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## Barriers of mental health professionals in "willingness to treat" AIDS and HIV seropositive clients

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BARRIERS OF MENTAL HEALTH PROFESSIONALS IN  
"WILLINGNESS TO TREAT"  
AIDS AND HIV SEROPOSITIVE CLIENTS

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A Thesis  
Presented to the  
Faculty of  
California State University,  
San Bernardino

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In Partial Fulfillment  
of the Requirements for the Degree  
Masters of Science  
in  
Psychology

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by  
Wendy Jean Kellogg

May 1992

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"WILLINGNESS TO TREAT"  
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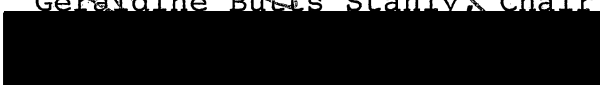
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by  
Wendy Jean Kellogg  
May 1992

Approved by:

  
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## Abstract

The relationship between mental health counselors' knowledge and attitudes about AIDS and their willingness to counsel AIDS and HIV clientele was studied to determine barriers that effect counselors' "willingness to treat." Sixty-three counselors who volunteered, completed a 142-item questionnaire. Findings indicate that almost two-thirds of the counselors have not treated HIV-infected clientele; "patient dumping" was not indicated; two-thirds anticipate working with HIV-infected clients in the future; 20% are unwilling to treat these clients given a choice; and over 80% agree that they have a responsibility to treat. Perceived risk and myth findings indicate a contradiction in knowledge and beliefs; as personal contact with HIV persons increases, personal risk increases. As expected from previous research with health care workers, the major barriers that bias counselors against treating AIDS and HIV clients appear to be homophobia, negative attitudes toward IV drug users, antipathy toward HIV clients, thanatophobia, perceived risk, responsibility to treat and knowledge. The study reveals no significant difference in barriers regarding counselors' experience. It appears that neither knowledge nor experience necessarily reflects proper treatment.



## ACKNOWLEDGMENTS

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## Introduction

The federal Centers for Disease Control (CDC) reported that a cumulative total of 213,641 individuals have been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) and that there has been 138,395 known AIDS deaths in the United States as of February 29, 1992 (California AIDS Update, 1992). The World Health Organization, Geneva, Switzerland, has estimated that there are 1.5 million cases of AIDS; twelve to eighteen million cases are predicted to exist globally by the year 2000 (Jama, 1992). While the general public's, physicians' and medical health care workers' responses to the AIDS epidemic have been studied, mental health care workers' responses have not been studied comparably. In what ways are the attitudes and behaviors of mental health care workers similar or different to medical health care workers in treatment of persons living with the Human Immunodeficiency Virus (HIV)?

### AIDS-Related Stigma

In addition to the epidemic of the AIDS disease itself, there is what Gregory Herek's Master Lecture called AIDS-Related Stigma. The public has identified AIDS as a deadly disease and there is an association of AIDS in the United States with the already stigmatized groups of gay men and intravenous drug users (IV drug users) (Freiberg, 1990; Herek & Glunt, 1988; and Landers, 1989).

In other words, gay men and IV drug users have been set apart from the mainstream of society due to cultural and religious biases toward the behaviors of these populations. These populations have been linked to HIV seropositive status since the onset of the epidemic. Therefore, due to the association between the AIDS epidemic and gay men and IV drug users, public opinion, public policy, research and funding have been negatively affected. Thus, AIDS-Related Stigma identifies gay men and IV drug users with AIDS... and AIDS with gay men and IV drug users. Public reaction has been negative to this stigma (which is defined as a mark of shame and discredit). The social implications have been directed toward the behaviors of transmission of the disease (blood transmission and sexual contact). Public opinion polls indicate that approximately 50 percent of Americans agree that, "Most people with AIDS have only themselves to blame" (Gallop poll, July 7 1987) and "... in general, it's people's own fault if they get AIDS" (Gallop poll October 23, 1987), (Herek & Glunt, 1988).

As reported by Freiberg (1990) and Herek and Glunt, (1991), a research study by Herek and Glunt included focus groups in 10 cities and 960 people in a national telephone survey. The major issue found in AIDS education was not getting the information to the people but getting the people to believe it. It appears that moralistic attitudes and distrust, including distrust of government policies, "shape

peoples' attitudes and feelings about AIDS." This study found that 34 percent of whites and 67 percent of blacks distrusted official information which included: belief of information being withheld and the use of a "homosexual lobby" manipulating government. It was found that belief of whether AIDS is transmitted by casual contact influenced public reaction - the coercion/compassion dimension; and attitudes toward gay men influenced a pragmatism/moralism dimension. Significant differences between attitudes expressed by blacks and whites were found. Blacks were more likely to believe that AIDS is spread by casual contact and to express more hostile attitudes toward gay men. Yet, blacks voiced more support for public health measures. Factors affecting attitudes also included religion and the idea that the disease is perceived as being a gay men's disease.

The stigma related to AIDS has evoked anxiety, prejudice, discredibility, and discrimination. Adequate public health response to the HIV epidemic has been deterred by discrimination against people with AIDS and HIV infection (Freiberg, 1990; Helquist, 1987; Herek & Glunt, 1988; Johnson, 1987; Landers, 1989; Limandri, 1989; and Morin, 1988).

Physicians' and health care workers' responses to the HIV epidemic

The United States health-care system has been slow in responding to the AIDS epidemic which was identified in 1981. The information collected by Rogers and Ginzberg (1989) regarding treatment to HIV patients revealed that fears, prejudices, and values of politicians and health providers interfere with providing adequate treatment and research. A major contributing factor has been the negative attitudes toward populations (male homosexuals and IV drug users) affected by this disease. Homophobia and fear of contracting this contagious, ultimately fatal disease have been barriers to treatment, regardless of professional ethics or legal sanctions regarding duty to treat, confidentiality, or patient "dumping" (Clever, 1988; Cooke, 1990; Douglas, Kalman, & Kalman, 1985; Gerbert, Maguire, Bleecker, Coates, & McPhee, 1991; Kain, 1988; Kelly, Lawrence, Smith, & Hood, 1987; Loewy, 1986; Natin, 1989; Richardson, Lochner, McGuigan, & Leach, 1987; Rogers & Ginzberg, 1989; and Shapiro, 1989).

A physician or health care worker has to confront the potential occupational hazard of contracting HIV. The CDC reported a study where 36 percent of medical residents surveyed in New York hospitals reported needlestick exposure to HIV while caring for infected patients. The CDC Cooperative Needlestick Surveillance

Group estimated, "One in 250 of those stuck are likely to become seropositive." It has been reported that physicians may plan a career path that is less likely to involve the care of HIV seropositive (HIV) patients (Richardson et al., 1987; and Rogers & Ginzberg, 1989).

Lack of adequate knowledge and education about the disease has created another barrier that has resulted in growing shortages of professional personnel including nurses and support personnel. Studies have indicated that sizable percentages of health care workers continue to believe even after educational programs, that AIDS can be transmitted by casual contact such as sharing coffee cups, doorknobs, and handshakes (Brandt, 1986; Melton, 1988; Rogers & Ginzberg, 1989; Treilier, Shaw, & Malcalm, 1987; and Wertz, Sorenson, Liebling, Kessler, & Herren, 1987).

Furthermore, the "mass hysteria" surrounding AIDS has demonstrated a type of discrimination that has sprung from cultural and religious attitudes (as described in AIDS-Related Stigma). Additionally, funding for government AIDS research has been affected by the types of patient populations: gay men and IV drug users (Cooke, 1990; Rogers & Ginzberg, 1989; Shapiro, 1989; and Wallack, 1989).

Rogers and Ginzberg reported that about one-third of physicians have reservations about gay lifestyle, "including those who believe that the gay community brought the epidemic upon itself and that it deserves the



consequences." This view has been supported by Blumenfield, Smith, and Milazzo (1987), Douglas et al. (1985), and Loewy, (1986).

The fear physicians have of becoming infected through contact with seropositive HIV patients is apparent. Additionally, when compared to cancer, diabetes, and heart disease, AIDS patients have been the most negatively evaluated and most rejected group by nurses, medical students, and college students (Katz, Hass, Parisi, & Astone, 1987). Additionally, physicians have shown support in mandatory reporting of serostatus and contact tracing of individuals to public health authorities.

However, one area of medicine, Obstetrics-gynecology, has responded to the HIV epidemic more positively. Obstetricians and gynecologists appear to believe that they are at a moderate risk of HIV infection as a result of patient care (slightly lower than average risk). It is not uncommon for obstetricians to have direct exposure to potentially infectious materials, blood, body fluids, skin contact, and punctures (Martin, Arnold, McHugh, Mandelbrot, & Spence, 1988). Martin et al. reported that, "Knowledge about HIV transmission was good" for ob-gyns. These doctors support testing for hospital patients. They also report that they will care for all patients, regardless of HIV status. Midwives had similar responses to ob-gyns.

It needs to be understood that respondents have yet

to treat large numbers of HIV infected patients. Women have had HIV infection in less significant numbers than other HIV populations. As the epidemic expands, the actual experience of caring for HIV patients is likely to influence attitudes and behaviors (Martin et al. 1988). It was projected that by the end of 1991, AIDS would be one of the five leading causes of death among women aged 15-44 years, and would be the second leading cause of death among men ages 25-44 (California AIDS Update, 1991).

