Effects of Client HIV Status and Race on Therapeutic Impressions of Counselor Trainees

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Submitted in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy
under the Executive Committee
of the Graduate School of Arts and Sciences

COLUMBIA UNIVERSITY

2014

Abstract

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Working with HIV-positive individuals may present a particular challenge to clinicians because of the phenomenon of stigma. Researchers have proposed that HIV stigma is layered with people's prejudiced attitudes toward already-stigmatized groups (e.g., sexual orientation, gender, race and ethnicity) in which people living with HIV/AIDS may have membership. Previous research has suggested that, clinicians' attitudes and reactions toward HIV and sexual orientation may significantly impact their therapeutic impressions, yet questions remain with regard to how clients' HIV status and racial identity may operate in confluence to influence clinicians' therapeutic impressions. This question may be particularly significant with regard to mental health professionals, as research also suggests that racial/ethnic minority clients can be perceived by their clinicians as more disturbed as a result of clinicians' biased racial attitudes. In the present study, case vignettes featuring hypothetical Black or White men who are either HIV-positive or HIV-negative were presented to participants to explore the influence of a client's HIV status and race upon participants' therapeutic impressions. Results indicated that participants' expectations of therapeutic process and evaluations of the clients' symptomatology were influenced by the clients' race and HIV status. Participants expected slightly greater session depth for the Black clients than the White clients in the vignettes, and their initial impressions of symptomatology were also slightly more negative toward the White clients in the vignettes. With regard to the main effect of client HIV status, participants expected slightly greater session depth for the HIV-positive clients than the HIV-negative clients in the vignettes. However, participants expected slightly less session smoothness for the HIV-positive clients in the vignettes, and they also reported lower assessment of

psychological, occupational, and social functioning toward the HIV-positive clients in the vignettes. The potential interaction of the hypothetical client's race and HIV status and its effect upon participants' clinical impressions was not found significant. Implications for research and practice are discussed.

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Acknowledgements

I would like to thank Dr. Laura Smith in recognition of her support and thoughtful guidance throughout my graduate training. Great appreciation is also extended to Dr. Melanie Brewster, Dr. Sarah Brazaitis, Dr. Robert Fullilove, and Dr. John Chin for their contribution as committee members. With much gratitude I also acknowledge all faculty and students in the Counseling Psychology Program. Thank you for allowing me to learn from all of you.

I would also like to express my heartfelt gratitude to my family and friends for their love and friendship. I could not imagine making it through the past six years without their support and encouragement. Thank you.

Dedication

This dissertation is dedicated to the people living with HIV/AIDS whom I have worked with in my clinical work.

Chapter I: Introduction

Since the first cases reported in the early eighties, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) have led to one of the most damaging epidemics in history. In the United States, 1.1 million people were estimated to be living with HIV/AIDS, and 201,807 of them are in the New York State (Centers for Disease Control and Prevention [CDC], 2011a). One unique aspect of the HIV epidemic is its disproportional impact on marginalized groups in society. For example, gay men and injected drug users (IDUs) have received the most damaging impact since the early outbreak of the HIV epidemic (Devine, Plant, & Harrison, 1999). In recent years, data have shown that socially and economically disenfranchised racial and gender groups have become the new face of the HIV epidemic. The Black community, in particularly, has experienced the most severe impact. A recent HIV surveillance report (CDC, 2011a) showed that African Americans account for nearly half of the extant HIV cases, although African Americans only represent 12 percent of the United States population. The rate of new HIV infection for African American men is about six times as high as that of White men, while the HIV incidence rate for African American women is almost 15 times as high as that of White women (CDC, 2011a). The increasing rates of HIV infection have led many researchers to suggest that mental health professionals are likely to encounter clients who are infected with or affected by HIV at some point of their professional lives (Crawford, Humfleet, Ribordy, Ho, & Vickers, 1991; Hayers & Erkis, 2000). The question of clinicians' preparedness to work with people living with HIV/AIDS (PLWHA) and to conjointly deal with multicultural issues during the therapeutic process therefore calls for further investigation.

Working with PLWHA may present a particular challenge to clinicians because of the phenomenon of stigma. Because of the disproportional impacts on gay and bisexual men since

the beginning of the HIV epidemic, an automatic association between homosexuality and HIV

has been commonly found in many people's belief system (Devine et al., 1999). Other

marginalized groups such as IDUs and ethnic minorities, which have experienced increasing

impact by HIV epidemic over the years, have also become the targets under the operation of this

type of automatic association. The idea of high risk *groups*, as opposed to high risk *activities,*

that may lead to HIV infection has become the dominating perceptions in people's understanding

of HIV epidemic (Devine et al., 1999). These perceptions can be manifested through people's

negative attitudes and behavior toward PLWHA, which in turn lead to PLWHA's experiences of

stigmatization and discrimination (Crawford, et al., 1991; Devine et al., 1999; McBride, 1998).

