Sending Paraprofessionals Out as Sheep to a Pack of Wolves: A Professional Reflection

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Abstract: Black and Brown men who have sex with men (BMSM) are often recruited as paraprofessionals to offer risk-reduction counseling services to their communities. Due to the high prevalence of HIV, mental health issues, substance use disorders, and suicidal thoughts among BMSM as compared to the general population, these service providers are often at risk themselves—yet are seldom obligated to receive continuing education or clinical supervision. This reflection shows the importance of providing organized, culturally competent support to paraprofessionals in community- and health-based institutions delivering services to an at-risk and vulnerable community. I demonstrate the implications of offering risk-reduction counseling without adequate clinical support. I also discuss what a successful supervisor of BMSM paraprofessionals might look like. Finally, I discuss what BMSM paraprofessionals need to succeed when delivering care and examine how unaddressed personal and structural factors can contribute to maladaptive coping in the face of such targeted workplace stressors.

***Keywords*:** BMSM, paraprofessionals, clinical supervision, clinical training

Introduction

I am a Black man whose childhood was shaped by trauma and chronic stress. My stepfather forced my mother to allow his paramour and her children to move into our home after child protective services discovered that he was sexually abusing the paramour's eldest daughter. Because I was not biologically his, I experienced physical, mental, and emotional abuse. My elementary school days were spent assuring the school counselor that my repeated threats of suicide were exaggerated, because my stepfather's violent threats prevented me from sharing the intimate details of what was happening in our home. The message that echoed through our house was clear: "What happens in this house stays in this house!" As an adult, I do not have a healthy relationship with any of my family members, and I often describe myself as a man who has no home. These early experiences of secrecy, violence, and silencing now inform the empathy and urgency I bring to my work with young people and with Black men who have sex with men.

I am a Black man who identifies as a man who has sex with men (MSM). I have seen friends and colleagues cope with intimate partner violence, substance use issues, HIV diagnoses, excessive drinking, and sex work. As a member of the MSM community, I am part of a marginalized group that experiences multiple forms of stigma and discrimination, which contribute to negative HIV-related outcomes (Babel et al., 2021). I am also a Black man who has earned an associate degree in child development, a bachelor's degree in communication, and two master's degrees. I hold two clinical licenses, in professional counseling and in drug and alcohol counseling. I have managed and created safe spaces for LGBTQIA+ communities of color in Paterson, New Jersey; Newark, New Jersey; and Brooklyn, New York. I was one of the first men to work at a domestic violence shelter in New Jersey, hired to assist LGBTQIA+ community members experiencing intimate partner violence and domestic violence. As a former

safe space liaison with New Jersey's Department of Children and Families, I provided LGBTQIA+ educational and cultural competency training to child protective services case managers at my local office and implemented LGBTQIA+-affirming practices so that our office functioned as a genuine safe environment for LGBTQIA+ youth and young adults.

My professional credentials allow me to support the BMSM community through risk-reduction services, and my own traumatic experiences remind me of how badly that support is needed. Research supports the recruitment of minority social service providers to serve minority populations, especially those who are Black and Hispanic (Hsu et al., 2014). Smith and Trimble (2016) concluded that matching a client with a provider from the same racial or ethnic background can foster increased engagement in mental health treatment. Licensed or certified providers are mandated to participate in supervision, training, and continuing education, avenues through which they may receive the support needed to confront and negotiate their own experiences. Even so, they do not always receive the necessary training to care for racially diverse populations (Fields et al., 2020). Recruiting paraprofessionals to help individuals with mental health concerns has become one response to counterbalancing a strictly medical approach to care (Morse et al., 2020).

However, those serving as paraprofessionals do not have the same professional requirements as licensed clinicians. In the United States, organizations such as the Paraprofessional Healthcare Institute and the Institute for Public Health Innovation offer community health worker and paraprofessional trainings and certificates (Xiong et al., 2019). With proper training, the use of paraprofessionals can be cost effective and lead to successful outcomes (Morse et al., 2020). Paraprofessionals from vulnerable communities, however, represent a group in need of more substantial, built-in support if they are to provide adequate services to the vulnerable communities with whom they are working and not risk their own mental health in the process. The following reflection builds on my lived experience and the existing literature on paraprofessional work to examine the costs of undertaking this work without adequate clinical supervision.

