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Perceptions, Emotions, and Competencies of Graduate Level Counselor Trainees Working with African American and Caucasion Female Clients with HIV/AIDS

Pamela McMichen Wright

ACCEPTANCE

The dissertation, PERCEPTIONS, EMOTIONS, AND APPRAISALS OF GRADUATE LEVEL COUNSELOR TRAINEES WORKING WITH AFRICAN AMERICAN AND CAUCASIAN FEMALE CLIENTS WITH HIV/AIDS, by PAMELA MCMICHEN WRIGHT, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree Doctor of Philosophy in the College of Education, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chair, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty. The Dean of the College of Education concurs.

_____
Gregory Brack, Ph.D.
Committee Chair

_____
Kenneth B. Matheny, Ph.D.
Committee Member

_____
Roger O. Weed, Ph.D.
Committee Member

_____
Michele Hill, Ph.D.
Committee Member

_____
Date

_____
JoAnna White, Ed.D.
Chair, Department of Counseling and Psychological Services

_____
Ronald P. Colarusso, Ed.D.
Dean, College of Education

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Pamela McMichen Wright

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Pamela McMichen Wright
95 Highland Park Drive
Sharpsburg, GA 30277

The director of this dissertation is:

Dr. Gregory Brack
Department of Counseling and Psychological Services
College of Education
Georgia State University
Atlanta, GA 30303-3083

VITA

Pamela McMichen Wright

ADDRESS: 95 Highland Park Drive
Sharpsburg, GA 30277

EDUCATION:

Ph.D.	2007	Georgia State University Counseling Psychology
Ed.S.	2002	Georgia State University Professional Counseling
M.S.	2001	Georgia State University Professional Counseling
A.B.J.	1994	University of Georgia Journalism/Broadcast News

PROFESSIONAL EXPERIENCE:

2006-Present	Pre-doctoral Psychology Intern Georgia State University Counseling Center, Atlanta, GA
2005-2005	ORISE Fellow Centers for Disease Control and Prevention, Atlanta, GA
2004-2006	Instructor Georgia State University, Atlanta, GA
2004-2006	Family Therapist Ridgeview Institute Day Hospital, Smyrna, GA
2004-2005	Group Leader/Research Assistant Emory University/Grady Health System IDP, Atlanta, GA
2002-2004	Case Manager/Therapist Ridgeview Institute Women's Center, Smyrna, GA
2000-2006	Balint Group Leader Atlanta Medical Center, Atlanta, GA
2001-2004	Clinician/Intake Counselor Ridgeview Institute Access Center, Smyrna, GA

PRESENTATIONS AND PUBLICATIONS:

Kourtis, A. P., Kraft, J., Gavin, L., Kissin, D., McMichen-Wright, P., & Jamieson, D. J. (2006). Prevention of sexually-transmitted Human Immunodeficiency Virus (HIV) infection in adolescents. *Current HIV Research, 4*(2), 209-219.

Ganske, K. H., Frazier, S. S., McMichen-Wright, P., & Berry, F. (2006). *Understanding black female college students' subjective well-being: A visual ethnographic perspective.* Poster presented at the annual meeting of the American Psychological Association, New Orleans, L.A.

Blasko, S., Brasfield, C. D., & McMichen-Wright, P. (2005). *Walking the graduate school tightrope: The benefits of being balanced.* Presentation at the annual meeting of the American Psychological Association, Washington, D.C.

McMichen-Wright, P., McMahon, G., Ashby, J. S., & Ganske, K. H. (2005). *Coping resources and depression in middle school students.* Poster presented at the annual meeting of the American Psychological Association, Washington, D.C.

Ganske, K. H., Berry, F., McMichen-Wright, P., & Smith, S. (2005). *Layered supervision: How does supervision of supervision affect trainees?* Poster presented at the annual meeting of the American Psychological Association, Washington, D.C.

Brack, G., Hill, M. B., Brack, C. J., McMichen-Wright, P., & Dean, J. (2005). *Stress, crisis, and trauma: The three certainties in the 21st century.* Poster presented at the annual meeting of the American Psychological Association, Washington, D.C.

Matheny, K. B., Ashby, J. S., Cup, P., Dickinson, W. L., Ganske, K. H., McMichen Wright, P., & Brasfield, C. D. (2005). *Gender differences in stress, coping, and illness among college students.* Poster presented at the annual meeting of the American Psychological Association, Washington, D.C.

McMichen-Wright, P. (2005). *Eating disorders: Core treatment strategies.* Presentation at The Anxiety & Stress Management Institute, Atlanta, G.A.

Schlacter, N., Lipton, E., McMichen-Wright, P., & Engstrom, C. (2004). *Working together: Treatment of challenging eating disorder cases*. Ridgeview Institute Professional Education Series CME/CE Seminars for Physicians and Clinicians, Atlanta, G.A.

Wells, M., Brack, C. J., & McMichen, P. J. (2003). *Women and depressive disorders*. In M. Kopala & M. Keitel (Eds.). Handbook of counseling women. Thousand Oaks, CA: Sage Publications.

PROFESSIONAL SOCIETIES AND ORGANIZATIONS:

2001-Present	American Psychological Association
2001-Present	American Counseling Association
2001-Present	National Board of Certified Counselors
2003-Present	Licensed Professional Counselors Association

ABSTRACT

PERCEPTIONS, EMOTIONS, AND APPRAISALS OF GRADUATE LEVEL COUNSELOR TRAINEES WORKING WITH AFRICAN AMERICAN AND CAUCASIAN FEMALE CLIENTS WITH HIV/AIDS

by

Pamela McMichen Wright

Many people with HIV/AIDS are experiencing increased life expectancy along with a better quality of life due to the advances of HIV/AIDS medications such as highly active antiretroviral therapies (HAART). Individuals in this growing population often experience psychological and psychosocial concerns that require the assistance of mental health counselors. Counseling interventions represent one of the most effective ways to address the psychosocial aspects of HIV/AIDS. The purpose of this study is to investigate counselor trainees' attitudes and perceptions about HIV/AIDS disease and individuals living with HIV/AIDS. Participants are masters and specialists level counseling students enrolled in a large southeastern university that is accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). The present study will qualitatively and quantitatively measure counselor trainees' attitudes toward women clients with HIV and women clients without HIV. The study will also quantitatively measure counselor trainees' potential biases toward black female clients.

Several hypotheses will be tested in this study. One hypothesis is that counseling students in the masters and specialists degree programs will express more negative emotions and perceptions about female clients with HIV than about female clients without HIV. The

second hypothesis is that these counseling students will express relatively more negative emotions and perceptions toward the African American female clients, particularly the African American client with HIV.

Four separate case vignettes will be used in the study. Each vignette is worded identically with the exception of four separate demographic characteristics. One vignette will feature an African American female who is not HIV positive. Another vignette will feature an African American female who is HIV positive. The same pattern will be followed for the other two vignettes, except a Caucasian female will be featured instead of an African American female. The Roseman et al. (1996) cognitive appraisal model will be used to obtain emotional responses about how a client is perceived. A questionnaire will be used to elicit demographic information and counselor training experiences.

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
APA	American Psychological Association
CACREP	Council for Accreditation of Counseling and Related Educational Programs
CD4+	T-lymphocyte Bearing CD4 Receptor
CDC	United States Centers for Disease Control and Prevention
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
UNAIDS	United Nations Programme on HIV/AIDS
WHO	World Health Organization

CHAPTER 1

COUNSELOR TRAINING AND THE HIV/AIDS POPULATION: A REVIEW

Counseling interventions represent one of the most important ways to address the psychosocial and medical adherence needs of the growing population of people with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) (Cook, Grey, et al., 2006; Gushue & Brazaitis, 2003; Hicks & Rundell, 1996; Hoffman, 1996; Weber et al., 2004; Zilber, 2006). Many studies confirm that counseling therapies are effective in reducing psychological concerns such as stress, anxiety, and depression for those with HIV/AIDS (Begley et al., 1994; Catalan, 1995; Wai-Ching & Barnard, 2004). In a society where there is considerable ignorance, fear, and moral contempt toward HIV/AIDS sufferers, counselors are encouraged to help the client with care, compassion, and empathetic understanding without bias (Dorre & Kinnier, 2006). Counselors and therapists can provide education, advocacy, and coping skills when other forms of support might be diminishing (Zilber). The purpose of this study is to investigate counselor trainees' attitudes and perceptions about HIV disease and about females living with HIV.

Scope of the HIV/AIDS Population

According to the Centers for Disease Control and Prevention (CDC) surveillance report through 2003, an estimated 850,000 to 950,000 persons in the United States are living with HIV, and approximately 929,985 have a diagnosis of AIDS (CDC, 2003b). Worldwide, approximately 40 million people are living with HIV (UNAIDS, 2006). The

CDC estimates that approximately 40,000 persons in the United States become infected with HIV each year (CDC). The epidemic continues to escalate in most countries, even among certain nations that have the educational and treatment capabilities to curb the spread of the disease (CDC).

Growth of the HIV/AIDS Population

Due to the use of highly active antiretroviral therapies (HAART), many people with HIV and AIDS are experiencing increased life spans (Altice & Friedland, 1998; Bing, Kilbourne, Brooks, Lazarus, & Senak, 1999; del Rio, 2001; Holzemer, Henry, Portillo, & Miramontes, 2000; Murphy et al., 2001). HAART works to suppress HIV, leading to a decreased risk of opportunistic infections, to enhanced functioning, and to increased patient survival (Palella et al., 1998). One study found that mortality fell by 80% when comparing the pre- and post-introduction of the drugs (Porter et al., 2003). These new life-prolonging treatments have shifted care from preparing patients to die to preparing them to live (Bartlett, 2002; Catalan, Meadows, & Douzenis, 2000; Emlet, 2005; Silverberg et al., 2006), increasing the opportunities for counseling.

Women in the HIV/AIDS Population

Women represent one of the fastest growing categories of new HIV cases, and 30% of all new HIV diagnoses each year are women (UNAIDS, 2006). Worldwide, women and girls comprise approximately half of the total HIV population (UNAIDS, 2006). In 2002, HIV was the fifth leading cause of death for women aged 25 to 34 and the sixth leading cause of death for women aged 35 to 44 in the United States (CDC, 2003b). In the past, the majority of women became infected through injection drug use. Recently, more women are contracting the disease through heterosexual contact (CDC,

2004). The transmission categories for the largest portion of infected women are high-risk heterosexuals (79%) and injection drug users (19%) (CDC, 2003a). The percentage of AIDS cases in women also continues to rise. In 2002, an estimated 26% of new AIDS cases were women (CDC).