In summary, studies have found physicians to have attitudinal barriers in treating the HIV disease. The barriers include homophobia, negative attitudes toward IV drug users, antipathy to HIV patients, thanatophobia (fear of dying patients), perceived risk, and lack of knowledge about the disease. These barriers were found to be significant predictors of physicians' "willingness to treat" HIV patients (Gerbert, Maguire, Bleecker, Coates, & McPhee, 1991; Ficarroto, Grade, Bliwise, & Irish, 1990; Richardson et al., 1987; Rogers and Ginzberg, 1989; Sadovsky, 1989; Shapiro, 1989; Treilier, 1987; and Wallack, 1989).

#### Persons living with HIV

Clinical counseling issues for the AIDS epidemic do clearly focus on the gay community who have been disproportionately affected by the disease. According to Hirsch & Enlow (1984), Martin (1989), and Morin, Charles,

& Malyon (1984), issues for the seropositive HIV client include mood disturbances, anxiety, and depression, which may be related to shame, guilt, blame, and a feeling that the individual has been given a death sentence (premature death). Shame and guilt emotional responses may be directed at (1) the pain and shame caused to one's family if AIDS develops or (2) toward one's past sexual behavior. Those clients that test seronegative for HIV have feelings of relief and guilt. Seronegative gay men have been known to "apologize to their seropositive gay friends for their seronegative serostatus" due to what is known as survivor's guilt related to one's sexual behavior (Martin, 1989).

Both seropositive and seronegative clientele are in need of therapeutic interaction for clinical depression, grief (bereavement and hopefulness), weighing options, safer sex behavior, phobic reactions, addictive behavior, and suicide ideation. Those who have lost many friends to the AIDS epidemic may experience post traumatic stress disorder (Joseph, Caumartin, Tal, Kirschit, Kessler, Ostrow, & Wortman, 1990; Lomax & Sandler, 1988; Martin, 1989; Rabkin, Williams, Neugebauer, Remier, & Goetz, 1990; and Schoen & Schindelman, 1989).

Helquist (1987) also reported that homosexuality and IV drug use have stigmatized the AIDS epidemic. He outlined three groups of individuals who request AIDS-related services from mental health practitioners as (1) the worried

well, sexually active men and women who are frightened by the possibility of contracting the illness; (2) persons with ARC (AIDS Related Complex); and (3) persons with AIDS. These populations cope with the following social factors (at different levels): social isolation fears and issues, self esteem, attitudes, anxiety, denial, death, hopelessness, and feelings of being out of control.

As the increasing number of people with AIDS continues, increasing numbers of AIDS clients are having suicide ideation-related concerns. Practitioners will be confronted by the myriad of issues related to suicide, especially isolation and support services, in working with AIDS population individuals (Goldblum & Moulton, 1986; and Schietinger, 1988).

Additionally, neuropsychiatric complications of anxiety and adjustment disorder may be present in the HIV client. Even though the role that anxiety plays is exacerbating, the immunologic aberration characteristics of AIDS is not known. HIV infection does appear to be associated with a high incidence of psychological and neuropsychological complications, including anxiety and adjustment disorder. These emotional responses may be due to the isolation effects that HIV clients experience and the fear related to the stigma attached to AIDS (Coleman & Remafed, 1989; Flaskerud, 1987; Fullilove, 1989; and Geis, Fuller, & Rush, 1986).

Dementia is an additional complication with AIDS. HIV clients might experience difficulties with memory, attention, or concentration, language, cognitive impairment, visual, spatial skills, motor abilities, and reasoning (Allers & Katrin, 1988; Buckingham & Van Gorp, 1988; Fernandez, Adams, Levy, & Holmes, 1988; Halstead, Riccio, Harlow, Oretti, & Thompson, 1988; Joyce, 1988; King, 1989; and Navia & Price, 1986).

The findings of Perry and Jacobson (1986) revealed that there is growing knowledge that the psychiatric symptoms related to the stress of contracting HIV disease may also be from direct organic effects on the central nervous system. For weeks, months, or even years before developing symptoms of HIV, patients have been known to suffer lethargy, apathy, and withdrawal. The depressed individuals, studied by Perry and Jacobson, who experienced mania, personality change or psychotic disorganization, had been previously well adjusted with no personal or family history of severe psychiatric disorders before acquiring AIDS.

In summary, persons living with HIV experience varied effects from the disease as well as psychosocial dilemmas. The management of persons living with HIV is complex. The complexities include physical and mental health treatment complications. Persons living with HIV are aware of (1) the intolerance of homosexuality and (2) that there

is a mistrust of public health officials regarding control of management of the AIDS epidemic (Sabin, 1987).

The psychosocial impact of HIV has been viewed as having three dimensions: (1) the disease itself - AIDS, and the physical complications; (2) the particular populations infected; and (3) the emotions encountered by any AIDS or HIV person. The issues that HIV clients experience are not unique to AIDS patients, but they are accentuated because more of them are likely to occur. Each HIV client could face family dilemmas, caregiver concerns, dependency, disfigurement, death, physical and emotional isolation, contagiousness, secrecy, changes in lifestyle and financial status, discrimination, and burnout (Cline, 1990).

"Psychology has a unique opportunity to make a difference" in the AIDS epidemic (Morin, 1988). Psychologists made the difference in the shift of emphasis from AIDS testing to counseling as a means of preventing behavior. It would be reasonable to expect mental health professionals to help mitigate the impact of the above issues. But are mental health professionals immune to the negative attitudes expressed by the general public and medical profession about the AIDS epidemic and AIDS related stigma? Are clinicians and medical health care workers similar in their attitudes, knowledge, and behaviors in relation to treatment of HIV clientele?

Batchlor (1988) has stated that AIDS clients have been exposed to discrimination, cruelty, and inadequate services as well as refusal of mental health treatment.

Backer, Batchelor, Jones, and Mays (1988) have said that psychology has been slow to evolve and intervene in the AIDS crisis; that attitudes cannot change as fast as change is needed. They added,

AIDS holds up a mirror it is said, to all that does not work in our health care system - and psychology is included in that reflection.

#### Clinical counseling issues

The new focus of the AIDS crisis is counseling, in comparison to the initial focus of AIDS testing. Jones (1988) has emphasized that psychology is a discipline that has an expertise that is critical to the blunting of the devastating effects of the AIDS disease.

The clinical counseling issues of psychology summarized by Batchlor (1988) revealed limits of treatment to persons living with AIDS and their significant others. Few professionals have received the specific training necessary for responding to issues of sexuality, disease, uncertainty, social ostracism, and death. The counseling profession needs to expand its capacity if they are going to respond effectively to AIDS. Barrows and Halgin (1988) add, "We urge clinicians to become educated about AIDS, to keep abreast of the ongoing medical updates, and to make attempts to separate out the factual from the sensational."

Bruhn (1989), Cline (1990), Grant & Anns (1988), Katoff & Ince (1988), and McKusick (1988) have stated that counseling strategies need to focus on crisis intervention, suicide risk, generalized anxiety, panic attacks, depression, hypochondriasis, grief, loss of family and relationship issues, stress reduction, promotion of social support and existential aspects, drug use, addiction, behavior intervention, health belief, interpersonal support models, coping (including the value of humor), stigmatization, and terminality. Significant others and caregivers need support as well, possibly group therapy. Allers and Katrin (1988) stated, "Counseling AIDS clients will require the utmost awareness, sensitivity, and skill on the part of the mental health counselor because there are complex moral, ethical, and legal implications to consider."

Professionally speaking, the clinical counseling needs of the HIV client have been explored, examined, and established as mentioned above. Similarly, medical needs of the HIV client have been established. Physicians and other health care workers have had responses to meeting those needs which are both professional and personal (described earlier in this article). Numerous studies have been conducted on physicians and health care workers. Yet, few articles have addressed or described the clinical and personal responses of counselors in regard to treating



persons living with HIV.

McKusick (1988) has written that it is the "client-therapist relationship that is the principle tool for successful psychology outcome" and that "it can be the principle obstruction also." What types of obstruction are being alluded to? In the field of therapy, therapists and counselors have been trained and alerted to specific detrimental aspects in therapeutic relationships. The issues that therapists are presumed to be aware of include: dealing with their own fears (conscious and unconscious) about AIDS, transference, countertransference, anxiety, helplessness, depression, distancing from client, fear of infection by client, prejudicial attitude, homophobia, anger, breaches of confidentiality, responsibility, distrust, paranoia, personal reaction to imagining testing positive, and burnout (Batchlor, 1988; Bruhn, 1989; Gaines, 1988; Lomax & Sandler, 1988; McKusick, 1988; and Morin, 1984).

Goldblum (1986) reported additional clinician responses which include: clinicians unfamiliar with working with HIV clients may feel overwhelmed by pertinent medical terminology and information, and anxiety of facing their own death. Other clinician issues are biases of sexual orientation, substance abuse, and racial and cultural background; an additional concern is lack of clear procedure in working with AIDS clients including pretesting and

posttesting (Jue, 1988; Leukefeld, 1988; and Perry & Markowitz, 1988).

Faltz (1988) discussed the complications involved when counseling substance abuse clients infected with HIV. The AIDS epidemic evokes strong feelings and emotions. Counseling staff difficulties and concerns in this study included: (1) sense of helplessness, e.g. "What's the use, the client will die anyway;" (2) treatment program focus on recovery, e.g. "My job is to help people get healthy, not to die;" (3) uncertainty and fear of the unknown, e.g. "So much is not known about AIDS;" (4) discomfort of lifestyle and prejudice, e.g. "They got what they deserved;" (5) facing death issues and mortality, e.g. "I don't want to think about dying;" (6) insecurity, fear of inadequacy, and insensitivity, e.g. "I have no experience with this kind of counseling;" and (7) work load burden and little reward in recovery of client, e.g. "In addition to all my other work, I'm suppose to be counseling dying people too?" Faltz pointed out that the barriers to dual treatment work are compounded in regard to recognizing one's own values and anxieties.