BMSM: An At-Risk Community

BMSM experience a range of medical and psychosocial challenges at a disproportionate rate. According to the Centers for Disease Control and Prevention (2024), more than one million people in the United States are living with HIV, and approximately 38,000 people are newly diagnosed each year. Men who have sex with men (MSM), who represent an estimated 2 percent of the U.S. population, account for roughly 70 percent of people living with HIV, and epidemiologic projections suggest that one out of two Black MSM and one out of three Latinx MSM will test positive for HIV in their lifetime if current trends continue (Ramchandani & Golden, 2019). Much of this research focuses on young men who have sex with men (YMSM), including young Black MSM, who face developmental as well as structural vulnerabilities (Fields et al., 2020).

BMSM also report higher rates of depression than White MSM and are more likely to experience stigma (Babel et al., 2021; Moore et al., 2019; Quinn et al., 2018). Black MSM encounter high levels of racism from White MSM and, at times, from other Black MSM through social dating applications (Wade & Harper, 2019). Because of the relative anonymity these platforms afford, users may feel more comfortable racially profiling or rejecting a person online than in physical settings. Reading profiles that state "no Blacks" or "I do not date Black people" can trigger feelings of rejection, exacerbate depressive symptoms, and further isolate Black MSM (Wade & Harper, 2019).

BMSM are also more likely to be sexually objectified or portrayed as thugs or uneducated, and they are often viewed as a homogenous group, in contrast to the heterogeneous reality of their lives. Wade and Harper (2019) describe racialized sexual discrimination as a process in which gay men of color are racially discriminated against and assigned stereotypical sexual roles, such as being presumed to have a large penis, to be dominant, and, in many cases, to be the "top" (inserting) partner. These stereotypical roles can prevent BMSM from engaging in desired romantic relationships or friendships and can contribute to social isolation and psychological distress (Wade & Harper, 2019). These patterns of racialized discrimination mirror what I have observed among Black and Brown MSM in my own work.

Additionally, internalized homonegativity is associated with elevated risk for adverse health outcomes among BMSM. Minority stress theory posits that sexual prejudice against BMSM may lead to chronic stress, including external pressure, anxiety related to the anticipation of discrimination, and internalized negative social attitudes (Moore et al., 2019). For many BMSM, these processes are associated with higher levels of depression, anxiety, substance use, and suicidal ideation, as well as increased engagement in sexual risk behaviors and reduced likelihood of accessing or remaining in HIV prevention and treatment services (Fields et al., 2020; Moore et al., 2019). Black MSM also have a higher likelihood of living in areas with multiple stressors such as crime, drug use, and poverty, which further increase the chances of engaging in behaviors that place them at heightened risk for HIV (Fields et al., 2020).

Reflections from Practice as a BMSM Counselor

In what follows, I reflect on how these broader patterns show up in my own life and work as a Black man who has sex with men working in HIV prevention. My experiences as a paraprofessional and later as a licensed clinician mirror findings from research on task-shared and peer-delivered mental health and HIV services, where non-specialist providers often carry substantial emotional burdens and are vulnerable to vicarious trauma, burnout, and compassion fatigue (Kemp et al., 2019; Kim et al., 2022; Rabie et al., 2023). These studies underscore the importance of supervision models that provide ongoing, structured support, including opportunities to process challenging client encounters, monitor emotional well-being, and strengthen practice skills, rather than relying on one-time trainings alone. Building on this literature, the following narrative illustrates how, in the absence of consistent, culturally responsive supervision, my own unresolved trauma intersected with the demands of frontline HIV prevention work.

In my own life and counseling practice as a BMSM working in the public health sector to eradicate HIV and raise mental health awareness, my unresolved childhood trauma has sometimes interfered with my ability to be fully present with clients. There have been sessions where a client's story activated my own pain so intensely that I left the room feeling overwhelmed, later engaging in risky behaviors to cope, returning to suicidal thoughts, or isolating in my office or home and crying myself to sleep. These reactions were not abstract case examples; they were my lived responses to holding other people's trauma without enough support. Thanks to employment benefits and supportive friends, therapists, and supervisors, I am now actively working through my trauma and learning to recognize early warning signs, so that my history does not prevent me from doing my job to help and reach others.