African American Women and HIV/AIDS

The rate of occurrence of HIV for African American women is 19 times higher than for Caucasian women, and the AIDS diagnosis rate is 25 times higher (CDC, 2004). Although African American women comprise only 13% of the population in the United States, they represented 51.3% of HIV/AIDS diagnoses from 2000 to 2003 (CDC, 2003b). Additionally, African American females are 21 times more likely to die from HIV infection than are non-Hispanic Caucasian females (Adams, Dey, & Vickerie, 2007). In fact, HIV disease is the leading cause of death in African American women aged 25 to 34 years old (Anderson & Smith, 2005).

Need for Effective Counseling for HIV/AIDS Population

Many people within this growing population with HIV/AIDS manifest poor psychological functioning, and psychiatric morbidity was detected early in the epidemic (Hoffman, 1984). Basic subsistence requirements, financial assistance, social support, and psychological care are often needed for those with HIV/AIDS (Katz et al., 2000; Marx, Katz, Park, & Gurley, 1997; Piette, Fleishman, Stein, Mor, & Mayer, 1993; Sherer et al., 2002). The comorbidity between depression and HIV/AIDS has been well established in the literature (Angelino, 2002; Overman & Anderson, 2001); however, reported rates of depression among those with HIV vary. Some report that up to 85% exhibit some depressive symptoms, and up to 50% experience a major depressive

disorder (Stolar, Catalano, Hakala, Bright, & Fernandez, 2005). Others report that approximately 25% to 40% of HIV/AIDS patients are depressed (Rabkin, McElhiney, & Fernando, 2004; Taso, Dobalian, Moreau, & Kobalian, 2004). A study of U.S adults aged 18 and older receiving care for HIV found that 47.9% demonstrated, on screening in the previous 12 months, a propensity for at least one psychiatric disorder (Bing et al., 2001). Those receiving care for HIV/AIDS demonstrated positive status for major depression (36.0%), dysthymia (26.5%), generalized anxiety disorder (15.8%), and panic attacks (10.5%). Another study of 322 individuals living with HIV/AIDS found that 22% met criteria for a current major depressive episode (Komiti et al., 2003).

Substance abuse is also prevalent among those living with HIV. In 2003, the exposure category for nearly 22% of new AIDS cases among adolescents and adults was injection drug use (IDU) (CDC, 2003a). At the end of 2003, IDU was the HIV exposure category for more than 35% of women living with AIDS (CDC). Of these injection drug users, 38% were African American women (CDC). Substance users often acquire and/or transmit HIV infection as a direct result of substance use (e.g. sharing needles) or indirectly (e.g. unprotected sex while under intoxication) (Starace, Ciafrone, & Nardini, 2005). Studies have shown that substance abuse decreases adherence to HIV medications (Liu et al., 2006; Lucas, Gebo, Chaisson, & Moore, 2002; Mellins et al., 2002), and some substances negatively impact responsiveness to medications (Starace et al.).

The combination of psychiatric or substance use disorders with HIV/AIDS illness has been found to reduce adherence to medications, to decrease health services use, and to impair health outcomes along with quality of life (Cook et al., 2002; Lagomasino & Rodriguez, 2006; Mellins et al., 2002; Mellins, Kang, Leu, Havens, & Chesney, 2003;

Tucker, Kanouse, Miu, Kogel, & Sullivan, 2003; Zinkernagel et al., 2001). Untreated substance abuse and psychological symptoms have been associated with poor medication adherence (Paterson, Potoski, & Capitano, 2002; Reif, Whetten, Lowe, & Ostermann, 2006; Spire et al., 2002) and with a lower likelihood of being on HARRT medications (Arnsten et al., 2002; Bing, et al., 1999; Fairfield et al., 1999; Turner et al., 2001). In fact, active untreated depression is one of the most consistent predictors of poor medication adherence across research studies (Boarts, Sledjeski, Bogart, & Delahanty, 2006; Bogart, Catz, & Kelly, 2001; Catz, Kelly, Bogart, Benotsch, & McAuliffe, 2000; Cheever, 2002; Elliott, Russo, & Roy-Byrne, 2002; Farinpour et al., 2003; Molassiotis et al., 2002; Paterson et al., 2000; Safren, Gershuny, & Hendriksen, 2003; Wagner, Kanouse, Koegel, & Sullivan, 2003). This connection between depression and adherence is significant, because, while HAART can slow disease progression and increase longevity, near perfect adherence of at least 95% is required to achieve optimal viral suppression and to prevent the development of drug resistant strains of HIV (Bangsberg et al., 2000; Boden et al., 1999; Clavel & Hance, 2004; Harrigan et al., 2005). Depression can also impact the course of the disease, often leading to faster disease progression (Kalichman, DiFonzo, Austin, Luke, & Rompa, 2002; Leserman, 2003) and lower natural killer cell activity for women with HIV/AIDS (Evans et al., 2002).

Psychiatric Illness and Women with HIV/AIDS

HIV-positive women have high rates of depression and depressive symptoms (Cook et al., 2002; Ickovics et al., 2001; Kaplan, Marks, & Mertens, 1997; Moore et al., 1999; Vedhara, Schifitto, & McDermott, 1999) which may interfere with their ability to begin or continue taking HAART regimens (Boland, 1997). Data collected on HIV-

infected women at an AIDS Center found that more than 60% met criteria for at least one current Axis 1 psychiatric disorder, with major depression and substance use disorders being the most prevalent (Burnam et al., 2001). A HIV longitudinal cohort study of women found the diagnosis of current major depressive disorder four times greater in HIV positive (19.4%) women compared to HIV negative (4.8%) women (Morrison et al., 2002). In fact, depressive symptoms have been reported in as many as 30% to 50% of infected women compared to 20% or less of infected men (Lagomasino & Rodriguez, 2006). AIDS-related deaths are also more probable among women with frequent depressive symptoms (Cook et al., 2004).

Adding to these depressive symptoms is the lack of social support often received by HIV positive women. African-American women are less likely than men and Caucasian women to receive social support from family and friends when they disclose their positive serostatus (Campbell, 1999). This lack of support can increase their experience of stigma and reduce their medication adherence. Conversely, women categorized as "always adherent" in one study were surrounded by supportive influences (Sankar, Luborsky, Schuman, & Roberts, 2002). Additionally, greater perceived AIDS-related stigma among HIV-infected women has been associated with poorer psychological functioning (Clark, Linder, Armistead, & Austin, 2003).

Suicide and HIV-infected Women

HIV positive women have an increased risk of suicidal ideation and attempts (Catalan, 2005; Komiti et al., 2003). Rates of suicide have been reported as higher in those with HIV/AIDS compared to the general population (Catalan; Hoffman, 1996). One study revealed that HIV infected women were five times more likely than HIV-negative

women to attempt suicide (Gielen, McDonnell, O'Campo, & Burke, 2005). Those with HIV/AIDS were found to be at an increased risk for suicidal thinking, suicide attempts, and suicide (Beckett & Shenson, 1993). Women who are recently diagnosed are also more likely to contemplate and attempt suicide (Cooperman & Simoni, 2005; Gielen et al.).

Counseling Interventions for Those with HIV/AIDS

Counseling can help individuals cope with mental illness and psychosocial concerns, and it can also lead to prolonged life by encouraging the use of HAART. Cook, Grey, et al., (2006) found that a combination of antidepressants plus mental health therapy or use of mental health therapy alone significantly increased the probability of HAART utilization in a group of HIV-infected women who screened positive for probable depression. Miranda et al. (2003) found that cognitively-oriented psychotherapy and pharmacotherapy were two individual treatment modalities that were superior in comparison to referrals to a community mental health center for treating depression in low-income African American and Latina women. They also found that assistance with transportation, childcare, outreach, engagement in treatment, and encouragement to adhere to medication regimens were factors that promote women's acceptance of treatment for depression. Conversely, lack of child care became an obstacle to persuading minorities to seek counseling (Conover & Whetten-Goldstein, 2002; Mundy et al., 2002). Additionally, counseling interventions, such as cognitive-behavioral strategies, have been effective for reducing stress, anxiety, and depression, and managing the course of the disease for women with HIV (Lechener et al., 2003). Cognitive behavioral therapy, psychodynamic therapy, and psychoeducation interventions all have been effective in

treating depression for those with HIV/AIDS, but psychodynamic therapy and CBT evidence more long-term effects (Lancee & DeRoche, 2000).

Counseling and psychotherapy services have also been effective in improving mental and HIV-related health, decreasing the frequency of alcohol and cocaine use, and enhancing social functioning among HIV-positive clients (Winiarski, Beckett, & Salcedo, 2005). Social support, problem-focused coping, and positive attribution were demonstrated to predict greater well-being and a lower level of depressed mood in HIV-infected patients (Farber, Mirsalimi, Williams, & McDaniel, 2003). Research has also shown that providing counseling prior to and after HIV testing evidenced decreases in anxiety, depression, and suicidal ideation (Minian, et al., 2003); and post-test counseling has led to harm reduction and to encouraging healthcare, including mental health, referrals (Eichler, Ray, & del Rio, 2002). New psycho-educational intervention programs are reducing depressive symptoms and improving psychological readiness for taking medications for those with HIV (Balfour et al., 2006).

Bias as an Obstacle to Effective Counseling for the HIV/AIDS Population

To the detriment of effective counseling, one of the defining characteristics of the HIV epidemic is its ongoing association with bias and stigma (Herek, 1999; Herek, Capitanio, & Widaman, 2002; Lentine et al., 2000; Swendeman, Rotheram-Borus, Comulada, Weiss, & Ramos, 2006). Black and Miles (2002) noted that few illnesses in modern times are associated with the high levels of stigma and resulting social isolation as the diagnosis of HIV. There are several aspects of HIV and AIDS that create stigma: the fact that it is an infectious disease associated with death, the perception that transmission behaviors are voluntary and avoidable which implies that infected persons

are responsible for their illness, and the view that it is transmitted by already stigmatized groups such as injecting drug users and homosexuals (Crawford, 1996; Díaz, Ayala, Bein, Henne, & Martin, 2001; Herek, 1999; Novick, 1997).