Melton (1988) has studied the ethical dilemmas of obligations to clients and third parties. Ethical and legal norms remain unsettled. The Duty to Treat and Duty to Protect Third Parties are issues of confidentiality and trust. Ethical principles require psychologists to

only provide service and use techniques for which they are qualified by training and experience. However, even if one is not competent to treat, it does not absolve responsibility. Is ignorance about AIDS and treatment modality for AIDS clients used as an excuse for not providing service? Are mental health workers intentionally not gaining knowledge and experience to avoid treatment services to AIDS and HIV clients?

What are the social responsibilities of therapists and counselors to persons living with HIV, their significant others, and family members? It appears that therapists and counselors face similar issues as physicians and health care workers in treating persons living with HIV. Will they have similar barriers?

Will therapists' and counselors' training to be aware and alert to negative feeling be enough to immunize them in order to meet the mental health needs of this AIDS crisis? Can one's commitment to a professional career and its ethical responsibilities somehow override personal prejudice? Is there an unwillingness to confront the counseling services required in this crisis or to confront prejudice (Batchlor, 1988)?

It is apparent that a need exists for counseling, education, support and altruistic activities, self help groups, political action groups, research projects, as well as the need for health care professionals and

psychologists to sensitize colleagues to their own prejudices concerning AIDS, sexuality, race, class, and disability (Helquist, 1987; Landers, 1989; and Morin, Charles & Malyon, 1894). Comparing what needs to be done to what is being done is the perplexity.

### Summary

Barret (1989) summarized this issue by simply stating that the more widespread AIDS becomes, the more counselors will need to become familiar with psychological manifestations of the virus. The basic concerns of therapists and counselors appear to be fear, contagion, and homophobia. Burnout is another concern but of a different nature (Morin, 1984; and Nichols, 1986).

To put this crisis in perspective, "More Americans have died from AIDS than from all the casualties in the Viet Nam War" (Jonhston & Wilson, 1990). As the cases of AIDS increases, mental health clinics will have greater demand upon services. The public is looking to counseling professionals for these services. Yet, many therapist believe that they will not be interacting with AIDS clients or even their significant others (Jonhston & Wilson, 1990).

The literature also indicates that a cultural stigma exists in the United States concerning the AIDS epidemic. It is expected that the counseling profession is not exempt from this stigma. Clinicians' fears, prejudices, and unrealistic attitudes could be keeping clinicians

unavailable to AIDS clients, thus limiting the counseling field.

Physicians and health care workers have had barriers in treating the HIV disease. These barriers include: homophobia, negative attitudes toward IV drug users, antipathy to HIV patients, thanatophobia, perceived risk, and some lack of knowledge about the disease. These barriers effect "willingness to treat" persons living with HIV, their significant others, and families. It is the purpose of this study to find whether there are the same or other barriers to treating persons living with HIV in counseling professionals as have been identified in physicians and other health care workers. Physicians' and health care workers' "willingness to treat" has been shown to be affected by these barriers. It is expected that counseling professionals' "willingness to treat" persons living with HIV will be effected comparably by the same barriers.

The current study will test the following hypotheses:

1. It is expected that counselors with less accurate knowledge about the disease will report less willingness to treat AIDS and HIV clientele.

2. It is expected that counselors who have homophobic attitudes will report less willingness to treat AIDS and HIV clientele.

3. It is expected that counselors who have negative

attitudes toward IV drug users will report less willingness to treat AIDS and HIV clientele.

4. It is expected that counselors who express antipathy toward HIV clients will report less willingness to treat AIDS and HIV clientele.

5. It is expected that counselors who express thanatophobic attitudes will report less willingness to treat AIDS and HIV clientele.

6. It is expected that counselors who believe that they are at risk of contracting the HIV by counseling AIDS and HIV clientele will report less willingness to treat AIDS and HIV clientele.

7. It is expected that counselors with less knowledge about the disease will report less responsibility to treat (duty to treat) AIDS and HIV clientele.

8. It is expected that counselors who have negative attitudes toward high risk groups will report less responsibility to treat (duty to treat) AIDS and HIV clientele.

9. It is expected that counselors who report experience working with AIDS or HIV clientele will report higher knowledge than those who report no experience with AIDS or HIV clientele.

10. It is expected that counselors who report experience working with AIDS or HIV clientele will express less feelings of antipathy toward this population than

those who report no experience with AIDS or HIV clientele.

11. It is expected that counselors who report experience working with AIDS or HIV clientele will express less thanatophobic feelings than those who report no experience with AIDS or HIV clientele.

12. It is expected that counselors who report experience with AIDS or HIV clientele will report less perceived risk of contracting the HIV by counseling AIDS or HIV clientele than those who report no experience with AIDS or HIV clientele.

13. It is expected that counselors who report experience with AIDS or HIV clientele will report greater responsibility to treat (duty to treat), than those who report no experience with AIDS or HIV clientele.

14. It is expected that counselors who report experience with AIDS or HIV clientele will express less homophobic attitudes than those who report no experience with AIDS or HIV clientele.

15. It is expected that counselors who report experience with AIDS or HIV clientele will express less negative attitudes toward IV drug users than those who report no experience with AIDS or HIV clientele.

## Method

### Subjects

Sixty-three counseling professionals, licensed psychologists (n = 11), Marriage, Family, and Child Counselors (MFCC/MFT, n = 18), Licensed Clinical Social Workers (LCSW, n = 4), Masters in Social Work (MSW, n = 1), interns (who are preparing for licensure, n = 18) and others (mediators, MAs, n = 11) in various public and private settings were asked to voluntarily participate in this survey. The survey response rate was 45%. The survey was anonymous; no identification was requested other than type of clinical setting, type of licensure (professional title), age, gender, sexual orientation, race, religion, and marital status. Subjects were treated in accordance with the ethical principles of the American Psychological Association.

### Materials

A paper and pencil questionnaire that was composed of knowledge, attitudes, and behaviors scales and demographic questions was derived from portions of several existing inventories. The 142-item questionnaire had yes/no, yes/no/don't know, true/false, frequencies, five-point scale (agree/disagree), seven-point scale (whole numbers) and write-in questions (write-in, included six short fill-in and nine expanded write-in).

Items on the questionnaire addressed knowledge,



homophobia, antipathy to clients, thanatophobia, IV drug user negativity, perceived risk of contracting HIV, morals and responsibilities, and willingness to treat.

(1) KNOWLEDGE: Fifteen knowledge-related questions were obtained from the 1990 National Health Interview Survey (U.S. Department of Health and Human Services, Center of Disease Control), Minority Health Research Laboratory AIDS Prevention Survey, 1987 (University of Maryland at College Park), and consultation with Inland AIDS Project (AIDS Knowledge Survey, Riverside, California).

Examples include: (a) knowledge about the disease, an agree/disagree question, "I think that a person can be infected with the virus and not have the disease AIDS." (b) transmission - true/false; "I believe that if a person with AIDS is bitten by a blood sucking insect, it is possible to get AIDS if that same insect bites you." (c) prevention - true/false; "You increase the chance of getting the HIV by having sexual intercourse with many different people." (d) knowledge - short fill-in; "Define what 'HIV+' stands for.

(2) HOMOPHOBIA: Sixteen homophobia questions were obtained from Survey of Internal Medicine Residents 1990-1991 (Cooke, Koenig, Beery and Folkman, 1990, University of California, San Francisco) and Primary Care Physicians and AIDS (Mcguire, 1990, University of California, San Francisco).

Examples include: (a) agree/disagree scale; "Most of the homosexuals with AIDS brought the disease on themselves." (b) agree/disagree; "I do not believe that homosexuality is a sign of pathology."

(3) ANTIPATHY: Four antipathy toward clients questions were obtained from Primary Care Physicians and AIDS.

Example: agree/disagree scale; " If I have a choice, I will not work with AIDS clients."

(4) THANATOPHOBIA: Four thanatophobic questions were obtained from Survey of Internal Medicine Residents.

Example: agree/disagree scale; "Treating people with AIDS is unpleasant because they always die."

(5) IV DRUG USER NEGATIVITY: Ten negativity to IV drug users questions were obtained from Survey of Internal Medicine Residents and Primary Care Physicians and AIDS.

Examples include: (a) agree/disagree scale; "Most of the IV drug users with HIV have brought the disease on themselves." (b) agree/disagree scale; "I would find no reward in caring for clients who use IV drugs."

(6) PERCEIVED RISK OF CONTRACTING HIV: Sixteen perceived risk/precautions questions were obtained from Survey of Internal Medicine Residents, Primary Care Physicians and AIDS, and Minority Health Research Laboratory AIDS Prevention Survey.

Examples include: (a) agree/disagree scale; "I am concerned that in the years to come, it will be found that

HIV infection can be transmitted in ways we now believe to be safe." (b) 7-point, scale, chance of becoming infected; "Being bitten by a person who has progressed to AIDS dementia." (c) true/false; "I believe you can get the HIV infection from donating blood."

(7) MORALS AND RESPONSIBILITY: Eleven questions pertaining to morals and responsibility were obtained from Survey of Internal Medicine Residents and Inland AIDS Project consultation.

Examples include: (a) agree/disagree scale; "I feel that it is my ethical responsibility to provide needed mental health treatment to persons living with the HIV." (b) agree/disagree scale; "It is morally justifiable for therapists to deny mental health care to persons who use illegal drugs."

