This study investigated the attitudes of mental health counselors toward persons with Acquired Immunodeficiency Syndrome (AIDS). Three hundred and fifty-eight members of the American Mental Health Counselors Association were mailed a survey packet including an Attitude Towards AIDS Victims scale and an additional two questions assessing comfort with clients with AIDS. Demographic information was also collected. There were 255 useable surveys, for a response rate of 72%. The results of the survey indicated that gender was not a significant independent variable in the attitudes of the mental health counselors. Professional and/or personal contacts with a person with AIDS were highly predictive of positive attitudes. Sexual orientation of the respondent was also highly significant as was personal acquaintance with a gay male or lesbian.

Formal AIDS training of one hour or more showed a significant relationship with attitudes of mental health counselors toward persons with AIDS, with the relationship becoming more significant at 11 or more hours. The study indicated that mental health counselors
are largely uninvolved in providing mental health treatment to persons with AIDS, with
5% of the subjects providing 70% of the services. Recommendations follow regarding
preservice and inservice AIDS training and the need for mental health counselors to be
more proactive in the AIDS epidemic.
An Assessment of Attitudes of Mental Health Counselors Toward Persons with Acquired Immunodeficiency Syndrome

by

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The completion of this dissertation could not have been possible without the love, support, and expertise of the people in my life. I dedicate this dissertation to my son, Elliott, who has lived with his ABD mom since his conception. The completion was accomplished to show him that perseverance towards a goal that sometimes seems out of reach is worthy in and of itself. I also dedicate this dissertation to my husband, Les, without whose love, cooking, and devoted support this project never would have seen completion. I also want to extend my appreciation to my family of friends who have lovingly encouraged me and now joyously celebrate the completion of this project, despite the impact it had on my ability to reciprocate at times.

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An Assessment of Attitudes of Mental Health Counselors Toward Persons with Acquired Immunodeficiency Syndrome

Chapter I
Statement of the Problem, Significance, and Hypotheses

Introduction

The statement of the problem regarding attitudes toward persons with Acquired Immunodeficiency Syndrome (AIDS) and the significance of these attitudes are explored in this chapter. An overview of the AIDS epidemic, including the definition, prognosis, and modes of transmission are discussed. Psychosocial aspects of the AIDS epidemic are related to the stigma of the disease, fear of contagion and homophobia. The rationale for this study of mental health counselors attitudes toward persons with Acquired Immunodeficiency Syndrome are presented, followed by a definition of the terms used. Finally, the hypotheses upon which this survey research is based, are listed.

Overview of AIDS

Acquired Immunodeficiency Syndrome is an infectious disease that currently has no cure or immunization. AIDS has reached epidemic proportions in the United States and worldwide (World Health Organization, 1994) and is now recognized as being the most serious epidemic of our times (St. Lawrence, Kelly, Owen, Hogan, & Wilson, 1990). The incidence of AIDS continues to double every 14-16 months and has become a major health and social emergency worldwide (Allen & Curren, 1988; Mann, Tarantola, & Netter, 1992). The World Health Organization (WHO) estimates 4.5 million cases of AIDS worldwide as of January 3, 1995. WHO also estimates that there have been 18 million adults and 1.5 children infected with AIDS since the onset of the epidemic and
that by the year 2000, 30-40 million people will be infected with Human immunodeficiency virus (HIV). Ninety percent of these will be within developing countries.

By the year 2000, deaths are estimated to be at 10 million cases worldwide with over 8 million of the dead being adults. WHO estimates that every day 6000 persons worldwide become infected with HIV (WHO, 1995). The documented number of AIDS cases increased from 2.5 million in July 1993, to 4 million by July of 1994 (WHO, 1994).

The disparity between the estimated numbers of people with HIV infections and those diagnosed with AIDS is due to the time interval between the initial HIV infection and the development of AIDS. The estimated time between infection of the HIV and the diagnosis of AIDS can be up to 10 years (WHO, 1993). This disparity is further compounded by the inaccuracies inherent in accumulating data about HIV infection due to the variations in methods of conducting surveillance (Centers for Disease Control, [CDC], 1994). The completeness of reporting of diagnosed AIDS cases in the United States to state and local health departments varies by geographic region and population. However studies indicate that the reporting of AIDS cases in most areas of the United States is more than 85% complete. (Rosenblum, Buehler, Morgan, Cost, Hidalgo, Holmes, Lieb, Shields, & Whyte, 1992).

In the United States there were 441,528 documented AIDS cases as of December, 1994 (CDC, 1995). The total number of deaths due to AIDS reported within this same time period is 270,870 worldwide and 170,658 within the United States. The government believes an additional one million people are carrying HIV in their blood without showing any symptoms of AIDS (CDC, 1993). In 1994, there were 80,691 new cases of AIDS reported to the CDC, which followed the 106,618 cases reported in 1993. The number of cases reported in each of these years was greater than that reported in 1992 (47,572).

The findings in 1994 indicate a continuation of trends for certain population groups, including an increase in the proportion of cases accounted for by women and
racial/ethnic minorities, a decrease in the proportion accounted for by homosexual/bisexual men, and an increase in the number of cases in children (CDC, 1994). However, men who have sex with men still account for the majority of the reported cases in the U.S.; 53% of cases were the result of gay male/bisexual contact from 1993 to December of 1994 (CDC, 1995). There has been an increase in cases in the heterosexual adult and children populations as well, especially among females (CDC, 1994; Devitt, 1993).

Sills (1994) summarized the movement of the AIDS pandemic through the United States population by characterizing it as having “moved forward in three waves: first, almost exclusively among male homosexuals; then, increasingly, among intravenous drug users; and later among the sexual partners of intravenous drug users and bisexual men” (p. 56). Women of color are the fastest growing HIV-positive group worldwide with transmission by heterosexual sexual contact with an infected partner putting them at 10 times the risk of contracting the virus than men. By the year 2000, women are expected to constitute the majority of Persons with AIDS (PWAs) (Mann, et al., 1992).

**Definition and Transmission**

AIDS is caused by the human immunodeficiency virus (HIV). HIV has been found in blood, semen, vaginal secretions, and breast milk. Persons infected by HIV will be infectious for life (Institute of Medicine, 1988). HIV infection is not casually transmitted, and studies show that HIV infection cannot be transmitted except through contact where there is an exchange of blood, vaginal secretion, semen, or perinatally from a woman to her unborn child. Minimal amounts of HIV have been found in the saliva of infected individuals, however this poses no health threat (Tallmer, 1991). The AIDS virus also cannot be transmitted by way of toilet seats, biting insects, or by eating food prepared by infected individuals (Corless & Pittman-Lindeman, 1989).
HIV attacks and slowly destroys the body's immune system, hampering the body's ability to prevent serious, life threatening infections, such as Kaposi's Sarcoma, pneumocystis, cytomegalovirus, and tuberculosis. It does this by attacking and depleting the T-Lymphocytes. The T-Lymphocytes bear the CD4 protein, known also as T4 cells, and are responsible for turning on and amplifying the body's immune system when it is under attack. When HIV enters the T cells, it attaches specifically to the CD4 protein on the cell surface. This allows the virus to access the CD4 and T cells and causes the body to lose the ability to mobilize an immune response while becoming vulnerable to the opportunistic infections that have come to define AIDS (Morse, 1992). When an opportunistic infection is manifested, the person is said to have developed AIDS.

Definitions for AIDS have undergone many changes since it was first recognized as a syndrome in 1981. AIDS was first referred to as the Gay Related Infectious Disease or Syndrome (GRID) because it was originally thought to be caused by the sexual practices of gay men. Theories that developed in the early 1980s were linked to groups that are socially stigmatized, such as gay men, intravenous drug users and minorities. The definition of AIDS was revised in 1985, 1987, and again in 1993 (CDC, 1985; 1987; 1993). The revisions incorporated a broader range of AIDS indicator diseases and conditions and HIV diagnostic tests to improve the sensitivity and specificity of the definition. The 1987 definition incorporated HIV-related encephalopathy, wasting syndrome, and other indicator diseases. The 1993 definition was expanded to include conditions that occur earlier in HIV disease and therefore includes severely immunosuppressed persons more recently infected with HIV. The current definition of AIDS, in those clinically confirmed to be HIV infected, includes CD4 T- Lymphocyte counts of less than 200 cells (less than 14%), a diagnosis of pulmonary tuberculosis, recurrent pneumonia, and/or invasive cervical cancer (CDC, 1995).
The Prognosis

The AIDS epidemic has been recognized as such for over 10 years; however, it is apparent that the majority of cases have yet to develop. Three factors have been identified as the reason for an expected increase in the number of AIDS cases: (a) there is an increasing and large number of HIV infected individuals who have not developed AIDS; (b) the survival rate of PWAs is increasing due to the treatment for opportunistic diseases and antiretroviral therapy, and (c) there is continuing incidence of transmission and infection (CDC, 1994).

The Stigma

Attitudes toward PWAs cannot be separated from attitudes toward the people that the disease impacted first: gay men and intravenous drug users (Cohen & Wiseberg, 1990). AIDS is most often perceived as a “demeaning disease, as an affliction of socially marginal groups” (Ludmerer, 1989, p.8). Because AIDS was first diagnosed in the gay male community and is viewed by many as primarily a gay male disease, attitudes toward the gay male lifestyle have strongly influenced the response of government, social institutions, and individuals (Cohen & Wiseberg, 1990; Shilts, 1987; Price & Hsu, 1992; Pryor, Reeder, Vinacco, & Knott, 1989). Studies have shown that PWAs are perceived as being more responsible for their disease and more socially unworthy than those with cancer, diabetes, severe heart condition, or leukemia (Katz, Hass, Parisi, Astone, & McEvaddy, 1987; St. Lawrence, Kelly et al., 1990; St. Lawrence, Husfeldt, Kelly, Hood & Smith, 1990). Although the tendency to discriminate against PWAs has decreased, many Americans still have very intense feelings about them and associate the disease with
the gay male lifestyle. They view it as proof of a breakdown in traditional (i.e., heterosexual) sexual values (Johnson, 1989).

Psychosocial Aspects

AIDS has reached all corners of the social, health, and political arenas and is characterized by the subtle stigmatization that not only prevents adequate health care, but also increases stresses and challenges that one must face when diagnosed with HIV or AIDS. Discrimination is very often an integral part of the struggle that PWAs face. It has its basis in fear, ignorance, and prejudice and “manifests in all areas of life in particularly harsh forms” (Cohen & Wiseberg, 1990, p. 3). Individuals who are HIV positive face a multitude of challenges that can create considerable stress. The resulting psychological stresses can have a direct and deleterious effect upon the functioning of the immune system of the PWAs, hastening the onset of opportunistic infections (Kiecolt-Glaser & Glaser, 1988). According to Forstein (1989), “HIV has created two epidemics, one of the disease, the other the consequence of the psychological response to that disease” (p. 160).

Fear of Contagion and Homophobia

The September, 1990, National Health Interview Survey conducted by the National Center for Health Statistics, estimated that 24 % of the public think it is “very likely” or “somewhat likely” that someone could contract AIDS from eating in a restaurant where the cook has the AIDS virus, while 19 % believe it is “very likely” or “somewhat likely” that they would contract AIDS from using public toilets (Adams & Hardy, 1991). Also, Dawson (1990) found that people believe AIDS is transmittable through casual contact.
According to many researchers, a fear of contagion of AIDS appears to have merged with a fear of gay males (homophobia) and does not appear to be affected by knowledge of the disease (Stipp & Kerr, 1989; Witt, 1989a; 1989b). Glassner & Owen (1976) came to the conclusion that homophobia is similar to prejudice against other minorities, especially Blacks. Perdew (1990) found that fear of homosexuals has led to a variety of discriminatory acts that range from “social snubbing to murder” (p. 64).

In 1989, eight years after the diagnosis of the first cases of AIDS in the United States, the National Gay and Lesbian Task Force (NGLTF) received reports of increased violence toward gay men and lesbians, which were felt by the victims to be directly related to the AIDS epidemic (National Gay and Lesbian Task Force, 1989). In a 1992 national survey conducted by the National Association of People with AIDS, 21.4% of the 1800 survey respondents reported being victimized because of their HIV status in the community (National Association of People with AIDS, 1992). An additional 12.3% of the respondents to this survey reported experiencing AIDS-related violence in their homes, from family members, and partners.

AIDS bias continued to be a factor in many of the anti-gay attacks documented by NGLTF in 1993 with eight percent involving victims who were perceived to have AIDS or actually had AIDS (1994). In 1994, NGLTF documented a seven percent decrease from the cases documented in 1993 (1995); however, violence against persons with HIV and AIDS continues to be widespread with some HIV-bias cases involving violence against AIDS service providers and organizations. The National Gay and Lesbian Task Force (1995) continues to find evidence that “anti-gay/lesbian and anti-AIDS/HIV prejudice and hate remain inextricably linked” (p. 17). Larsen, Serra, and Long (1990) concluded in their research that “attitudes toward AIDS victims is (sic) primarily a consequence of attitudes toward homosexuality” (p. 104).

Others have concluded that gender of the respondent is a major variable with males being more homophobic than females (Herek, 1986; Kite, 1984; Millham, San
Miguel, & Kellogg, 1976). Some researchers found a relationship between religiosity and authoritarianism and attitudes toward PWAs (Bouton, Gallaher, Garlinghouse, Leal, Rosenstein, & Young, 1989) while Witt (1989a; 1989b) portrayed authoritarianism as correlating significantly with negative attitudes toward PWAs.

Larsen, Serra, and Long (1990) questioned the effectiveness of massive education efforts about the disease. Other data confirmed the hypothesis that homophobia limits a person’s acceptance of the facts about AIDS transmission (Stipp & Kerr, 1989; Pryor et al., 1989). Important predictors of public opinion concerning the public health policies related to AIDS appear to have two variables: the levels of misinformation regarding the contagion of HIV and the levels of negative sentiment towards gay males (Price & Hsu, 1992). Price and Hsu found that AIDS misinformation and negative attitudes were correlated, but appeared to function as independent predictors of policy preferences. However, some researchers found that the avoidance of PWAs is primarily a function of the fear of contagion of the disease, rather than a fear of gay males (Bishop, Alva, Catu, & Rittiman, 1991). Still, the overall results supported the perception that gay males are more responsible for contracting the disease and are rated more negatively on personality dimensions.

**Rationale for the Research**

By the end of the current decade, it is predicted that 1 in 10 U.S. residents will be HIV-positive (Cohen & Wiseberg, 1990). With the rise in the number of PWAs, the demand for professional mental health treatment for PWAs, their partners, friends, and family members will also rise. The diagnosis of AIDS reveals many men as gay to their family for the first time; thus family members are often dealing with their grief over the prospect of losing a loved family member as well as their reactions of homophobia over the revelation of the gay lifestyle of their family member (Bruhn, 1989). Additionally,
many health care providers have expressed revulsion at the prospect of caring for patients with AIDS, despite training, and they avoid contact with them (Hayward & Shapiro, 1991). Numerous studies indicate that health care providers perceive gay males with the AIDS virus as being more responsible for their HIV positive status and less deserving of sympathy (Kelly, St. Lawrence, Hood, Smith, & Cook, 1988; Kelly, St. Lawrence, Smith, Hood, & Cook, 1987a, 1987b; St. Lawrence, Husfeldt et al, 1990).

Mental health professionals, made up of social workers and clinical/counseling psychologists, were shown to rate a patient with AIDS as less deserving of sympathy than patients with leukemia and were less likely to accept them for treatment, make physical contact with them, or to have positive attitudes towards gay men and PWAs (Crawford, Humfleet, Ribordy, Chu Ho, & Vickers, 1991; St. Lawrence, Kelly et al., 1990). Psychologists' reactions to PWAs highlighted the central role that homophobia may play in attitudes of mental health professionals (Trezza, 1994).

Gender of mental health professionals may also play a role in the treatment delivery for PWAs. Research indicates that male mental health counselors experience more discomfort with HIV-positive clients than with HIV-negative clients, with a significant relationship between verbal avoidance behavior and homophobia towards gay males (Hayes & Gelso, 1993). Other research indicates a slight difference in response of female psychologists with male psychologists being slightly more negative towards PWAs (Trezza, 1994).