Research early in the epidemic showed that individuals with HIV were deemed responsible and blamed for the onset of their disease because of their behavior, which was thought to be controllable (Westbrook & Nordhom, 1986). More recently, groups with high rates of infection are often also stigmatized on the basis of race or ethnicity, sexual orientation or behaviors, poverty, or substance use (Díaz et al., 2001; Parker & Aggleton, 2003). Stigma about those with HIV/AIDS has led to physical violence toward them, negative feelings about them, expressions of discomfort about them, wishes to avoid them, and support for policies to isolate them from others in society (Gostin, 1990; Herek, 2002; Herek et al., 2002; Zierler et al., 2000). One survey reported that one in five Americans feared people with AIDS and one in six admitted to feelings of disgust related to people with AIDS (Herek et al., 2002). Another national Internet survey of more than 5600 American adults produced similar findings, with one in five respondents agreeing with the statement that “people who got AIDS through sex or drug use have gotten what they deserve” (CDC, 2000).

Sources of Bias

These stigmatized or negative attitudes likely originate from the lack of accurate information regarding the transmission of the disease. For example, many adults believe that AIDS can be spread through casual social contact such as drinking from the same glass as a person infected with HIV (Herek et al., 2002; Lentine et al., 2000), and others believe AIDS can be transmitted during sex, even when neither partner is infected (Herek

& Capitanio, 1999; Herek, Widaman, & Capitanio, 2005). This lack of knowledge about the transmission of HIV/AIDS has been correlated with negative and antigay attitudes toward those who are infected (Herek, 2002; Herek & Capitanio, 1999; Lentine et al.; Price & Hsu, 1992).

Effects of Bias

A recent study of HIV-infected individuals found that women, the majority of whom were African American, reported feeling isolated as a result of stigma (Lichtenstein, Laska, & Clari, 2002). Several studies have reported the association between stigma and depression among those afflicted with HIV (Berger, Ferrans, & Lashley, 2001; Crandall & Coleman, 1992; Lee, Kochman, & Sikkema, 2002; Lichtenstein et al.). Stigma is often cited as one reason that African Americans are less likely to disclose their HIV status (Bungerner, Marchand-Gonod, & Jouvent, 2000) and are less integrated into HIV-related community networks than are Caucasians (Kass, Flynn, Jacobson, Chmiel, & Bing, 1999). African American women have cited stigma as an impediment to HIV medication adherence (Edwards, 2006; Roberts & Mann, 2000). As a result, these disadvantaged populations have encountered barriers in accessing adequate HIV care (Shapiro et al., 1999).

Negative characterizations and biases can have a harmful impact on the relationship between the healthcare provider and the HIV-infected patients. Research has demonstrated the harm of this debilitating relationship on medication adherence (Heckman, Catz, Heckman, Miller & Kalichman, 2004; Roberts, 2002), on following medical advice (Hauck, Zyranski, Alemagno, & Medalie, 1990; Uhlmann, Inui, Pecoraro, & Carter, 1988; Zrinyi & Horvath, 2003), on appointment attendance (Pettinati,

Monterosso, Lipkin, & Volpicelli, 2003), and on communication with medical staff (Holzemer et al., 1999; Wilson & Kaplan, 2000). Recent literature supports the importance of the HIV-patients' reactions to and attitudes toward health care providers, and several scales have been designed to measure these attitudes (Bodenlos et al., 2004; Chinoweth & Piterman, 1995). One study found that 71% of HIV-positive patients reported having experienced discrimination based on their race or color when receiving treatment from healthcare providers, and 66% reported discrimination attributed to their socioeconomic status, position, or social class (Bird, Bogar, & Delahanty, 2004). These discriminatory experiences were found to interfere with the healthcare of the participants. HIV-infected women reported that their feelings of resistance to seeking HIV services were exaggerated by their negative encounters with healthcare providers, including providers' lack of knowledge, providers' fears, and providers' insensitivity (Sullivan, Stein, Savetsky, & Samet, 2000). Clients are more likely to seek and continue in HIV services that they perceive to be non-threatening and non-judgmental (Valdiserri, 2002).

Healthcare Providers and Bias toward HIV/AIDS

Unfortunately, client's perceptions of bias from counselors and health care workers are not necessarily unfounded. Studies have determined that health care professionals, including physicians, nurses, counselors, and psychologists, lacked accurate information about HIV/AIDS, resulting in negative attitudes, fears, and prejudices (Alston, Wilkins, & Holbert, 1995; Crawford, Humfleet, Ribordy, Ho, & Vickers, 1991; Fliszar & Clopton, 1995; Herek, 1999; Knox, Dow, & Cotton, 1989; Landon et al., 2002; Young, Henderson, & Marx, 1990). Clinicians have been found to hold negative attitudes toward HIV-infected clients and to show reluctance to work with

them (McCann, 1999; St. Lawrence, Kelly, Owen, Hogan, & Wilson, 1990). One study found that substance abuse and mental health workers held strongly negative perceptions of HIV-infected clients (Dow & Knox, 1991). Another study found that nearly 200 social workers and psychologists responded that people with AIDS were less deserving of sympathy than those with leukemia and that these respondents were less likely to accept AIDS patients as clients or make physical contact with them (Crawford et al., 1991). Trezza (1994) found that homophobia was related to AIDS stigma for both undergraduates and psychologists. The psychologists in this study viewed the rights of the public as superseding the rights of those with HIV, and many were uncertain if they would knowingly eat in a restaurant where an HIV-infected individual worked. Also, one study found that psychology students made biased decisions toward lesbian and gay HIV-positive clients (Palma & Iannelli, 2002). Similarly, doctors and nurses have expressed reluctance to treat those with HIV/AIDS due to perceptions of sexual promiscuity, discriminatory care, and patient blame (McCann); and some medical residents have reported a lack of confidence in caring for HIV-infected patients (Segal, Poznansky, Connors, Sands, & Barlam, 2001). A more recent study demonstrated that psychology trainees made biased decisions regarding the maintenance of confidentiality of an HIV-infected client (Palma & Iannelli).

It seems that those whose goal is to assist HIV/AIDS sufferers are not free of attitudinal bias that extends beyond a client's serostatus. Counselors and other healthcare workers have been found to be susceptible to systematic biases associated with specific client variables such as gender, race, age, sexual preference, socioeconomic status, and disability type (Strohmer & Leierer, 2000). These variables have been found to influence

clinician's beliefs about patients (Kearney, Miller, Paul, & Smith, 2000; Schneider, Davis, & Phillips, 2000; Schulman et al., 1999; Shortt, 2001; van Ryn & Burke, 2000). Thus, healthcare workers who do not view themselves as biased nonetheless make healthcare allocation decisions that have adversely affected African Americans when negative characteristics are also present (Murphy-Berman, Berman, & Campbell, 1998). In that study, respondents expressed greater resentment, gave lower healthcare priority scores, and exhibited more reluctance to make a financial contribution to the healthcare costs of patients who presented as unemployed and African American in comparison to those who presented as unemployed and Caucasian. In another study, health care workers rated their African American patients as less educated and less likely to have demanding careers than their Caucasian patients, despite their actual level of education and occupation (van Ryn & Burke, 2000).

Use of Stereotypes as a Source of Bias and Counseling

The very nature of the counselor/patient relationship requires that the counselor make judgments about the status and behavior of clients. Given limited time to gather a complete and unbiased impression of the client, the counselor often relies on judgment partly based on generalization and stereotype (Rosenthal & Berven, 1999). Research into such generalization has shown that people have two separate, interconnected learning and memory systems which are described as low-learning and fast-binding (Smith & DeCoster, 2000). Information in the slow-learning system is gathered routinely and is extracted and applied quickly and often unconsciously. This system is beneficial because it does not require consciously processing every stimulus; yet it can be problematic when the general information associated with a category (stereotype) is inaccurately applied to

a given instance of the category, or individual. The fast-binding system is utilized when making a decision that requires more effort. Despite this research, clinicians are expected to view each client impartially; yet many continue to apply stereotypes (Burgess, Fu, & van Ryn, 2004). Evidence has verified that when people categorize individuals as belonging to a particular group, the characteristics are unconsciously applied to the individual, which is stereotyping (Burgess, et al.).

Other phenomena such as diagnostic overshadowing may lead counselors to neglect salient client information (Jopp & Keys, 2001; Spengler, Strohmer, & Prout, 1990). Overshadowing bias occurs when a clinical problem (e.g., AIDS) is salient to the point of inhibiting the clinician's processing of information related to a second clinical problem (e.g., depression) also afflicting the client (Reiss, Levitan, & Szyszko, 1982; Spengler & Strohmer 1994). Reiss et al. (1982) found that most clinicians succumbed to the overshadowing bias. Perry and Tross (1984) reviewed medical records and found that, of 52 AIDS inpatients, 83% suffered from some affective disorder and 17% fit the criteria for major depression; but none of these clients was ever diagnosed as having depression or received treatment for depression. Walker and Spengler (1995) demonstrated that overshadowing bias among psychologists existed in the treatment of major depression in AIDS patients, with cognitive complexity about AIDS issues showing a significant moderating effect. Attention should be given to such overshadowing bias since counselors' perceptions of their clients can ultimately influence the types of interventions along with the directions and outcomes of therapy (Berven, 1997; Rahimi, Rosenthal, & Chan, 2003; Rosenthal, 2004; Rosenthal & Berven, 1999; Rosenthal & Kosciulek, 1996).

Therefore, bias can be triggered when automatic stereotypes are activated, leading to negative characterizations. Further, these stereotypes often lead to differential treatment. For example, in one study providers reading a vignette were less likely to rate black HIV-positive patients as adherent to medications, independent of other factors; thus they were less likely to prescribe HAART (Bogart, Kelly, Catz, & Sosman, 2000). In light of the impact that stigma can have, mental health providers and other healthcare providers should be cognizant of their own negative attitudes or stigmatization which might affect their judgment toward those with HIV/AIDS.