(8) WILLINGNESS TO TREAT: Twenty-seven willingness to treat questions, practice intent, and career decisions were obtained from Survey of Internal Medicine Residents and Inland AIDS Project consultation.

Examples include: (a) "Have you had any clinical experience working with persons living with the human immunodeficiency virus (HIV-infected clients)?" (b) "Do you believe the AIDS epidemic has influenced or will influence your choice of counseling setting?"

Additional questions pertained to treatment to significant others and families of AIDS and HIV clients,

time demands, clinical and personal experience with terminally ill clients, gratification from care to terminally ill clients, exposure to HIV and testing, personal care with HIV persons, and demographics.

### Procedures

The experimenter approached counseling agencies and clinics by telephone, mailings, and in person requesting volunteers. The experimenter requested permission of participants to complete the inventory. It was emphasized that all information was confidential, that no names would be included, that subjects could refuse to answer any questions, and that debriefing information and results would be available after the survey. The experimenter's name, telephone number, and address were included with the survey. Debriefing information, including public health informational handouts, and results were supplied to all agencies and clinics. Individuals could also request debriefing and results information. The approximate time to complete the inventory was 20-30 minutes. Completed inventories were mailed to the experimenter using the provided return envelope.

## Results

Of the 63 participants, 17 were male and 46 were female. Age ranged from 23-62 years of age; the mean was 40 years; the median was 39 years; and the mode was 33 years. The ethnicity was 84% white, not of Hispanic origin; 10% Hispanic; 3% Asian or Pacific Islander; 2% Black; and 1% Black and White. Marital status was 57% married; 24% single, living alone; 10% single, living with significant other; 6% single, living with roommate; 2% coupled, living in separate residences; and 1% divorced, living with roommate. Sexual orientation was 92% heterosexual and 8% gay or lesbian.

Current religious background included: 19% Protestant; 18% Fundamentalist; 14% Agnostic/Atheist; 11% Catholic; 5% percent Jewish; and 33% other.

Subject's professional positions included: Licensed Psychologist, Marriage, Family, and Child Counselor (MFCC/MFT), Licensed Clinical Social Worker (LCSW), Masters in Social Work (MSW), Master degrees, pre-licensed clinical therapist, interns and trainees. Clinical settings were private practice, private non-profit practice, out-patient health clinics (community and county settings), schools (public, private, or college), AIDS/HIV agencies, government, institutional placements, drug/alcohol rehabilitation centers, and Christian family services.

The number of years of experience in counseling ranged

from 1-40; the mean was 9 years; the median was 6 years; and the mode was 1 year.

### Counselor Experience

Counselor-response to clinical and personal experience questions can be found in Table 1. The questionnaire asked respondents whether they had any clinical experience working with HIV-infected clients. Forty-one percent had experience with one or more HIV-infected client; 59% had not. Of those who had experience working with HIV clients, the response ranged from having had 1-500 clients; the mean was 56; the median was 3; and the mode was 1.

Participants were asked whether they had clinical experience working with the significant others of HIV-infected persons. Thirty percent had experience working with one or more significant other of HIV-infected persons. Of those who had experience working with the significant others, the response ranged from having had 1-500 clients; the mean was 45; the median was 3; and the mode was 1.

Participants were asked whether they had clinical experience working with family members or friends of HIV-infected persons. Thirty-four percent had experience working with one or more family member or friend of HIV-infected persons. Of those who had experience with family members or friends, the response ranged from having had 1-250 clients; the mean was 30; the median was 6; and the mode was 1.

Table 1  
Counselor Response to Clinical and Personal Experience

Item	Total Response (N = 63)	Career HIV Treatment Experience	
		Treated 1 or more HIV (N = 26)	Treated No HIV (N = 37)
Clinical experience w/one or more HIV client	41%	100%	
Clinical experience w/one or more significant other of HIV	30%	65%	5%
Clinical experience w/one or more family member or friend of HIV	34%	62%	14%
Currently working w/HIV clients	21%	50%	
Currently working w/significant others	16%	39%	
Currently working w/family or friends	19%	42%	3%
Clinical experience w/terminal ill client	49%	81%	24%
Personal ongoing experience w/terminal ill person	24%	35%	16%
Personal ongoing experience w/HIV person	7%	15%	
Counselor referral of HIV clients	25%	54%	5%

Twenty-one percent of the participants reported that they are currently working with HIV clients. The response range of clients was 1-40; the mean was 9; the median was 5; and the mode was 1. Sixteen percent of the participants reported currently working with significant others of HIV persons. The response range of clients was 1-12; the mean was 4; the median and mode was 2. Nineteen percent of the participants reported currently working with family members or friends of HIV persons. The response range of clients was 1-25; the mean was 6; the median was 5; and the mode was 1.

Forty-nine percent of the participants reported having had counseling experience with terminal-ill clients other than HIV-infected. Twenty-four percent of participants had provided personal "ongoing care" for terminal-ill persons; and 7% had provided personal "ongoing care" for HIV-infected persons.

The data indicated that of the 25% of participants who had referred HIV-infected clients to other counselors or agencies, 5% of those who had no experience referred clients and 54% of those with experience referred clients.

#### Willingness to Treat

Table 2 contains counselor response to "willingness to treat" and "responsibility to treat" HIV-infected persons. This table includes example questions that address attitudinal preference in treating HIV regarding (1)



Table 2

Counselor Response to "Willingness to Treat" and  
"Responsibility to Treat" HIV-infected Persons

Item	Total Response (N = 63)	Career HIV Treatment Experience	
		Treated 1 or more HIV (N = 26)	Treated No HIV (N = 37)
<b>Willingness to Treat</b>			
If I have a choice, I will not work with AIDS clients.	A: 19%	23%	16%
	N: 14%	4%	22%
	D: 65%	73%	62%
Homosexuality is a threat to many of our basic social institutions.	A: 17%	15%	19%
	N: 8%		13%
	D: 73%	85%	68%
My preference is to refer IV drug users to another therapist for counseling.	A: 48%	58%	43%
	N: 27%	19%	32%
	D: 24%	23%	24%
I think that AIDS is getting too much attention from the mental health field.	A: 6%	8%	5%
	N: 8%	8%	8%
	D: 85%	84%	87%
Treating people with AIDS is unpleasant because they always die.	A: 19%	19%	19%
	N: 16%	8%	22%
	D: 60%	69%	54%
Do you anticipate that you will be working with HIV- infected clients in the future?	Yes: 66%	77%	60%
	No: 27%	19%	33%

Table 2 --Continued

Item	Total Response (N = 63)	Career HIV Treatment Experience	
		Treated 1 or more HIV (N = 26)	Treated No HIV (N = 37)
<b>Responsibility to Treat</b>			
I feel that it is my ethical responsibility to provide needed mental health treatment to persons living with the HIV.	A: 83%	88%	81%
	N: 8%	8%	8%
	D: 6%	4%	8%
It is morally justifiable for therapists to deny mental health care to persons who use illegal drugs.	A: 20%	15%	24%
	N: 14%	23%	8%
	D: 62%	61%	65%
Do HIV-infected persons have the responsibility to inform others?	Yes: 91%	92%	92%
	No: 8%	8%	8%

Values in table represent percentage of counselors indicating: A: agree strongly/agree somewhat; N: neither agree nor disagree; and D: disagree strongly/disagree somewhat. Values in table do not add up to 100 percent due to missing values of respondents.

homophobia: 17 percent agree that homosexuality is a threat to society; (2) antipathy toward HIV persons: 19 percent agree that they will not work with HIV clientele given a choice; (3) negativity to IV drug users: 48 percent prefer to refer IV drug users to other counselors; (4) thanatophobia: 19 percent view treating HIV clientele as unpleasant; and (5) willingness to treat: 66 percent anticipate working with HIV clientele in the future. Additionally, 83 percent reported feeling an ethical responsibility to care for HIV clients; 20 percent agree that care can be justifiably denied to persons using illegal drugs; and 91 percent agree that HIV-infected persons have the responsibility to inform others of their HIV seropositive status.

Pearson product-moment correlations are found in Table 3. The hypothesis that counselors who lack knowledge about the disease will report less willingness to treat AIDS and HIV clientele was supported. A Pearson product-moment correlation revealed a significant positive relationship such that those counselors with greater knowledge about AIDS and HIV infection expressed more willingness to treat AIDS and HIV clientele  $r(63) = .33, p < .01$ .

The hypothesis that counselors who have homophobic attitudes will report less willingness to treat AIDS and HIV clientele was supported. A Pearson product-moment correlation revealed a significant negative relationship

Table 3

Pearson Product-moment Correlations Between Barriers  
(attitudes and perceived risk) and Willingness To Treat  
HIV Clients and Responsibility To Treat HIV Clients

Condition	Attribution	
	Willingness To Treat HIV	Responsibility To Treat HIV
Knowledge	.33**	.32**
Homophobia	-.21*	-.27**
Antipathy toward HIV	-.43***	
Thanatophobia	-.40***	
IVDU Negativity	-.16	-.09
Perceived Risk of disease	-.43***	

\*  $p < .05$ .    \*\*  $p < .01$ .    \*\*\*  $p < .001$ .

such that those counselors with homophobic attitudes expressed less willingness to treat AIDS and HIV clientele  $r(63) = -.21, p < .05$ .

The hypothesis that counselors who express antipathy toward HIV clients will report less willingness to treat AIDS and HIV clientele was supported. A Pearson product-moment correlation revealed a very significant negative relationship such that those counselors with antipathy toward HIV-infected clients expressed less willingness to treat AIDS and HIV clientele  $r(63) = -.43, p < .001$ .