Stigma has been conceptualized as an "attribute that is deeply discrediting" as well as "a

special kind of relationship between attribute and stereotype" (Goffman, 1963, p. 3-4). The

stigmatization experienced by PLWHA is called as *HIV stigma* (or AIDS stigma, HIV-/AIDS-

related stigma) – "prejudiced, discounting, discrediting, and discrimination directed at people

perceived to have AIDS or HIV, and the individuals, groups, and communities with which they

are associated" (Herek, 1999, p. 1107). This definition suggests the multiple layers of HIV

stigma. On the surface, HIV stigma is about people's negative reactions to the illness itself (e.g.,

fear of contagion). Moreover, HIV stigma is often layered with additional biases toward the

already-stigmatized groups (such as sexual, racial, and ethnic minorities) with which many

PLWHA are associated with (Crawford, et al., 1991; Reidpath & Chan, 2005). Evidence to

support the layering of HIV stigma has been found in studies on the general public's reactions to

HIV. For instance, results from telephone surveys conducted in the United States have shown

that participants tended to exaggerate the risk of HIV transmission by believing some forms of

casual contacts to be high risk (Herek, Capitanio, & Widaman, 2002 & 2003). Furthermore,

participants who supported unfriendly HIV testing policy (name-based reporting of HIV results to the government) also had greater negative feelings toward PLWHA, gay community, and IDUs (Herek et al., 2003).

Research results have shown that when interacting with individuals with stigmatized conditions, avoidant behaviors, as well as strong and impulsive emotional reactions that contain a negative tone, are some common responses found among the nonstigmatized individuals (e.g., Dijker, Kok, & Koomen, 1996; Kurzban & Leary, 2001; Mooney, Cohn, & Swift, 1992; Pryor, Reeder, Yeadon, & Hesson-McInnis, 2004). Some PLWHA have even reported experiencing stigma and acts of discrimination during interactions with medical care providers (Bird, Bogart, & Delahanty, 2004; Rintamaki, Soctt, Kosenko, & Jensen, 2007; Zukoski & Thorburn, 2009). Moreover, results from these studies have frequently highlighted the association between stigmatized individuals' mental distress and their stigmatization experiences.

It is possible that counselors may have negative reactions toward PLWHA that are similar to those present in broader society – reactions that could potentially damage the working alliance to the detriment of HIV-positive clients. Several researchers have used case vignettes featuring individuals with different HIV status, illness, sexual orientation, or source of HIV infection to explore participating clinicians' reactions toward the hypothetical clients. Results from these studies showed that some mental health professionals were less willing to work with a client having AIDS than a client with leukemia (Crawford, et al., 1991), and showed less sympathy and greater discomfort toward HIV-positive clients (Fliszar & Clopton, 1995; Hayes & Gelso, 1993). Furthermore, results from these studies frequently identified clinicians' prejudiced attitudes toward gay men, often conceptualized as homophobia, as a major predictor to their unfavorable reactions to HIV-positive clients (Crawford, et al., 1991; Hayers & Erkis, 2000; Hayes & Gelso,

1993). Overall, results from these studies suggest that mental health professionals' attitudes toward both HIV and its associated stigmatized groups may significantly impact their reactions and clinical judgments to the HIV-positive clients. Additionally, these results provide further support to the concept of the multiple layers of HIV stigma mentioned previously.

This body of literature has generated helpful guidelines and precautions to clinicians regarding providing effective treatment to PLWHA, particularly those who also identify themselves as gay or bisexual. However, in empirical studies, other client variables (e.g., HIV-positive clients' racial and ethnic group memberships) that may additionally factor into clinicians' reactions to HIV-positive clients have rarely been examined. With the rising rates of HIV infection in the Black community in recent years (CDC, 2011a), this lack of empirical investigation is particularly significant for the mental health professionals. Many researchers (e.g., Roberts & Miller, 2004; Stevenson, 1994) have argued that the manifestations of HIV epidemic and HIV stigma in the Black community are greatly informed by the cultural norms and values. For instance, HIV/AIDS conspiracy beliefs held by some African Americans is a unique phenomenon that is associated with the racism and oppression that African Americans have endured (Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2005). Nevertheless, since literature on the psychosocial issues of PLWHA tends to focus on the experience of White gay and bisexual men, clinicians' awareness and reactions with regard to these culturally-related experiences of racial and ethnic minority clients have rarely been explored (Hoffman, 1993).