Counselors and Bias toward HIV/AIDS

A counselor's attitude toward a client with HIV/AIDS is important for effective treatment of the disease (Britton, Rak, Cimini, & Shepard, 1999; Zilber, 2006). Counselors should be cognizant of their own attitudes and biases toward people with HIV (Kiemle, 1994), and majority-culture practitioners need to be cognizant of the possibility of their unconscious racism toward different cultures (Winiarski, 1997; Winiarski et al., 2005). Perceptual bias has been found to influence clinical decisions. Research suggests that counselors and clinicians often form early client impressions based on biases and preconceived perceptions that do not alter, even when contradictory information later emerges (Butcher & Scofield, 1984; Strohmer & Shivy, 1994). Counselors must continue to examine the negative impact that biases and stereotypes have on the counseling process when working with this population.

The Role of Education in Bias

The framework of training for counselors on multicultural issues was established by Sue, Arrendondo, and McDavis (1992). However, it is not clear that the

current emphases and approaches to cultural sensitivity will address systemic discrimination or unconscious bias. For example, researchers found a correlation between clinical psychology graduate students' training in HIV/AIDS treatment and perceived competence in treating special populations; however, they found little correlation between any multicultural training and perceived competence in working with multicultural HIV clients (Kindermann, Matteo, & Morales, 1993). These researchers emphasize the ethical dilemma raised by students who believe that complex multicultural issues can be addressed without specialized training, citing the need for training guidelines. Other researchers found that even model cultural sensitivity programs for medical students and residents do not address unconscious discrimination or bias (Robins, Mantone, Hermann, Alexander, & Zweifler, 1998; Zweifler & Gonzalez, 1998). King (1996) has advocated for more research on provider attitudes and behaviors to identify strategies that may be most effective in identifying and reducing bias. Pettigrew (1998) found that inter-group contact can increase mutual appreciation and possibly lead to inter-group friendship when the contact contains: a) equal status within the immediate setting, b) shared goals, c) cooperation in pursuit of those goals, and d) support of authorities. Inter-group friendships that are genuine have been found to reduce stereotyping, prejudice, and discrimination (Fiske, 2002).

In partial summary, research overwhelmingly demonstrates that counselors, just as members of the culture at large, exhibit a degree of bias. This bias is often unconscious and harmful in the counselor/client relationship. Such insidious counselor bias is often present when treating clients with HIV/AIDS. Clearly, a

framework of training and education must be fostered to ameliorate or eliminate the negative impact of counselor bias in dealing with HIV/AIDS clients.

Training for Counselors Concerning HIV/AIDS Infected Individuals

Several studies indicate that mental health providers lack critical knowledge, hold stigmatizing attitudes, and perpetuate institutional barriers to providing adequate HIV care (Dow & Knox, 1991; Herman, Kaplan, Satriano, Cournos, & McKinnon, 1994; Sullivan et al., 1999; Wright & Martin, 2003). Surveys of mental health workers report concerns about the readiness of staff members to provide basic HIV care (Mitchell, Grindel, & Laurenzano, 1996; Sullivan et al.; Walkup, Satrino, Hansell, & Olfson, 1998). A study of 223 certified rehabilitation counselors found that 27% of respondents reported being “uncomfortable” providing personal adjustment services to those with HIV/AIDS and ranked them as the most difficult group to obtain employment among a list of 13 disabling conditions (Alston et al., 1995). Souheaver and colleagues (1996) noted that rehabilitation professionals did not have complete HIV knowledge, and 89% of the 362 rehabilitation professionals in the study said they wanted more training on HIV/AIDS. Even psychiatrists were found to have a deficiency of knowledge in dealing with the neuropsychological manifestations of HIV/AIDS and in working with these patients’ dealing with death (McDaniel et al., 1998).

Training for counselors is important in order to increase their willingness and readiness to treat those with HIV/AIDS by reducing their negative attitudes and biases. Counselors who had training or education on HIV/AIDS were less likely to hold negative attitudes or biases (Britton, Rak, et al., 1999; Crawford et al., 1991). However, many counselors may not receive adequate training regarding HIV/AIDS. Carney, Werth, and

Emanuelson (1994) found that counselors in training had merely a moderate knowledge of HIV/AIDS, similar to the general knowledge readily available to the public.

Due to this lack of knowledge, there is increased need for special training of mental health counselors to prepare them to treat effectively those with HIV/AIDS (American Association for Counseling and Development, 1989; Hunt & Robertson, 2001; Werth, 1993). Research emphasizes the importance of knowledge about HIV in order to increase the quality and scope of mental health services provided to HIV-affected clients. This knowledge includes basic facts about HIV/AIDS, such as the prevalence, transmission, disease progression, diagnosis, treatment, risk factors, prevention strategies, medication adherence, and psychosocial aspects of the disease. Some professionals maintain that this basic information is not enough, but that mental health professionals should also know the neurological and psychological symptoms of the disease as well as the social stigmatization that clients face (Carney et al., 1994; Gushue & Brazaitis, 2003; Knapp & VandeCreek, 1990; Werth, 1993; Zilber, 2006). Research has found that mental health providers' readiness to provide care is influenced by professional education and HIV-specific training, and research suggests that education on basic HIV care and on primary and secondary HIV prevention is indicated (Wright & Martin, 2003).

The Lack of Adequate HIV Training in Educational Programs

One of the most effective means of addressing the lack of counselors' training and knowledge concerning HIV/AIDS is to reevaluate graduate training programs. Such programs have not traditionally been found to offer adequate training and education about HIV/AIDS (Britton, Rak, et al., 1999; Campos, Brasfield, & Kelly, 1989; Diaz & Kelly, 1991; Escoto, 2002; Hoffman, 1991; Hunt, 1996). In 1987, more than 75% of clinical and

counseling psychology graduate programs failed to offer training in their curricula regarding HIV/AIDS. Only 19% of graduate psychology programs offered HIV/AIDS courses (Campos et al.). Ten years later, the American Psychological Association (APA) surveyed graduate teaching faculty who offered courses related to HIV/AIDS in various areas of psychology. The survey results indicate that only 14% of courses had HIV/AIDS as their primary focus and only 54% offered HIV/AIDS information as part of other psychology courses (Anderson, Campos, & Hamid, 1998). More recently, Escoto (2002) found that, of 202 graduate training programs in psychology, approximately half offered HIV/AIDS training. Other researchers found a similar, limited increase in the number of training activities, but only 4% of responding programs offered specific doctoral level coursework in HIV (Pingitore & Morrison, 1993). Even psychology textbooks reviewed for content analysis did not address the contributions psychology could make to curb the HIV/AIDS pandemic (Wong, Duffy, Faulring, Eggleston, & Harper, 2001).

One marker of interest in any topic on the graduate level is the amount of research dedicated to a specific area. The number of faculty members involved in research or clinical activities related to HIV/AIDS has not increased in recent years. Escoto (2002) found that of 3,438 faculty members in clinical and experimental psychology programs, 3% were conducting research related to HIV/AIDS, 1% had grants for HIV/AIDS research, and 4% provided clinical or counseling services to those with HIV/AIDS. The lack of training at the graduate level is likely impacting the amount of HIV/AIDS research. In fact, a special APA committee recommended that psychologists take a more active role in the prevention and treatment of HIV/AIDS, noting that research in the area

of behavior modification could cut the number of new HIV infections in half (Michaelson, 1993).

In support of additional research and training, mental health practitioners who are extensively involved in working with individuals with HIV/AIDS reported needing additional information (HIV Frontline, 1993). These professionals highlighted several areas for additional training: addressing psychosocial issues of specific groups, such as women; presenting models of successful treatment and counseling programs; influencing psychological aspects of HIV; decreasing depression and anxiety; implementing a treatment team approach; discussing difficult cases; decreasing fear in clients; decreasing prejudice in individuals or groups; increasing hope in clients; and obtaining knowledge on how working with people of other ethnicities affects practitioners. These needs are significant in the planning of training for graduate students and less experienced professionals.

Lack of Adequate HIV Training for Counselors

There is a dearth of research pertaining strictly to counselor training programs; however, these few studies also reflect a deficiency in HIV/AIDS research and training. According to a 1995 study, 243 counseling programs were surveyed, and 38% reported offering no basic information about HIV/AIDS, 57% offering no training about counseling people who were infected with HIV/AIDS, and only 2% offering specific programs devoted to HIV (House & Gray, 1995). Another survey found that 60%-80% of programs offered some HIV education, but the training primarily occurred indirectly via clinical training experiences (Hunt 1995, 1996). More recently, Hunt and Robertson (2001) found that the majority of rehabilitation counseling programs noted that they offer

some level of training on HIV/AIDS, but there are still some programs which do not offer any coursework on this subject. Additionally, topics that addressed counseling and HIV/AIDS were most frequently "not offered," and only a small percentage of faculty members were involved in HIV/AIDS-related activities, including research. Even counselors working with HIV-infected clients acknowledged that they received training outside of educational settings due to the lack of educational opportunities in their programs (Ullery & Carney, 2000).

Education is vital since counselors-in-training who tended to have greater levels of knowledge regarding HIV/AIDS also expressed more positive attitudes toward this population (Carney et al., 1994; Ullery & Carney, 2000). Research has shown that counselors' participation in educational activities is positively correlated with increased knowledge about HIV clients (Glenn & Datillo, 1993; Hunt, 1997; Hunt & Robertson, 2001). Training and educational programs have also been positively correlated with more favorable HIV/AIDS related attitudes among counselors and mental health professionals (Crawford et al., 1991; Hunt & Robertson; Hunt; Wiener & Siegel, 1990). Increased knowledge has also led to an increase in the amount of HIV-related services, including counseling (Cook, Razzano et al., 2006). Despite these enhancements, Lalonde et al. (2002) have noted the shortage of published studies exploring the influence of provider education on the actual care of clients, highlighting the need for additional research.

The Future of Education for HIV Training and Proposed Models for HIV Training

Due to the need for better training which includes addressing attitudes toward those with HIV, several models have been proposed (Britton, Cimini, & Rak, 1999; Hoffman, 1991; Hunt & Robertson, 2001; Robiner, Parker, Ohnsorg, & Strike, 1993;

Werth & Carney, 1994). Such training encourages counselors to be aware of their own feelings and attitudes toward those with HIV/AIDS (Hunt & Robertson) and suggests how their reactions, such as internalized homophobia, willingness to explore sexual or drug practices, and anxiety about the dying process, can affect the counseling relationship (Hoffman, 1996). Students should also be encouraged to complete their practica and internships with agencies that provide services to people living with HIV/AIDS and to engage in research activities related to this population (Hunt & Robertson).