Service Provision and Professional Support

Federal, state, and local health departments often encourage community-based organizations to recruit staff from the target population to implement evidence-based interventions with their peers. For example, to modify maladaptive behaviors and educate communities, the Centers for Disease Control and Prevention (2024) have diffused several evidence-based interventions to community-based organizations in which BMSM professionals and paraprofessionals provide services to other BMSM. Two widely used group- and individual-level interventions are Many Men, Many Voices (3MV) and CLEAR (Choose Life, Empowerment, Action, and Results), which are designed for MSM, including Black MSM (Carter & Flores, 2019). In many settings, these interventions are delivered by paraprofessionals and peer workers who come from the same communities they serve and thus share many of the same risks and stressors. If these tools are to be effective, the providers using them must be appropriately trained, supported, and supervised, not only to deliver the interventions with fidelity but also to protect their own well-being.

In Jackson, Mississippi, which is ranked among the highest cities in the United States for new HIV diagnoses, several community-based initiatives have been implemented to educate BMSM about HIV prevention (Burns et al., 2020). One such initiative is Connect with Us (CWU), which employs BMSM "ambassadors" drawn from the local community (Burns et al., 2020). These CWU ambassadors play the role of outreach, educating and informing BMSM about HIV prevention and care and providing resources to effectively reduce risk behaviors. What makes this program unique is the training ambassadors receive in HIV prevention, which includes but is not limited to safer sex practices, health literacy, and pre-exposure prophylaxis (PrEP) adherence (Burns et al., 2020). Through these training sessions, ambassadors gain confidence in delivering HIV prevention education and in using their lived experience to connect with peers. At the same time, they shoulder the weight of listening to and holding the trauma, fear, and stigma that their peers disclose.

Having multiple college degrees and two clinical licenses, I understand why local and national certification and regulation boards require counselors to complete a minimum number of continuing education credits, even after completing years of clinical internship hours and supervised practice. Clients or patients can trigger or re-traumatize a counselor, professional

boundaries can be crossed, and, without support, a clinician may engage in unhealthy behaviors to cope. Continuous training and monitoring offer planned opportunities to work with such experiences, acquire new competencies, and protect clients and providers. Such formal training and supervision are not typical of paraprofessionals and peer workers, despite their frequent presumption of being called upon to navigate the same trauma-filled conversations with clients.

Consequences of Insufficient Support or Training

The models used in clinical supervision of paraprofessionals and peer workers can be based on three fundamental functions: the promotion of ethical and competent practice (normative), skill development (formative), and support of the emotional well-being of the worker (restorative). Restorative and culturally responsive supervision is essential to BMSM paraprofessionals. The supervisors must be clinically trained in mental health or social work, in working with queer and trans communities of color, and with demonstrated anti-racist, trauma-informed practice (Kemp et al., 2019; Morse et al., 2020; Xiong et al., 2019). Supervision that addresses all three functions can assist paraprofessionals in navigating complicated client situations without compromising their health.

Adequate supervision of BMSM paraprofessionals in practical terms would involve having weekly or bi-weekly individual or group supervision by a licensed clinician. These sessions would allow systematic processing of vicarious trauma and of countertransference, role-playing of awkward interactions, and ethical questions. The sessions would also lay stress on the distinction between personal and professional roles, allowing the workers to discuss the experiences of racialized and homophobic individuals in the workplace and the community (Kemp et al., 2019; Kim et al., 2022; Rabie et al., 2023). Such supervision is not a luxury; it is a necessary condition for paraprofessionals to sustain themselves emotionally while they provide life-saving information and support to their peers.

I first began to recognize the problem of inadequate training and support for BMSM paraprofessionals while attending the 2008 annual National African American MSM Leadership Conference on HIV/AIDS and Other Health Disparities (NAESM). During a community forum, a colleague asked the group, “How can I help my community when I am still dealing with my shit?” At the time, I experienced his question as odd and even inappropriate, but it stayed with me. Over the years, I heard variations of that same question from different colleagues at different venues and, each year, at the NAESM conference. It began to feel as though my community was calling out into an empty void for help. That recurring question forced me to reflect on the quality of my own risk-reduction training and on the trajectories of colleagues who had either died or left the public health field.

When I started my public health journey, many of my colleagues, if not all, were not living with HIV, did not have substance use disorder diagnoses, and were in healthy relationships. As the years passed and we began providing intensive risk-reduction counseling and implementing evidence-based interventions designed to modify the target population’s behavior and increase awareness, I watched my colleagues’ well-being decline. I observed Black and Brown, same-

gender-loving paraprofessionals undergoing hardship in my day-to-day work as they lacked sufficient clinical support or supervision. They were employed due to their origin, being part of the same communities and identities as the clients we served, yet they received little training and practically no long-term room to process the trauma they were observing and experiencing.