As the AIDS epidemic continues to spread in the gay, lesbian, bisexual, and heterosexual communities, it will become more crucial for mental health counselors to develop new skills in death and dying and to become more aware of their own countertransferences (Gutierrez & Perlstein, 1992) while treating PWAs and their loved ones. Gay males and lesbians, who tend to seek counseling two to four times more than the heterosexual population, report negative experiences with mental health practitioners due to the lack of understanding and prejudice of the mental health practitioner (Rudolph,
A large percentage of counselors have reported perceiving homosexuality as pathological and less desirable than heterosexuality, although a large percentage reported that they may be willing to accept homosexuality in other people (Rudolph, 1988). Mental health counselors are not immune from prejudices, fears, or judgments of PWAs.

A literature review revealed information on attitudes of psychologists and social workers towards PWAs (Wiener-Brawerman, 1988; Dhooper, Royse, & Tran, 1988; Sheridan & Sheridan, 1988; Lester, 1988; Bouton et al., 1989; Samuel & Boyle, 1989; Wexler, 1989; Wiener & Siegel; 1990; St. Lawrence, Kelly et al., 1990; Gillman, 1991; Peterson, 1991; Kindermann, Matteo, & Morales, 1993). While there has been some research into the area of attitudes of mental health counselors toward PWAs (Larson, 1991), more research is needed to more clearly identify the factors that influence the attitudes that impede or enhance mental health services for PWAs.

Definitions

Acquired Immunodeficiency Syndrome (AIDS): “a specific group of disease or conditions which are indicative of severe immunosuppression related to infection with the human immunodeficiency virus (HIV)” (Centers for Disease Control, 1994).

Homophobia: “The revulsion toward homosexuals and often the desire to inflict punishment and retribution” (Weinberg, 1973, p. 132).

Human Immunodeficiency Virus (HIV): A virus that destroys the white cells in the blood that are essential for the functioning of the body’s immune system. It is transmitted through blood, semen, vaginal fluid, and breast milk (Institute of Medicine, 1988).
Internalized Homophobia: “Internalized homophobia is produced by the negative messages about homosexuality that gay men and lesbians hear from early childhood on. Because gay men and lesbians are stereotyped, kept isolated and uninformed, or fed inaccurate, distorted information about homosexuality, the messages are internalized and result in low self-esteem. Internalized homophobia leads to self-hatred and often to psychological problems” (Dworkin & Gutierrez, 1992, p. xx).

Mental Health Counselor: One who “... performs counseling/therapy with individuals, groups, couples, and families; collects, organizes, and analyzes data concerning a client’s mental, emotional, and/or behavior problems or disorders; helps clients and their families to effectively adapt to the personal concerns present; ... utilizes community agencies and institutions to develop mental health programs that are developmental and preventive in nature. Trained to provide a wide variety of therapeutic approaches to assist clients, which may include therapy, milieu therapy, and behavioral therapy ... [and] required to have knowledge and skills in client management, assessment, and diagnosis through a post-graduate program in mental health or community mental health counseling” (Palmo, 1981, cited in Palmo & Weikel, 1986, p. 43).

Mental Health Counseling: “The practice of mental health counseling includes, but is not limited to, diagnosis and treatment of mental and emotional disorders, psychoeducational techniques aimed at the prevention of such disorders, consultation to individuals, couples, families, groups, organizations, and communities, and clinical research into more effective psychotherapeutic treatment modalities” (Definition of Mental Health Counseling adopted by the Board of the Academy of Clinical Mental Health Counselors, Sept. 1985, and the Board of Directors of the American Mental Health Counselors Association, April, 1986).
PWA: A person with AIDS, which is a current and preferred way to refer to persons diagnosed with AIDS.

Hypotheses

The purpose of this study is to assess the attitudes of mental health counselors toward PWAs. The null hypotheses are as follows:

1. There is no significant difference between the attitudes of male mental health counselors and the attitudes of female mental health counselors toward persons with AIDS.

2. There is no significant difference between the attitudes of mental health counselors who have had no professional contact with a PWA within the past year and the attitudes of mental health counselors who have had professional contact with a PWA within the past year toward persons with AIDS.

3. There is no significant difference between the attitudes of mental health counselors who report personal acquaintance, other than with a client, with a PWA and the attitudes of mental health counselors who report no personal acquaintance with a PWA toward persons with AIDS.

4. There is no significant difference between the attitudes of mental health counselors who identify themselves as gay or lesbian as compared to mental health counselors who identify themselves as heterosexual toward persons with AIDS.
5. There is no significant difference between the attitudes of mental health counselors toward persons with AIDS who report personal acquaintance with a gay male or lesbian, other than with a client, and the attitudes of mental health counselors who report no personal acquaintance with a gay male or lesbian.

6. There is no significant difference between the attitudes of mental health counselors who have had one or more hours of formal training regarding AIDS and the attitudes of mental health counselors who have had no formal training regarding AIDS toward persons with AIDS.
Chapter II
Review of Literature

“I hope that one day, when death finally comes, by chance or by any infection caused by the virus, nobody says that I was defeated by AIDS. I have succeeded in living with AIDS. AIDS has not defeated me.”

From The Soul of a Citizen by Herbert Daniel, (1946-1992, Brazilian poet; AIDS activist; and member of the Global AIDS Policy Coalition)

“Any disease that is treated as a mystery and acutely enough feared will be felt to be morally, if not literally, contagious” From Susan Sontag Illness As Metaphor

Introduction

This chapter begins with an exploration of society's attitudes toward past epidemics and the stigmatizing attitudes related to past epidemics and the attitudes of the general public toward PWAs. Attitudes toward gay men and AIDS are reviewed as well as the impact of the diagnosis of HIV/AIDS on the individual, their families, friends and lovers. The effect of AIDS on health care workers are explored in terms of their fear of contagion, homophobia, and the stress of caregiving of PWAs. The attitudes of health care providers are reviewed including physicians and nurses. The attitudes of mental health professionals are also reviewed, including psychiatrists, psychologists, social workers, marriage and family therapists, and mental health counselors.
Attitudes Toward Past Epidemics

In exploring the impact of attitudes on people who have contracted an epidemic disease, it is useful to explore society's historical attitudes toward similar occurrences. Western society has not responded well in the past to epidemic outbreaks of disease. There is a strong tendency of the fearful majority to look for a minority group as a scapegoat. Society not only comforts itself and engenders hope by placing the blame on socially disapproved groups, but it also stigmatizes, isolates, and quarantines these groups with the aim of bringing the epidemic under control (Ludmerer, 1989).

Sontag (1978) views illness as a societal and value-laden metaphor: "The melodramatics of the disease metaphor in modern political discourse assume a punitive notion: of the disease not as a punishment but as a sign of evil, something to be punished" (p. 82). In the fear and hysteria surrounding an epidemic, "unclean body fluids, taboo sexual conduct, forbidden drugs, deviant individuals, and deadly disease become mutually reinforcing metaphors of physical, moral, and social danger" (Nelkin & Hilgartner, 1986, p. 139). The tendency to seek out a scapegoat is an effort to place responsibility on already stigmatized groups, to explain the moral causation, and perhaps, to contain the disease. In each epidemic, the social stigmatization of certain groups has "served only as a vent for society's deep seated fears and prejudices toward the outcast groups" (Ludmerer, 1989, p. 9). This allows for an expression and justification of the religious, political, and cultural views of society and for some sense of control amid the fear.
The Stigmatization of AIDS as Related to Past Epidemics

The social parallels found in past epidemics are strikingly similar in the AIDS epidemic. Beliefs about HIV transmission seem to coincide with societal fears. Homophobia has been an intrinsic factor in the response of society to the AIDS epidemic (Croteau & Morgan, 1989) and affects perception of risk factors and influences development of research, social service, and educational programs (Paxton & Susky, 1988). Comparisons with other highly contagious diseases have been made in the media pairing it in the mind of many Americans. Many diseases are as highly contagious and as lethal as AIDS; however "few diseases have created so much irrational fear, and at time, hysteria among the general public as AIDS" (St. Lawrence, Husfeldt, et al. 1990).

Grover (1988) pointed out that the fear of contagion was fueled by initial public health reports on the cause of AIDS as compared to the highly contagious Hepatitis B Virus (HBV). Comparisons were made because both appeared to be borne by blood, sexually transmitted, and found with great frequency in urban gay men. Even though HBV is much more infectious than HIV, these reports encouraged the fear of easy transmission from an AIDS infected individual when transmission of the AIDS virus is actually quite difficult without exchange of bodily fluids. The similarities of transmission, sexual contact and intravenous drug use are so "socially charged...that they masked the important differences and encouraged people to regard both diseases as highly contagious and easily transmissible to the unsuspecting diner or drinker" (Grover, 1988, p. 20).
Attitudes of the General Public Toward PWAs

The attitudes that are evident toward PWAs are similar to the attitudes and fears that have arisen in other epidemics and plagues (Brandt, 1988a). The appearance of the AIDS epidemic initially in the gay male and IV drug user populations has had a very significant impact on society's social, political and medical responses, and for many has come to symbolize moral decadence and promiscuity (Pryor, et al., 1989) and thus delayed the United States government response (Shilts, 1987). Discrimination toward those with AIDS and those who are suspected of having AIDS is found nationwide in housing, insurance, employment, child custody, and health care (Boodman, 1986; Cohen & Wiseberg, 1990; NGLTF, 1995). Attitudes of the public towards PWAs do not appear to be mitigated by living in a high incidence area; however they are influenced positively by personal contact with someone who is living with AIDS (Gerbert, Sumser, & Maguire, 1991).

Attitudes Toward Gay Men and AIDS

Persons with HIV infection do not pose a danger to others through casual contact in the workplace, housing, or in customary social interchanges (Institute of Medicine, 1988, p. 6). Nevertheless, discrimination and fear appear to be present despite the scientific evidence of transmission (St. Lawrence, Husfeldt, et al., 1990). These judgments appear to be related directly to the stigmatizing attitudes held by many in our society toward minority groups, such as gay men and lesbians, and they are apparent not only in the general public, but also in health care providers who have direct contact with persons who
are HIV positive or who have been diagnosed with AIDS. Gender appears to have an impact on attitude, with females tending to have a more positive attitude toward gay males than males (Black & Stevenson, 1984; Kite, 1984; MacDonald, 1974; Millham, San Miguel, & Kellogg, 1976) and those who are older being less tolerant than those who are younger (Irwin & Thompson, 1978, Millham et al., 1976). Herek and Glunt (1993) found that interpersonal contact with a gay man or lesbian predicted attitudes toward gay men more than any other demographic or social psychological variable, with highly educated, politically liberal, young females showing the most positive attitudes towards gay men. Ellis and Vasseur (1993) supported this in their study of discrimination in employment interviews. They found that previous interpersonal contact or exposure to gay men and lesbians reduced the negativity of attitudes towards both of these groups. Their results indicated that males tended to rate gay males more negatively than females did however, the male subjects did not rate lesbians differently than the female subjects did.

Other researchers have found that people hold more negative attitudes toward gay men or lesbians of their own sex in regards to personal contact (Millham, et al., 1976; Whitley, 1988). A survey of 15-to-19 year old males' attitudes toward homosexual activity and gays as friends indicated that nearly all (89%) of the respondents thought that sex between two men “disgusting,” while only 12% felt that they could be friends with a gay male (Marsiglio, 1993). This supports Herek's contention “heterosexual men reaffirm their male identity by attacking gay men” (1986, p. 567). This has significance as the AIDS epidemic has been closely linked with the gay male lifestyle (O'Donnell, O'Donnell, Pleck, Snarey, & Rose, 1987) and has been manifested as discrimination and violence (NGLTF, 1995).
Several researchers concurred that attitudes toward PWAs are primarily a consequence of attitudes toward the gay lifestyle (Larsen et al., 1990; St. Lawrence, Husfeldt et al., 1990; Sheehan, Lennon, & McDevitt, 1989), or of attitudes toward gay rights (Stipp & Kerr, 1989). The Larsen et al. (1990) survey of attitudes toward PWAs suggests there is a strong relationship between the authoritarian personality and an unwillingness to combat the disease, or to provide responsive services for those affected. This supports previous research in which the authoritarian personality emerged as the most negative toward homosexuals (Smith, 1971; MacDonald & Games, 1974) and PWAs (Witt, 1989a; 1989b). Ficarrotto (1990) found a strong link between discrimination towards racial minorities and anti-gay sentiment.

The Stigma of AIDS

“AIDS related stigma,” a term coined by Herek and Glunt (1988), refers to a “socially constructed reaction to a lethal illness that has been most prevalent among groups that already were targets of prejudice” (p. 886). The irrational fear of AIDS that appeared in heterosexuals appears to have heightened homophobic attitudes and mingled with fear of contagion even though there is no evidence that even close social contact can be a cause of transmission of the virus (St. Lawrence, Husfeldt et al., 1990).

Those who are HIV positive and/or diagnosed with AIDS continue to be stigmatized by the general public without regard to the method of initial transmission of the virus, or to the gender, age, race, or sexual orientation of the infected person. “Just as syphilis created a disease oriented xenophobia in the early twentieth century, AIDS has today generated a new homophobia” (Brandt, 1988b, p. 368). Other studies show that the
mode of transmission does have an impact on the attitudes toward PWAs, with those who could not control the transmission of the disease, (i.e., blood transfusion) receiving more sympathy than those who are perceived as having control, (gay/bisexual males and intravenous drug users) (Dowell, Lo Presto & Sherman, 1991, Merrill, Laux, Thornby & Valbona, 1989).

The public’s attitudes toward gay males and fear of contagion play an important role in the quality and expediency of the response to this epidemic. The psychological reactions to the fear of AIDS, such as paranoia and prejudice, and subsequent behavioral changes are speculated by some social researchers to have an impact on individual’s psychological make-up and ultimately on social structural factors (Singh, Unnithan, & Jones, 1988). To one writer, the public’s fear that the AIDS virus is out of control parallels the persistent fears that society in general has about addictive and sexual behaviors, which also are perceived as being out of control (Forstein, 1989). Russell (1991) disputed this view based on the 1988 General Social Survey, a public opinion poll conducted by the National Opinion Research Center, and asserted that the general United States population shows little evidence of unreasonable panic over the AIDS epidemic. It is important to note, however, that this interpretation was made based on the respondents’ negative response to one question regarding restriction of children from the public schools.
Impact of Diagnosis of HIV/AIDS

Individual

The individual who is diagnosed with AIDS can be expected to experience two primary challenges: the disease process itself, and the psychosocial stressors and societal reactions inherent in the diagnosis of a stigmatized disease (Nichols, 1985). The psychosocial stressors include legal issues, housing, work, taking care of oneself, and discrimination in health and social services. PWAs, relative to a person with another serious, life-threatening illness, are viewed by society as being more deserving and responsible for contracting the disease and more dangerous, deserving of death, less entitled to work, and of less intrinsic worth (St. Lawrence, Husfeldt et al., 1990). The diagnosis of AIDS often reveals a lifestyle that had been previously unknown by the family of the PWA and may cause the PWA to experience anguish and fear of the consequences of the disclosure (Stulberg & Buckingham, 1988).

During the initial crisis following the diagnosis, an acute response of denial alternating with intense periods of anxiety, commonly occurs. The stigma of AIDS and its association with the gay lifestyle often produces shock, withdrawal, fear, anger, and depression (Grant & Anns, 1988). The PWA may be overwhelmed by emotions that cause stress to the self and to those around him or her and may lead to a mental health crisis. Psychiatric symptoms may emerge including depression, anxiety, and preoccupation with the illness. PWAs may be in a state of hypervigilance in regards to their disease progression (Tross & Hirsch, 1988). Often crisis intervention is needed to
ensure appropriate medical care and to help the person regain some control over his or her life after the initial stage of shock, numbness, and disbelief (Forstein, 1984).