Positive correlations have been found between favorable/tolerant attitudes and professional contact or relationships with HIV/AIDS clients (Berger & O'Brien, 1998; Ullery & Carney, 2000). Professionals who treat people with HIV/AIDS expressed more positive attitudes than those without similar clinical experience. One survey of rehabilitation counselors found that clinical training and clinical experience working with HIV/AIDS clients would help the counselors feel more comfortable and capable to provide services to the population (Hunt, 1997). Another study found similar results with social work trainees (Wiener & Siegel, 1990).

Intimate and personal contact with people with HIV/AIDS provides the strongest influence in the role of attitude development and change. Studies of undergraduates found that students who had a friend who was homosexual and/or an acquaintance with HIV/AIDS reported more knowledge about AIDS, less homophobic attitudes, and more empathy toward people with HIV/AIDS (Walters, 1997). A longitudinal study of medical students showed that the number of personally known HIV-infected individuals seen by students was correlated with a significant increase in positive attitude, knowledge, and willingness to treat people with HIV/AIDS (Anderson, Vojir, & Johnson, 1997). Herek

and Capitanio (1997) found that direct contact with an individual with HIV/AIDS was associated with less avoidance and less blame for people with HIV/AIDS.

Werth and Carney (1994) have authored several articles outlining comprehensive recommendations for the inclusion of HIV/AIDS training in graduate psychology programs. The American Psychological Association has also noted the need for increased training (APA, n.d. b). The APA and Werth's (1993) recommendations include knowledge of HIV transmission, including an understanding of sexual and drug practices; disease progression; and medical interventions. Therapists are encouraged to maintain knowledge of psychosocial issues that accompany or predispose an individual to acquiring HIV disease, skill in designing and delivering psychotherapeutic interventions, and awareness and sensitivity to the social, cultural, economic, and political forces that affect responses to HIV. They are also encouraged to design and implement prevention interventions for HIV positive and uninfected clients. Finally, counselors should exhibit knowledge of ethical, professional, and case management issues related to HIV; self-awareness of their own attitudes toward diverse client groups; insight into behaviors relevant to HIV transmission; and the ability to explore issues regarding death and dying, sexuality, substance abuse, and spirituality (Zilber, 2006).

The Council for Accreditation of Counseling and Related Educational Programs (CACREP), the national accrediting body for counseling programs, has not issued specific curricula recommendations on HIV/AIDS; however, they do support the inclusion of material that increases the understanding of issues in a diverse and multicultural society into the curricula as part of their standards (CACREP, 2001). Clearly, HIV and AIDS should fit into this category. Researchers suggest that mental

health providers should focus on the development of strategies to promote medication adherence (Kelly, Otto-Salaj, Sikkema, Pinkerton, & Bloom, 1998; Rabkin & Ferrando, 1997). Additionally, counselors are encouraged to be conversant in the psychological aspects of HIV/AIDS and to address the stigmatization and isolation felt by clients (Gushue & Brazaitis, 2003). Counselors should also be trained in career development models to help clients account for the disruptions and career fluctuations due to cycles of illness (Gushue & Brazaitis).

Researchers advocate that counselor training could be effective in the context of a course specific to HIV disease or in courses addressing related issues such as sexuality, multiculturalism, or health promotion (Hoffman, 1991; Hunt, 1996; Hunt & Robertson, 2001; Werth, 1993). APA has highlighted the need for training students in prevention and treatment methodologies to appropriately address the multicultural nature of the epidemic, the ethnic and racial populations represented in the epidemic, and the groups who are socially stigmatized by the majority culture (APA, n.d. a). Their recommendations provide resources for teaching courses or training students to conduct research on HIV/AIDS, to treat clients, and to carry out prevention programs (APA, n.d. c). Cultural competency training is also indicated for healthcare providers (Valverde et al., 2006). Similar training recommendations are needed for those in graduate counseling programs.

More training is needed for counselors to be effective in their work with those with HIV. Special attention should be given to counseling African American women, who represent the fastest growing population of HIV/AIDS infections. Counselors should be prepared to deal with the salient concerns that impact women in particular, since they

are more likely to feel stigmatized, less likely to have support, less likely to adhere to medications, and less likely to prioritize their own health due to caring for others (Sherr, 2005). Factors such as age, social support, and employment should be addressed since they are related to quality of life for women with HIV/AIDS (Cowdery & Pesa, 2002). Additionally, counselors should engage in more research on the unique impact of HIV/AIDS on women. Counselors should use evidence-based practices to apply findings to women instead of merely relying on information gathered from other infected groups, such as gay men. Most importantly, counselors are called upon to be aware of their own attitudes and potential biases toward HIV-infected women since such attitudes can lead to perceptions and actions that might jeopardize the clients' health. Women suffering with HIV/AIDS have complex needs, including emotional, physical, family, support, individual, psychosexual, and occupational needs. These needs can be best met by counselors who are adequately trained and culturally competent in delivering treatment and preventative services to women with HIV/AIDS.

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CHAPTER 2

A STUDY OF TRAINING COUNSELORS' EMOTIONS, PERCEPTIONS, AND APPRAISALS OF WOMEN WITH HIV/AIDS

Introduction

Negative characterizations and biases on the part of healthcare providers can have a harmful impact on the relationship between healthcare providers and HIV-infected patients. This is a wide-ranging problem, as an estimated 1.2 million persons in the United States are living with HIV (UNAIDS, 2006). Worldwide, approximately 40 million people are living with HIV (UNAIDS). The CDC estimates that approximately 40,000 persons become infected with HIV each year (CDC, 2003)

Research has demonstrated that negative characterizations and biases on the part of the physician may be so harmful that there can be an adverse effect on patients' medication adherence (Heckman, Catz, Heckman, Miller & Kalichman, 2004; Roberts, 2002), on following medical advice (Hauck, Zyranski, Alemagno, & Medalie, 1990; Uhlmann, Inui, Pecoraro, & Carter, 1988; Zrinyi & Horvath, 2003), on appointment attendance (Pettinati, Monterosso, Lipkin, & Volpicelli, 2003), and on communication with medical staff (Holzemer et al., 1999; Wilson & Kaplan, 2000). Recent literature supports the importance of the HIV-patients' reactions to and attitudes toward healthcare providers, and several scales have been designed to assess these attitudes (Bodenlos, Grothe, Kendra, Whitehead, Copeland, & Brantley, 2004, Chinoweth & Piterman, 1995). One study found that 71% of HIV-positive patients reported having experienced

discrimination based on their race or color when receiving treatment from healthcare providers, and 66% reported discrimination attributed to their socioeconomic status, position, or social class (Bird, Bogar, & Delahanty, 2004). These discriminatory experiences were found to interfere with the health and healthcare of the participants. HIV-infected women reported that their feelings of resistance to seeking HIV services were exacerbated by their negative encounters with healthcare providers, including providers' lack of knowledge, providers' fears, and providers' insensitivity (Sullivan, Stein, Savetsky, & Samet, 2000). Clients are more likely to seek and continue to use HIV services that they perceive to be non-threatening and non-judgmental (Valdiserri, 2002).

Women represent one of the fastest growing categories of new HIV cases, with African American women comprising the largest group (UNAIDS, 2006). The rate of occurrence of HIV for African American women is 19 times higher than Caucasian women, and their AIDS diagnosis rate is 25 times higher (CDC, 2004). Among the growing needs for counseling, HIV-positive women have high rates of depression and depressive symptoms (Cook et al., 2002; Ickovics et al., 2001; Kaplan, Marks, & Mertens, 1997; Moore, Schuman, Schoenbaum, Boland, Soloman, & Smith, 1999; Vedhara, Schifitto, & McDermott, 1999) which may interfere with their ability to begin or continue taking HAART regimens (Boland, 1997). HIV positive women also have an increased risk of suicidal ideation and attempts (Catalan, 2005; Komiti et al., 2003). Adding to the negative impact of these depressive symptoms is the lack of social support received by many HIV positive women. African American women are less likely than men and Caucasian women to receive social support from family and friends when they

disclose their positive serostatus (Campbell, 1999), which can increase their experience of stigma and reduce their medication adherence.

Counseling can help women cope with mental illness and psychosocial concerns and lead to prolonged life by encouraging the use of HAART. Cook and collegues (2006) found that a combination of antidepressants plus mental health therapy, or the use of mental health therapy alone, significantly increased the probability of HAART utilization in a group of HIV-infected women with depression. Miranda et al. (2003) found that cognitively-oriented psychotherapy and pharmacotherapy were effective treatment modalities for depression in low-income African American and Latina women.

To the detriment of effective counseling, one of the persistent characteristics of the HIV epidemic is its ongoing association with stigma (Herek, 1999; Herek, Capitanio, & Widaman, 2002; Lentine et al., 2000; Swendeman, Rotheram-Borus, Comulada, Weiss, & Ramos, 2006). In fact, Black and Miles (2002) noted that few illnesses in modern times are associated with the high levels of stigma and resulting social isolation as the diagnosis of HIV. In light of the impact that stigma can have, mental health providers and other healthcare providers should be cognizant of their own negative attitudes or stigmatic biases toward those with HIV/AIDS. Research shows that many mental health professionals hold negative attitudes toward HIV-infected clients and show reluctance to work with them (McCann, 1999; St. Lawrence, Kelly, Owen, Hogan, & Wilson, 1990). Training for counselors is important in order to increase their willingness and readiness to treat those with HIV/AIDS by reducing their own negative attitudes and biases. Counselors who had training or education on HIV/AIDS were less likely to hold negative attitudes or biases (Britton, Cimini, Rak, & Shepherd, 1999; Crawford,

Humfleet, Ribordy, Ho, & Vickers, 1991). The importance of HIV/AIDS education is reflected in a study that found counselors in training who had greater levels of knowledge regarding HIV/AIDS expressed more positive attitudes toward this population (Carney, Werth, & Emanuelson, 1994). Research has shown that counselors' participation in educational activities is positively correlated with increased knowledge about HIV clients (Glenn & Datillo, 1993; Hunt, 1996; Hunt, 1997; Hunt & Robertson, 2001). Training and educational programs have also been positively correlated with more favorable HIV/AIDS related attitudes among counselors and mental health professionals (Crawford et al., 1991; Hunt & Robertson; Hunt; Wiener & Siegel, 1990).