In my own life, I have tried to engage in a journey of self-care alongside my professional growth, even as I have watched my colleagues struggle. I have seen Black and Brown, same-gender-loving colleagues work tirelessly to implement group-level, evidence-based interventions for at-risk communities while silently carrying their own unresolved trauma. I have witnessed colleagues who spread HIV prevention knowledge seroconvert—test positive for HIV—without the support needed to process their experiences. I have spent hours on the phone listening to colleagues describe intimate partner violence and substance misuse in their own lives. Same-gender-loving men experience higher rates of intimate partner violence than heterosexual individuals, and these experiences can have lasting effects (Chen et al., 2020). I have sat at large conference tables with empty chairs where friends once sat with me to champion HIV policy; some of those chairs are now empty because colleagues burned out and left the field, and others because colleagues died.

As a participant at national conferences populated with Black and Brown MSM professionals, I have repeatedly observed colleagues share, in group settings, their concerns about providing clinical services or facilitating group-level conversations among MSM while carrying unresolved childhood and adult trauma. In these spaces, paraprofessionals described how certain topics in group or individual sessions triggered them, leading them to shift internally from the role of clinician to the role of client. The similarity in their stories was not in their deficiency of commitment or empathy; the difference was in their deficiency of proper training and supervision. Most paraprofessionals said they had only a few days of training before they were left to begin facilitating groups and giving counseling without either any continuity in clinical supervision or even consultation with a supervisor who was licensed. This puts group participants at risk of no life-saving information and paraprofessionals at risk of additional psychological damage.

Listening to these testimonies got me to think critically about the way I prepare. Fifteen years after I started my career in public health, I still recall that I pursued so-called “moderately intense” courses in risk-reduction counseling, specifically designed to equip me with the knowledge of how to decrease the spread of HIV in marginalized and vulnerable groups. In reality, the training lasted no more than three business days and ended with an exam that I was essentially guaranteed to pass because the instructor provided the correct answer to every question. At the time, this felt too good to be true. Looking back, I can see how my colleagues and I would have benefitted from being held accountable for our mistakes on that exam, from being required to retake the course if we scored below a reasonable threshold, and from having some form of follow-up to ensure that we were applying the information correctly and not being re-traumatized by clients’ disclosures. In many ways, it felt as if the health department had sent us, as risk-reduction counselors, out as sheep to a pack of wolves.

I am concerned that different regions of the United States continue this trend of putting a vulnerable community at further risk even as funding is allocated to address HIV. What is happening in the Southern region of the country is one example of poor planning. The Southern states account for approximately 38 percent of the U.S. population but 50 percent of new HIV diagnoses (Moore et al., 2019). Studies have shown that racial disparities in HIV treatment and prevention are driven by factors such as delayed access to care, mistrust of providers, and stigma and discrimination associated with being MSM (Sullivan et al., 2021). In my visits to many Southern community-based organizations, I have seen the same mistakes that were made on the East Coast in the 1990s: Organizations hire community members to do HIV prevention and counseling but fail to invest in meaningful training and supervision. It is not that training is unavailable—for example, Jackson, Mississippi, has programs that offer substantial HIV prevention training—but that organizations and health departments do not always acknowledge the need for comprehensive training or prioritize the resources required to provide it (Burns et al., 2020; Carter & Flores, 2019).

Addressing disparities in the HIV epidemic in the United States requires more than increased funding. While additional dollars directed toward education in Black and Brown MSM communities are helpful, it is even more important to address long-standing structural racism—systemic, institutional, and procedural—which shapes who receives care and who is supported to provide it (Bailey et al., 2017). One of the steps that should be taken towards equity is to make sure that Black and Brown MSM paraprofessionals are properly trained, clinically supervised, and emotionally supported. In order to maximize the possibility of eliminating the HIV epidemic in the United States, a multifactorial intervention is required that considers the social, cultural, economic, and environmental factors leading to the transmission of HIV (Bailey et al., 2017; Burns et al., 2020; Carter & Flores, 2019; Moore et al., 2019; Sullivan et al., 2021). Research and program design, partnerships with other community members to learn more about target populations, and holistic approaches can all be helpful in solving these social and structural factors. But, unless these discussions and findings find their way to the relevant policymakers, my community will continue to be in danger of continued inequity.