Nichols (1985) found that PWAs typically experienced psychological responses that are similar to those that Kubler-Ross (1969) found in her observation of dying patients, however these responses tend to be more intense and variable. Nichols found that after the period of shock and denial that no predictive sequence is identifiable, with periodic feelings of anger, fear, anxiety, bargaining, resignation, and guilt. Forstein (1984), however, reported observing a definitive progression of psychological responses following the denial stage. He asserts that PWAs will enter the bargaining stage followed by the final stage of acceptance as their health status becomes more tenuous. According to Forstein, changes in the patients' physical condition may result in the regression or progression of these psychological stages related to AIDS, and not all PWAs experience the exact sequence.

Individuals may increase their denial and engage in life-threatening behavior, with a possible increase in the likelihood of suicidal acting out if HIV was contracted in a socially stigmatized manner (Harris & Barraclough, 1994). Marzuk, Tierney, Tardiff, Gross, Morgan, Hsu & Mann (1988) reported a high rate of suicide in patients with AIDS and a tendency for these suicides to occur early in the course of the illness. Chronic physical symptoms, feelings of hopelessness about the future, and loss of career, and loss of social and sexual relationships combine to place the PWA at a high risk for suicide attempts (Donlou, Wolcott, Gottlieb, & Landsverk, 1985) or passive suicidal ideation (Tross & Hirsch, 1988).
PWAs in the initial stage of crisis following diagnosis often have problems retaining information related to their health status and may appear dispassionate about discrimination or unprofessional treatment that would otherwise bother them (Nichols, 1985). Fears of death and dying, isolation, exposure of sexual or drug-related lifestyle to family and community, contagion issues, hopelessness, loss of self-esteem, and an increase in internalized homophobia are common responses to the diagnosis of AIDS among PWAs who are gay males, or who are drug abusers (Morin, Charles, & Maylon, 1984; Nichols, 1985; Macks & Turner, 1986; Namir, 1986; Price, Omizo, & Hammett, 1986; Lima, Lo Presto, Sherman, & Sobelman, 1993). Psychiatric symptoms may emerge, especially if they existed prior to the diagnosis, and may be complicated by neurological involvement of AIDS (Tross & Hirsch, 1988; Maj, 1990).

Shock, anger, anxiety, sexual dysfunction, and depression are common short-term reactions following diagnosis (Grant & Anns, 1988) followed by altruism, sadness and acceptance (Goldmeier, 1987). After the initial crisis, more existential and spiritual issues emerge as well as issues related to relationships (Coward, 1994). For the previously unidentified gay/bisexual male, this may be particularly anxiety producing since disclosure of his HIV status will also reveal hidden information about his sexual orientation that may create crises and rejection in families (Strommen, 1989), and in the workplace (Sheehan, Lennon, & McDevitt, 1989). Further, central nervous system dysfunction and subsequent neuropsychiatric manifestations, such as lack of concentration, psychomotor retardation, and confusion, are common and can result in disorientation, delusions, and global cognitive deficits that make it more difficult to function or process information (Faulstich, 1987).
Social support has been shown to be highly correlated with psychological well-being of gay men with AIDS, to the extent that the person felt reciprocation from others (Hays, Chancey, & Tobey, 1990). Friends who are also PWAs have been shown to be a great informational support and had higher reciprocity ratings. In contrast, professionals provided high informational support, but little reciprocity. Social isolation and lack of a social support system have been shown to correlate with high levels of anxiety, depression, and lethargy (Goldmeier, 1987).

Incidents of violence and harassment from community and family members continue to be reported by PWAs, and these range from verbal attacks to homicides (NGLTF, 1995). Anecdotal evidence from sources across the country indicate that bias attacks on persons with HIV/AIDS can exacerbate already frail health. PWAs are likely to report sudden weight loss, fatigue, and the onslaught of new opportunistic infections following an attack (NGLTF, 1995). Organic brain disease and opportunistic illness episodes necessitate the planning and finalizing of worldly affairs and coming to terms with the finality of the disease (Goldmeier, 1987). The resulting emotional distress may increase distress-related immunosupression and contribute to morbidity and mortality (Kiecolt-Glaser & Glaser, 1988).

Families, Friends, and Lovers

Families, friends, and lovers of PWAs are likely to experience significant distress at the news of the positive diagnosis and may need mental health services (Morin & Batchelor, 1984). Those closely involved with PWAs experience denial, depression, guilt, and anxiety over the imminent loss of a family member, and may feel increasingly
hopeless about controlling the disease process. The issues that the lovers, families, and friends of PWAs struggle with are similar to what PWAs struggle with (Stulberg & Buckingham, 1988). They may feel anger, shame, denial, loss of hope, fear of rejection, and social isolation (Christ, Wiener, & Moynihan, 1986; Furstenberg & Olsen, 1984; Stulberg & Buckingham, 1988). They may also feel anger at the PWA for putting them through the stress and emotional struggles and then leaving them behind after death (Sheridan & Sheridan, 1988).

The chronic aspects of the disease and the unpredictability of its course increases the need for long-term care. Often the PWA turns to the family of origin for support, re-entering it as a chronically ill member and disrupting the family system. The manner in which the disease was contracted is likely to affect the family’s reactions (Cates, Graham, Boeglin, & Tielker, 1990). The diagnosis of AIDS usually adds new complications to already difficult family situations (Geis, Fuller, & Rush, 1986). For those families that were previously unaware of their child’s sexual orientation, grief is a common reaction to discovery, as they struggle with the death of their heterosexual child in their minds and dreams (Robinson, Walters, & Skeen, 1989), as well as strong reactions, including ambivalence, to the fact of the diagnosis (Cates et al., 1990).

When the families assume the role of caregiver of the PWA, they are obliged to share the stigma of AIDS in the form of rejection, loss of friends, and harassment. Fear of contagion, disability, and issues regarding death have profound effects on the caregivers of PWAs (Powell-Cope & Brown, 1992; Stulberg & Buckingham, 1988). Some of the family caregivers studied by Powell-Cope and Brown chose to live in secrecy in fear of losing their employment or their housing. In addition to society’s fear of contagion and
guilt by association aimed at the caregivers of PWAs, the caregivers also have to deal with the stigma related to society's avoidance of death and dying issues. An early study by Boltz, Dobro, Spalinks, Kaplia, and Oleske (1983) found that the reaction of the family to the diagnosis, and their ultimate adjustment to it, has a profound impact on the PWA's emotional adjustment to the diagnosis. They found that PWAs with longer survival rates have been those whose families have been accepting of them and who were strongly committed to their physical and emotional well-being.

Lovers of gay male PWAs often feel stress related to the societal stigma associated with AIDS. They often experience anger at the medical establishment, concern about their future, concerns about sexual relationships, and conflicted responses to the Judeo/Christian tradition of condemning sexual behavior of the gay male (Geis, Fuller, & Rush, 1986). Disclosure of themselves as caregivers to others also may mean inadvertent disclosure of their sexual orientation (Powell-Cope & Brown, 1992), followed by problems in employment, housing, and possible harassment or violence (NGLTF, 1995). Gay men who experience AIDS-related bereavement due to one loss, or multiple losses, experience symptoms of traumatic stress response, sleep problems, depression, a tendency to use sedatives and recreational drugs, and increased use of mental health services (Martin, 1988).
Impact of AIDS on Health Care Workers

Fear of Contagion and Homophobia

Fear of contagion is pervasive among health care workers despite the fact that the actual risk of infection from an AIDS patient is low (Henderson, 1988; Link, Feingold, Charap, Freeman, & Shelov, 1988; O'Donnell, O'Donnell, Pleck, Snarey, & Rose, 1987; Treiber, Shaw, & Malcom, 1987). Homophobia and professional resistance to providing services to stigmatized high risk groups have also been shown to be major issues associated with negative feelings towards those with AIDS, as well as the fear of contagion and death anxiety (Bliwise, Grade, Irish, & Ficarrotto, 1991). Some research indicates that the gender of the health care provider influences reactions towards PWAs and may have an impact on the quality of care provided (Merril et al., 1989).

Worry and comfort were used as two different indicators of concern in a study of direct care health professionals who treat AIDS patients (Dworkin, Albrecht, & Cooksey, 1991). The researchers found that professional position (i.e., doctor, nurse, or social worker) to be an important factor as nurses tend to have the most invasive contact with patients with AIDS. The findings showed that as the invasiveness of the contact (i.e., lab testing, starting an IV, or drawing blood) increased in the medical setting, the level of worry and discomfort also increased. Social workers showed the least amount of worry, while one third of the nurses and one quarter of the doctors reported being worried about spreading HIV to their families. The study suggested that emotional reactions to PWAs are specifically related to the type of patient contact. It was also noted that the majority of their sample believed that AIDS patients should be treated on a specialized AIDS ward.
and the majority of the respondents stated that they would not willingly work on such a ward, although the reasons behind this were not explored in the study.

Stress of Caregiving of PWAs

Psychological distress is reported by professional caregivers of PWAs, resulting in high levels of exhaustion and stress (Shulman & Mantell, 1988; Silverman, 1993). Treiber, Shaw & Malcolm (1987) found that doctors and nurses experience more professional distress when providing care to AIDS patients. Their subjects reported increased anxiety, greater interference in nonwork activities, more frequent negative rumination, and negative perceptions regarding the patient's behavior while caring for the AIDS patient. Doctors and nurses perceived the AIDS patient as much more resistant to routine medical procedures due to uncooperativeness, depression, and inflexibility. In non-work settings, these medical personnel reported intrusive ruminations over fear of contagion and tended to avoid discussions of these fears with family or friends.

Silverman (1993) reported descriptions of psychological distress experienced by health professionals from several disciplines, that include AIDS-related nightmares, intrusive thoughts, irritability, avoidance of PWAs, physical exhaustion, and diminished interest in professional and personal activities. He concluded that AIDS-related stress can exacerbate the manifestation of other psychiatric conditions, such as mood disorders, anxiety disorders, substance abuse, and relationship and professional problems in susceptible professional AIDS caregivers. Weiner and Seigel (1990) stated that AIDS caregivers are especially vulnerable to high levels of stress, guilt, depression, and anxiety.
Attitudes of Health Care Providers Toward PWAs

Unjustified discrimination by medical and dental treatment providers has been reported by gay and bisexual males. Men with AIDS reported significantly more likelihood (18%) of being denied treatment based on their known or suspected HIV-related condition, while men who were seropositive reported less treatment denials (5%), and men who were seronegative reported the least treatment denials (1%). The diminished access to services is thought to be related at least partially to the association of the provider between the risk of HIV infection and the gay/bisexual male lifestyle (Kass, Faden, Fox, & Dudley, 1992). A study of medical, nursing and paramedical students found that homophobia was a stronger predictor for the fear of AIDS than age, sex, marital status, or chosen specialty area (Royse & Birge, 1987). The damaging psychological effects of discrimination due to fear of contagion or homophobia is not to be underestimated, according to Morin, Charles & Maylon (1984).

Wertz, Sorenson, Liebling, Kessler, and Heeren (1988) found in their survey of 1,047 health care providers that providers who established regulations for the care of PWAs and outpatient care providers reported the most accurate knowledge about AIDS and felt most comfortable with PWAs while those who had the least accurate knowledge and felt least comfortable were the inpatient care providers with no supervisory responsibilities. Another study by Henry, Campbell, and Willenbring (1990) examined variables correlated with AIDS-related knowledge, attitudes, and behaviors of 2,391 Midwest hospital employees. They found that lower homophobia scores, higher AIDS knowledge scores, expressed confidence in AIDS-related medical information, and a greater number of
professional contacts with PWAs were highly correlated with positive behaviors and attitudes towards PWAs. They also found that those medical personnel with a family member or a close friend who was also a PWA correlated with greater positive attitudes towards patients with AIDS.

Allender, Senf, Bauman, and Duffy (1991) found in their study of 336 health care providers' attitudes before and after an AIDS educational training, that there was a significant relationship between the fear of AIDS and level of education ($F = 6.98$, $p < .001$), having children ($F = 5.25$, $p < .023$), and frequency of contact with PWAs ($F = 3.58$, $p < .015$). Health care providers with less than a college degree demonstrated the greatest fear of AIDS and the most negative attitudes toward gay males and lesbians. Those with children scored higher on the “Fear of AIDS” subscale than those without children; however their scores showed no significant relationship with scores on the “homophobia” scale. Contact with PWAs was a significant predictor of lessened fear of AIDS and of lessened homophobia.

Physicians

Physicians have been shown to have strongly negative attitudes toward treating PWAs which parallel negative attitudes toward gay and lesbian patients (Kelly, St. Lawrence et al., 1987b). A study of physician attitudes by Kelly, St. Lawrence et al. presented a male patient “Mark” in one of four vignettes where the patient's illness was identified as either AIDS or leukemia and the patient's sexual orientation was either gay or heterosexual. The subjects strongly reported less willingness to interact even casually with the PWA “Mark” compared to “Mark” with leukemia, even when there would be no
danger of contagion. Physicians considered PWA “Mark” as more responsible for his illness, more deserving of contracting it, more dangerous to others, to be experiencing more pain but less deserving of sympathy, and more deserving of quarantine. Sexual orientation of the patient was not found in this study to be related to the strong stigmatizing responses that the physicians had to the PWA “Mark.”

Second year medical students in a high incidence area were surveyed about their attitudes toward AIDS (Imperato, Feldman, Nayeri, & DeHovitz, 1988). Sixty percent of them believed that drawing blood from an AIDS patient carried a high-to-moderate risk of contracting HIV, while performing surgery was rated as the greatest risk (66.7%). More than 22% believed that there was a moderate-to-high risk of transmission during a regular physical examination. When asked if physicians should have the prerogative to refuse to treat new patients with AIDS, 48.3% responded affirmatively. Referral of longstanding patients who develop AIDS was identified as a preferred prerogative of physicians by 41.4% of the medical students, as long as there was care available elsewhere.

In another study, 25% of the medical and pediatric interns and residents responded that they would rather not care for AIDS patients if given a choice (Link, Feingold, Charap, Freeman, & Shelov, 1988). Both studies reveal a high fear of contagion among physicians and medical students. Heath, Acklin, and Wiley (1991) found that 17% of the physicians they surveyed would refuse to treat patients with AIDS if they had the choice and 4.5% of the respondents stated that they had considered changing occupations due to the perceived threat of AIDS contagion on the job. Hayward and Shapiro (1991) found that 23% of the residents they surveyed would not provide care to patients with AIDS if
given the choice and 37% felt that treating an AIDS patient was dangerous because of the fear of contagion of HIV. Rizzo, Marder, and Willke (1990) found that 19.4% of their sample of 2,884 physicians did not agree that a physician is obligated to treat patients with AIDS, while 75.3% agreed, and 5.3% were not sure. Orthopedic surgeons surveyed about their ethical obligation to operate on a patient with AIDS responded strongly (79%) that they are not obliged to operate if there is substantial risk of contagion, however 90% of those surveyed had operated on patients with HIV/AIDS (Arnow, Pottenger, Stocking, Siegler, & DeLeeuw, 1989).

A study conducted by Yedida, Barr, and Berry (1993) examined the differences in career stage and medical specialty regarding the fear of AIDS. The data were collected using self-administered questionnaires and were received by 363 faculty members, 438 house staff, and 487 medical students. The fear of AIDS superceded the concerns about interference with training with the house surgical staff. The medical faculty reported the fear of AIDS to be greater than concerns about AIDS interfering with medical training. Fear of AIDS was greater among surgeons than internists, regardless of career stage. General medical students were more concerned about AIDS interfering with their training than were students in surgery, who expressed more concern about AIDS contagion. All groups within surgery were less willing to treat AIDS patients than patients who had another contagious or terminal disease.

The concern that the AIDS epidemic is taking away the opportunity to learn about other diseases was expressed by those who had the most contact with patients with AIDS. There was a greater unwillingness to treat AIDS patients at all career stages than other patients. Another study of physician attitudes towards treating the patient with
AIDS revealed that general and specialized surgeons, such as oncologists, infectious and pulmonary disease specialists, hematologists, and obstetrician/gynecologists were least likely to agree that physicians have an ethical responsibility to treat the patient with AIDS (Rizzo, Marder, & Willke, 1990).