The potential influence of HIV-clients' race upon clinicians' reactions in the therapeutic process also has implications within the development of clinicians' multicultural counseling competence, an issue that has received increasing attention during the past several decades (e.g., D. W. Sue & Sue, 2003; Sue et al., 1998). One major contention of the multicultural counseling

movement is that psychotherapy often operates according to White, middle-class, North American values. These values may lead counselors to make inaccurate diagnoses based on minority clients' behaviors that are actually considered to be typical for among their cultural groups (Abreu, 1999; Sue et al., 1998; Wachtel, 2002). Mixed results have been reported from empirical studies using case vignettes that differ in the designation of client race to examine clinicians' racial biases (e.g., Bishop & Richards, 1987; Fisher, Matthews, Robinson Kurplus, & Burke, 2001; Garb, 1997; Kales, et al., 2005). However, researchers have continued to ask whether clinicians' racial biases may account for the disparities found in clinical data, such as the fact that Black patients are more likely to be diagnosed with schizophrenia than are White patients (e.g., Pavkov, Lewis, & Lyons, 1989; Snowden & Cheung, 1990; Sohler, & Bromet, 2003). Many scholars have also suggested that manifestations of prejudice and discrimination against stigmatized individuals have evolved and presented themselves in different forms over the years (Crocker, Major, & Steele, 1998). Therefore the conflicting results from empirical studies may reflect the more subtle forms of racism that individuals may hold. For instance, in recent years, the concept of *color-blind racial attitudes* (Neville, Lilly, Duran, Lee, & Browne, 2000) has been applied in counseling research on racial-related prejudiced attitudes. Findings have shown that individuals with high color-blind racial attitudes (greater tendency to deny or underplay the existence of racism and believe that race has little meaning in people's lives in the United States) reported more biased and negative clinical judgments to the hypothetical Black client featured in the vignette (Burkard & Knox, 2004; Gushue, 2004). Results from these studies indicated that racial bias may still have a significant impact on clinicians' clinical judgments in treatment with people of color. Consequently, it is important to explore how clinicians' reactions

and clinical judgments may differ in response to the clients' race when working with HIV-positive clients.

Building upon previous research results on the relationship of clinicians' biases in treatment with HIV-positive clients or people of color, the purpose of the present study was to explore whether client's race (Black or White) may have an impact on counselor trainees' therapeutic impressions of HIV-positive clients. Case vignettes featuring a client who was either White or Black and either HIV negative or HIV positive were randomly presented to participants so that the extent of any biases pertaining to HIV and race could be estimated and compared.

Chapter II: Literature Review

The review of literature will begin with the discussion of common mental health issues among PLWHA, which will be followed by a presentation of psychosocial issues of Black Americans living with HIV/AIDS that have been documented in the literature. As will be demonstrated, the unique issues presented by Black HIV-positive clients require counselors' awareness and attention within the therapeutic process.

Mental Health Issues among PLWHA

Being infected with HIV can be a source of mental distress in and of itself; moreover, due to organic changes and opportunistic infections that can take place over the course of living with HIV, neuropsychological issues may arise and also become a major concern for PLWHA (Werth & Carney, 1994). As such, PLWHA have been found to be vulnerable to a range of mental health disorders and issues (Hoffman, 1991). For instance, epidemiologic studies have shown that the rates of depressive disorder approach 37% among PLWHA, as compared to 20% among patients in primary care clinics (as cited in Berg, Mimiaga & Safren, 2004, p.636). Elevated risks of anxiety disorders, substance abuse, personality disorders, and AIDS dementia are other common mental health concerns for PLWHA (Dworkin, & Pincu, 1993; Schmeller-Berger, Handal, Searight, & Katz, 1998). These mental disorders, without proper treatment strategies and knowledge of effective coping, may lead to other serious HIV-related concerns such as poor HIV medication adherence (Catz, Kelly, Bogart, Benotsch & McAuliffe, 2000) and high risk sexual behavior (Courtenay-Quirk, Wolitski, Parsons, Gomez, & Seropositive Urban Men's Study Team, 2006).

In addition to these mental health concerns, PLWHA often experience greater levels of general psychological distress and less satisfaction with their quality of life (Buseh, Kelber,

Hewitt, Stevens, & Park, 2006; van der Veek, Kraaij, Van Koppen, Garnefski, & Joekes, 2007).

One contributing factor may be that PLWHA have to deal with issues related to disclosure, stigma, and loneliness in their everyday lives (Buseh et al., 2006; Courtenay-Quirk et al., 2006; Yoshioka & Schustack, 2001). Results from a study conducted in Netherlands showed that disturbance of PLWHA's daily events can significantly contribute to psychological distress (van der Veek, 2007). Findings revealed that due to their HIV diagnosis, participants could not achieve higher-order goals that were previously able to achieve. Furthermore, participants who reported high on goal disturbance also had more depressive symptoms and were generally less satisfied with their quality of life. In a study on the relationship between perceived stigma and life satisfaction among urban African American men living with HIV/AID, higher levels of personalized stigma and negative self-image were found to be associated with lower levels of life satisfaction (Buseh et al., 2006). The issue of stigma will be further discussed in a later section of this article.