Recommendations

I intend to use this essay not only to enhance practices in HIV prevention but also to enhance how clinical services can be designed so that Black and Brown paraprofessionals who work with Black and Brown MSM will have the means and resources necessary to deliver quality services in a safe way. Paraprofessional supervision may be based on integrated clinical models of supervision that provide a balance between competency building and emotional support. In particular, supervisors may find success in reflective supervision methods, which focus on the feelings and reactions of their workers alongside the typical case analysis and support in ethical judgement seen by most. Particularly when paraprofessionals identify themselves with their clients—and especially when the work done with those clients is directly related to said identity, as it is in many cases for BMSM workers—the border between personal and professional experience may fade.

The use of BMSM paraprofessionals by organizations creates an ethical duty to incorporate supervision and support within programs. This duty is achieved by paying paraprofessionals back time in supervision, offering benefits which include mental health care access, and by fostering a culture where it is not stigmatized by staff to seek help. Agencies can provide routine debriefing rooms following hard groups or sessions, guard against the move to reschedule supervision time to meet the demand of productivity, and ensure that policies acknowledge the compound effect of vicarious trauma and structural racism on the staff.

Supervisors for BMSM paraprofessionals should meet clear qualifications. Ideally, they should hold a clinical license in counseling, social work, psychology, or a related field; have substantive experience working with BMSM and other LGBTQIA+ communities of color; demonstrate cultural humility and anti-racist practice; and be trained to recognize and respond to vicarious trauma, burnout, and compassion fatigue among staff. My own ability to seek therapy, consult with supervisors, and access benefits has helped me remain in this work, but many of my peers never had this level of support. When supervisors lack these qualifications, paraprofessionals are left to manage intense clinical situations with little guidance and no safety net.

Supervision for paraprofessionals should be regular, predictable, and focused. At a minimum, BMSM paraprofessionals should have weekly or biweekly individual or group supervision with a licensed clinician. These sessions should include time to process vicarious trauma; discuss countertransference and emotional reactions to clients; role-play difficult conversations (e.g., HIV status, intimate partner violence, sex work); and review ethical dilemmas and boundary issues. Supervision should also explicitly address the challenges of working in communities where staff and clients share racialized and homophobic experiences. Clear boundaries between personal and professional roles should be discussed and revisited, with supervisors helping staff recognize when they are slipping from the role of helper into the role of unacknowledged client.

Training cannot be a one-time event. Paraprofessionals should receive extensive initial training and ongoing continuing education in areas such as trauma-informed care, cultural humility, sexual and gender diversity, HIV prevention and treatment, and intimate partner violence. Funders can play a powerful role by requiring, in requests for proposals, that agencies seeking support demonstrate how they will provide clinical supervision and emotional support for staff, offer monthly support groups or reflective practice groups, and ensure that paraprofessionals complete a meaningful number of continuing education hours each year to maintain their competence. Funding streams should recognize that supervision time, consultation, and staff development are core program components, not optional add-ons.

Closing Reflection and Call to Action

The myth that having a high level of education or being in the position of leadership removes one's childhood or multi-faceted trauma is dangerous. Trauma shows up differently in each of us. Many of my colleagues eventually moved into supervisory positions and managed staff and grant-funded programs, yet our own trauma remained unaddressed. After statewide retreats, we

would gather and consume large amounts of alcohol, talking about everything in our lives except what had happened in the retreat rooms. We did not discuss the client who broke down after disclosing abuse, the fight we had to break up between romantic partners, or the moment someone revealed that he had exchanged sex for a warm bed. Instead, some of my friends snorted cocaine or inhaled marijuana to cope, rather than processing what these stories stirred up in them. To talk about what happened in the group would have been to risk revealing our own unresolved traumatic pasts. Yes, we are gay men. Yes, we are same-gender-loving men. But we are also men who were raised to believe that men do not show emotions or weakness, and we carried forward the rule that governed so many Black and Brown homes: What happened in our houses stayed in our houses.

Growing up, that rule kept me silent about the violence and pain in my own family. As an adult paraprofessional and clinician, I now see how that culture of secrecy can keep both clients and counselors quiet about their suffering. My hope is that organizations will refuse to send paraprofessionals out as sheep to a pack of wolves and will instead invest in supervision, training, and support that honor our communities and protect those doing the work. Only then can Black and Brown MSM paraprofessionals offer the care our communities deserve without sacrificing their own well-being in the process.

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