The majority of health profession students in another study believed that by working with AIDS patients, that they put their own health in danger (Currey, Johnson, & Ogden, 1990). Only 25% of the students reported a willingness to perform mouth-to-mouth resuscitation on a PWA. Unwillingness to work with AIDS patients predicted a higher level of homophobic attitudes. Health profession students indicated a fear of contagion and concerns about being at risk while treating AIDS patients.

Medical students and faculty were found by Feldmann, Bell, Stephenson, and Purifoy (1990) to report fear of contagion and lack of comfort with AIDS patients. They held negative attitudes toward PWAs and lacked accurate information regarding the legal and ethical issues of providing treatment to AIDS patients. One third of those surveyed reported feeling more negative about the gay lifestyle as a result of the AIDS epidemic and reported feeling that the rights of PWAs had been overemphasized. Another study revealed no inherent discriminatory attitudes toward PWAs among medical students, however these students had been voluntarily attending educational programs on AIDS (Johnson, Campbell, Toewe, & Bell, 1990).

Sexual orientation of the physician, as related to attitudes about AIDS, was the focus of a study by Marks, Richardson, Lochner, McGuigan, and Levine (1988). Heterosexual physicians' attitudes were found to be more negative than those of gay or lesbian physicians. Another study found that over one third of physicians (36%) agreed with the
statement that "homosexual behavior between two men is just plain wrong" (Gemson, Colombotos, Elinson, Fordyce, Hynes & Stoneburner, 1991, p. 1104). Ten percent of physicians and nurses in an earlier study responded that "homosexuals who contract AIDS are getting what they deserve" (Douglas, Kalman, & Kalman, 1985, p. 1309) and the homophobic responses of the subjects, while tending to be low overall, were significant according to the authors. The level of homophobia was found to be mitigated by personal contact with a gay friend or relative. This is one of the few studies that found males less homophobic than females. Females were found to be less homophobic and less fearful of contagion of HIV than their male medical student counterparts in another study (Merrill, Laux, & Thornby, 1989). These authors also found in their survey of 4,000 physicians that 50% believed that they had the right not to treat PWAs and 15% responded that they would refuse to treat PWAs. They hypothesize that this attitude is based on fear of contagion, homophobia, and fear of caring for dying patients. A survey of California physicians homophobic attitudes found strongly negative attitudes expressed by 25% of the respondents with 30% stating that they would not admit a gay or lesbian applicant to medical school and 40% would not approve of a gay or lesbian physician entering training for pediatrics or psychiatry (Mathews, Booth, Turner, & Kessler, 1986).

The results of studies of physicians and medical students reflect the fear of AIDS being the greatest within the groups where there is more potential exposure to HIV in the treatment of patients with AIDS. This fear of contagion and homophobic attitudes affect the attitudes of physicians toward PWAs (Feldmann, Bell, Stephenson, & Purifoy,
Condit and Frater (1989) support this assertion in their study of cardiac surgeons who reported a high level of fear of contagion when considering surgery for a PWA.

Norton, Schwartzbaum, and Wheat (1990) found that the metaphors that physicians use to describe AIDS and PWAs often show discrimination and a perception that AIDS is a death sentence. Only 44% of AIDS patients surveyed by Valdiserri, Tama, and Ho (1988) felt that they had been given an accurate idea of the expected progression of their condition by their physician. The majority of physicians did not recommend testing for the PWAs' lovers or instruct the PWA about daily activities as they related to contagion or sexual contact precautions except to advise the use of condoms with the message that abstinence was preferred.

Nurses

Kelly, St. Lawrence, Hood, Smith, and Cook (1988) conducted a study to examine if nurses perceive PWAs in a stigmatized manner and to what extent homophobia affects their attitudes toward PWAs. Five hundred nurses were sent a vignette describing a patient named “Mark” who was either gay or heterosexual, and diagnosed with AIDS or with leukemia. The response rate of the subjects was 32.2% with 166 returns. The researchers utilized the Prejudicial Evaluation Scale (PES), the Social Interaction Scale (SIS) and the Interpersonal Attraction Inventory (IAI).

Results of the PES indicated that the nurses rated the gay “Mark” as more responsible for his illness, less deserving of sympathy and understanding, and more deserving of the illness whether it was AIDS or leukemia. The PWA “Mark” was rated stronger in a negative direction, however, than the leukemia “Mark.” The SIS results indicated a
significant desire not to interact with PWA "Mark," or the gay "Mark," regardless of his illness. Conversely, the IAI showed that the nurses perceived PWAs as more truthful, more flexible, open-minded, warm and skilled socially than patients diagnosed with leukemia. Overall, this study showed that nurses perceived PWAs and gay males in a stigmatized manner that may interfere with their ability to provide quality medical care (Kelly et al., 1988).

Masters' level nursing students were given one of six vignettes about a male patient which differed in diagnosis and sexual orientation (Strasser & Damrosch, 1992). The diagnosis was either AIDS contracted in an unspecified manner, AIDS contracted by a hemophiliac during a blood transfusion, or leukemia. The patient with AIDS that was contracted in an unspecified manner was judged more responsible for the disease and more deserving of the illness than the PWA hemophiliac or the leukemia patient. Both patients with AIDS were rated as equally dangerous to others. The heterosexual and the gay PWA were stigmatized in terms of social interactions with the evaluation of the heterosexual lifestyle rated more positively than the gay lifestyle. While the mode of contraction of HIV was a significant factor in the attitudes of the student nurses, they responded that all three of the categories of diseases presented deserved the best medical care available.

Other studies have indicated that empathy for PWAs is strongly impacted by homophobic attitudes of nurses (Lester & Beard, 1988; Royse & Birge, 1987), fear of contagion of HIV (Armstrong-Esther & Hewitt, 1989; Blumenfield, Smith, Milazzo, Seropian, & Wormser, 1987), and discomfort treating dying patients (Scherer, Haughey, & Wu, 1989). Fear of contagion was so great in one study of nurses, that one-half of them would refuse to treat PWAs if assigned to do so (Blumenfield et al., 1987). Twenty
five percent of nurses reported that their attitudes toward gay males had become more negative since the onset of the AIDS epidemic (Scherer, Wu, & Haughey, 1991). Rural nurses' attitudes towards the gay lifestyle and attitudes toward AIDS has been shown to be significantly related to feelings of fearfulness and willingness to treat PWAs, which the authors believe can be mitigated through adding an affective component to AIDS educational trainings (Young, Koch, & Preston, 1989). More than one half of rural nurses (56%) were fearful of contagion of AIDS and 51% reported feeling revolted when thinking of two men having sex with each other, in a study of 731 rural nurses (Koch, Preston, Young, & Wang, 1991). Thirty-five percent of the rural nurses in the sample felt that gay sexual relationships should be considered "immoral" (p. 34). Age was not a significant factor related to homophobia, although religious affiliation and educational level were found to be significant.
Attitudes of Mental Health Professionals

Psychiatrists

Very few studies are available in the professional literature surveying the attitudes of psychiatrists towards PWAs. In one survey of several medical specialty groups of physicians, psychiatrists conveyed a fear of contagion of AIDS while treating PWAs, while being nonjudgmental about the sexual orientation of the patient (Frierson & Lippman, 1987). A study of homophobic attitudes conducted in Canada of 19 psychiatric residents, 22 family practice residents, and 31 psychiatric faculty found that the groups studied tended to fall within the lower part of their homophobic scale (Chaimowitz, 1991). This study also found that the psychiatry and family practice residents were more willing to see a patient with AIDS than were the faculty. Those who felt that gay PWAs deserved to contract the disease represented 4.2% of the overall subjects. Female subjects were shown to be less homophobic than male subjects in this study. All of the groups were generally unaware of the statistics regarding AIDS.

Another study done by surveying all members of the American Academy of Child and Adolescent Psychiatry in nine states produced a return rate of 511 respondents (54%) out of 952 mailed questionnaires (Brown, Etemad, Brenman, & Dwight, 1991). Personal attitudes were measured by three questions assessing the psychiatrists' comfort with HIV patients, from 0 (little comfort) to 9 (substantial comfort). Sixty four percent of the respondents claimed to feel comfortable working with HIV patients, and few expressed fear of contagion from their patients or their personal lifestyle. Experience working with HIV positive children and/or adolescents was correlated highly with the reported comfort
level of the psychiatrist ($p < 0.05, r = 0.13$). Conversely, those who indicated more comfort working with HIV positive patients ($t = 2.24, p < 0.05$) had significantly more experience treating these patients. There were no differences in the comfort level when working with HIV positive patients between psychiatrists based on gender, age, work setting, or geographical setting.

Attitudes toward PWAs were also revealed in a study of 301 psychiatrists, psychologists, and social workers in their response to one in four hypothetical therapy cases in which the client had AIDS and refused to disclose to their partner, or did not have AIDS and had homicidal intent (Stewart & Reppucci, 1994). The relationship of the client to the partner was either heterosexual or homosexual. The PWAs were rated as being significantly more dangerous than those with homicidal intent and were less likely to receive intervention. Homicidal gay men were the least likely of receiving intervention, while homicidal heterosexual men were the most likely to receive intervention. PWAs were also rated the most negatively on an adjective rating scale included in the study.

Psychologists

Crawford, Humfleet, Robordy, Ho, and Vickers (1991) conducted a survey of attitudes towards PWAs by clinical psychologists and clinical social workers from 13 United States cities. The 185 respondents completed questionnaires that assessed their attitudes toward a patient in a vignette which described an individual, “John,” who was described as learning from his doctor that he has a terminal illness. The subjects received one of four possible vignettes that described either a gay or heterosexual male with either AIDS or leukemia. The subjects then responded to five attitudes measures that measured
prejudicial attitudes towards PWAs, willingness to interact, personal attraction, and likeability, homophobia, and professional comfort with the individual described in the vignette. Subjects who rated “John” as a PWA were significantly less likely to take “John” on as a client, more likely to refer him to another professional, and less likely to make any physical contact with him than those who were rating “John” with leukemia. These subjects also rated the PWA as significantly more responsible for his disease, less deserving of sympathy, more dangerous than the individual with leukemia, and saw AIDS as being more traumatic and involving more pain and suffering than leukemia. No significant differences were found between the responses of psychologists and social workers, gender, or geographical location. Subjects who rated high on the homophobia scale were less willing to take John on as a client, when he was described as gay in the vignette. Those respondents who had previous training in AIDS indicated more willingness to treat the PWA, rated themselves as more comfortable, and would have more physical contact with them as compared to mental health professionals who had not had any previous AIDS training. The authors found that the disease of AIDS was the most significant variable in the responses of the mental health professionals. However they note that unwillingness to be in close proximity may suggest pervasive homophobia among mental health professionals rather than fear of contagion.

A study of psychologists done by St. Lawrence, Kelly, Owen, Hogan, and Wilson (1990) utilized the same vignettes as the one by Crawford et al. (1991) described above, except the name of the individual in the vignette was “Mark.” These researchers utilized a prejudicial evaluation scale (PES), a social interaction scale (SIS) and an interpersonal evaluation inventory (IEI) to measure the psychologists' attitudes. The final sample size
included 94 male and 32 female psychologists from 37 states with a mean age of 49.3 years and an average of 18.6 years in their profession. The results indicated that psychologists considered the PWAs to be more responsible for his illness, more deserving of quarantine, more dangerous to others, deserving of the best medical care available, experiencing more pain and suffering, and a person for whom suicide is likely to be the best solution to the disease. The psychologists also were more reluctant to interact with the PWA as compared to the leukemia patient; however, there were no indications of negative attitudes due to the sexual orientation of the individual described in the vignette. The results show that the psychologists have more negative attitudes towards PWAs as compared to leukemia patients, including fear of contagion, assigned responsibility for contraction of AIDS, and suggested extreme measures such as suicide or quarantine.

Kindermann, Matteo, and Morales (1993) conducted a training needs assessment of doctoral students in psychology at the California School of Professional Psychology, Berkeley/Alameda. Out of 425 surveys, 100 were returned for a response rate of 24.3%. They found that the students perceived themselves to be competent providing clinical services to PWAs and those who are at risk for HIV infection. The perceived competence had a moderate correlation with their total training in AIDS. The authors found no correlation between the perceived clinical competence of the subjects and training in multicultural issues in AIDS education. The authors were alarmed at the ethical considerations of those who believe that they are competent to provide clinical mental health services to PWAs in multicultural populations without adequate training.

Hayes and Gelso (1993) studied male psychologists and psychology doctoral students at two university counseling centers and their discomfort with gay and
HIV-infected clients. The subjects completed a scale that measured death anxiety and homophobia, utilizing items from Templer's (1970) Death Anxiety Scale and Daly's (1990) Homophobia Scale. The subjects were then shown one of eight videotapes showing a 20-year-old white male who was either gay or heterosexual; HIV-negative or HIV-positive. Efforts were made to keep the emotional content on the same level despite the sexual orientation or disease status of the client. For both HIV-negative clients (both gay and heterosexual) the issues discussed on tape were being in love, fear of rejection, living with one's partner, concern about parental disapproval, and uncertainty about the future. The two HIV-positive clients, one gay and one heterosexual, addressed issues related to relationships, fear of infecting others, fear of being alone, changes in sexual practice due to infection, and guilt about dying early. The gay client also discussed the fears of coming out to his parents, while the heterosexual client talked about his parents probable reaction to his moving in with his girlfriend. The subjects completed a State-Trait Anxiety Inventory (Speilberger, Gorsuch, & Lushene, 1970) in response to how they felt while viewing the videotaped client. The subjects were also asked to recall client material from the videotape following the viewing to measure cognitive accuracy and distortion. The psychologists responded verbally into a microphone during pauses during the client's dialogue. These responses were used to measure the behavioral component of the psychologist’s discomfort and were rated on a scale of approach and avoidance of the client's material.

Results of this study showed that the psychologists experienced more discomfort with HIV-positive clients than with HIV-negative clients, and did not show a significant difference in their comfort level between gay and heterosexual clients. The sample scored
below the mean for men in the norm group on the homophobia scale; however, there was a significant relationship between the psychologists' homophobia and their verbal avoidance behavior. There was also no significant relationship between HIV status and sexual orientation of the client found in the subjects' responses. Death anxiety was shown to be unrelated to the subjects' discomfort with gay male clients.

Social Workers

Riley and Greene (1993) conducted a survey of undergraduate social work and health administration students and other human service personnel, following training programs on HIV/AIDS, to determine if the attitudes of the participants were affected by the length or type of training. The survey specifically focused on fear of AIDS and comfort working with PWAs. The authors found that all of the trainings increased self-assessed attitude scores. Program content and length were found to have an impact on the subjects' attitude change. The training programs that were longer in length and contained more experiential components had a more positive impact on the attitudes of the participants. This agrees with the work of Van Servellen, Lewis, and Leake (1988) who suggested that longer educational programs with experiential aspects aimed at attitude change are more likely to have the most impact on service providers' behavior. Health care providers who had invasive contact with AIDS patients continued to report fear, even following the educational program.

Weiner-Brawerman (1988) conducted a study of 264 hospital social workers regarding their attitudes toward providing services to the AIDS patient population. Factors related to comfort in working with AIDS patients indicated that 60% of the respondents would
not be likely to apply for a position in which the primary responsibility was to work with AIDS patients, although 90% would not refuse to treat an AIDS patient. Sixty-eight percent had not made themselves available for providing professional service to AIDS patients, although 45% would have liked to. She examined the extent to which social workers' level of comfort in providing services to PWAs was affected by certain variables. The study concluded that the strongest motivating variable was moral attitude, followed by fear of contagion, homophobia, understanding of the disease and factors related to contagion, job satisfaction, and knowledge of community resources. A negative moral attitude was correlated with homophobia, fear of contagion, and limited knowledge about the disease. Fear of contagion seemed to be lessened when the respondent had previously provided services to AIDS patients. Homophobic respondents reported limited or no contact with AIDS patients and felt uncomfortable having contact with other high risk patients.