PLWHA's coping strategies play an important role in dealing with stressful events in their daily lives. Unfortunately, studies have found that many PLWHA may frequently apply avoidance coping strategies that can lead to feelings of isolated and hopeless (Courtenay-Quirk et al., 2006; Fleishman & Fogel, 1994; Fleishman et al., 2000). Fleishman and Fogel (1994) found that PLWHA who used more avoidance coping tended to have higher measures of psychological distress. On the contrary, those who applied active-positive coping (e.g., try to learn more about AIDS, make plans for the future) reported fewer depressive symptoms. Negative and harmful encounters with others may push PLWHA to become isolated from their social network. This type of coping may create more conflicts in their personal lives since others might misunderstand or misinterpret their coping behaviors (Fleishman et al., 2000).

In a study on the experience of HIV-positive men who have sex with men (MSM) in the gay community, results showed that participants experienced HIV-negative men's stigmatizing attitudes through experiences of sexual rejection and discrimination. Some participants also reported receiving judgmental attitudes from other HIV-positive men (Courtenay-Quirk et al., 2006). Results from this study suggest that these negative interpersonal experiences were significantly related to participants' anxiety, loneliness, and depressive symptoms. Moreover, perceived stigma and discrimination were found to be associated with more avoidant coping strategies used by the participants.

Results from these studies suggest that ineffective coping, depression, and experience of stigma and discrimination appear to be some of the most commonly found mental health issues among PLWHA (e.g., Courtenay-Quirk et al., 2006; Fleishman & Fogel, 1994; Fleishman et al., 2000; van der Veek, 2007). However, manifestations of these issues may differ significantly in the context of an individual's racial and cultural background, which may pose as a challenge to clinicians' multicultural competence. To illustrate this assumption, the focus of the following section will be on the unique psychosocial factors associated with the mental health issues among Black Americans living with HIV/AIDS.

Psychosocial Issues Unique to Black Americans Living with HIV/AIDS

Data from HIV surveillance reports have indicated that disease trends among Black Americans are continually worsening (CDC, 2011b). Among all heterosexually acquired AIDS cases in the United States, Blacks account for the largest number. Women, IDUs, and MSM have experienced the most severe impact of HIV epidemic in Black American community. Pervasive poverty and the issue of racial and ethnic disparities in health care further complicate many HIV prevention and intervention efforts in the Black American community (Roberts & Miller, 2004).

Scholars have consistently pointed out that HIV programs and services for racial and ethnic

minority groups are often underfunded. In contrast, HIV programs and services targeting Whites

often receive more funding support even when White clients are the numerical minority in a

particular service area (Gutierrez, 1997). This is a common issue experienced by the Black

community in many epicenter cities, where the major AIDS and HIV service providers have

been built largely by gay and lesbian as well as AIDS activism efforts. Although these

organizations provide services to all people, the geographic location and infrastructure of the

organizations often fail to meet the needs of Black community (Roberts & Miller, 2004).

Therefore, for many professionals in the HIV field, it has been a challenge to develop culturally

informed HIV programs and prevention strategies that are not based on models of White gay

men as the target populations (Croteau, Nero, & Prosser, 1993).

The lack of HIV-related services in the Black community may be partly due to the fact that,

relatively speaking, Black Americans did not immediately experience the full brunt of the impact

during the beginning of the HIV epidemic. However, Black Americans have since experienced

the impact of HIV epidemic in different forms. For instance, the widespread belief that Africa

was the origin of the HIV virus may have led some Americans to blame the Black community

for the HIV epidemic in the United States (Stevenson, 1994). In his writing on sexual racism and

AIDS in the Black community, Stevenson (1994) suggested that Western culture's perceptions of

minorities or people of color have roots in the historical events of enslavement and scientific

racism (e.g., Tuskeegee syphilis experiments [CDC, 2011b]) in the United States. These

perceptions include distorted ideas about the sexual behaviors of Black people such beliefs that

they are sexual deviants or people poor impulse control (Stevenson, 1994). These stereotypes

have further reinforced some Americans' assumptions that Black people are to blame for the

problem of HIV epidemic (Stevenson, 1994). In 1983, the CDC placed Haitians on the list of

high risk groups for HIV infection. Ethnicity and nationality, therefore, rather than individuals'

particular high-risk behaviors, was defined as a risk factor for HIV infection for the first time. At

that time, many Haitians reported being harassed in the major cities of the United States. In this

unfortunate example, a public health decision turned into discriminating and alienating

stereotypes regarding a certain racial and ethnic group (Farmer, 1992).

The history of scientific misinterpretation and Black people being seen as the "sexual other"

has also contributed to the Black community's distrust of public health efforts, a phenomenon

acknowledged by researchers as one of the greatest barriers to effective HIV interventions in the

Black community (Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2005; Stevenson, 1994).