The hypothesis that counselors who express thanatophobic attitudes will report less willingness to treat AIDS and HIV clientele was supported. A Pearson product-moment correlation revealed a very significant negative relationship such that those counselors with thanatophobic attitudes expressed less willingness to treat AIDS and HIV clientele  $r(63) = -.40, p < .001$ .

The hypothesis that counselors who believe that they are at risk of contracting the HIV by counseling AIDS and HIV clientele (see Table 4 Perceived Risks and Myths about AIDS and HIV Infection) will report less willingness to treat AIDS and HIV clientele was supported. A Pearson product-moment correlation revealed a very significant negative relationship such that those counselors who believe that they are at risk of contracting HIV by counseling

Table 4

## Perceived Risks and Myths about AIDS and HIV Infection

Item	Total Response (N = 63)	Career HIV Treatment Experience	
		Treated 1 or more HIV (N = 26)	Treated No HIV (N = 37)
I am concerned that in the years to come, it will be found that HIV infection can be transmitted in ways we now believe to be safe.	A: 52% N: 16% D: 31%	58% 19% 22%	49% 14% 38%
Despite all I know about how HIV infection is transmitted, I am still afraid of contracting it.	A: 36% N: 9% D: 53%	46% 4% 50%	30% 14% 57%
I feel that I have sufficient knowledge to protect myself from transmission of HIV infection.	A: 75% N: 13% D: 11%	80% 8% 12%	73% 16% 11%
I already know enough about AIDS for my practice.	A: 13% N: 6% D: 78%	23% 15% 62%	8% 92%
I think that a person can be infected by the HIV virus and not have the disease AIDS.	A: 75% N: 8% D: 14%	77% 12% 11%	76% 5% 16%
AIDS can damage the brain.	A: 77% N: 20% D: 2%	77% 19% 4%	78% 22%

Table 4 -- Continued

Item	Total Response (N = 63)	Career HIV Treatment Experience	
		Treated 1 or more HIV (N = 26)	Treated No HIV (N = 37)
My risk of being infected with HIV if I do treat HIV-infected clients.	NR: 56% PR: 34%	65% 31%	51% 38%
My risk of being infected with HIV if I do treat the significant other(s) of HIV-infected persons.	NR: 63% PR: 29%	73% 23%	57% 33%
Interacting with a coworker who is living with the HIV.	NR: 63% PR: 32%	77% 20%	54% 41%
Shaking hands with an AIDS client who has numerous Kaposi's Sarcoma lesions.	NR: 30% PR: 51%	46% 39%	19% 60%
Being sneezed upon by an HIV-infected person.	NR: 42% PR: 48%	46% 46%	41% 49%
Sharing a drinking glass with a person who is infected with the HIV.	NR: 33% PR: 55%	39% 54%	30% 56%
Being bitten by a person who has progressed to AIDS dementia.	NR: 9% PR: 77%	15% 73%	5% 82%

Table 4 --Continued

---

Values in table represent percentage of counselors indicating: A: agree strongly/agree somewhat; N: neither agree nor disagree; D: disagree strongly/disagree somewhat; and NR: no risk and PR: perceived risk including 1/500,000; 1/50,000; 1/5,000; 1/500; 1/50; and 1/5. Values in table do not add up to 100 percent due to missing values of respondents.



AIDS or HIV clientele, expressed less willingness to treat AIDS and HIV clientele  $r(63) = -.43, p < .001$ .

The hypothesis that counselors who lack knowledge about the disease will report less responsibility to treat AIDS and HIV clientele was supported. A Pearson product-moment correlation revealed a significant positive relationship such that those counselors with greater knowledge regarding AIDS and HIV infection expressed more responsibility to treat AIDS and HIV clientele  $r(63) = .32, p < .01$ .

The hypothesis that counselors who have negative attitudes toward high risk groups will report less responsibility to treat AIDS and HIV clientele was supported. A Pearson product-moment correlation revealed a significant negative relationship such that those counselors with homophobic attitudes expressed less responsibility to treat AIDS and HIV clientele  $r(63) = -.27, p < .01$ .

The hypothesis that counselors who have negative attitudes toward IV drug users will report less willingness to treat AIDS and HIV clientele was not supported. However, a Pearson product-moment correlation did reveal a trend towards the effect that counselors with negative attitudes toward IV drug users express less willingness to treat AIDS and HIV clientele.

The hypothesis that counselors who have negative

attitudes toward IV drug users will report less responsibility to treat AIDS and HIV clientele was not supported. However, a Pearson product-moment correlation did reveal a trend to the effect that counselors with negative attitudes toward IV drug users express less responsibility to treat AIDS and HIV clientele.

An analysis was performed examining differences by clinical experience of counselors. Subject's responses were separated into two independent groups, those with clinical experience working with one or more HIV-infected client and those with no experience working with HIV-infected clients. T-tests were performed with the scores on knowledge, homophobia, antipathy toward HIV clientele, thanatophobia, negativity toward IV drug users, responsibility to treat HIV clientele, perceived risk of contracting the disease, and willingness to treat HIV clientele (Table 5). T-tests revealed no significant difference between the two groups with the exception of "willingness." There was a very significant difference between the two groups willingness to treat, as one would expect, with counselors' experience with HIV clients more willing to treat such clients,  $t(63) = 3.46$ ,  $p < .001$ .

In addition to quantitative data, counselors responded to open-ended questions regarding (1) qualifications believed to be necessary to work with HIV-infected clientele; (2) counselors' emotional responses in regard

Table 5

Means, Standard Deviations, and T-tests of Perceived Barriers of Counselors as a Function of Clinical Experience with HIV

Perceived Barrier	Experience w/HIV Clients		No Experience w/HIV Clients		t-value	p
	Means	SDs	Means	SDs		
Knowledge	10.46	1.10	10.57	1.30	-.34	ns
Homophobia	2.08	2.56	2.62	2.46	-.85	ns
Antipathy toward clients	.54	.91	.62	.72	-.41	ns
Thanatophobia	.81	1.13	.95	.91	-.54	ns
IVDU Negativity	2.73	2.05	2.89	2.07	-.31	ns
Perceived Risk of contracting the disease	3.27	2.39	3.32	2.53	-.09	ns
Responsibility to treat HIV	5.92	1.88	6.24	1.92	-.66	ns
Willingness to treat HIV	11.85	3.63	8.54	3.81	3.46	.001

to counseling HIV-infected clientele; (3) attitudes about ultimately treating HIV-infected clientele; (4) problems in counseling HIV-infected clientele; (5) clinical impressions of clients who are sexually active with many partners; and (6) personal impressions of persons who are sexually active with many partners.

(1) Qualifications believed to be necessary to work with HIV-infected clientele include (a) knowledge, training, and understanding of HIV and gay issues (N = 52); (b) emotional stages of death and dying (N = 42); (c) empathic skills (N = 29); (d) understanding of stigma related to AIDS (N = 11); and (e) knowledge of effects of medications (N = 11).

(2) Counselors' emotional responses in regard to counseling HIV-infected clientele include: (a) empathy (N = 25); (b) pain, loss, and sadness (N = 23); (c) anger and frustration (N = 16); and (d) helplessness (N = 11).

(3) Attitudes about counselors ultimately treating HIV-infected clientele include: (a) acceptance (N = 30); (b) need for preparedness and education (N = 10); (c) want to be of help (N = 9); (d) mixed feeling, want to have a choice of treatment (N = 8); and (e) anxious and uneasy (N = 6).

(4) Problems in counseling HIV-infected clientele include: (a) acceptance of mortality (N = 16); (b) anger at inadequate systems (N = 11); (c) lack of support systems

and resources (N = 16); and (d) watching people die and deteriorate (N = 6).

(5) Clinical impressions of clients who are sexually active with many partners include: (a) unresolved emotional issues (N = 21); (b) endangering self and others (N = 11); (c) intimacy and attachment problems (N = 13); and (d) low self esteem and insecurities (N = 8).

(6) Personal impressions of persons who are sexually active with many partners include: (a) unresolved emotional issues (N = 21); (b) irresponsibility (N = 12); (c) need for safe sex, behaving with high risk of infection (N = 11); (d) lacking boundaries and low self esteem (N = 10); and (e) endangering self and others (N = 9).

Ninety-one percent of the counselors reported that HIV-infected persons have the responsibility to inform others. Responsibilities of HIV-infected persons (clients) include: (1) to practice consistent safe sex (N = 32); (2) to inform those at risk (N = 30); and (3) to take care of themselves (N = 11).

## Discussion

The study reveals that almost two-thirds of the counselors have not treated HIV-infected clientele. Of those counselors who have treated HIV-infected clients, most have treated only one and a few have treated as many as 500 clients. The diverse counseling placements and agencies appear to account for this discrepancy. Agencies that service only HIV clientele clearly treated more of the HIV population. Half have clinical experience with terminally ill clients other than HIV-infected clientele; and one quarter have personal ongoing experience with terminally ill persons. But only a few have personal ongoing experience with HIV-infected persons. The sample is somewhat of an inexperienced counseling group. Whereas, one counselor has had counseling experience for forty years, half have five years or less experience in the field. Additionally, half of those experienced with HIV-infected clientele are not treating any HIV clients today. This indicates that the HIV population is being treated by relatively few counselors, a matter that addresses disproportionate distribution of caseloads which could reflect (1) low treatment request by HIV clients and/or self selection of agencies by clients (a subject-matter for future research study), and (2) counselor selection of expertise including counselor susceptibility to burnout.