Another study was completed by Weiner and Siegel (1990) with 406 hospital social workers responding to a mail questionnaire assessing the respondents' comfort in providing services to PWAs, homophobia, fear of contagion, knowledge about AIDS, negative attitudes toward PWAs and the respondents' perceptions of their families' and friends' reactions to their working with PWAs. This study examined two levels of comfort through the Comfort with AIDS Patients Index (CAPI) developed for this study. The first level concerned an individual's interest in or willingness to work with PWAs. The second measured the level of confidence in establishing a positive professional relationship with the client, characterized by rapport, empathy, and acceptance. Most social workers reported a moderate level of comfort with the idea of working with PWAs.
Sixty percent of the respondents reported they were “not very likely” or “not at all likely” to apply for a position where the main job responsibility would be providing direct services to PWAs. Scores on the homophobia measure were found to be negatively associated with the subjects’ comfort in working with PWAs, with the respondents who were more homophobic being less likely to have had professional contact with PWAs. Age, gender, marital status, or years of professional employment had no association with the level of comfort reported by the social workers in this study. Another result of the study showed that the level of comfort diminished when providing services to a PWA was associated with the perceived concerns and fears of family and friends. The inverse of this also proved true, with the level of comfort increasing when their family or close friends were supportive of this type of service work.

A previous study of homophobic attitudes of mental health providers included data about social workers (De Crescenzo, 1984). Social workers in this study achieved the highest homophobic scores as compared to psychologists, who scored the lowest. Another study (Wisniewski & Toomey, 1987) found in its preliminary survey of 77 social workers providing clinical services in agencies that nearly one third of the respondents measured as homophobic within Hudson and Ricketts’ (1980) Index of Attitudes toward Homosexuals scale (IAH).

Another study by Dhooper, Royse, and Tran (1987-88) found that the age of the social worker respondent was a variable. The respondents younger than 35 were more empathic toward PWAs, less homophobic, and less fearful of contagion than those over 35. Eighty percent of the respondents in this study said that they would refuse the assignment of an AIDS case if they were a hospital social worker. This study was
limited, however, as it surveyed only the alumni of the College of Social Work in Kentucky, a low incidence state, and had a low response rate, perhaps, the authors stated, due to the subject matter it was surveying.

Another study by Royse, Dhooper, and Hatch (1987) surveyed undergraduate social work majors (39%), nonmajors (25%), and graduate social work students (36%) to investigate how the fear of AIDS might be influenced by knowledge about AIDS and empathy toward PWAs. This study found that knowledge was positively associated with increased empathy and that greater knowledge and empathy were indicative of reduced fear. Age, sex, race, and academic status were not related in this study to the fear of AIDS.

Shi, Samuels, and Richter (1993) found that AIDS related knowledge and skill were significantly associated with improving the general attitudes of social worker toward HIV/AIDS clients. Other significant covariates found in this study that have a positive effect upon attitudes, included levels of professional contact with PWAs, and sensitivity to minorities. In this particular study, the gender of the respondent was not found to be significantly related to attitudes.

Another study of social workers examined the relationships between the information possessed about AIDS and its relationship to attitudes (Samuel & Boyle, 1989). Age of the social worker emerged as a variable in this study, with younger subjects demonstrating more knowledge, positive attitudes toward PWAs, and less self-rated anxiety toward PWAs.

Wexler (1989) surveyed 61 second year graduate students at the University of California at Berkeley regarding their knowledge and attitudes about AIDS. She found
that although a majority of the attitudes expressed by the social work students were consistent with the values of the social work profession, there was a gap in the knowledge about diagnostic issues, minorities, and substance abusers. This survey showed a slightly positive association between knowledge and attitude scores. The total attitude scores did not vary in any significant way according to gender, race, age, or field of specialization. This survey was very limited in scope and took place in a high incidence area of the AIDS epidemic where some of the first cases of AIDS were reported in 1981.

Silberman (1991) conducted a survey of social work graduate students in six East Coast universities aimed at identifying the concerns of students working with AIDS populations. The frequency of reported concerns was low and tended to revolve around the concern of not having adequate information about how to provide services to PWAs and a lack of knowledge about available community resources. Twenty five percent of the students reported feeling overwhelmed by clients’ feelings of anger, helplessness, guilt, and sadness, while 11% reported significant discomfort with the issues related to death. Recommendations were made in this study for AIDS-focused field placement supervision and AIDS specific training needed in social work graduate programs. Of the 240 students that returned the surveys, 23% had professional and/or personal contact with PWAs during the previous one to two years.

Family Therapists

One study was found that surveyed 1000 clinical members of the American Association for Marriage and Family Therapy regarding their knowledge and attitudes toward AIDS and PWAs (Green & Bobele, 1994). The AIDS and related attitudes scale
ARAS used was developed by Gold-Neil & Dixon (1989). The survey had a response rate of 46% with a total sample of 457. The researchers also assessed the impact of personal and professional contact with PWAs and gay men or lesbians.

Respondents reported considerable professional contact with gay men and lesbians. Fifty-three percent reported having provided family therapy to a gay male or lesbian client for over one year. Only 8% reported never having treated a gay male or lesbian, while 38% reported doing therapy with a gay male or lesbian for under one year. Seventy-two percent of the respondents indicated that 10% of their practice was with gay men or lesbians. Twenty percent reported no current lesbian or gay male clients.

Professional services had been provided to a PWA by 10% of the respondents for over one year, while 68% reported no professional contact with a PWA. Seventy percent reported not currently having a PWA as a client. Ninety-one of the respondents (20%) reported that less than 10% of their practice was devoted to services to PWAs.

The majority of the respondents (70%) reported having had a personal relationship with a gay man or lesbian for over one year. Twenty-four percent reported never having any personal contact with a gay man or lesbian. Forty-five percent of the sample reported never having a personal relationship with a PWA, while 19% reported having had a personal relationship with a PWA that spanned more than one year.

The results of the study indicated that the marriage and family therapists who had had contact with gay males, lesbians, and PWAs were less likely to have avoidant attitudes toward PWAs. The respondents who indicated both personal and professional contact with gay males, lesbians, and PWAs were the least likely to express phobic attitudes toward PWAs. The level of knowledge regarding AIDS and percentage of gay males and
lesbians in clinical practice were significant predictors of attitudes toward PWAs. Knowledge alone was not a predictor of attitudes toward PWAs. The authors considered that the therapists may inaccurately assess their own level of knowledge and therefore not seek further AIDS training. They also considered that those who had treated PWAs may become more negative toward them as they become overwhelmed by the multitude of issues that PWAs face.

**Mental Health Counselors**

Only two studies were found in the literature that assessed the attitudes of mental health counselors toward PWAs. One survey of mental health counselors surveyed the knowledge of, opinions about, and attitudes towards PWAs of members of the American Humanistic Education and Development Association (AHEAD) (Maione & McKee, 1987). The methodology included eliciting responses to a short survey included on the back of the association newsletter which was mailed to all members. Seventy-four respondents answered the questions, removed it from the back of the newsletter and mailed it into the researchers. The results showed that the respondents were moderately to well informed about AIDS. Responses to questions indicating attitude and opinion about AIDS resulted in the majority of counselors disagreeing with the statement that “children infected with the AIDS virus should be allowed in the school system”. The majority of counselors responded affirmatively to the statement “I would feel comfortable counseling a person with the AIDS virus”. The greatest diversity of responses was to the statement “I believe that I know enough about the disease to counsel a person who has AIDS effectively”. This study is quite limited in that it elicited
responses from participants who were interested enough in the topic to respond to the newsletter request and to take the time to mail it in. The results were also not analyzed in depth and tended to be confusing.

Larson (1991) conducted the most comprehensive assessment of mental health counselors' attitudes towards PWAs or clients with leukemia utilizing the dependent variable of the clients' sexual orientation. The 451 subjects were members of the American Mental Health Association and received a 500 word vignette about a client “Mark” who was either gay or heterosexual, and was ill with either AIDS or leukemia. After reading the vignette, the subjects responded to the Interpersonal Attraction Scale (IAS), the Prejudicial Evaluation Scale (PES), and the Social Interaction Scale (SIS). Attitudes were measured for one half of the sample with the Heterosexual Attitudes Toward Homosexuality scale (HATH), while the other half responded to the Attitudes Toward AIDS Victims scale (ATAV).

This study found that mental health counselors expressed more interpersonal attraction toward the gay “Mark” with AIDS on the IAI. They expressed more prejudicial attitudes (PES) toward the “Mark” with AIDS regardless of his sexual orientation and found the leukemia “Mark” more socially attractive (SIS) regardless of his sexual orientation. A post hoc test of Larson’s results showed no clear pattern, although the mental health counselors who scored low on the ATAV scale rated the gay “Mark” with significantly greater personal attractiveness. Conversely, when the ATAV score was high and “Mark” was identified as a heterosexual with leukemia, he was seen as the least interpersonally attractive in comparison to the other stimulus client combination. The results, according to Larson, are confusing and may be influenced by her samples'
overall lack of contact with a PWA (53%), altruism, countertransference issues and an attempt on the part of the counselors to be politically correct. Larson also pondered the possibility that educational trainings may have heightened the counselors' awareness about AIDS which resulted in increased sympathy for PWAs.
Chapter III

Overall Design and Methodology

Introduction

This study was designed to assess the attitudes of mental health counselors toward PWAs utilizing twenty items from the ATAV scale (Larsen et al., 1990). This instrument measured subjects' responses to the 20 items on a Likert type scale. Items on the scale range from: (1) strongly disagree, (2) disagree, (3) no opinion, (4) agree, and (5) agree strongly. There are nine items that are reversed for negative items in the scale. The results of these attitudes were examined in relation to reported demographic information collected in the survey. The information collected assessed whether gender, contact with PWAs within the past year, personal acquaintance with a PWA, counselor sexual orientation, personal acquaintance with a person who is gay, or formal training had any impact on the attitudes of mental health counselors toward PWAs. The methodology utilized surveys distributed by mail to a random sample of members of the American Mental Health Counselors Association (AMHCA). The number of subjects (358) necessary for analysis, assuming a 40% return rate out of the sample size, was determined by Cohen's Sample Size Tables (Cohen, 1969).
Null Hypotheses

Hypothesis I: There is no significant difference between the attitudes of male mental health counselors and the attitudes of female mental health counselors towards persons with AIDS.

Hypothesis II: There is no significant difference between the attitudes of mental health counselors who have had no professional contact with a PWA within the past year and the attitudes of mental health counselors who have had professional contact with a PWA within the past year toward persons with AIDS.

Hypothesis III: There is no significant difference between the attitudes of mental health counselors who report personal acquaintance, other than with a client, with a PWA and the attitudes of mental health counselors who report no personal acquaintance with a PWA toward persons with AIDS.

Hypothesis IV: There is no significant difference between the attitudes of mental health counselors who identify themselves as gay or lesbian and the attitudes of mental health counselors who identify themselves as heterosexual toward persons with AIDS.

Hypothesis V: There is no significant difference between the attitudes of mental health counselors toward persons with AIDS who report personal acquaintance with a person who is a gay male or lesbian, other than a client, and the attitude of mental health counselors who report no personal acquaintance with a person who is a gay male or lesbian.
Hypothesis VI: There is no significant difference between the attitudes of mental health counselors who have had one or more hours of formal training regarding AIDS and the attitudes of mental health counselors who have had no formal training regarding AIDS toward persons with AIDS.

Subjects

The subjects chosen were randomly selected from the membership of AMHCA, which is a division of the American Counseling Association (ACA). The total membership of AMHCA at the time of this study was 11,600. The total number of subjects chosen was based on Cohen's table (1969) which indicates that a 40% response rate (140 subjects) is needed in order to ensure minimum same size response. The total number of subjects who were mailed the survey materials was therefore 358.

The demographic characteristics of the AMHCA membership at the time of this study are as follows:

- Gender: 65% female; 35% male.

- Ethnicity: 94% Caucasian; 2% African-American; 1.5% Hispanic; less than 1% Asian and Native American.

- Primary Professional Role: 65% mental health counselor; 10% students; 4% supervisor consultants; 6% counselor educators; 5.6% administrators.
• Primary Work Setting: 46% private counseling practice: 11.5%
college/university setting; 8% community mental health center; 6% school setting.

• Education: 68% masters degree; 19% doctorate degree; 9% associate degree;
3.3% education specialist degree.

Instrumentation

Data collection was accomplished through a self-administered questionnaire mailed out to the 358 subjects. The assessment of attitudes of mental health counselors toward persons with AIDS was measured by the ATAV scale (Larsen, et al., 1990). This instrument has twenty items responded to by the subject on a Likert type scale rating the statement from: (1) Disagree strongly, (2) Disagree, (3) No opinion, (4) Agree, and (5) Agree strongly. An additional two items were added at the end of the ATAV scale, utilizing the Likert scale measuring the self-reported comfort with counseling PWAs and perceived competence in providing counseling to PWAs and family, friends, and lovers of the PWA, based on the work of Wiener-Brawerman (1988). One item (8) was inadvertently left off of the ATAV scale in the survey publication, which will have no negative effect on the internal reliability of the instrument according to the author (Larsen, 1991, personal correspondence).

The ATAV scale was developed by Larsen in five phases utilizing a total of 582 undergraduates with the mean age of 24.2 with 249 males and 333 females. The results of
Phase 1, which was an item analysis of the scale, yielded 20 items which produced a scale with high part-whole correlations (.62-.90, \( p < .001 \)), corrected split-half reliability (.87, \( p > .001 \)), and alpha coefficients (.91, \( p < .001 \)). The following phases yielded significant correlations between the ATAV scale and attitudes of the subjects toward homosexuals utilizing the 20-item Heterosexual Attitudes Toward Homosexuality (HATH) scale also developed by Larsen (1980). The correlation between the two scales was .60, \( p < .001 \); thus attitudes toward homosexuals were shown by Larsen to be the central component in attitudes of the respondents towards AIDS Victims.\(^1\)

The alpha coefficient and construct validity was supported in phase 2 which found that the prediction of attitudes toward PWAs are a function of attitudes toward gays and lesbians. The authors accomplished this by administering the ATAV scale to male and female undergraduate students, along with the HATH scale and the 16-item Campbell self-assessment scale (Robinson & Shaver, 1973) which measured self-esteem. The alpha coefficient was .91 (\( p < .001 \)), which supported the high internal consistency found in phase 1. The correlation between the ATAV and HATH scales was .60 (\( p < .001 \)) and the Campbell self-esteem scale, .19 (\( p < .05 \)). The results also supported the hypotheses that persons with low self-esteem have more negative attitudes toward PWAs.

Phase 3 of the scale development utilized the administration of the ATAV scale along with a 20-item attitudes scale measuring heterosexual attitudes toward homosexual parenting and yielded moderately strong correlations ranging from .58 to .72. Phase 4 paired the ATAV scale with a 24-item, anti-Semitism scale (Eysenck & Crown, 1948),

\(^1\) It is to be noted that Larsen uses the terminology “homosexual” instead of gay male or lesbian. The ATAV scale utilizes the term “AIDS Victim” instead of the more current “Persons with AIDS”.

the 16-item, anti-Black scale (Steckler, 1957), and the 15-item attitudes toward capital punishment scale (Balogh & Mueller, 1960). The evidence showed that negative attitudes toward PWAs are, according to Larsen (1990), a part of the negative attitude held towards Jews and Blacks, and a tendency to favor capital punishment. The final phase (5), reported results related to sexually liberal attitudes: correlating the ATAV scale with a 21-item attitude toward condom advertisement scale and a 20-item Wang and Thurston attitudes toward birth control scale (Shaw & Wright, 1967).

The five phases of the ATAV scale development produced high part-whole correlations and internal consistency as measured by both Spearman-Brown and Alpha coefficients. The ATAV scale supports the theory that attitudes toward PWAs are primarily a function of attitudes toward homosexuals and the related concept of homosexual parenting.

Demographic data items were treated descriptively and supplemented the statistical analysis portion of this research. The ATAV scale was combined for purposes of efficiency with a knowledge instrument utilized by another counseling doctoral candidate (Turner, 1992). The data were treated separately for purposes of collection for this study.