Results from a survey conducted on professionals working in AIDS programs serving people of

color revealed that many African American administrators have often heard the community

members endorse the belief that AIDS is a genocidal plot developed by the government to

destroy Black people (Stevenson & White, 1994). A national survey found that less than 40

percent of the African Americans participants agreed with the statement, "The government is

telling the truth about HIV," while about 44 percent of them believed the statement, "People who

take the new medicines for HIV are human guinea pigs for the government." Male participants

endorsed significantly stronger HIV/AIDS conspiracy belief than female participants (Bogart &

Thorburn, 2005).

Studies on HIV patients' attitudes have also produced similar findings. Data collected from

an urban academic HIV clinic between 2005 and 2008 showed that African American patients

expressed lower levels of trust in their medical providers than did White patients and were less

likely to be receiving antiretroviral therapy than were White patients when eligible (Saha, Jacobs,

Moore, & Beach, 2010). Compared to White patients, racial and ethnic minority patients generally reported more negative attitudes and beliefs toward antiretroviral therapy adherence (Siegel, Karus, & Schrimshaw, 2000; Thrasher, Earp, Golin, & Zimmer, 2008). These results suggest that HIV/AIDS conspiracy beliefs exist among some African Americans, and it may partly explain the lower level of receiving HAART, less adherence to HAART, and less successful HAART outcomes that are found in studies on African Americans' responses to HIV treatment (e.g. Gebo, et al., 2005; Giordano, et al., 2010; Weintrob, et al., 2009).

Scholarly literature has also suggested that the experiences of living with HIV/AIDS can be very different between gay men of color and White gay men. In research on gay and bisexual men of color, discrimination and prejudice based on race and ethnicity within the mainstream gay community has been found to be a common experience among these individuals (e.g., Ibañez, Van Oss Marin, Flores, Millett, & Diaz, 2009; Wilson & Yoshikawa, 2004; Yoshikawa, Wilson, Chae & Cheng, 2004). Furthermore, gay and bisexual men of color often experience distress as a result of their multiple racial and cultural identities. For instance, Bogart and her colleagues (2011) found that among the Black MSM participants, perceived discrimination based on HIV status, race and ethnicity, and sexual orientation were all significantly associated with greater symptoms of depression and posttraumatic stress disorder. To these individuals, racial and ethnic identity might be important aspects of their self-identities, and embracing a gay identity may present a dilemma since it may symbolize a closer association with the White community (Morales, 1990). On the other hand, maintaining a stronger affiliation with racial and ethnic communities has positive implications for HIV-positive gay and bisexual men of color's mental health. Such men may have a difficult time in finding support within their communities if HIV stigma is prevalence among the community members (Gutierrez, 1997; Hoffman, 1993).

Another relevant issue in working with HIV-positive African Americans men is the topic of sexual orientation. To some Black MSM, bisexuality or non-gay-identifying are preferable labels for sexual identification in cultures that maintain strong stigmas around homosexuality. Gay, bisexual men, and MSM in these racial and ethnic communities may still maintain intimate or married relationships with women (Gutierrez, 1997; Williams, Wyatt, Resell, Peterson, & Asuan-O'Brian, 2004). These women, usually unaware of their male partners' risky behaviors, therefore become highly vulnerable to HIV infection. This interplay between the stigma related to homosexuality and HIV has been suggested as one of the reasons for the increasing rates of HIV infection among both men and women of color (Chu, Peterman, Doll, Buehler, & Curran, 1992). Moreover, with regard to gender roles and social expectations, men are expected to be physically dominant and sexual, while women are expected to be submissive and obedient. These sex-role differences are also played out in the gay and bisexual subcultures in the Black community. One worrisome consequence is that the dominant, "macho" person in either a heterosexual or gay relationship may enforce the myth that protection is not needed during sex, which puts them and their partners at greater risk for HIV infection (Gutierrez, 1997). In addition, when church and religion are important parts of their culture, many HIV-positive Black MSM experience conflicts associated with their sexuality, HIV status, and religious beliefs. A focus group study on HIV-positive Black MSM's experiences showed that many participants identified church and religion as an essential aspect in their life. However, they also reported guilt and conflicting feelings caused by their sexual desire and pressure to conform to religious rules (Williams, et. al., 2004).