Detecting biases and unhealthy attitudes in counselors and healthcare providers requires some clear, dependable methodology. Anecdotal and self-evaluative measures may not be quantifiably dependable. I. J. Roseman, working with several other researchers across several studies, has recommended a quantifiable scale for bias based on perception and emotion. This research has found that cognitive appraisals cause people to feel emotions (Roseman, 2001; Roseman, 1984; Roseman & Evdokas, 2004; Scherer, 2001; Smith & Lazarus, 1990). In 1996, Roseman, Antoniou, and Jose found evidence for using cognitive appraisals instead of actual events to provide evidence for the deterministic quality of emotions. In essence, an emotional response is elicited by how an event is perceived. Roseman, Spindel, & Jose (1990) maintain that individuals immediately, automatically, and involuntarily appraise the things that they encounter in their environments. Individuals often express different emotional responses about the same event when their appraisals differ. The Roseman et al. (1996) cognitive appraisal

model focuses on the importance of an individual's appraisals without judging their accuracy.

Roseman et al. (1996) used seven cognitive appraisals to predict specific emotions in his model. "Unexpectedness" is the first appraisal and is characterized by whether the individual assesses an event as being expected or unexpected. "Situational state" is the second appraisal and is characterized by whether the individual assesses an event as consistent or inconsistent with his/her desires. "Motivational state" is the third appraisal and specifies whether the individual is seeking something positive (appetitive) or avoiding something negative or painful (aversive). "Probability" is the forth appraisal and refers to the perceived likelihood of an event occurring (i.e. totally unknown, uncertain, or certain). "Control potential" is the fifth appraisal and is characterized by the perception of how controllable an event is and if an individual can "do something about an event" (Roseman et al., 1996). "Problem source" is the sixth appraisal and is based on non-characterological and characterological factors. "Agency" is the seventh appraisal and is divided into self-agency, other-agency, and circumstance agency.

Vignettes are characterized as stories about people and situations which can make reference to important points in the study of perceptions, beliefs, and attitudes (Hughes, 1998). Vignettes have been found to be useful because they enable the participant to define and respond to a situation in their own words (Barter & Renold, 2000). Vignettes may initially provide socially desirable responses, but participants will reveal how they truly believe they would respond to the situation if the appropriate probing questions are included in the research (Barter & Renold). Since the Roseman model is intended to measure emotional, appraisal, and perceptional responses, vignettes are especially

effective in investigating attitudes and biases. The purpose of this study is to investigate, using the Roseman et al. cognitive appraisal model along with four vignettes, counselor trainees' attitudes, emotions, and perceptions about HIV disease and about females living with HIV.

Method

Participants

Participants were graduate level counseling students enrolled in a large southeastern university that is accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). Participants were in the masters or specialists degree programs. For the purposes of this study, there were no exclusionary criteria with respect to program of study (i.e., professional counseling, rehabilitation counseling, and school counseling). Each year at this university approximately 110 masters and specialist level students enroll in the professional counseling program, while approximately 15 students enroll in the rehabilitation counseling program, and approximately 30 enroll in the school counseling program. The mean age of the participants was thirty. Twenty-six of the participants were male, and 146 of the participants were female. The racial make-up of the participant pool was 117 Caucasian, 41 African American, and 14 other races. Participation in this study was completely voluntary.

Procedures

Participants were recruited from departmental courses during the spring and fall semesters of 2006. Professors and instructors of record were contacted in January 2006 to ask permission for the principle investigator to distribute the packets in their classrooms.

Volunteer participants received a survey packet that included a study overview, informed consent, demographic information, case vignette, survey questions, and relevant training questions. Participants were asked to complete the survey outside the class room experience and submit completed packets to an instructor or to an assigned box located at the front desk within the department. In some cases participants earned extra credit points from their professors. Data was identified using an arbitrary numeric code.

Instrumentation

For this study, permission was secured to make some minor changes to the Roseman et al. (1996) measure of emotions and appraisals. One of the changes included requesting that participants read a case exemplar or vignette instead of merely describing a situation or event that happened to them and then answering questions regarding emotions. Participants' responses were reported using a nine point scale. Therefore, the initial qualitative questions in this study were in response to a vignette about a female client. Further, each question was reworded to refer to the client in the vignette. For example, one of Roseman et al.'s cognitive appraisal items states, "My emotion was caused by: (1) thinking that specific event A was consistent with what I wanted, to (9) thinking that specific event A was inconsistent with what I wanted." This statement was changed to "My emotions were caused by, (1) thinking what happens in the counseling session as consistent with what I wanted, to (9) thinking what happens in the counseling session as inconsistent with what I wanted."

The vignette chosen for the study was published in The Handbook of Addiction Treatment for Women (Straussner & Brown, 2002), which is intended to assist counselors and therapists in their ability to work with clients. The chosen vignette was

highly probable, and it contained sufficient context for participants to understand the situation. Finally, a high number of questions which were detailed and overlapping in subject were provided after the vignette in order to elicit more accurate responses related to the subjects' potential biases.

There were four case vignettes used in the study. Each vignette was worded identically with the exception of four separate demographic characteristics. Two of the vignettes each featured a client who is not HIV positive, but one client was an African American female (Vignette 2) and the other was a Caucasian female (Vignette 4). The other two vignettes noted that the client was HIV positive, and, again, one was an African American female (Vignette 1) and the other was a Caucasian female (Vignette 3).

The primary mental health diagnostic issue listed in the vignette was the client's use of alcohol. Alcohol was selected as the presenting concern because substance abuse is indicated in half of the cases of those with HIV/AIDS, and because substance abuse should be managed before addressing concerns with HIV/AIDS (Hoffman, 1996). Additionally, substance use and abuse plays a role in vulnerability to HIV disease, engaging in high-risk behaviors, transmitting the virus, and failing to maintain one's health status.

After reading the randomly assigned vignette, participants were asked to report their reactions to working with the client, plans for treating the client, and prognoses for the client. Responses were written on the form to provide the qualitative portion of the data. By asking subjects to imagine themselves in a therapy session with the client and then eliciting their own responses, the subject is likely to provide a personal emotional response. Roseman, Wiest, and Swartz (1994) and other researchers (Frijda, Kuipers, &

ter Schure, 1989; Mauro, Sato, & Tucker, 1992; Scherer, 1993; Smith & Ellsworth, 1985) conclude that subjects can answer more accurately about what they think, feel, feel like doing, and want when they actually experience an emotion instead of asking them about the feelings, thoughts, actions, and goals that they believe are associated with an emotion. Recall and self-reports are commonly used in emotion research because they allow for data gathering on real and intense emotional experiences that cannot realistically be studied in laboratory or natural settings; these techniques are valuable because there are few alternatives to using self-reports to assess emotional feelings, thoughts, and goals (Roseman et al., 1994). The Roseman et al. (1996) cognitive appraisal model also elicits the appraisals that generate emotional responses instead of eliciting appraisals that are generated by emotional responses (Roseman et al., 1990). This is important, because what a subject thinks during an emotional experience might be different from the thoughts that caused the emotion.

Participants were then provided with a list of seventeen emotions, including joy, relief, affection, pride, hope, surprise, disgust, distress, sadness, fear, unfriendliness, anger, frustration, shame, regret, guilt, and contempt. The positive or non-negative emotions (joy, relief, hope, affection, and pride) have been found to occur in situations appraised as relatively motive-consistent; whereas the negative emotions (disgust, distress, sadness, fear, frustration, unfriendliness, anger, shame, guilt, regret, and contempt) occur in situations appraised as motive-inconsistent (Roseman et al., 1990). Surprise could be considered either a positive or negative emotion (Roseman et al., 1996). These seventeen specific emotions have been related to different motives. Joy and sadness are elicited by events appraised as salient to appetitive motives, and relief,

distress, and disgust are elicited by events appraised as relevant to aversive motives (Roseman, 1991; Roseman et al., 1990). Hope and fear are elicited by events appraised as uncertain, and joy is elicited by motive-consistent events appraised as certain (Bermond & Frijda, 1987; Roseman, 1991; Roseman et al., 1990; Smith & Ellsworth, 1985). Pride, shame, guilt, and regret are elicited by events appraised as self-agency; and love, dislike, and anger are elicited by events appraised as other-agency (Reisenzein & Hofmann, 1990; Roseman, 1991; Roseman et al., 1990; Weiner, Graham, & Chandler, 1982).

Each participant was asked to circle a word from the list of 17 emotions which identified the counselor's predominant emotional response. They were then asked to rate the intensity of each of the 17 emotions from "1" (least intense) to "9" (most intense). If participants did not experience the emotion at all, they were requested to circle "0." Participants were then asked their final qualitative question, which was to describe what directly caused them to select the circled emotions. This portion of the questionnaire, along with the majority of the qualitative questions, directly conforms to the original Roseman et al. measure (Roseman et al., 1990). Participants were then asked to answer forty-two questions related to their reactions and perceptions of the client as they imagine working with her.

The validity and reliability of each appraisal and the items associated with it were established through previous research, which reported reliability alphas of .86 for Situational state, .62 for Motivational state, and .56 for Probability (Roseman et al., 1990). The remaining four appraisals were developed as revisions of previous appraisal dimensions. Each dimension was included in the model based on its ability to predict discrete emotions over appraisals (Roseman et al., 1996).

Following the survey, participants were asked a series of demographic questions to elicit the perceived quality of their training, their perceived level of competence in counseling knowledge and skills, their practica experiences, and their experiences in working with clients who are HIV-infected. The questionnaire provided basic information about the participants, including gender, race/ethnicity, type of graduate program, length of time in the program, types of courses completed in the program, and type and quality of multicultural, disability, or health-related counseling courses they have taken. Lastly, the demographic questionnaire asked the participants if they had a chronic illness or disability. The authors used an umbrella MANOVA, followed by stair stepping MANOVAs for significant interaction and main effects and ANOVAs for the resultant significant variables, followed by non-parametric tests on the variables found to be significant after all the above analyses. A variable was only considered significant if it remained significant through all these tests. In this way, as recommended by Tabachnick and Fidel (2006), Type I error and homogeneity of variance problems were addressed.