Procedure

A survey packet was mailed to a random sample of subjects (358) from the current membership of the American Mental Health Counselors Association (AMHCA). The packet included the ATAV attitudinal scale (Larsen et al., 1990), an AIDS knowledge
instrument, a demographic information form, and a letter describing the study and requesting that the instrument be filled out and returned in the enclosed self-addressed, stamped envelope (Appendix A). A week after the first mailing, a follow-up card was sent to all subjects (358) thanking them for their participation in the study and requesting return of the completed survey. Two weeks after the follow-up card a final letter with a duplicate survey was sent to subjects who had not yet responded. Names of the subjects were kept confidential by assigning a number to each subject. As each completed survey was returned, the name of the subject was crossed off the master list. Dillman (1978) recommended this process for assuring a valid response.

Analysis Procedure

The primary methodological design is a 2-way fixed Analysis of Variance model. T-tests were used at the .05 level to determine if there are significant differences in the dependent variables. Dependent variables were gender, contact with a PWA within the previous year, sexual orientation, acquaintance with a gay man or lesbian, personal acquaintance with a PWA, and professional training received about AIDS. Utilizing Cohen’s table (1969), the minimal responses needed for each of the four cells is a sample size of 64. This is based on power at .80 and effect size at .25. The degree of freedom (df) total is 255.
Chapter IV

Results

Data Analysis

This chapter presents the results of the study as applied to each of the hypotheses. The hypotheses are stated in the null form. Demographic descriptions of the subjects are followed by results of the data as they relate to each of the null hypotheses. Additional subject characteristics are also included as well as selected survey comments by the respondents.

Descriptive Analysis

The survey subjects were a random sample of members of AMHCA, a division of the ACA, with a membership of 11,600 at the time of the survey. Surveys were sent to 358 subjects and 255 usable surveys were returned. The response rate was 72%.

Subject Characteristics

The work setting of the respondents was as follows: 40%, private mental health counseling practice; 23.1%, outpatient mental health clinics; and 11.8%, hospitals or medical clinics. The educational levels of the respondents were predominantly master's level (68.2%) with an additional 15.7% at the doctoral level (Table One).
Table 1

Mental Health Counselor Characteristics (N = 255)

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<th>Gender</th>
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<td>Masters Student</td>
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<td>4.0</td>
</tr>
<tr>
<td>Bachelors</td>
<td>7</td>
<td>2.7</td>
</tr>
<tr>
<td>Educational Specialist</td>
<td>4</td>
<td>1.6</td>
</tr>
<tr>
<td>Associates/Certificate</td>
<td>2</td>
<td>0.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principal Work Setting</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Practice</td>
<td>102</td>
<td>40.0</td>
</tr>
</tbody>
</table>
Table One (cont'd)

<table>
<thead>
<tr>
<th>Location</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Mental Health Clinic</td>
<td>59</td>
<td>23.1</td>
</tr>
<tr>
<td>Hospital/Clinic</td>
<td>30</td>
<td>11.8</td>
</tr>
<tr>
<td>College Counseling Center</td>
<td>15</td>
<td>5.9</td>
</tr>
<tr>
<td>School</td>
<td>12</td>
<td>4.7</td>
</tr>
<tr>
<td>Social Service Agency</td>
<td>10</td>
<td>3.9</td>
</tr>
<tr>
<td>Student Placement</td>
<td>9</td>
<td>3.5</td>
</tr>
<tr>
<td>Government Agency</td>
<td>4</td>
<td>1.6</td>
</tr>
<tr>
<td>Parochial Agency</td>
<td>4</td>
<td>1.6</td>
</tr>
<tr>
<td>Drug &amp; Alcohol Agency</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Retired</td>
<td>2</td>
<td>.80</td>
</tr>
<tr>
<td>Corrections</td>
<td>1</td>
<td>.40</td>
</tr>
<tr>
<td>Rehabilitation Agency</td>
<td>1</td>
<td>.40</td>
</tr>
<tr>
<td>Unemployed</td>
<td>1</td>
<td>.40</td>
</tr>
</tbody>
</table>

Years worked as a professional mental health counselor (Mean years) \( \bar{M} = 9.1 \)

<table>
<thead>
<tr>
<th>Age Categories</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-25</td>
<td>5</td>
<td>1.9</td>
</tr>
<tr>
<td>26-30</td>
<td>25</td>
<td>9.8</td>
</tr>
<tr>
<td>31-35</td>
<td>23</td>
<td>9.2</td>
</tr>
<tr>
<td>36-40</td>
<td>45</td>
<td>17.5</td>
</tr>
<tr>
<td>Age Range</td>
<td>n</td>
<td>Percent</td>
</tr>
<tr>
<td>--------------</td>
<td>----</td>
<td>---------</td>
</tr>
<tr>
<td>41-45</td>
<td>66</td>
<td>25.8</td>
</tr>
<tr>
<td>46-50</td>
<td>32</td>
<td>12.5</td>
</tr>
<tr>
<td>51-60</td>
<td>47</td>
<td>18.4</td>
</tr>
<tr>
<td>60 &amp; above</td>
<td>12</td>
<td>4.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual (Male)</td>
<td>91</td>
<td>92.8</td>
</tr>
<tr>
<td>Gay male</td>
<td>4</td>
<td>4.1</td>
</tr>
<tr>
<td>Bisexual (Male)</td>
<td>3</td>
<td>3.1</td>
</tr>
<tr>
<td>Heterosexual (Female)</td>
<td>143</td>
<td>91.0</td>
</tr>
<tr>
<td>Lesbian</td>
<td>7</td>
<td>4.5</td>
</tr>
<tr>
<td>Bisexual (Female)</td>
<td>7</td>
<td>4.5</td>
</tr>
</tbody>
</table>

The ages of respondents were primarily between 41 and 45 (25.8%). The second largest group consisted of those between the ages of 51 and 60 (18.4%), followed by those between the ages of 36 and 40 (12.5%). Those between the ages of 26 and 30 and those between the ages of 31 and 35 each represented 9% of the respondents. Only 12 of the sample population were over the age of 60 (4.7%), while the smallest group represented consisted of those under the age of 26 (1.9%).
A majority of the respondents were female (61.6%), with the male respondents representing 38.4% of the sample. The majority of the respondents reported their sexual orientation as heterosexual (91.4%). The remaining identified themselves as lesbians (4.5%), gay males (4.1%), or as having a bisexual orientation (female, 4.5%; male 3.1%).

The sample was comprised primarily of subjects who reported their ethnic group as Caucasian (95.3%) with the next largest group reporting their ethnicity as African American (2%) or Hispanic (2%). Native American subjects made up .8% of the sample. The respondents reported having worked an average of 9.1 years in their profession as mental health counselors.

**Professional Contact with PWAs within the Past Year**

The subjects reported professional contact within the past year with a total of 278 HIV positive clients. (The survey question referred to the more inclusive “HIV positive” instead of PWAs to include the contact that mental health counselors had had with both AIDS and HIV.) The mean number of PWAs seen by each mental health counselor was 1.090, with a standard deviation of 3.703.

A majority of mental health counselor respondents (72.9%) had not provided services to clients diagnosed with HIV/AIDS within the past 12 months (Table 2). A total of 12.5% of the respondents had seen one client diagnosed with HIV/AIDS within the previous 12 months, while 6.3% had seen two clients. Five (2%) of the respondents had
seen six clients diagnosed with HIV/AIDS within the previous 12 months, while three (1.2%) had seen eight clients the previous 12 months.

Table 2

<table>
<thead>
<tr>
<th>Contact with HIV/AIDS Clients within past 12 months</th>
<th>Number of Mental Health Counselors</th>
<th>Percentage of Sample</th>
<th>Cumulative Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>186</td>
<td>72.9</td>
<td>72.9</td>
</tr>
<tr>
<td>1</td>
<td>32</td>
<td>12.5</td>
<td>85.5</td>
</tr>
<tr>
<td>2</td>
<td>16</td>
<td>6.3</td>
<td>91.8</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>.8</td>
<td>92.5</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>.4</td>
<td>92.9</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>.8</td>
<td>93.7</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>2.0</td>
<td>95.7</td>
</tr>
<tr>
<td>8</td>
<td>3</td>
<td>1.2</td>
<td>96.9</td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>.8</td>
<td>97.6</td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>.4</td>
<td>98.0</td>
</tr>
<tr>
<td>12</td>
<td>2</td>
<td>.8</td>
<td>98.8</td>
</tr>
<tr>
<td>20</td>
<td>1</td>
<td>.4%</td>
<td>99.2%</td>
</tr>
</tbody>
</table>
When the contact by mental health counselors with clients diagnosed with HIV/AIDS is analyzed according to gender of the mental health counselors, the results indicate that 65 (66.3%) male subjects and 121 (77.1%) female subjects reported no contact with HIV/AIDS clients within the previous 12 months (Tables 3 & 4). Twenty (12.7%) of the female subjects and 12 (12.2%) of the male subjects reported working with 1 client who was diagnosed with HIV/AIDS. There were 11 female subjects (7.0%) and 5 male subjects (5.1%) who reported providing services to 2 HIV/AIDS clients within the previous 12 months. One female subject (.6%) reported providing services to 25 HIV/AIDS clients while one (1.0%) male subject reported having seen 40 clients within the previous 12 months. In total, less than 5% of the subjects reported any professional service contact with clients diagnosed with HIV/AIDS within the previous 12 months and provided services to 70% of the clients diagnosed with HIV/AIDS.
Table 3

Female Subjects Who Reported Providing Professional Mental Health Services within the Previous 12 Months to Persons Diagnosed with HIV/AIDS

<table>
<thead>
<tr>
<th>Number of HIV/AIDS clients</th>
<th>Number of female counselors</th>
<th>Percent of female counselors</th>
<th>Cumulative percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>121</td>
<td>77.1</td>
<td>77.1</td>
</tr>
<tr>
<td>1</td>
<td>20</td>
<td>12.7</td>
<td>89.8</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>7.0</td>
<td>96.8</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>.6</td>
<td>97.5</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>.6</td>
<td>98.1</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>.6</td>
<td>98.7</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>.6</td>
<td>99.4</td>
</tr>
<tr>
<td>25</td>
<td>1</td>
<td>.6</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 4

Male Subjects Who Reported Providing Professional Mental Health Services within the Previous 12 Months to Persons Diagnosed with HIV/AIDS

<table>
<thead>
<tr>
<th>Number of HIV/AIDS clients</th>
<th>Number of male counselors</th>
<th>Percent of male counselors</th>
<th>Cumulative percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>65</td>
<td>66.3</td>
<td>66.3</td>
</tr>
<tr>
<td>1</td>
<td>12</td>
<td>12.2</td>
<td>78.6</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>5.1</td>
<td>83.7</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1.0</td>
<td>84.7</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>1.0</td>
<td>85.7</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>4.1</td>
<td>89.8</td>
</tr>
<tr>
<td>8</td>
<td>3</td>
<td>3.1</td>
<td>92.9</td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>2.0</td>
<td>94.9</td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>1.0</td>
<td>95.9</td>
</tr>
<tr>
<td>12</td>
<td>2</td>
<td>2.0</td>
<td>98.0</td>
</tr>
<tr>
<td>20</td>
<td>1</td>
<td>1.0</td>
<td>99.0</td>
</tr>
<tr>
<td>40</td>
<td>1</td>
<td>1.0%</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Ninety-three mental health counselor subjects reported that they provided individual and/or family counseling with PWAs and/or their families. Group counseling was
reported as a service to PWAs by 35 of the subjects, while 14 reported delivering concrete services, such as transportation, housing, and financial services. Crisis intervention was reported as a service by 52 of the subjects, while 23 of the mental health counselors reported including the teaching of alternative healing methods such as meditation, visualization, and nutrition-focused counseling.

**Attitudes Towards PWAs Survey Results**

**Internal Reliability**

The internal reliability of the ATAV scale and the two additional questions indicating level of comfort in counseling people who are diagnosed with AIDS (Q7U) and level of perceived competence in providing mental health services for persons diagnosed with AIDS, their family, friends and partners (Q7V) were assessed utilizing Chronbach's Alpha. The internal reliability of the attitudes scale and additional comfort and competence questions that made up the survey proved to be reliable with the alpha at .9126.

**Hypotheses and Results**

Hypothesis I: There is no significant difference between the attitudes of male mental health counselors and the attitudes of female mental health counselors toward persons with AIDS.
The results indicate no significant difference in attitudes between male and female mental health counselors toward PWAs, utilizing gender as the independent variable and the ATAV scale as the dependent variable. An analysis of variance was conducted and produced an $F$ value of 1.28 with a corresponding $p$ value of .18, which failed to reach .05 level of significance. Therefore the study failed to reject the null hypothesis that there is no difference between the attitudes of male and female mental health counselors toward PWAs.

Hypothesis II: There is no significant difference between the attitudes of mental health counselors who have had no professional contact with a PWA within the past year and the attitudes of mental health counselors who have had professional contact with a PWA within the past year toward persons with AIDS.

The results are significant utilizing the $T$-test, which compared professional contact versus no professional contact with PWAs within the past year, and produced a $t$-value of -3.46 with degrees of freedom of 253. The corresponding probability was .001. Professional contact with PWAs was found to be significant in those mental health counselors having more positive attitudes towards PWAs ($t = -3.46$, $df = 253$, $p = .001$).

Hypothesis III: There is no significant difference in attitudes of mental health counselors who report personal acquaintance, other than with a client, with a PWA and the attitudes of mental health counselors who report no personal acquaintance with a PWA toward persons with AIDS.
A strong relationship was found between personal acquaintance and positive attitudes toward PWAs. An analysis of variance was conducted utilizing personal acquaintance as the independent variable and the ATAV scale as the dependent variable. The findings were $F = 12.683$, $p = .0001$ with 1 degree of freedom. Therefore the null hypothesis is rejected and the alternative is accepted. The study reveals a strong relationship between the positive attitudes of mental health counselors toward PWAs who report personal acquaintance, other than with a client, with a PWA.

Hypothesis IV: There is no significant difference between the attitudes of mental health counselors who identify themselves as gay or lesbian as compared to mental health counselors who identify themselves as heterosexual toward persons with AIDS.

An analysis of variance was conducted with sexual orientation as the independent variable and the ATAV scale as the dependent variable. It produced a significant $F$ value ($F = 10.057$, $p = .0001$) within, indicating a significant relationship between sexual orientation and respondent attitudes towards PWAs. A posthoc Student-Newman-Keuls test found a significant difference at the .05 level between heterosexual and gay/lesbian attitudes towards PWAs. It is to be noted that the results of this portion of the study is skewed as there were only 11 respondents who identified themselves as gay/ lesbian while there were 233 respondents that identified themselves as heterosexual, and 10 identified themselves as bisexual.

Hypothesis V: There is no significant difference in the attitudes of mental health counselors toward persons with AIDS who report personal acquaintance with a gay male
or lesbian, other than a with a client, and the attitudes of mental health counselors who report no personal acquaintance with a person who is a gay male or lesbian.

An analysis of variance was conducted. This test found a significant difference in the attitudes of mental health counselors who report personal acquaintance with a person who is gay or lesbian, other than a client, compared to mental health counselors who report no personal acquaintance with a person who is a gay male or lesbian in their attitudes toward PWAs ($F = 6.942, p = .009$). Therefore the null hypothesis is rejected and the alternative is accepted.

Hypothesis VI: There is no significant difference between mental health counselors who have had one or more hours of formal training regarding AIDS as compared to mental health counselors who have had no professional training regarding AIDS toward persons with AIDS.

An analysis of variance was conducted utilizing the hours of formal training as the independent variable and the ATAV survey as the dependent variable. The results show a significant difference between mental health counselors who have had one or more hours of formal training regarding AIDS as compared to mental health counselors who have had no professional training regarding AIDS ($F = 6.3615, p = .0001$). A post hoc Student-Newman-Keuls test found a significant difference between those mental health counselors who reported no formal hours of training and those mental health counselors who had received any other level of training. The minimum level of training was one hour.
Table 5

Analysis of Variance Post Hoc Comparisons: Number of Hours of Professional Training in AIDS and Mean Values of Counselor Attitudes Toward PWAs.