The economic and social hardships faced by many Black communities have also complicated the struggles and challenges experienced by HIV-positive Black individuals, as well

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as their ability to access mental health services. For instance, in discussions on HIV transmission through drug injection in the Black community, some researchers have suggested that difficult social and economic situations may force some drug users to choose drugs (e.g. crack) and use practices (e.g. share of reuse needles) that could expose them to greater risk of HIV infection (Storey, 1997). When these individuals are referred to therapy, group therapy is sometimes suggested as the preferred treatment option for this population because of the common belief among clinicians that these HIV-positive individuals' impulsive tendencies and negative patterns in maintaining stable relationships might prevent them from achieving meaningful outcomes in individual treatments (Storey, 1997). However, competing needs and responsibilities in these individuals' lives may also account for seeming difficulties in committing to treatment. For example, HIV-positive women of color may put the needs of significant others or children before their own needs. Thus getting treatment for HIV and mental health or drug issues may not be the priority since there are other more pressing issues to deal with in their lives (Goggin & Rabkin, 1997).

The various psychosocial issues among Black Americans living with HIV/AIDS illustrated so far provide a snapshot of how social inequality and stigma are manifested in these individuals' lives based on their memberships in multiple minority statuses. The stigma and discrimination experienced by these individuals is at times based on their HIV status, while at times, it may be related to the experiences of being Black in America. Perhaps most significantly, they may often feel oppressed as a result of the combined effects of being HIV-positive and being Black – a phenomenon called *double discrimination* or *double jeopardy* in the intersectionality literature (Cole, 2009). The double discrimination/double jeopardy issue has important implications for therapists since it suggests that when working with individuals who have multiple categories of

identities and disadvantages, treatment may be more effective if clinicians can also considerate how these categories jointly affect the clients' experiences. This is important in treatment with HIV-positive individuals since many of them are living with more than one stigmatized condition (e.g., chronic illness, ethnic minority, and sexual minority).

Since PLWHA's experiences of stigma are often central in their daily struggles -- and are often referenced within the HIV literature -- the stigma phenomenon itself will be presented. Black HIV-positive individuals' racial minority status will also be conceptualized and explored with the perspective of stigmatization.

HIV and Race-related Stigma

In stigma literature, the terms *stereotypes*, *prejudice*, and *discrimination* are often mentioned. *Stereotypes* are special types of cognitive structures, including positive and negative ones, involved in the categorizations of individuals or social targets. Stigma, usually understood as a social process, is associated with only negative attributes (Goffman, 1963, Crocker et al., 1998, Scambler, 2009). *Prejudice* and stigma both refer to an individual's negative attitudes. However, prejudice exists in the minds of individuals, while stigma resides in social constructs and relations (Herek, 2002). Every individual can have prejudiced attitudes toward any group of people regardless of their power differential. When a personal prejudice represents society's negative perceptions toward individuals with certain social identities, then it becomes a manifestation of stigma (Herek, 2002). *Discrimination* is often conceptualized as a manifestation of stigmatizing attitudes and beliefs, although it is not an essential component of the stigma process (Herek, 2002). These terms, not to be confused with stigma, will be mentioned throughout this article.

Overview of Stigma. Discussion of stigma has been significantly influenced by Goffman's (1963) groundbreaking book *Stigma: Notes on the Management of Spoiled Identity.* Based on his research experiences with homosexuals, criminals, and individuals with mental illness or physical disability, Goffman proposed that stigma is an "attribute that is deeply discrediting" and "a special kind of relationship between attribute and stereotype" (Goffman, 1963, p. 3-4). The stigmatized individual is seen by the society as someone possessing an "undesirable difference," which results in a "spoiled identity" (Goffman, 1963). In other words, stigmatized individuals are devalued by society for possessing an attribute that conveys a negatively valued social identity (Crocker et al., 1998). Category and membership of social identity is not defined by nature but by social rules or even government ruling (e.g., gender, race, and disability). Therefore, comparing to individuals in marginalized groups, people who are in power are less likely to experience stigmatization (Crocker et al., 1998).

Jones et al. (1984) proposed that stigma includes the following six dimensions: (1) concealability (visibility) – whether the stigma is visible to others, (2) course of the mark – whether the stigmatizing condition progresses over time, (3) disruptiveness – the degree to which the stigma condition interferes with social interactions, (4) aesthetic – how much the stigmatizing condition makes the stigmatizing individual repellent and upsetting to others, (5) origin – how much responsibility the stigmatizing individual takes for the stigmatizing condition, and (6) Peril – whether the stigmatizing condition poses dangers to others (Jones et al., 1984). These characteristics can be used to understand the interpersonal patterns of a stigmatized individual. For instance, research has shown that individuals with a concealable stigma may appear at ease in appearance, but it comes with the cost of extensive cognitive and psychological efforts to maintain caution in interpersonal interactions (Quinn & Chaudoir, 2009; Smart & Wegner, 1999;

Yoshioka & Schustack, 2001). With regard to the dimension of *origin*, perceived responsibility of the stigmatizing condition can affect people's perceptions and reactions toward the stigmatized individuals. For instance, Brickman et al. (1982) found that people treat individuals with a stigmatizing condition that are believed to be controllable with more hostile attitudes.