Results

Overall, participants responded favorably to the clients depicted in the vignettes (see Table 1). Hope was the most frequent emotional response as participants imagined working with the clients (Mean = 6.80, SD = 1.90), and Affection was the second most frequent emotional response (Mean = 4.12, SD = 2.50). Participants also reported feeling Empathy toward the clients (Mean = 7.57, SD = 1.31) and expressed feeling Hopeful that the clients would likely be happy again (Mean = 7.26, SD = 1.51); despite perceiving the clients as Depressed (Mean = 6.65, SD = 1.52) and Anxious (Mean = 6.45, SD = 1.50). Descriptives for each vignette are reported in Table 1.

Table 1

Means and Standard Deviations for Emotions, Appraisals, and Perceptions

Emotions

	Overall	Vignette 1	Vignette 2	Vignette 3	Vignette 4
	M SD	M SD	M SD	M SD	M SD
Joy	2.70 (2.38)	2.81 (2.52)	3.18 (3.26)	2.32 (2.37)	2.58 (2.27)
Relief	2.45 (2.17)	2.19 (2.14)	3.00 (2.00)	2.02 (2.31)	2.67 (2.12)
Affection	4.12 (2.50)	4.50 (2.68)	4.00 (2.29)	3.98 (2.46)	4.02 (2.61)
Pride	2.58 (2.43)	2.69 (2.41)	2.00 (2.31)	3.17 (2.48)	2.35 (2.42)
Hope	6.80 (1.90)	6.69 (2.33)	6.65 (2.02)	6.85 (1.65)	7.00 (1.59)
Surprise	1.78 (2.09)	2.55 (2.34)	1.58 (1.82)	1.34 (2.06)	1.70 (1.98)
Disgust	0.50 (1.22)	0.90 (1.73)	0.18 (0.50)	0.34 (0.84)	0.58 (1.33)
Distress	2.45 (2.28)	3.71 (2.86)	1.93 (1.73)	2.34 (2.09)	1.84 (1.83)
Sadness	3.97 (2.77)	5.02 (2.94)	3.30 (2.47)	4.13 (2.76)	3.40 (2.62)
Fear	2.06 (2.29)	3.10 (2.87)	1.45 (1.71)	1.96 (2.39)	1.74 (1.69)
Unfriendliness	0.45 (1.02)	0.52 (1.11)	0.25 (0.74)	0.34 (0.81)	0.67 (1.30)
Anger	0.59 (1.07)	0.74 (1.25)	0.38 (0.70)	0.57 (1.01)	0.65 (1.21)
Frustration	1.92 (2.16)	2.60 (2.51)	1.90 (2.25)	1.62 (1.83)	1.60 (1.96)
Shame	0.45 (1.13)	0.45 (1.17)	0.35 (1.21)	0.40 (0.87)	0.60 (1.27)
Regret	0.85 (1.68)	1.38 (2.47)	0.68 (1.26)	0.77 (1.37)	0.58 (1.25)
Guilt	0.56 (1.14)	0.50 (1.13)	0.48 (0.93)	0.66 (1.14)	0.58 (1.31)
Contempt	0.52 (1.28)	0.60 (1.21)	0.40 (1.17)	0.51 (1.53)	0.58 (1.16)

Appraisals

	Overall	Vignette 1	Vignette 2	Vignette 3	Vignette 4
	M SD	M SD	M SD	M SD	M SD
Control	4.76 (1.62)	4.79 (1.70)	5.13 (1.52)	4.87 (1.52)	4.26 (1.64)
Desirable	3.51 (1.51)	3.62 (1.49)	3.58 (1.76)	3.62 (1.45)	3.21 (1.33)
Anticipate	5.03 (1.38)	4.83 (1.36)	4.93 (1.43)	5.02 (1.46)	5.35 (1.23)
Weak	6.66 (1.33)	6.12 (1.51)	6.68 (1.45)	6.83 (1.00)	7.00 (1.19)
Pleasure	4.65 (1.72)	4.60 (1.76)	4.60 (1.90)	4.70 (1.64)	4.67 (1.63)
Right	3.50 (1.58)	3.19 (1.68)	3.58 (1.48)	3.53 (1.65)	3.70 (1.49)
Cost	6.67 (1.76)	6.67 (1.83)	6.43 (1.83)	6.81 (1.71)	6.77 (1.68)
Predict	5.03 (1.50)	4.55 (1.71)	5.13 (1.36)	5.21 (1.50)	5.21 (1.35)
Consequence	4.86 (1.52)	5.10 (1.60)	4.83 (1.66)	4.83 (1.38)	4.70 (1.45)
Results	6.15 (1.57)	6.00 (1.66)	6.18 (1.55)	6.17 (1.50)	6.23 (1.58)
Doubt	4.40 (1.43)	4.71 (1.55)	4.30 (1.71)	4.26 (1.29)	4.35 (1.13)

Circumstance	4.10 (1.71)	4.00 (1.71)	4.33 (1.73)	4.13 (1.62)	3.98 (1.83)
Powerful	4.11 (1.46)	4.55 (1.72)	3.85 (1.64)	4.23 (1.37)	3.79 (0.91)
Wanted	3.83 (1.34)	4.00 (1.32)	3.75 (1.59)	3.96 (1.36)	3.58 (1.31)
Negative	6.69 (1.89)	6.81 (1.74)	6.20 (2.13)	6.83 (1.64)	6.88 (2.01)
Bad	6.26 (1.58)	6.40 (1.85)	6.00 (1.66)	6.45 (1.61)	6.16 (1.13)
Consistent	4.02 (1.40)	4.00 (1.48)	3.90 (1.31)	4.09 (1.57)	4.09 (1.25)
Cope	7.32 (1.47)	6.74 (1.65)	7.40 (1.56)	7.55 (1.36)	7.56 (1.18)
Improve	2.74 (1.47)	2.71 (0.97)	2.93 (2.08)	2.72 (1.33)	2.63 (1.13)
Cause	4.97 (1.40)	5.00 (1.21)	5.03 (1.33)	4.98 (1.45)	4.86 (1.59)
Undesirable	3.53 (1.57)	3.45 (1.62)	3.48 (1.46)	3.57 (1.54)	3.60 (1.67)
Strong	5.72 (1.84)	5.76 (2.08)	5.75 (1.82)	5.66 (1.84)	5.70 (1.67)
Morally	4.43 (1.27)	4.36 (1.44)	4.33 (1.30)	4.26 (1.31)	4.79 (0.94)
Powerless	6.63 (1.35)	6.83 (1.39)	6.60 (1.31)	6.53 (1.35)	6.56 (1.38)
Unable	6.58 (1.30)	6.29 (1.35)	6.55 (1.15)	6.64 (1.31)	6.84 (1.34)
Blame	4.84 (1.71)	4.33 (1.74)	5.43 (1.63)	4.62 (1.80)	5.05 (1.51)

Perceptions

	Overall		Vignette 1		Vignette 2		Vignette 3		Vignette 4	
	M	SD	M	SD	M	SD	M	SD	M	SD
Guilty	6.22	(1.47)	6.33	(1.44)	6.05	(1.82)	6.28	(1.47)	6.19	(1.13)
Happy	7.26	(1.51)	6.40	(1.91)	7.85	(1.33)	7.17	(1.29)	7.65	(1.02)
Hopeful	4.90	(1.58)	4.67	(1.63)	4.73	(1.53)	5.13	(1.62)	5.05	(1.51)
Naïve	3.48	(1.52)	3.46	(1.49)	3.38	(1.49)	3.23	(1.53)	3.95	(1.51)
Anxious	6.45	(1.50)	6.76	(1.26)	6.58	(1.33)	6.32	(1.63)	6.16	(1.69)
Support	3.62	(1.75)	3.60	(1.82)	3.95	(1.99)	3.30	(1.53)	3.70	(1.64)
Depressed	6.65	(1.53)	6.79	(1.71)	6.58	(1.56)	6.62	(1.52)	6.62	(1.33)
Careless	3.97	(1.60)	4.07	(1.60)	4.30	(1.77)	3.98	(1.51)	3.53	(1.48)
Suicidal	4.53	(1.70)	5.17	(1.60)	4.18	(1.78)	4.79	(1.47)	3.98	(1.75)
Ill	4.31	(1.70)	4.88	(1.65)	4.05	(1.51)	4.55	(1.71)	3.72	(1.72)
Resilient	6.15	(1.46)	6.29	(1.67)	6.25	(1.50)	6.11	(1.32)	5.98	(1.37)
Honest	6.03	(1.37)	6.38	(1.30)	5.80	(1.38)	6.21	(1.33)	5.72	(1.42)
Destructive	5.08	(1.59)	5.12	(1.26)	5.00	(1.52)	5.17	(1.72)	5.02	(1.53)
Empathy	7.57	(1.30)	7.57	(1.58)	7.63	(1.27)	7.47	(1.38)	7.63	(0.95)
Emotional	5.41	(1.52)	5.52	(1.43)	5.30	(1.57)	5.32	(1.49)	5.51	(1.63)
Homicidal	2.10	(1.35)	2.55	(1.56)	1.70	(1.04)	2.09	(1.39)	2.07	(1.26)

Results demonstrated neither a significant interaction for client HIV status by client ethnicity nor a significant main effect for client ethnicity related to the emotions, perceptions, or appraisals of the particiants. Client HIV status main effect was significant for emotions (Pillai's Trace = .19, F = 2.21, df = 17,154, $p < .05$) and perceptions (Pillai's Trace = .29, F = 3.96, df = 16, 153, $p < .05$).

Several emotions were significantly different across client HIV status. Participants were more likely to endorse positive emotions such as Relief (F = 4.93, Mean HIV positive = 2.10; Mean non HIV = 2.83, df = 1, $p < .028$) and Pride (F = 4.21, Mean HIV positive = 2.94; Mean non HIV = 2.18, df = 1, $p < .042$) when the vignette did not specify HIV status. Participants were more likely to endorse negative emotions such as Distress (F = 11.88, Mean HIV positive = 2.99; Mean non HIV = 1.88, df = 1, $p < .001$), Sadness (F = 8.80, Mean HIV positive = 4.55; Mean non HIV = 3.35, df = 1, $p < .003$), and Fear (F = 7.42, Mean HIV positive = 2.49; Mean non HIV = 1.60, df = 1, $p < .007$) when the client in the vignette was HIV positive. A summary of these data are reported in Table 2.