<table>
<thead>
<tr>
<th>Mental Health Counselors</th>
<th>Hours of professional training on AIDS</th>
<th>Mean</th>
<th>Significant differences .05 level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>zero</td>
<td>3.9187</td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>1-5</td>
<td>4.1455</td>
<td>*</td>
</tr>
<tr>
<td>Group 3</td>
<td>6-10</td>
<td>4.1091</td>
<td>*</td>
</tr>
<tr>
<td>Group 4</td>
<td>11-20</td>
<td>4.4833</td>
<td>*</td>
</tr>
<tr>
<td>Group 5</td>
<td>21 and above</td>
<td>4.3442</td>
<td>*</td>
</tr>
</tbody>
</table>

There is a significant difference between group one, which reported no professional training and the other four groups with one or more reported hours of professional training. There is also a significant difference between the attitudes toward PWAs of group three with a mean of 4.1091 and group four with a mean of 4.4833. Therefore, this study concludes that having from 11 to 20 hours of professional training regarding AIDS as compared to 6 to 10 hours of training appears to have a significant positive impact on the attitudes of mental health counselors toward PWAs.
**Additional Factors**

Other respondent characteristics found to be confounding factors in other studies concerning attitudes toward PWAs were investigated in this study. It was found that there was no significant relationship between mental health counselors' attitudes and the age of the mental health counselor. A Pearson correlation was conducted ($r = .026, p = .340$). There was also no significance found between the professional degree and attitudes utilizing the analysis of variance procedure ($F = 1.1631, p = .3277$) comparing differences between groups. Religion was also found to be nonsignificant, utilizing the analysis of variance procedure ($F = 1.1513, p = .3332$). Ethnicity of the respondents was also nonsignificant ($F = 1.0688, p = .3629$), although the results were skewed as there was a marked lack of diversity of the respondents with the majority being Caucasian (95.3%). Years of work as a mental health counselor was not a significant factor at .05 level ($p = .096, r = .82$), although there does appear to be a trend towards more positive attitudes of mental health counselors the longer they work in the field. Principal work setting, such as private practice, mental health or medical clinic, college counseling center, and social services agency, ($F = .7512, p = .6288$) or types of services, such as individual/family, group, concrete services, or crisis intervention, provided in their mental health work does not show any significant relationship to attitudes.

A correlation was run using the Pearson correlation to determine the relationship between the mental health professionals' attitudes towards PWAs and the response to the
question, "I feel personally comfortable counseling people who are diagnosed with AIDS." This resulted in a high correlation between the response and the ATAV score at \( p = .0001 \). Subjects who reported knowledge of any community services for PWAs had significantly more positive attitudes toward PWAs than subjects who reported no knowledge of any community services for PWAs \( (t = 2.14; df = 253; p = .033) \). This would indicate that knowledge of community services by mental health counselors is a predictor of positive attitudes towards PWAS, or that those who are more accepting of PWAs are also more interested in knowing about community resources for them.

**Survey Comments**

Survey comments were solicited pertaining to counseling PWAs. Below are some of the comments that reflect the attitudes of some of the respondents.

"I feel sorry for people with AIDS, but I have to admit that I would be leary of spending close time with them."

"I'd have apprehensions sharing quarters with an AIDS victim."

"I find the disease is just too new to know HOW you get it."

"I worked with AIDS inmates . . . . I must admit I felt it was risky."

"I think good professional counseling techniques would apply pretty well. AIDS is not a special psychological condition in and of itself."

"More additional information [is] wanted about the right to suicide because AIDS is a terminal illness."
"I don't avoid them (PWAs), but sometimes I want to avoid them out of fear, regardless of my knowledge about transmission."

"My personal fears include the fact that I feel there is still a lot to be learned about the disease . . . . research has seemed to slow down."

"... I was embarrassed to be honest. The fear of the unknown is too human a factor to deny . . . . Is he an innocent victim or a hardened junkie?"

"... There are no absolutes in contagion."

Many of the respondents commented about their need for more training in the areas of medical transmission and counseling models. One of the survey recipients contacted the authors in a very angry verbal communication and conveyed outrage at the content of the study regarding PWAs.
Chapter V

Summary, Recommendations, and Conclusions

Introduction

This chapter summarizes the purposes of the study and reviews the procedures used for obtaining the results. The findings based on the statistical analyses described in chapter four are summarized. Other factors and conclusions based on the results are included. Finally, recommendations based on the results and possibilities for future research are offered.

There is a lack of research on the attitudes of mental health counselors’ attitudes toward PWAs. The two studies located either utilized a very small sample (Maione & McKee, 1987), or had results that were confusing and inconclusive (Larson, 1991). The number of people affected by the AIDS pandemic will continue to increase in the United States and the world throughout the remainder of this century. The psychosocial issues that PWAs and their loved ones confront, such as stigma, loss, grief, discrimination, and isolation, create a dire need for mental health counselors to be active providers of mental health treatment in this public health emergency.
Summary of the Findings

Description of Mental Health Counselor Subjects

This study investigated the attitudes of mental health counselors toward persons with AIDS. Three hundred and fifty-eight members of the American Mental Health Counselors Association were mailed a survey packet including the Attitude Toward AIDS Victims Scale (ATAV) (Larsen et al., 1990) and an additional two questions assessing comfort with clients with AIDS (Weiner-Brawerman, 1988). There were 255 usable surveys for a response rate of 72%. The majority of the respondents (61.6%) were female, Caucasian (95.3%), and heterosexual (91.9%). The primary work setting was either private practice (40%), in an outpatient mental health clinic (23.1%), or in a hospital or clinic (11.8%). The average number of years working as a professional mental health counselor was 9.1 and the average age of the respondents was 43.3 years. The majority of the respondents (68.2%) had an earned masters degree while 15.7% had doctorate degrees. The majority of the respondents (91.4%) reported their sexual orientation to be heterosexual. A majority of mental health counselor respondents (72.9%) had not provided services to HIV/AIDS clients within the past 12 months. Overall, 5% of the respondents reported providing services to 70% of the HIV/AIDS clients.
Results and Discussion

Six hypotheses were developed and tested for this study. An analysis of variance was used to examine hypotheses I, III, IV, V, and VI. Hypothesis II was examined utilizing the T-test. Additionally a posthoc Student-Newman-Keuls test was used on hypotheses IV and VI to further examine the results.

Analysis of the results of Hypotheses I indicated that there was no significant difference in the attitudes of male and female mental health counselors toward PWAs. An analysis of variance produced an $F$ value of 1.28 with a corresponding $p$ value of .18, failing to reach .05 level of significance. The null hypotheses was accepted. This result is in contradiction to the majority of the studies found in the literature that show that females tend to be more accepting of PWAs than do males (Merril, Laux, Thornby & Valbona, 1989). However the result agrees with a study of social workers attitudes toward HIV/AIDS clients in which gender was not found to be significant (Shi, Samuels, & Richter, 1993).

The reason for the support of the null hypothesis in this study is unclear, however it may be attributed to the voluntary and anonymous nature of the survey. Males who were more interested in the topic may have returned the survey, while those who held more negative attitudes toward PWAs may have chosen to not complete it and therefore were not a part of the sample. Females, on the other hand, may have completed the survey based on their more positive attitudes toward PWAs.
Another factor that may have influenced the results is the fact that male mental health counselors had more professional contact with a PWA within the past year than female mental health counselors. The impact of professional contact has been shown in this study to have a significant relationship with attitudes towards PWAs by mental health counselors and may have influenced the results of the relationship of gender to attitudes found in previous studies of health care providers.

In Hypothesis II, professional contact with a PWA within the past year corresponded with mental health counselors having significantly more positive attitudes toward PWAs. A T-test produced a t value of -3.46 with degrees of freedom of 253. The corresponding probability was .001. The null hypothesis was therefore rejected. This finding is in concurrence with the studies of other researchers who found that professional contact with a PWA was a significant factor in attitudes of health care providers (Henry, Campbell, & Willenbring, 1990; Wiener & Siegel, 1990), marriage and family therapists (Green & Bobele, 1994), and psychiatrists (Brown, Etemad, Brenman, & Dwight, 1991). In contrast, other studies have shown that professional contact is not related to positive attitudes toward PWAs by those medical care providers who are potentially exposed to HIV in the treatment of patients with AIDS (Condit & Frater, 1989; Feldmann, Bell, Stephenson, & Purifoy, 1990). Dworkin, Albrecht, and Cooksey (1991), suggested in their study of health care providers, including nurses, doctors, and social workers, that emotional reactions to PWAs are specifically related to the type of patient contact. They found social workers to have the least amount of discomfort with AIDS patients. This is probably also true for other mental health professionals, including mental health
counselors as they do not normally perform invasive physical procedures during treatment with PWAs.

Hypothesis III examined the difference in the attitudes of mental health counselors who reported personal acquaintance, other than with a client, with a PWA as compared to those mental health counselors who reported no personal acquaintance with a PWA. An analysis of variance produced an $f = 12.683$, $p = .0001$ with one degree of freedom. The null hypothesis was rejected. The result indicates a strong relationship between personal contact with and positive attitudes toward PWAs. This study did not examine the differences between mental health counselors who had relatives who are PWAs. The results of this study correspond with the results of other findings regarding personal acquaintance with a PWA by health care workers (Henry, Campbell, & Willenbring, 1990) and stresses the importance of this variable.

Hypothesis IV showed a significant difference between the attitudes of mental health counselor toward PWAs who identified themselves as gay or lesbian, as compared to the attitudes toward PWAs of mental health counselors who identified themselves as heterosexual. An analysis of variance produced a significant $f$ value ($f = 10.057$, $p = .0001$). A posthoc Student-Newman-Keuls test found a significant difference at the .05 level between gay/lesbian and heterosexual attitudes toward PWAs. Therefore the null hypothesis is rejected. It is important to note that the responses are skewed as there were only 11 respondents who identified themselves as gay or lesbian out of the 233 respondents. Ten of the respondents identified themselves as bisexual and were not included in the testing of this hypothesis. This result is in agreement with the findings of
other research of health care providers sexual orientation and their attitudes toward PWAs. Marks, Richardson, Lochner, McGuigan and Levine (1988) found that sexual orientation of physicians was significantly related to attitudes toward PWAs, with gay or lesbian physicians having more positive attitudes than heterosexual physicians.

Hypothesis V examined the difference between the attitudes of mental health counselors who reported personal acquaintance with a gay or lesbian as compared to mental health counselors who report no personal acquaintance with a gay or lesbian. The null hypothesis was rejected. A significant difference was found in the attitudes of mental health counselors with those who had had personal contact with a gay or lesbian showing a significantly more positive attitudes toward PWAs. An analysis of variance produced \( f = 6.942, p = .009 \). This is in concordance with other studies that have shown that people who have personal acquaintance with a gay or lesbian friend or relative tend to have more favorable and positive attitudes toward PWAs (Douglas, Kalman, & Kalman, 1985; Green & Bobele, 1994; Weiner & Siegel, 1990).

The final hypothesis found a highly significant difference in the attitudes of mental health counselors toward PWAs who had completed one or more hours of formal training regarding AIDS as compared to mental health counselors who had completed no formal training regarding AIDS. Therefore the null hypothesis was rejected. An analysis of variance produced \( f = 6.3615, p = .0001 \). A post hoc Student-Newman-Keuls found a significant difference in the impact of the amount of training with a significant break between the attitudes of the groups that had received 11 or more hours of training as compared to the groups that had received between 1 and 10 hours of formal training on
AIDS (Table 5). Training has been found to have an effect on the attitudes of people in health care with a positive effect being noted by Riley and Greene (1993) and no positive effect for the provider whose work required invasive procedures with a patient with AIDS (Van Servellen, Lewis & Leake, 1988). Both of these studies showed that the program content and length were found to have an impact on the subjects’ attitude changes as to how they perceived workplace risk. Their findings agreed that training programs that were longer in length and contained more experiential components had a more positive impact on the attitudes of the participants. The current study concurs with these findings, showing a more positive attitude of mental health counselors who reported 11 hours or more of formal training on AIDS. There are two apparent uncontrolled variables when considering this finding. One is that the study did not gather data about the content of the training and whether or not it contained an experiential component. Another variable that was not controlled for is whether the training was a mandatory or training that was taken voluntarily. It may be that the mental health counselors with more positive attitudes would seek out further training voluntarily in the area of AIDS and that the trainings themselves did not have a significant impact on the already positive attitudes toward PWAs.

Additional Factors

Other factors that could potentially affect mental health counselors’ attitudes toward PWAs were analyzed outside of the stated hypotheses. Results indicated that there was
no significant relationship between the attitudes of mental health counselors and age.

Other studies have found a significant relationship between attitude and age, with younger health care professionals demonstrating a more positive attitude toward PWAs, especially those under 35 (Dhooper, Royse, & Tran, 1987-88; Samuel & Boyle, 1989). The majority of respondents in this study were primarily between the ages of 41-45, with the second largest group being between the ages of 51-60. It is interesting that the respondents under 35 years of age only represented 9% of the sample. There was no data available from the American Mental Health Counselors Association to see if this was representative of the membership.

Professional degree was an insignificant factor in this study. Professional degree has been found by some to be a significant factor in attitudes toward PWAs (Koch, Preston, Young, & Wang, 1991). Allender, Senf, Bauman, and Duffy (1991) found that health care providers with less than a college degree demonstrated the most fearful and negative attitudes towards PWAs and gays and lesbians. The reason for the insignificance in this study may be that the majority of the sample (68.2%) were masters level, while the next largest group (15.7%) were doctoral level. The sample in this study is therefore skewed in terms of professional degree, with the majority being masters level and above, representing a highly educated sample.

Principal work setting was insignificant in relation to attitudes of mental health counselors toward persons with AIDS. Due to the nature of mental health counseling, this would be an expected result as the literature shows that attitudes are linked to the level of invasiveness of the treatment of people with AIDS. The two primary work
settings were private practice and outpatient mental health clinics. These two settings are very similar in terms of the contact one would expect the mental health counselor to have with the client with AIDS. Therefore, the sample was not representative of a variety of work settings and the principal work setting was found to be insignificant.

Religion has been found in many studies to be a significant factor in attitudes towards PWAs (Larsen, et al., 1990; Koch, Preston, Young, & Wang, 1991) The majority of mental health counselors in this study described themselves as being Protestant or Catholic. There was no significant relationship between religious preference and attitudes toward PWAs. There was no attempt in this study to ascertain the extent of religiosity as a factor in attitudes toward PWAs.

**Recommendations**

Professional and/or personal contact with PWAs was found to be significantly related to positive attitudes toward PWAs. Sexual orientation of the respondent was also significant as was personal acquaintance with a gay male or lesbian. Education about AIDS is also shown to be significantly related to positive attitudes toward PWAs, with a significant relationship at one or more hours and a significant increase in positive attitudes at 11 or more hours of training. Based on these results, the following recommendations for preservice and inservice training are presented.

(1) Mental health counselor trainees and counseling faculty need to have the opportunity to experience professional and personal contact with PWAs. AIDS
preservice and inservice education needs to be 11 hours or more and to provide contact with PWAs and gay males and lesbians. Counselor education programs could place students in agencies that serve PWAs for internships. The impact on attitude of the graduate student and faculty would, according to the results, be significantly impacted by this amount of training and types of contact. This study was limited in that it did not gather data about the content of trainings received by the respondents. In other studies, however, it has been shown that trainings need to include both cognitive and experiential components in order to be effective in influencing health care workers attitudes toward PWAs. Based on the other researchers results, it would seem important to include these components in training of graduate counseling students and faculty.

(2) AIDS education needs to be extended to mental health counselors who are licensed by States as Licensed Professional Counselors as mandatory inservice training and needs to include contact with PWAs and gay males or lesbians. These type of contacts were found to be significant in this study. This study also showed a significant impact on attitudes toward PWAs of 11 or more hours of formal AIDS training. Therefore, it is recommended that the trainings be over 11 hours and include significant contact with PWAs and gays and lesbians. This recommendation is based on the fact that the AIDS epidemic is continuing to grow and is affecting a wider range of the population, especially women and children. It appears then that many more mental health counselors will see a PWA or loved one as a mental health client. Currently, there are only a few states that require AIDS training for Licensed Professional Counselors.
(3) The formation of an AIDS Interest Group in the American Mental Health Counselors Association would enhance the goal of providing inservice training to mental health counselors. This interest group could provide information about AIDS through monthly publications, journals and conference workshops. Based on the results of this study, one hour or more of formal AIDS training is a significant factor in the attitudes of mental health counselors toward PWAs. It is also of interest to note that 5% of mental health counselors in the sample were providing 70% of the services. More education is needed for working mental health counselors to become aware of the need for their services in this epidemic.