One point of interest in this study is that counselors

are not "patient dumping." One quarter of the counselors, primarily the counselors with experience with HIV, have referred HIV clientele with the reported reasons for referral including: (1) inability to offer long term ongoing services; (2) not qualified or equipped to offer service; (3) not knowledgeable of medical concerns; (4) need of support groups - not offered; and (5) understaffed. The counselors are referring with apparently valid reasons.

It appears that the reasons for referral are linked with understaffing, qualifications, and available services. All of which can be dealt with professionally, -- yet, may be hindered at an economic level as previous studies have found. Effective financial intervention is crucial and basic to effective mental health services to HIV-infected clientele.

Another aspect of intervention is treatment itself. Are counselors available and willing to treat HIV clientele? It is encouraging to see that two-thirds of the sample anticipate working with HIV-infected clients in the future. However, 20% are apparently unwilling to treat these clients given a choice and another 15% are non-committal in spite of the fact that over 80% agree that they have a responsibility to treat.

Interestingly, approximately 20% see homosexuality as a threat to our basic social institutions and approximately 60% of those describing themselves as Fundamentalists (a

more commonly known religious orientation opposing homosexuality) express homosexual bias. Additionally, approximately 40% of the Fundamentalists express unwillingness to treat HIV-infected clientele, however, only 13 percent express no ethical responsibility to treat HIV.

Half of the counselors prefer to refer IV drug users which is even greater than the HIV client referral preference ... but than, more IV drug users are likely to have been counseled. Counselors indicate a justifiable reason, illegal drug use, to be less responsible to treat. This could indicate prejudice and reluctance to treat and/or IV drug users could be less receptive to counseling treatment, thus resulting in referral.

Some counselors have additional adverse responses to treating HIV-infected clientele. Antipathy toward these clients and thanatophobic feelings reflect heavily on their willingness to treat. These attitudes could be experienced singly or together. Because the HIV disease is ultimately fatal (at this time), the connection between thanatophobic attitudes and antipathy to HIV clientele is likely. However, disliking HIV clients may be adversely related to other negative attitudes such as homophobia and IV drug use negativity.

The counselors themselves, three-quarters of them, perceive that they do not know enough about HIV for their practice and over half agree that in the years to come, it



will be found that HIV infection will be transmitted in ways now believed to be safe. Clearly, this lack of knowledge affects counselors' treatment. Three-quarters of them indicate that they feel they have sufficient knowledge to protect themselves from transmission. Yet, perceived risk and myth findings indicate a contradiction in knowledge and beliefs, supporting the findings of Herek and Glunt (1990). It is not surprising to see this reflection of contradiction in the over one-third who agree that despite all they know about how HIV-infection is transmitted, they are still afraid of contracting it. The more obvious differences between cognitive and emotional conditions, can be seen in the following perceived risks: (1) counseling HIV clients, counseling the significant others of HIV clients, and interacting with a coworker who is living with HIV, have perceived risk of 34%, 29% and 32%, respectively; (2) being sneezed upon by an HIV-infected person has a perceived risk of 48%; (3) shaking hands with an AIDS client with numerous Kaposi's Sarcoma lesions has a perceived risk of 51%; (4) sharing a drinking glass with a person who is HIV-infected has a perceived risk of 55%; and (5) being bitten by a person who has progressed to AIDS dementia has a perceived risk of 77%. As personal contact increases, perceived risk increases.

Interestingly, some very basic information was not understood; twenty-five percent of the counselors did not

know that a person can be infected by the HIV virus and not have the disease AIDS, and also that AIDS can damage the brain.

Similar barriers as predictors of willingness to treat are found between counselors and physicians. The barriers found in the physicians study of Gerbert, Maguire, Bleecker, Coates, and McPhee (1991) are indicated in counselors. In contrast to the findings of Gerbert et al., these same barriers show no distinction regarding experience. Physicians with experience with HIV have shown more favorable attitudes than physicians without HIV experience. This study found no significant differences in attitudes relating to counselors' experience. The sample experience levels could account for the different results; this study's counselor experience included one or more clients and Gerbert's et al. physicians experience included 10 or more patients.

The implication signifies favorable differences in HIV treatment by physicians; it is encouraging to know that those physicians treating HIV clients are less homophobic, less thanatophobic, less negative to IV drug users, show less antipathy toward HIV clients, and show less perceived risk fear. But what does that say about HIV treatment by counselors? Some counselors with the above unfavorable attitudes are treating HIV

clients. This poses a serious problem -- what kind of treatment are the HIV clientele getting? What messages are these clients receiving regarding acceptance, rejection, and distancing? The consequences of biased counseling are negative and irresponsible. Negative attitudes, biased by counselors treating HIV clients is a major area of concern. Since these counselors were more knowledgeable and had experience it indicates that neither knowledge nor experience changes these biases.

The comments of counselors reflect their admission of lack of knowledge, training, and education. Yet, some counselors with attitudinal barriers are treating HIV clientele. This is a reason for grave concern. It is now the task of the profession to intervene and modify counselors negative attitudes. The attitudes that reflect past and present society norms, religions, and governments, need to be addressed. This is a most perplexing challenge... to bridge the gap between knowledge and feelings. The emotional confines of HIV treatment must be processed to effective, responsible treatment. Even subtle bias has negative impact on clients. It is up to today's professionals to alter the counseling treatment modality of this devastating disease.

APPENDIX A

COUNSELOR CONSENT AND INFORMATION FORM



**CALIFORNIA STATE UNIVERSITY  
SAN BERNARDINO**

Thank you for participating in this survey. The questionnaire contains a series of questions pertaining to HIV infection and clinical therapeutic services. Counseling the AIDS population is a new area in the field of therapy. Many therapists (counselors) have little clinical experience or training in this area of counseling. Your personal and clinical experience and clinical impressions with HIV infected clients and their significant others are the key aspects of this study. Your answers are entirely anonymous and confidential. You may have unsure/uncomfortable feelings while answering this inventory. It is expected that participants not answer all the questions or know the right answers. You may refuse to answer any questions. However, it is important that you be honest. This will help the counseling field gather information for the purposes of training and discovering therapists' needs.

Estimated time to complete questionnaire: 20-30 minutes.

Please return the questionnaire in the envelope provided. Debriefing materials of the study will be provided to you upon telephone or mail request and will be supplied to your employing agency upon completion of survey collection. Please direct survey inquires (including results) to

Wendy Kellogg  
Dr. Geraldine Stahly  
Psychology Department  
California State University, San Bernardino  
5500 University Parkway  
San Bernardino, CA 92407-2397

or call (714) 796-9752

For additional information contact  
Inland AIDS Project (IAP) (714) 784-AIDS or  
1-800-451-4133 (San Bernardino & Riverside Counties)  
AIDS Project Los Angeles (APLA)  
1-800-922-AIDS (Los Angeles County)

**PLEASE REMOVE AND KEEP THIS LETTER FOR YOUR INFORMATION**

APPENDIX B  
STUDY QUESTIONNAIRE

Section I

1. Have you had any clinical experience working with persons living with the human immunodeficiency virus (HIV-infected clients)?

\_\_\_ yes                    \_\_\_ no  
\_\_\_ number of HIV-infected clients that you have worked with (approximately)

2. Have you had any clinical experience working with the significant others of HIV-infected persons?

\_\_\_ yes                    \_\_\_ no  
\_\_\_ number of significant others that you have worked with (approximately)

3. Have you had any clinical experience working with the family members or friends of HIV-infected persons?

\_\_\_ yes                    \_\_\_ no  
\_\_\_ number of family members or friends that you have worked with (approximately)

4. Of the HIV-infected clients that you have treated, please check the risk group(s) worked with.

\_\_\_ Gay male  
\_\_\_ Gay IV drug user  
\_\_\_ IV drug user  
\_\_\_ Transfusion (blood or blood products)  
\_\_\_ Heterosexual male  
\_\_\_ Women  
\_\_\_ Children  
\_\_\_ Other \_\_\_\_\_  
\_\_\_ Unknown

5. Are you currently working with HIV-infected clients?

\_\_\_ yes                    \_\_\_ no                    \_\_\_ don't know  
\_\_\_ If so, how many (approximately)?

6. Are you currently working with significant others of HIV-infected persons?

\_\_\_ yes                    \_\_\_ no                    \_\_\_ don't know  
\_\_\_ If so, how many (approximately)?

7. Are you currently working with family members or friends of HIV-infected persons?

\_\_\_ yes                    \_\_\_ no                    \_\_\_ don't know  
\_\_\_ If so, how many (approximately)?

8. Do you anticipate that you will be working with HIV-infected clients in the future?

\_\_\_\_\_ yes            \_\_\_\_\_ no  
If so, in  
\_\_\_\_\_ 0 months - 6 months  
\_\_\_\_\_ 7 months - 1 year  
\_\_\_\_\_ 1 year - 3 years  
\_\_\_\_\_ 4 years - 6 years  
\_\_\_\_\_ 7 years - 10 years  
\_\_\_\_\_ over 10 years

9. Do you feel that you are qualified to work with HIV-infected clients?

\_\_\_\_\_ yes            \_\_\_\_\_ no

10. Have you had HIV-infected clients that you have referred to other therapists or agencies?

\_\_\_\_\_ yes            \_\_\_\_\_ no

11. What were reasons for referral? \_\_\_\_\_  
\_\_\_\_\_

12. In your opinion, what qualifications do you believe are necessary to work with HIV-infected client? \_\_\_\_\_  
\_\_\_\_\_

13. Do you feel that you are qualified to work with the significant others of HIV-infected persons?

\_\_\_\_\_ yes            \_\_\_\_\_ no

14. In your opinion, what qualifications do you believe are necessary to work with the significant others of HIV-infected persons? \_\_\_\_\_  
\_\_\_\_\_

15. Define what "HIV+" stands for \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ other  
 \_\_\_\_\_ through community service work  
 \_\_\_\_\_ person whom you voluntarily provided care for  
 \_\_\_\_\_ friend  
 \_\_\_\_\_ other relative  
 \_\_\_\_\_ spouse  
 \_\_\_\_\_ significant other  
 \_\_\_\_\_ If yes, was the person(s)  
 \_\_\_\_\_ yes \_\_\_\_\_ no  
 2. Have you provided personal "ongoing care" for a person living with the HIV?