Scholars have suggested that stigma should be understood as a social process in which power and domination within and between groups play an important role (Link & Phelan, 2001; Parker & Aggleton, 2003). To illustrate this concept, Link and Phelan (2001) proposed that the process of stigmatization is composed of the following four interrelated components. The first component is the process of social selection to distinguish and label human differences. Differences that matter socially are identified and categories are created largely based on the rule of oversimplification. The second component occurs when the dominant cultural belief ascribes negative attributes to the labeled differences. Stereotypes and categories are formed and presented automatically at the preconscious level. In the third component, the labeled individuals are put into undesired categories, which results in the separation of "us" and "them". Finally, the targeted persons experience status loss and discrimination. Labeled individuals are devalued by the mainstream society due to their status loss, which leads to concrete inequality in accessing better education, medical treatment, job, and other necessities in maintaining a quality life (Link & Phelan, 2001).

People learn stereotypes of stigmatized groups early in life. Studies on stereotypes of skin color, disability, and people who are overweight showed that as early as the age of three years, children in the United States already displayed negative attitudes toward these stigmatizing conditions (Dion & Berscheid, 1974; Sigelman & Singleton, 1986). Through early exposure and repeated learning, accessing to stereotypes becomes an automatic process to most people. As a

result, individuals with a stigmatizing condition may be stereotyped automatically by nonstigmatized individuals who are not consciously aware of their intentions (Banaji & Greenwald, 1995; Devine, 1989; Steele & Aronson, 1995). Furthermore, stigmatized individuals, who are often perceived as deviants and outcasts of the society, may evoke fear and anxiety by posing as a threat to the validity of nonstigmatized individuals' worldviews. To reduce these intense feelings, people may subscribe to a worldview or cultural norm that imposes order and meaning on an otherwise random world, and use stigmatization as a coping mechanism (Crocker et al., 1998; Greenberg, Solomon, & Pyszczynski, 1997; Pyszczynski, Greenberg, & Solomon, 1999).

Even though stigmatization can be used as a coping mechanism to deal with intense feelings triggered by stigmatized individuals, studies have shown that many nonstigmatized individuals still experience anxiety when interacting with stigmatized individuals (Crocker et al., 1998; Stephan & Stephan, 1985). This anxiety may be caused by the fear that one's behaviors toward the stigmatized individuals might lead to negative behavioral and psychological consequences for the self, as well as unfavorable evaluations by both ingroup and outgroup members (Stephan & Stephan, 1985). Sometimes when individuals try to interact with the stigmatized individuals in a nonjudgmental and nonprejudiced manner, it can induce greater anxiety (Devine, 1989). Discrepancies between expressed attitudes and behaviors toward stigmatized individuals can also induce feelings of ambivalence and anxiety (Devine et al., 1991; Katz & Hass, 1988). In Devine and his research team's (1991) study, participants reported how they should respond and how they would respond to black people and homosexual men. They found that should-would discrepancy resulted in discomfort feelings among the participants. This result suggests that pressure to be nonprejudiced and lack of confidence in one's ability to interact with stigmatized

individuals appropriately may induce anxiety and discomfort within nonstigmatized individuals (Devine et al., 1991).

Interacting with stigmatized individuals, as examined in these studies, can trigger strong reactions from nonstigmatized individuals, particularly in a context that is unfamiliar to both parties, and where rules and norms for appropriate behaviors are unclear (Frable, Blackstone, & Sherbaum, 1990; Stephan & Stephan, 1985). Therapeutic interactions between clinicians (nonstigmatized individuals) and clients with stigmatizing conditions, in many ways, resemble this process. In the following sections, discussions on stigma pertaining to race and HIV will be presented to further explore the potential effects of stigma on clinicians' clinical impressions when working with clients of color who are HIV-positive.

Race-related Stigma. The stigma concept has been applied to explain a wide range of societal issues and circumstances. When discussing *racism* from the perspective of stigmatization, the focus falls upon the discriminatory attitudes and actions of the perpetrators (Sayce, 1998). Racism was originally conceptualized as overt attitudes and behaviors that were used to deny the basic rights of African Americans (Burkard & Knox, 2004). Over the years, contemporary theories of racism have evolved to reflect the more subtle and covert forms of prejudice and discrimination. Examples of contemporary theories of racism proposed by researchers include symbolic racism (Kinder & Sears, 1981), aversive racism (Dovidio & Gaertner, 2004), and color-blind racial attitudes (Neville, et al., 2000, Neville, Worthington, & Spanierman 2001). Sources of these contemporary forms of racism may be traced back to the ambivalent and conflicting feelings caused by endorsement of both egalitarianism (which emphasizes equality, social justice, and the worth of human beings) and individualism (which emphasizes personal freedom, self-reliance, and achievement) values that are rooted in many

Americans (Katz & Hass, 1988). Sympathy for stigmatized individuals can be triggered by the value of egalitarianism. On the other hand, since blame and responsibility are easy to be placed on the stigmatized individuals for their own disadvantaged conditions, negative stereotypes and feelings coming from the individualism perspective could also be easily evoked (Katz & Hass, 1988). Therefore people may rationalize that their negative reactions are evoked by the individual behaviors while failing to recognize their hostility toward racially and ethnically diverse groups (Crocker, et al., 1998).

