides supportive housing and case management for the homeless and those at imminent risk for homelessness.
Duties and Projects:
- Develop and launch mental health impact questionnaire to determine the level of impact of mental health issues on clients' daily lives and ability to procure and maintain stable housing
- Participate in case management and home visits with case managers
- Develop organization and planning strategies for clients with SPMI
- Assist in grant writing, donation sourcing, and coordination for veteran warming shelter project in partnership with a local veteran task force
- Develop informational materials for programs available through Arches
- Work directly with case managers and staff in order to plan

effective methods for interacting with and assisting clients with mental illness

TEACHING AND ACADEMIC APPOINTMENTS

7/2020-Present

Supervising Teaching Assistant
PSYD 557 Cognitive Assessment
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Professor: Kenneth Logan, PsyD
Duties:

- Participate in restructuring of course
- Develop assignments and exams for course
- Create study and testing materials for students
- Participate in training and weekly supervision of primary teaching assistants for course

1/2020-6/2020

Teaching Assistant
PSYD 701 Foundations of Primary Care
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Professor: Kristie Knows His Gun, PsyD
Duties:

- Aid in the organization and structuring of the course
- Develop assignments and exams for course
- Participate in classes to aid in facilitating learning of students
- Present in a teaching capacity for topics including: risk assessment, gender and sexual diversity, transgender healthcare

6/2019-12/2019

Teaching Assistant
PSYD 522 Cognitive Assessment
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Professor: Kenneth A. Logan, PsyD
Duties:

- Aid in the organization and structuring of the course
- Aid in the teaching and practice of individualized assessment of intellectual and other selected cognitive functions (*i.e.* WAIS-IV, WISC-V, WIAT-III, WMS-IV)
- Facilitate weekly lab group meetings with students for administration practice and continued support in course
- Attend weekly meetings with course professor and other teaching assistants to address student concerns and course components
- Participate in meetings with other teaching assistants to address strict grading criteria for APA competency in test

administration, test scoring, and test interpretation and facilitate internal grading consistency

RESEARCH EXPERIENCE

2020	*Dissertation:* HIV/AIDS Training: A Study of Stigma Reduction. Committee: Mary Peterson, PhD, ABPP (chair), Marie-Christine Goodworth, PhD, Elisa Rudd, PsyD Preliminary Defense: 9/23/2019 Final Defense: 12/16/2020
2018-Present	*Research Vertical Team Member* George Fox University, Newberg, OR Chair: Mary Peterson, PhD, ABPP *Research*: Meet bi-monthly to discuss and evaluate progress, methodology, and design of group and individual research projects. *Areas of team focus*: Health Psychology, Integrated and Primary Care, self-efficacy and treatment adherence, resiliency.
2020	*Researcher* Gauging Collective Confidence of Peer-to-Peer Engagement Surrounding LGBTQ+ Experiences- Elisabeth Owen, MA, Haley Hedrick, MS. George Fox University, Newberg, OR Supervisor: Amber Nelson, PsyD *Research:* Develop and conduct assessment of students at varying levels of training in doctoral clinical psychology program to determine relationship of collective confidence and competence in working with LGBTQ+ individuals.
2018	*Research Assistant* Mindfulness Dissertation- Elizabeth Grace, M.A, QMHP George Fox University, Newberg, OR Supervisor: Mary Peterson, PhD, ABPP *Research*: facilitate weekly group meetings with control group and experimental mindfulness group, support participants in beginning to practice mindfulness, provide tracking of hours of practice and group involvement.
2018-2019	*Research Assistant* Emergency Department Crisis Protocol- Colten Wayne Larsen, M.A, QMHP George Fox University, Newberg, OR Supervisor: Mary Peterson, PhD, ABPP *Research*: work with team to develop and format protocols for use in interventions with high risk patients awaiting hospitalization.

CONSULTATIONS AND REVIEWS

Aug 12, 2020	*Presenter/Consultant* with Colten Larsen, MA, QMHP Topic: Transgender Healthcare within the Emergency Department Behavioral Health Crisis Consultation Team Yamhill County Mental Health Graduate School of Clinical Psychology George Fox University, Newberg, OR
2019-2020	*Consultant* Topic: Transgender Healthcare/Working with Transgender Clients in the Judicial System. Supervisor: Marie-Christine Goodworth, PhD Supplemental Supervisors: Jeri Turgesen, PsyD; Patricia Warford, PsyD In consultation with: • Providence Newberg Medical Center, Internal Medicine • Providence Newberg Medical Center, Family Medicine • Metropolitan Public Defender, Hillsboro, OR Law Office • Metropolitan Public Defender, Portland, OR Law Office

PRESENTATIONS

Owen, E.A. (2020) LGBTQ+ Self-Care in 2020. Invited presentation at Parents and Friends of Lesbians and Gays (PFLAG) Newberg, October 13, 2020.