\_\_\_\_\_ other  
 \_\_\_\_\_ through community service work  
 \_\_\_\_\_ person whom you voluntarily provided care for  
 \_\_\_\_\_ friend  
 \_\_\_\_\_ other relative  
 \_\_\_\_\_ spouse  
 \_\_\_\_\_ significant other  
 \_\_\_\_\_ If yes, was the person(s)  
 \_\_\_\_\_ yes \_\_\_\_\_ no

1. Have you provided personal "ongoing care" for a terminally ill person?

Section III

3. What positive aspects are there in treating the terminally ill?

\_\_\_\_\_ If yes, specify type of terminal illness?  
 \_\_\_\_\_ yes \_\_\_\_\_ no

2. Have you had terminally ill clients that you have referred to other therapists or agencies?

\_\_\_\_\_ If yes, specify type of terminal illness:  
 \_\_\_\_\_ yes \_\_\_\_\_ no

1. Have you had any clinical experience with clients who are terminally ill?

Section II

3. If you have provided personal "ongoing care" for a terminally ill person or a person living with the HIV, how did you become involved in the care?

\_\_\_\_\_

\_\_\_\_\_

#### Section IV

1. What are your clinical impressions of a client who is sexually active with many partners? \_\_\_\_\_

\_\_\_\_\_

2. What are your personal impressions of a person who is sexually active with many partners? \_\_\_\_\_

\_\_\_\_\_

3. What are the responsibilities of persons (clients) who are HIV infected? \_\_\_\_\_

\_\_\_\_\_

4. Do HIV-infected persons have the responsibility to inform others?

\_\_\_\_\_ yes \_\_\_\_\_ no

If yes, to whom are they responsible (check all that are applicable)?

\_\_\_\_\_ spouse  
\_\_\_\_\_ sexual partner(s)  
\_\_\_\_\_ relatives  
\_\_\_\_\_ employers  
\_\_\_\_\_ IVDU who share needles  
\_\_\_\_\_ friends  
\_\_\_\_\_ others \_\_\_\_\_



Section V

Using the scale of 1 - 7, fill in the blank with the number representing the category which comes closest to your estimate of your consequent risk (chance) of becoming infected. Please use whole numbers only.

No risk	1 in	1 in	1 in	1 in	1 in	1 in
	500,000	50,000	5,000	500	50	5
-1-	-2-	-3-	-4-	-5-	-6-	-7-

1. \_\_\_\_\_ My risk of being infected with HIV if I do not treat HIV-infected clients.
2. \_\_\_\_\_ My risk of being infected with HIV if I do not treat the significant other(s) of HIV-infected persons.
3. \_\_\_\_\_ My risk of being infected with HIV if I do treat HIV-infected clients.
4. \_\_\_\_\_ My risk of being infected with HIV if I do treat the significant other(s) of HIV-infected persons.
5. \_\_\_\_\_ Interacting with a coworker who is living with the HIV.
6. \_\_\_\_\_ Shaking hands with an AIDS client who has numerous Kaposi's Sarcoma lesions.
7. \_\_\_\_\_ Being sneezed upon by an HIV-infected person.
8. \_\_\_\_\_ Sharing a drinking glass with a person who is infected with the HIV.
9. \_\_\_\_\_ Being bitten by a person who has progressed to AIDS dementia

## Section VI

Indicate "T" for true and "F" for false for the following statements.

1. \_\_\_\_ I believe you can get the HIV virus from donating blood.
2. \_\_\_\_ I believe that if you sit on the same toilet seat that someone who is HIV infected has been on, then it is possible to get HIV infection from the seat.
3. \_\_\_\_ Receiving a transfusion, with blood infected by the HIVS virus, is one way to get the disease.
4. \_\_\_\_ AIDS is a disease which destroys the body's natural immunity against infection.
5. \_\_\_\_ AIDS is caused by a virus.
6. \_\_\_\_ Symptoms of the HIV will usually appear within 12-24 hours after being infected.
7. \_\_\_\_ If you wet kiss (French kiss) someone with the HIV you will get the disease.
8. \_\_\_\_ I believe that if a person with AIDS is bitten by a blood sucking insect, it is possible to get AIDS if that same insect bites you.
9. \_\_\_\_ Using a condom (rubber) during sexual intercourse can reduce the spread of HIV infection.
10. \_\_\_\_ You increase the chance of getting the HIV by having sexual intercourse with many different people.

Section VII

1. Do you believe the AIDS epidemic has influenced or will influence your choice of counseling setting?

\_\_\_ yes \_\_\_ no

If yes, how did or will it affect your choice?

- \_\_\_ sought or seeking low incidence/avoided high incidence site
- \_\_\_ sought or seeking high incidence/avoided low incidence site

2. Has or will the AIDS epidemic influence your choice of specialty?

\_\_\_ yes \_\_\_ no

If yes, how did or will it affect your choice?

- \_\_\_ sought or seeking low incidence/avoided high incidence specialty
- \_\_\_ sought or seeking high incidence/avoided low incidence specialty

Section VIII

1. Have you ever had exposure to the human immunodeficiency virus (HIV)?

\_\_\_ yes \_\_\_ no \_\_\_ don't know

If so, was it through

\_\_\_ personal sexual contact  
\_\_\_ IV drug use  
\_\_\_ blood transfusion  
\_\_\_ exposure to blood to your eyes, mouth, or  
unprotected skin from a person believed to be  
HIV-positive  
\_\_\_ other \_\_\_\_\_

2. Have you had an HIV antibody test?

\_\_\_ yes \_\_\_ no

If yes, how was it done?

\_\_\_ anonymous/alternative test site  
\_\_\_ donating blood or plasma  
\_\_\_ employee health service, health care worker,  
or personal physician  
\_\_\_ other \_\_\_\_\_

3. If you have not had an HIV antibody test, have you seriously considered having it done?

\_\_\_ yes \_\_\_ no

If you would have a test done, how do you think you would have it done?

\_\_\_ anonymous/alternative test site  
\_\_\_ donating blood or plasma  
\_\_\_ employee health service, health care worker,  
or personal physician

Section IX

Please answer by indication the extent to which you agree with each statement.

Agree Strongly -1-	Agree Somewhat -2-	Neither Agree or Disagree -3-	Disagree Somewhat -4-	Disagree Strongly -5-
--------------------------	--------------------------	-------------------------------------	-----------------------------	-----------------------------

1.    \_\_\_    To protect my children from infectious diseases,  
I would not take them to the hospital.
2.    \_\_\_    I am concerned that in years to come, it will be  
found that HIV infection can be transmitted in ways  
we now believe to be safe.
3.    \_\_\_    Despite all I know about how HIV infection is  
transmitted, I am still afraid of contracting it.
4.    \_\_\_    I feel that I have sufficient knowledge to protect  
myself from transmission of HIV infection.
5.    \_\_\_    Pregnant therapists or therapists whose wives are  
pregnant should not treat persons with HIV infection.
6.    \_\_\_    People with AIDS should be legally separated to  
protect the public health.

Section X

1. Do you have any gay or lesbian friends or relatives?  
 yes     no     don't know
2. Do you have any friends or relatives who have used intravenous drugs?  
 yes     no     don't know
3. Have you known anyone personally (relatives, friends, associates) with HIV infection (excluding clients)?  
 yes     no     don't know
4. I would feel uncomfortable working alongside a male or female homosexual.  
 yes     no     don't know
5. I would feel comfortable if I learned that my best (same sex) friend was gay.  
 yes     no     don't know
6. Homosexual behavior is not accepted in our society.  
 yes     no     don't know
7. Homosexuals should not be condemned.  
 yes     no     don't know
8. If a member of my sex propositioned me, I would be offended.  
 yes     no     don't know

Section XI

Have you had any clinical experience with HIV infection?

\_\_\_\_\_ yes \_\_\_\_\_ no

Please answer by indicating the extent to which you agree with each statement. If you have had no clinical experience with HIV infection, answer as you believe you would feel.