(4) Mental health counselors need to do more outreach to community organizations that serve PWAs in order to become involved in serving this population. Based on the results of this study, very few mental health counselors are providing the majority of services to PWAs that are delivered by mental health counselors. Professional contact has been shown to have a significant impact on the attitudes of mental health counselors toward PWAs. It is imperative that mental health counselors become more proactive in the delivery of mental health services to PWAs, their families, and loved ones.

Limitations and Advantages of the Study

The sample of this study was limited in that it used members of the American Mental Health Counselors Association (AMHCA). Membership in this organization does not require any documentation of clinical experience or expertise. Conversely, the majority of
the study respondents were clinically oriented, and so this limitation did not seem to affect the desired make-up of the sample.

The instrument was a self-administered questionnaire that was voluntarily returned by the participants. It may be that the voluntary nature of the instrument may have skewed the results with those with more positive attitudes responding while those with negative attitudes would tend to not respond. This is difficult to assess utilizing the voluntary survey method. There was, however, sufficient interest to produce a high return rate of 72%. The questionnaires were also scored anonymously and it is hoped that this process encouraged honest responses.

Limitations of the study also include some missing data due to unanswered items and the inability to check the answers with the respondents. There was also a marked lack of ethnic diversity in the sample which prevented meaningful collection of data comparing attitudes of various ethnic groups to the attitudes scale. Caucasians made up the majority of the sample and the majority of the membership of AMHCA.

**Recommendations for Further Research**

There is a limited amount of research in the area of attitudes of mental health counselors toward PWAs. Based on the sparse data available, it is recommended that more research be conducted and published in professional journals. Professional journals were cited by the respondents in this study as their primary source of information about AIDS. Based on this finding the following recommendations are presented.
(1) This study found no difference in attitudes of male and female mental health counselors toward PWAs. Gender has been found to be a significant factor in most other studies of health care providers attitudes toward PWAs. This issue deserves more research to assess what other factors may have influenced these results and caused gender to have an insignificant relationship to attitudes toward PWAs.

(2) The relationship of attitudes and knowledge needs to be explored in further research. Some research has indicated that mental health professionals tend to have a higher perception of competence in comparison with their training. This issue needs to be researched in regards to mental health counselor attitudes toward PWAs.

(3) Currently there are only a few states that require mandatory AIDS training. Research needs to be conducted on the impact on attitudes of mental health counselors toward PWAs in states that require AIDS training as compared to states that do not require training.

(4) Preservice research on attitudes toward PWAs needs to be conducted on the attitudes of counseling graduate students who are in programs that require AIDS training as compared to counseling graduate students who are in programs that provide no formal AIDS training.

(5) The content of the trainings reported by the subjects in this study is an unknown. Further research needs to be done on the type of trainings that are most effective in affecting the attitudes of mental health counselors toward PWAs. Other research of mental health providers shows that experiential and cognitive trainings are most effective.
This type of research needs to be conducted with mental health counselors with a focus on trainings for both preservice and inservice purposes.

(6) Further research needs to be conducted to ascertain the type and amount of contact with a PWA before mental health counselor attitudes are significantly affected. It is unclear whether those with more positive attitudes seek out experiences with PWAs or if the previous contact with PWAs is truly the mediating factor.

(7) Further research needs to be conducted into the differences in counseling services to PWAs and attitudes toward PWAs of urban and rural mental health counselors.

Conclusions

Mental health counselors can play an important role in providing needed mental health services to PWAs, their lovers and families. Currently, there are few mental health counselors involved in providing mental health services to PWAs. The professional contact with PWAs results in this study indicated that a few mental health counselors (5%) are providing most of the services (70%) provided by mental health counselors. Some studies have shown that sustained contact with PWAs as a treatment provider can have an adverse effect on attitudes toward PWAs as the provider approaches burn-out. Further research regarding this phenomena would be useful in planning services for PWAs.

It is important that mental health counselors become more involved in being treatment providers in this epidemic that is projected to continue into the next century. Mental
health counselors need to become more actively involved in the treatment of this population through contact with AIDS organizations and seeking internship and career opportunities in an agency that serves PWAs, their family and friends. Professional mental health organizations and counselor education programs must become aware that since mental health counselors are largely uninvolved in this worldwide epidemic as treatment providers, professional mental health organizations and counselor education programs must become more proactive at encouraging students and practitioners to become involved.
REFERENCES


APPENDICES
Appendix A

Letter of Request and Research Instrument
Dear Colleague:

Acquired Immunodeficiency Syndrome (AIDS) has reached epidemic proportions, with well over 157,525 people being diagnosed as of November 30, 1990 in the U.S. alone. Every mental health professional has been or will be touched by this pandemic. As a professional Mental Health Counselor, you are in a unique position to respond to the challenges of AIDS.

Our study assesses the knowledge and attitudes Mental Health Counselors have toward people with AIDS. It is a collaborative effort of two doctoral candidates enrolled in the Counselor Education program at Oregon State University. The ultimate validity and usefulness of this study’s findings depends on your willingness to provide candid responses.

You have been chosen to be one of a random sample of the American Mental Health Counseling Association’s Mental Health Counselors. Your answers will be confidential. The enclosed questionnaire is numbered only so that we will not contact you again after you have returned it.

Please take a few minutes to complete and return this questionnaire in the stamped, self-addressed envelope. Your part in the success of the study is greatly appreciated.

Sincerely,

Terri Jo Christenson, M.S., NCC
Ph.D. Candidate

(503) 838-3816

Micki Turner, M.S.W., L.C.S.W.
Ph.D. Candidate

(503) 371-4510
The attitude scale was developed by Larsen, K., Long, E., & Serra, M. (1988), the knowledge scale by Gray, L., & Saracino, M. (1989), and the comfort scale was adapted from an instrument developed by Weiner-Brawerman, L. (1988).
MENTAL HEALTH COUNSELORS SURVEY ON AIDS

1. Please indicate how many clients you have seen in the 1st 12 months for each of the following categories:

   NUMBER

   a. Diagnosed HIV Positive
   b. Family, partners, and/or friends of a person diagnosed HIV Positive

(IF YOU HAVE NO CLIENTS IN THESE TWO CATEGORIES, PLEASE SKIP TO QUESTION 4)

2. Of those clients who are HIV positive, what number contracted the virus through each of the following (indicate all that apply):

   NUMBER

   a. homosexual/bisexual contact
   b. blood transfusion
   c. heterosexual contact
   d. IV drug use
   e. unknown

Please turn page
3. Please indicate whether or not each of the following is a part of the work you do with clients diagnosed with AIDS and/or the family, partners, or friends of diagnosed persons: (circle one for each)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Individual, couples, and/or family counseling</td>
<td>1</td>
</tr>
<tr>
<td>b. Group counseling</td>
<td>1</td>
</tr>
<tr>
<td>c. Concrete services, i.e. transportation, housing financial services, etc.</td>
<td>1</td>
</tr>
<tr>
<td>d. Crisis interention</td>
<td>1</td>
</tr>
<tr>
<td>e. Alternative healing practices, i.e. nutrition, meditation, visualization, etc.</td>
<td>1</td>
</tr>
<tr>
<td>f. Other (PLEASE SPECIFY)</td>
<td></td>
</tr>
</tbody>
</table>

4. What is your principle work setting? (circle one)

1. PRIVATE PRACTICE
2. OUTPATIENT MENTAL HEALTH CENTER
3. HOSPITAL OR CLINIC
4. OTHER (PLEASE SPECIFY)

5. What is your highest professional degree? (circle one)

a. BA IN HUMAN SERVICES FIELD
b. MA IN HUMAN SERVICES FIELD
c. PhD OR EdD IN HUMAN SERVICES FIELD
d. OTHER (PLEASE SPECIFY)

6. How many years have you worked as a professional mental health counselor?
   ____________ YEARS

Please turn page
7. Below is a list of statements that have been made about AIDS. There are no right or wrong answers. Please indicate the extend to which you agree or disagree with the statements. First impressions are best. Circle only one number for each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>DISAGREE</th>
<th>STRONGLY DISAGREE</th>
<th>NO OPINION</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Victims of AIDS represent a forgotten part of our society</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>b. More media coverage should be given to the plight of AIDS patients</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>c. People with AIDS should be grouped together and isolated</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>d. I would be worried for my health if a co-worker had AIDS</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>e. Persons with AIDS are dangerous to allow in public</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>f. People with AIDS are a menace to society</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>g. I would avoid someone if I knew they had AIDS</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>h. I would work alongside someone I knew had AIDS</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>i. I would offer whatever support necessary if a friend had AIDS</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>j. People with AIDS should be grouped together and isolated</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>k. I would open up my house to anyone with AIDS</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>l. I wouldn’t mind if one of my child’s classmates had AIDS</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>m. I avoid people with AIDS</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Please turn page
n. I would not want a person with AIDS to touch me......................................1 2 3 4 5
o. I feel no sympathy for someone with AIDS ......................................................1 2 3 4 5
p. I would probably not embrace someone with AIDS ............................................1 2 3 4 5
q. I would frequent a business which employed AIDS victims.......................................1 2 3 4 5
r. If someone gets AIDS, they should be allowed to continue living as normally as possible..........................................................1 2 3 4 5
s. I would not associate with a person who had AIDS, even if they were a close friend .....1 2 3 4 5
t. People with AIDS are probably living promiscuous lives.........................................1 2 3 4 5
u. I feel personally comfortable counseling people who are diagnosed with AIDS........1 2 3 4 5
v. I feel professionally competent providing mental health services for persons diagnosed with AIDS, their family, friends, and partners..........................................................1 2 3 4 5

8. How many hours altogether of formal professional training have you had regarding AIDS? (Circle one response)

1. NONE
2. 1-5
3. 6-10
4. 11-20
5. 21 OR OVER

Please turn page
9. From the list of sources below please indicate which one has been your **most important** source of information about AIDS, and which has been your **second most important** source. Finally, indicate your **least important** source of information about AIDS. Place the letter of your choice in the appropriate space.

**SOURCE**
- A. newspaper or magazine
- B. television
- C. personal experience
- D. colleagues
- E. professional journals
- F. friends or acquaintances
- G. OTHER (SPECIFY)

_____ MOST IMPORTANT
_____ SECOND MOST IMPORTANT
_____ LEAST IMPORTANT

10. To your knowledge are there any resources or specific agencies in your community that provide services to persons diagnosed with HIV? (circle one number)

1. YES
2. NO

10a. Please list agencies _________________________________

11. What additional information, if any, do you feel you need to know about the medical aspects of AIDS, e.g. etiology, transmission, treatment?

12. What additional information, if any, do you feel you need about mental health counseling of people diagnosed with HIV, e.g. psychosocial aspects, psychological treatment models?
13. For this list of statements about AIDS, please indicate if you think each statement is true or false. Circle one number for each item.

<table>
<thead>
<tr>
<th></th>
<th>TRUE</th>
<th>FALSE</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Use of a natural skin condom during intercourse greatly reduces the risk of transmitting AIDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. The AIDS virus can be present in vaginal fluid</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. Unprotected heterosexual intercourse carries a risk of transmitting AIDS from a man to a woman</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. Unprotected heterosexual intercourse carries a risk of transmitting AIDS from a woman to a man</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. AIDS can be transmitted by anal intercourse</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. AIDS can be transmitted in semen</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. Having sex with fewer partners decreases the risk of getting AIDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. A person can contract AIDS through oral-genital sex</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. Receiving a blood transfusion with infected blood can give a person AIDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>j. You can get AIDS by sharing a needle with a drug user who has the disease</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Please turn page
k. Shaking hands with someone who has AIDS can give it to you.....1 2 3

l. AIDS can be spread by using someone else’s comb or hairbrush...1 2 3

m. AIDS is a medical condition in which the body has a difficult time fighting off infection .........................................................1 2 3

n. You can get AIDS from casual contact (such as shaking hands, coughing, using the same telephone, or toilet seat) with people who have the disease........................................................................1 2 3

o. Some babies born to mothers with AIDS will carry the AIDS virus.................................................................................1 2 3

p. Stress causes AIDS ........................................................................1 2 3

q. If you kiss someone with AIDS, you will get the disease..........1 2 3

r. The majority of gay men have AIDS .........................................1 2 3

s. If you touch someone with AIDS without exchanging bodily fluids you can get AIDS.................................................................1 2 3

t. What you eat can give you AIDS...............................................1 2 3

u. AIDS can be cured .....................................................................1 2 3

Please turn page
<table>
<thead>
<tr>
<th>v.</th>
<th>AIDS is not at all serious; it is like having a cold</th>
<th>TRUE</th>
<th>FALSE</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>w.</td>
<td>AIDS is caused by a bacteria</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>x.</td>
<td>AIDS is caused by the same virus that causes gonorrhea</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>y.</td>
<td>Having sexual intercourse with someone who has AIDS is one way of getting it</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>z.</td>
<td>The majority of people with AIDS die from the disease</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>aa.</td>
<td>The majority of lesbian women have AIDS</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>bb.</td>
<td>People with AIDS usually develop other diseases as a result of AIDS</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>cc.</td>
<td>I can avoid getting AIDS by exercising regularly</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>dd.</td>
<td>You can get AIDS from sharing plates, forks, or glasses with someone who has AIDS</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>ee.</td>
<td>There is a vaccine available with prevents AIDS</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>ff.</td>
<td>It is possible to get AIDS by donating blood</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
14. What is your present religious affiliation, if any?

1. CATHOLIC
2. PROTESTANT
3. OTHER CHRISTIAN (NON-DENOMINATIONAL)
4. JEWISH
5. OTHER (SPECIFY) ____________________________
6. NONE

15. Have you been personally acquainted with someone, other than a client, who has been diagnosed with AIDS? (i.e., friend, family member, or partner)

1. YES
2. NO

16. Are you personally acquainted with someone, other than a client, who is homosexual?

1. YES
2. NO

17. Do you consider yourself to be: (CIRCLE ONE)

1. HETEROSEXUAL
2. HOMOSEXUAL
3. BISEXUAL

Please turn page
18. Please indicate your gender

a. FEMALE

b. MALE

19. What is your age?

____________ AGE

20. What is your ethnic background? ________________________________

21. Do you have any additional comments pertaining to your experience counseling people with AIDS or about this questionnaire?

THANK YOU VERY MUCH FOR YOUR PARTICIPATION
Appendix B

One-Week Follow-up and Thank You Card
February 14, 1991

Last week a mental health counselors AIDS survey was mailed to you. Your name was chosen from a random sample of members of American Mental Health Counselors Association.

If you have already completed and returned the survey to us, please accept our sincere thanks. If you have not, please do so today. Because the survey is being sent to only a small, but representative sample of mental health counselors it is extremely important that your responses be included if the results are to accurately represent the mental health counseling profession.

If by chance you did not receive the survey, or it got misplaced, please call 1-503-737-4317. A replacement survey will be mailed right away.

Sincerely,

Terri Jo Christenson, M.S., NCC
Ph.D. Candidate

Micki Turner, L.C.S.W.
Ph.D. Candidate
Appendix C

Three Week Follow-up Letter
February 27, 1991

Dear Mental Health Counselor:

About three weeks ago, we wrote to you seeking your responses to the mental health counselors AIDS survey. As of today we have not received your completed questionnaire.

We have chosen the study of AIDS and mental health counseling because we believe that the response of mental health counselors to the growing AIDS epidemic is important and timely.

We are writing to you again because of the significance each completed survey has to the usefulness of this study. Your name was chosen by a random sampling process. All results are confidential. In order for the results of the study to be truly representative of mental health counselors, it is essential that each person return the survey.

In the event your survey has been misplaced, a replacement is enclosed. Please feel free to contact either of us by phone if you have any questions or concerns about the questionnaire.

Sincerely,

Terri Jo Christenson, M.S., NCC
Ph.D. Candidate
1-503-838-3816

Micki Turner M.S.W., L.C.S.W.
Ph.D. Candidate
1-503-371-4510