Hedrick, H., **Owen, E.A.**, Nelson, A. (2020) Gauging Collective Confidence of peer-to-peer engagement Surrounding LGBTQ+ Experiences. Accepted for presentation at Western Psychological Association Annual Conference, San Francisco, CA, November 2020.

Grace, E.M., Buckles, Z., **Owen, E.A.**, Neff, M.A., George, M., Peterson, M. (2020) Toward Connection: How Mindfulness and Social Engagement may induce Non-Judgmental Presence. Presented at the American Psychological Association Annual Conference, Virtual, August 2020.

Shim, P., Standhal, W., Harberts, J., **Owen, E.A.**, Peterson, M. (2020) Impact of Biofeedback/Mindfulness Intervention on General Self-Efficacy. Presented at the American Psychological Association Annual Conference, Virtual, August 2020.

Larsen, C. W., **Owen, E.A.**, Hamilton, S., Jones, C., & Peterson, M. (2019). Behavioral health crisis intervention for adolescent emergency department patients pending psychiatric hospitalization. Presented at the American Psychological Association Division 53 Annual Conference, Chicago, IL, August 2019.

Hampton, C.L, **Owen, E.A.** (2018) *A History of Queer Moments.* Presented at Diversity of Sexuality and Gender Student Interest Group and Parents and Friends of Lesbians and Gays (PFLAG) Newberg Inaugural Meeting.

OTHER PROFESSIONAL EXPERIENCE

2011-2012 *Branch Coordinator*
Vanderhouwen and Associates, Inc., Portland, OR
Manager: Brian Hathaway
Description:

- Coordinate new hire orientations for contract employees
- Administer benefits program along with serving as the main point of contact for benefits questions and inquiries
- Maintain employee files for all contract employees ensuring compliance with HIPAA regulations
- Coordinate with recruiters, account managers, and clients to ensure all background check, drug screening, and paperwork requirements are fulfilled in a timely manner

2008-2011 *Branch Coordinator/Program Coordinator*
Volt Information Sciences, Portland, OR
Supervisor: Brianna Dewy
Description:

- Coordinate orientations, paperwork completion, and pre-employment screening with both employees and hiring managers
- Point of escalation for inquiries regarding payroll, benefits, and timekeeping
- Continuously update and maintain customer requirements regarding paperwork and procedures to ensure compliance.
- Responsible for ongoing employee relations and maintenance for high volume government agency
- Maintain reporting for multiple large head count clients utilizing internal and external systems

ASSESSMENT COMPETENCIES

Cognitive/Achievement/Memory:

WAIS-IV WISC-V WIAT-III WMS-IV

Personality:

16PF MMPI-A MMPI-2/RF MCMI-IV PAI

Neuropsychological:

CVLT-II C-TONI DKEFS Grooved Pegboard

MOCA RBANS RCFT WCST

GRANTS RECEIVED

2019-2020	*Integrated Care Models for Practicum Training in Addictions and Culturally congruent treatment using Tele-Behavioral Health (IMPACT)* through George Fox University Granting Agency: Health Resources and Services Administration Grant Purpose: This project seeks to expand services to underserved, vulnerable populations through simultaneous training for graduate psychology students in treatment for OUD/SUD and establishment of telebehavioral health services (TBS).

PROFESSIONAL AFFILIATIONS

2017-Present	Division 38, American Psychology- Society for health psychology (Associate-at-Large) SfHP Campus Representative (2018-2019)
2018-Present	Division 44, American Psychology- Society for psychology of sexual orientation and gender diversity (Associate-at-Large)
2015-Present	American Psychology Association (Graduate Student Affiliate)
2019-Present	The International Honor Society in Psychology Psi Chi

RELEVANT MEMBERSHIPS & PARTICIPATION

2017-Present	Health Psychology Student Interest Group (member) George Fox University, Newberg, OR Student Interest Group Co-Facilitator (2018-2019)
2017-Present	Gender, Sexuality, and Identity Student Interest Group (member) George Fox University, Newberg, OR Student Interest Group Co-Facilitator (2018-2019)

ATTENDED COLLOQUIUM & GRAND ROUNDS

Lee, J., PhD. *Pediatric Cancer and the Psychology of Oncology and Hematology.* Graduate School of Clinical Psychology, George Fox University, Newberg, OR. October 14, 2020.