- | Agree<br>Strongly<br>-1- | Agree<br>Somewhat<br>-2- | Neither<br>Agree nor Disagree<br>-3- | Disagree<br>Somewhat<br>-4- | Disagree<br>Strongly<br>-5- |  |
|--------------------------|--------------------------|--------------------------------------|-----------------------------|-----------------------------|--|
| 1. _____                 |                          |                                      |                             |                             | I feel confident in managing the social support needs of persons with HIV infection.                                 |
| 2. _____                 |                          |                                      |                             |                             | My uncertainty about how aggressively to pursue mental health interventions makes caring for AIDS clients difficult. |
| 3. _____                 |                          |                                      |                             |                             | I am comfortable with the degree of emotional involvement I have with HIV-infected clients.                          |
| 4. _____                 |                          |                                      |                             |                             | AIDS care is unrewarding because as a therapist I have so few effective treatment modalities to offer.               |
| 5. _____                 |                          |                                      |                             |                             | I enjoy the relationships that I establish with AIDS clients.  |
| 6. _____                 |                          |                                      |                             |                             | I am so fatigued by meeting the treatment needs of AIDS clients that I am unable to be empathic.                     |
| 7. _____                 |                          |                                      |                             |                             | Treating people with AIDS is unpleasant because they always die.   |
| 8. _____                 |                          |                                      |                             |                             | I do not have the skills to talk to an AIDS client about death.  |
| 9. _____                 |                          |                                      |                             |                             | I think that AIDS is getting too much attention from the mental health field.  |
| 10. _____                |                          |                                      |                             |                             | I already know enough about AIDS for my practice.  |
| 11. _____                |                          |                                      |                             |                             | I find it frustrating to have to continue talking with the relatives of clients who are not going to get well.       |
| 12. _____                |                          |                                      |                             |                             | If I have a choice, I will not work with AIDS clients.   |

13. \_\_\_\_\_ I would be comfortable if my other clients knew that I was treating people with HIV infection.
14. \_\_\_\_\_ It makes me uncomfortable when a dying client wants to say goodbye to me.
15. \_\_\_\_\_ I already have the specific knowledge that I need to care for people who are living with the HIV.
16. \_\_\_\_\_ I think that a person can be infected by the HIV virus and not have the disease AIDS.
17. \_\_\_\_\_ AIDS can damage the brain.
18. What feelings do you experience when you are counseling AIDS clients or their significant others? If you have not or do not counsel AIDS clients or their significant others at this time, what do you expect your feelings to be? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
19. What are your thoughts and/or feelings when your profession tells you that you will ultimately treat AIDS clients? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
20. What would you consider to be the most difficult problems in counseling AIDS clients or their significant others? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Section XII

1. Have you had any clinical counseling experience with male homosexuals?

\_\_\_\_\_ yes \_\_\_\_\_ no

In the following statements the word "homosexual" is meant to refer to male homosexuals. Please answer by indicating the extent to which you agree with each statement.

Agree Strongly -1-	Agree Somewhat -2-	Neither Agree nor Disagree -3-	Disagree Somewhat -4-	Disagree Strongly -5-
--------------------------	--------------------------	--------------------------------------	-----------------------------	-----------------------------

1. \_\_\_\_\_ Most of the homosexuals with AIDS brought the disease on themselves.
2. \_\_\_\_\_ I have as much sympathy for a homosexual AIDS client as I do for other AIDS clients.
3. \_\_\_\_\_ It's useless to try to change the sexual behavior of homosexuals to help them avoid contracting AIDS.
4. \_\_\_\_\_ I would not like to have a lot of homosexuals in my practice.
5. \_\_\_\_\_ The demands of homosexual clients are more annoying than the demands of other clients.
6. \_\_\_\_\_ Most homosexual clients are people that I'd ordinarily like having as clients.
7. \_\_\_\_\_ If a person has homosexual feelings, he/she should do everything to overcome them.
8. \_\_\_\_\_ Homosexuality is a threat to many of our basic social institutions.
9. \_\_\_\_\_ I do not believe that homosexuality is a sign of pathology.

Section XIII

1. Have you had any clinical counseling experience with IV drug users (IVDU)?

\_\_\_\_\_ yes \_\_\_\_\_ no

Please answer by indicating the extent to which you agree with each statement.

Agree Strongly -1-	Agree Somewhat -2-	Neither Agree nor Disagree -3-	Disagree Somewhat -4-	Disagree Strongly -5-
--------------------------	--------------------------	--------------------------------------	-----------------------------	-----------------------------

1. \_\_\_\_\_ Most IVDU clients are people I'd ordinarily like as clients.
2. \_\_\_\_\_ It is useless to try to change the behavior of IVDU to help them avoid contracting AIDS.
3. \_\_\_\_\_ The demands of IVDU clients are more annoying than the demands of other clients.
4. \_\_\_\_\_ I would find no reward in caring for clients who use IV drugs.
5. \_\_\_\_\_ I have as much sympathy for an IVDU AIDS client as I do for other AIDS clients.
6. \_\_\_\_\_ My awareness of AIDS has made me more committed to caring for IVDU clients.
7. \_\_\_\_\_ Most of the IVDU with HIV have brought the disease on themselves.
8. \_\_\_\_\_ My preference is to refer IVDU to another therapist for counseling.
9. \_\_\_\_\_ It is just as sad to see an IVDU die of AIDS as it is to see someone die of sexually contracted AIDS.

Section XIV

- | Agree<br>Strongly<br>-1- | Agree<br>Somewhat<br>-2-   | Neither<br>Agree nor Disagree<br>-3- | Disagree<br>Somewhat<br>-4- | Disagree<br>Strongly<br>-5- |
|--------------------------|--|--------------------------------------|-----------------------------|-----------------------------|
| 1. _____                 | I feel that it is my ethical responsibility to provide needed mental health treatment to persons living with the HIV.              |                                      |                             |                             |
| 2. _____                 | It is morally wrong to refuse to care for a client because of his or her sexual orientation.                                       |                                      |                             |                             |
| 3. _____                 | Therapists in private practice have a responsibility to treat persons with HIV infection.  |                                      |                             |                             |
| 4. _____                 | It is ethically responsible to refer HIV-infected individuals to therapists who are clinically trained in counseling AIDS clients. |                                      |                             |                             |
| 5. _____                 | It is morally justifiable for therapists to deny mental health care to persons who use illegal drugs.                              |                                      |                             |                             |
| 6. _____                 | It is morally wrong to refuse to treat a client because of his or her race or ethnic background.                                   |                                      |                             |                             |
| 7. _____                 | Therapists have no ethical responsibility to treat persons with AIDS or their significant others.                                  |                                      |                             |                             |

Comments

1. Have you had any experiences that have affected your attitudes toward working with HIV-infected patients (please explain)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. Additional comments on the topic of AIDS or this questionnaire. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Section XV

1. Type of clinical setting \_\_\_\_\_

2. Professional title \_\_\_\_\_

3. Number of years of experience in counseling \_\_\_\_\_

4. Gender \_\_\_\_\_ male \_\_\_\_\_ female

5. Age \_\_\_\_\_

6. Your race and/or ethnic origin \_\_\_\_\_

American Indian or Alaskan Native \_\_\_\_\_  
 Asian or Pacific Islander (please specify, e.g. Japanese-American): \_\_\_\_\_  
 Black \_\_\_\_\_  
 Hispanic/Latino (please specify, e.g. Mexican-American): \_\_\_\_\_  
 White, not of Hispanic origin \_\_\_\_\_

7. Are you \_\_\_\_\_

Married \_\_\_\_\_  
 Coupled, living in separate residences \_\_\_\_\_  
 Single, living with significant other \_\_\_\_\_  
 Single, living with roommate(s) \_\_\_\_\_  
 Single, living alone \_\_\_\_\_

8. Do you have children? \_\_\_\_\_  
 yes \_\_\_\_\_  
 no \_\_\_\_\_

9. Do you consider yourself to be \_\_\_\_\_  
 heterosexual \_\_\_\_\_  
 bisexual \_\_\_\_\_  
 gay or lesbian (homosexual) \_\_\_\_\_

10. Religious background \_\_\_\_\_

10a. Dominant religious affiliation (s) of the family in which you grew up (check those applicable)  
 Fundamentalist \_\_\_\_\_  
 Christian \_\_\_\_\_  
 (Born Again) \_\_\_\_\_  
 Protestant \_\_\_\_\_  
 Catholic \_\_\_\_\_  
 Jewish \_\_\_\_\_  
 Agnostic/Atheist \_\_\_\_\_

10b. What is your current religious affiliation?  
 Fundamentalist \_\_\_\_\_  
 Christian \_\_\_\_\_  
 (Born Again) \_\_\_\_\_  
 Protestant \_\_\_\_\_  
 Catholic \_\_\_\_\_  
 Jewish \_\_\_\_\_  
 Agnostic/Atheist \_\_\_\_\_  
 Other \_\_\_\_\_

APPENDIX C

PARTICIPANT DEBRIEFING STATEMENT



CALIFORNIA STATE UNIVERSITY  
SAN BERNARDINO

PARTICIPANT DEBRIEFING STATEMENT

Thank you for completing our survey regarding your personal and clinical experience and impressions concerning the human immunodeficiency virus (HIV). The information from your inventory will be helpful in evaluating clinical therapeutic services for HIV infected persons and their significant others (including family members).

The specific aspects this study focused upon are knowledge, attitudes, and behaviors of therapists (counselors) who may or may not be providing services to persons living with the HIV and their significant others. Included in this study are physicians' and other health care workers' responses to health care issues regarding HIV infection.

Counseling the HIV population is a new area in the field of therapy. Many therapists have little clinical experience or training in this area of counseling HIV infected clients or their significant others. You may have had unsure or uncomfortable feelings while answering the questionnaire. Please feel free to ask any questions that may be on your mind. No question, thought, or feeling is insignificant. A brochure on HIV infection is provided for your information. Also the following AIDS projects are available for your calls:

INLAND AIDS PROJECT (IAP) (714) 784-AIDS or  
1 -800-451-4133  
(San Bernardino & Riverside Counties)

AIDS PROJECT LOS ANGELES (APLA)  
1-800-922-AIDS  
(Los Angeles County)

Thank you for your participation. Additional inquiries can be directed to:

Wendy Kellogg  
Dr. Geraldine Stahly  
Psychology Department  
California State University, San Bernardino  
5500 University Parkway  
San Bernardino, CA 92407-2397

(714) 796-9752

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