Table 2
Analysis of Variance for Significant Emotions and HIV Status

Source	df	F	p
	Between subjects		
Relief	1	4.93	.028
Pride	1	4.22	.042
Distress	1	11.89	.001
Sadness	1	8.81	.003
Fear	1	7.42	.007

Additionally, client HIV status was found to be significant for several perceptions (see Table 3). Clients designated as HIV-positive in the vignettes were perceived by participants as Suicidal (F =12.75, Mean HIV positive = 4.97; Mean non HIV = 4.07, df = 1, $p < .000$), Ill (F = 10.76, Mean HIV positive = 4.71; Mean non HIV = 3.88, df = 1, $p < .001$), Honest (F = 6.66, Mean HIV positive = 6.29; Mean non HIV = 5.76, df = 1, $p < .01$), and Homicidal (F = 4.48, Mean HIV positive = 2.30; Mean non HIV = 1.89, df = 1, $p < .036$). Participants viewed clients who were not designated as having HIV as Happy (F = 19.66, Mean HIV positive = 6.81; Mean non HIV = 7.75, df = 1, $p < .000$). A summary of these data can be found in Table 3

Table 3

Analysis of Variance for Significant Perceptions and HIV Status

Source	df	F	p
	Between subjects		
Suicidal	1	12.75	.000
Happy	1	19.66	.000
Ill	1	10.76	.001
Honest	1	6.66	.011
Homicidal	1	4.48	.036

Discussion

The results indicate that counseling students viewed the client vignettes significantly different based upon the client's HIV status. The focus of the vignettes was on the client's use of alcohol, yet HIV did make a significant difference in the emotions

and perceptions of the students. HIV positive clients were generally viewed more negatively according to the participants' emotions and perceptions. Training counselors reported feeling more distress, sadness, and fear toward HIV positive clients. They also reported feeling more relief and pride toward those not infected with HIV. Clients with HIV were perceived as more suicidal, ill, honest, and homicidal, while clients not mentioned as having HIV were more likely to be perceived as happy. However, students did not appraise the clients differently. Ethnicity did not make a significant difference in participant responses on any measure.

These findings are important for counselors in training. Counselors with biased emotions and perceptions toward clients with HIV should be cautious if they plan to work with this population. The counselors should evaluate their emotions and perceptions before working with these clients. Counselors should also utilize research and consider the unique characteristics of each client to prohibit their emotions and perceptions from creating a bias that could have a debilitating effect on their relationship with and/or treatment of the client.

Taking precautions such as developing awareness of their emotions regarding those with HIV is an important step for counselors. Tending toward negative emotions can hinder counselors from obtaining vital information that might help them effectively counsel clients. These emotions might also keep counselors from making accurate risk assessments and helping clients gain access to needed services. If counselors are feeling fear as they work with an HIV infected client, then their ability to make adequate therapeutic interventions might be confounded by their fear. Likewise, a counselor who feels distress or sadness toward a client with HIV could provide inadequate counseling

interventions if they are not cognizant and/or actively addressing these emotions through supervision or other modalities.

Awareness combined with additional training can also help counselors with unfounded or faulty perceptions. If counselors have more training about HIV and specifically about treating those with HIV, they will attain a greater understanding of the research regarding the population, and they will be able to conceptualize the client based on knowledge, theory, and research, and not their own biases. For example, if a counselor misperceives an HIV client as homicidal, then that might impact the focus of counseling sessions leading to inaccurate or ineffective treatment and potentially harmful measures, such as unnecessary crisis interventions or hospitalizations. Similarly, if a counselor perceives an HIV client as suicidal, then the counselor should be cognizant of any potential bias behind that perception. For example, although research has shown that HIV positive women have an increased risk of suicidal ideation and attempts (Catalan, 2005; Komiti et al., 2003), counselors should be careful that their perception is accurate for this particular client. Just as counselors are encouraged to challenge perceptions and assumptions about various racial, cultural, and ethnic groups, the same should apply to those with HIV. Interestingly, the client with HIV in the vignettes of this study was perceived as more suicidal despite the dearth of other confounding data, which would indicate a bias in counselor perception.

The Roseman et al. cognitive appraisal instrument was somewhat successful in this study because HIV status did make a difference in emotions and perceptions. The vignette in this study was focused on alcohol, yet the clients designated as HIV-positive

were still seen as more negative. This shows that the Roseman measure was sensitive to counselor bias regarding the HIV status of clients.

Implications for the Future of Education for HIV Training and Proposed Models for HIV Training

The present study suggests that students perceive clients differently based on the client's HIV status. Students and practitioners need to be aware that knowing about a client's HIV status affects their emotions and perceptions. Based on the negative emotions and perceptions of clients with HIV, the present study would suggest more training and supervision of students concerning the issues of bias.

Research emphasizes the importance of basic knowledge about HIV to increase the quality and scope of mental health services provided to HIV-affected clients. This knowledge includes basic facts about HIV/AIDS, such as the prevalence, transmission, disease progression, diagnosis, treatment, risk factors, prevention strategies, medication adherence, and psychosocial aspects of the disease. Some professionals suggest that this basic information is not enough, but that mental health professionals should also know the neurological and psychological symptoms of the disease along with the social stigmatization that clients face (Carney et al., 1994; Gushue & Brazaitis, 2003; Knapp & VandeCreek, 1990; Werth, 1993; Zilber, 2006). Research has found that mental health providers' readiness to provide care is influenced by professional education regarding primary and secondary HIV prevention and basic HIV care (Wright & Martin, 2003).

There is a dearth of literature addressing the training of counselors and other mental health workers to work effectively with individuals with HIV/AIDS (Britton, Cimini, & Rak, 1999). Additionally, few studies have examined counselors' attitudes and

biases in working with this population. More studies are needed to evaluate the perceptions that counselors have toward those with HIV/AIDS. Knowledge concerning potential biases can assist counselors in viewing HIV-positive clients individually instead of making generalized or biased assumptions. Future studies should evaluate not only counselors' emotions, perceptions, and appraisals, but further focus on how these factors impact the counseling relationship and subsequent therapy.

The impact of training regarding HIV, including knowledge acquirement, practica experiences, and research involvement, should also be explored for future counselors. Due to the need for better training, which includes addressing attitudes toward those with HIV, several models have been proposed (Britton, Cimini, & Rak, 1999; Hoffman, 1991; Hunt & Robertson, 2001; Robiner, Parker, Ohnsorg, & Strike, 1993; Werth & Carney, 1994). Such training encourages counselors to be aware of their own feelings and attitudes toward those with HIV/AIDS (Hunt & Robertson, 2001), and suggests how their reactions can affect the counseling relationship (Hoffman, 1996). Researchers advocate that counselor training could be effective in the context of a course specific to HIV disease or in courses addressing related issues such as sexuality, multiculturalism, or health promotion (Hoffman, 1991; Hunt, 1996; Hunt & Robertson, 2001; Werth, 1993). Students should also be encouraged to complete their practica and internships in agencies that provide services to people living with HIV/AIDS and to engage in research activities related to this population (Hunt & Robertson, 2001).

Werth and Carney (1994) have authored several articles outlining comprehensive recommendations for the inclusion of HIV/AIDS training in graduate psychology programs. These recommendations include knowledge of HIV transmission, including an

understanding of sexual and drug practices; disease progression; and medical interventions. Therapists are encouraged to maintain knowledge of psychosocial issues that accompany or predispose an individual to acquiring HIV disease, skill in designing and delivering psychotherapeutic interventions, and awareness and sensitivity to the social, cultural, economic, and political forces that affect responses to HIV. They are also encouraged to design and implement prevention interventions regarding the further spread of the disease for HIV positive and uninfected clients. Finally, therapists should exhibit knowledge of ethical, professional, and case management issues related to HIV; self-awareness of their attitudes toward diverse client groups; insight into behaviors relevant to HIV transmission; and the ability to explore issues regarding death and dying, sexuality, substance abuse, and spirituality (Zilber, 2006). Researchers advocate for training which incorporates an exploration of attitudes and/or personal interactions with HIV-infected individuals through practica or similar training experiences (Britton, Rak, Cimini, & Shepherd, 1999; Ullery & Carney, 2000). While these guidelines were recommended for psychology graduate programs, similar recommendations are warranted for counseling graduate programs.

Limitations

In interpreting the findings, several limitations of the study should be considered. Because the present study examined only one school, though with 172 student participants, the generalizability of the study needs to be taken with caution until other settings replicate the results. Second, the vignettes need to be further utilized to illustrate their effectiveness in examining perceptional differences among trainees. In particular, a qualitative analysis of the participants' experiences as they process and respond to the

questionnaire would be enlightening. Third, the number of analyses was large since perceptions, appraisals, and emotions were assessed. The authors used an umbrella MANOVA, stair stepping MANOVAs for significant interaction and main effects, and ANOVAs for the resultant significant variables. Fourth, despite the findings that students do exhibit a biased view toward those with HIV/AIDS, this study does not evaluate whether or not the subjects would actually counsel clients with HIV differently. Finally, these procedures were followed by non-parametric tests on the variables found to be significant after all the above analyses. A variable was only considered significant if it remained significant through all these tests. Even though, as recommend by Tabachnick and Fidel (2006), Type I error and homogeneity of variance problems were addressed, more studies with larger numbers of subjects are needed.

Conclusions

Due to the growing number of persons with HIV disease, more counselors are needed to work with this population. This study suggests that there are concerns about the training and preparation of counselors to meet these needs based on certain emotions and perceptions of graduate-level counselors. More training is needed for counselors to offset biases in their work with those with HIV. Special attention should be given to African American women, who represent the fastest growing population of HIV/AIDS infections (UNAIDS, 2006). Counselors should be prepared to deal with the salient concerns that impact women in particular, since they are more likely to feel stigmatized, less likely to have support, less likely to adhere to medications, and less likely to prioritize their own health due to caring for others (Sherr, 2005). Counselors should use evidence-based practices to apply findings to women instead of merely transferring information gathered

from other infected groups, such as gay men. Most importantly, counselors are called upon to be aware of their own attitudes and potential biases toward HIV-infected women as such attitudes can lead to implications and actions that might jeopardize the clients' health. Women suffering with HIV/AIDS have complex needs, including emotional, physical, family, support, individual, psychosexual, and occupational. These needs can be better met by counselors who are adequately trained and culturally competent in delivering treatment and preventative services to women with HIV/AIDS.

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