Stoeber, A., PhD. *Adverse Childhood Experiences to Adults with Substance Use Problems.* Graduate School of Clinical Psychology, George Fox University, Newberg, OR. February 12, 2020.

Forster, C., PhD. *Intercultural Communication.* Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. October 16, 2019.

Worthington, E., PhD. *Promoting Forgiveness.* Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. September 25, 2019.

Marlow, D., PhD. *Couples Therapy: Gottman Method.* Grand Rounds, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. March 20, 2019.

Safi, D., PsyD & Alexander Millkey, PsyD. *Opportunities in forensic psychology.* Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. February 13, 2019.

Pengelly, S., PhD. *Old pain in new brains.* Grand Rounds, George Fox University, Newberg, OR. October 10, 2018.

McMinn, M., PhD, Lisa McMinn PhD *Spiritual formation and the life of a psychologist: looking closer at soul-care.* Colloquium, George Fox University, Newberg, OR. September 26, 2018.

Vogle, M., PsyD. *Integration and ekklesia.* Colloquium, George Fox University, Newberg, OR. March 14, 2018.

Taloyo, C., PhD. *The history and application of interpersonal psychotherapy*. Grand Rounds, George Fox University, Newberg, OR. February 14, 2018.

Sordahl, J., PsyD. *Telehealth*. Colloquium, George Fox University, Newberg, OR. November 08, 2017.

Gil-Kashiwabara, E. , PsyD. *Community based participatory research and tribal participatory research with Indian American/Alaskan Natives*. Grand Rounds, George Fox University, Newberg, OR. October 11, 2017.

ADDITIONAL PROFESSIONAL TRAINING & EDUCATION

Stoeber, A., PhD. *Mitigating the Effects of ACES & Transforming Primary Care through Resilience Building & Compassionate Connection.* Graduate School of Clinical Psychology, George Fox University, Newberg, OR. February 21, 2020.

Strosahl, K., PhD. *Focused Acceptance and Commitment Therapy (fACT): The Basics and Beyond.* Graduate School of Clinical Psychology, George Fox University, Newberg, OR. December 9-10, 2019.

Olezeski, C., PhD. *Minority stress and the impact of acceptance for transgender youth: policy and practical implications.* APA Convention, Chicago, IL. August 6, 2019.

Boot, W.R, PhD. *LGBT issues across the lifespan: how social stigma and multiple inequities present challenges to successful aging.* APA Convention, Chicago, IL. August 7, 2019.

Wolf, J.R., PhD and Davis, E.B., PhD. *Forming community partnerships to reduce health disparities for vulnerable populations.* APA Convention, Chicago, IL. August 8, 2019.

Nyblade, L., PhD. *Symposium: Addressing the Opioid and HIV Epidemics.* APA Convention, Chicago, IL. August 8, 2019.

Ackerman, C., PsyD. *Transgender Healthcare.* Student Interest Group Presentation, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. April 17, 2019.

Choi, O., MD, PhD. *Real-life monsters: Psychopathy and the neuroscience of morality.* Portland, OR. October 30, 2018.

Andrashko, J. M.S.W., LCSW & Sommers, K., PsyD, LP. *Ethics and boundaries in rural America: A practical approach.* Newberg, OR. October 5, 2018.

Society for the Psychology of Sexual Orientation and Gender Diversity (Div. 44) and Society for the Psychological Study of Social Issues (Div. 9). *Pre-convention LGBTQ Advocacy Workshop.* San Francisco, CA. August 8, 2018.

Dunn, D., PhD. *Leadership Training Workshop.* Newberg, OR. September 27, 2017.

CERTIFICATIONS

August 2020	Neuroanatomy Certificate of Completion Instructor: Glena Andrews, PhD, MSCP, ABPP Graduate School of Clinical Psychology George Fox University
2019-Present	Qualified Mental Health Professional Yamhill County, Oregon

CONFERENCES ATTENDED

2018	American Psychological Association Convention
2019	American Psychological Association Convention

OFFICES HELD

2017- Present	Student Council Graduate School of Clinical Psychology George Fox University, Newberg, OR

Member-at-large (2019-Present)
Secretary (2018-2019)
Cohort Representative (2017-2019)

2018-2019 Student Wellness Committee
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Coordinator