Manifestations of these subtle forms of racism are different from traditional forms of racism in several ways. For instance, in aversive racism, individuals may react and behave in an overly positive way as an attempt to demonstrate their nonracist attitudes (Dovidio & Gaertner, 2004). Some scholars have also suggested that racially and ethnically diverse individuals can hold contemporary forms of racism as well (Burkard & Knox, 2004; Neville et al., 2000). For example, studies have shown that high levels of color-blind racial attitudes -- the tendency to overlook the social significance of race and deny the existence of any individual, institutional, and cultural manifestations of racism in the United States (Neville et al., 2000) -- can be found in both White and African American people. These individuals, regardless of their race, tend to have less empathic reactions toward racism and racial inequality in America (Neville, Coleman, Falconer, & Holmes, 2005; Spanierman & Heppner, 2004).

When working with racially and ethnically diverse clients, race-related stigma may also affect clinicians' reactions and perceptions in ways that are similar to those documented in the literature. Moreover, race-related stigma and attitudes may affect the therapists' cognitive schemas that are used to understand racial stimuli, and then in turn influence clinicians' clinical judgments and decisions on racial and ethnic minority clients (Gushue, 2004). Relevant studies

on the effects of racial bias on clinicians' reactions and clinical judgments will be presented in a later section of this article.

HIV Stigma. Several characteristics of HIV may have contributed to the prevalence of HIV stigma. First, since behaviors (e.g., particular sexual behaviors, drug use) that cause HIV infection are thought to be avoidable and immoral by the mainstream society, PLWHA are often blamed for their illness. Moreover, the fact that no cure is available triggers stronger fear that may lead to greater stigma among people. Also, a contagious disease such as HIV that is perceived to pose danger to others evokes stronger stigma (Herek, 2002). Deacon (2006) proposed a model to illustrate how stigma is formed in the context of HIV epidemic. One central assumption is that illness is seen as being under each individual's control, and everyone is expected to take proper preventative action. Therefore, behaviors that cause the illness are identified and labeled as "immoral". At the next stage, association between individuals who carry out the "immoral" behaviors and these people's memberships in the "other" groups of the society is established. Hence a sense of "us" and "them" is created. The labeled persons are blamed for their infection and illness, and ultimately they experience status loss (Deacon, 2006).

In the United States, the HIV epidemic has been most prevalent among socially marginalized groups such as gay men, IDUs, African Americans, Hispanics/Latinos, and women of color (CDC, 2011a; Devine, et al., 1999; Hoffman, 1993). Many researchers, in their conceptualizations of HIV stigma, often emphasize that stigma toward these marginalized groups is an important component of HIV stigma. For instance, a report from USAID (2006) stated that HIV stigma includes the following three elements: *pre-existing stigma*, *HIV specific stigma*, and *enacted stigma*. Pre-existing stigma refers to the general public's negative perceptions toward labeled groups whose behaviors or mere existences are perceived as a deviation from the "norm."

An example to illustrate this type of stigma is that during the 1980s and even nowadays, some people refer to HIV and AIDS as the "gay disease" (Herek & Capitanio, 1999).

HIV-specific stigma is about people's misunderstanding and exaggerated sense of danger toward PLWHA. Enacted stigma happens when people act out their stigma by identifying the infected individuals, distancing themselves from "them", and isolating "them". Many social scientists have also used *instrumental stigma* and *symbolic stigma* to differentiate two different types of stigmatizing attitudes and behaviors toward PLWHA (Herek, 2002; Pryor, Reeder, & Landau, 1999). Instrumental stigma, similar to the concept of HIV specific stigma, refers to the fear of getting infected with HIV and the immediate strong reactions of protecting oneself from the infection. Symbolic stigma refers to the use of AIDS as a vehicle to act out people's negative attitudes and perceptions toward already-stigmatized groups. Symbolic stigma is usually deeply rooted in people's perceptions is often robust and hard to change even when contradictory evidence is presented. For instance, research has found that many Americans still equated HIV with homosexuality even though the proportion of AIDS cases in the United States had been decreasing among this population (Herek, 2002; Pryor et al., 1999).

Based on their research on people with epilepsy, Scambler and Hopkins (1986) proposed the concepts of *enacted* and *felt stigma*. Enacted stigma occurs when people enact their stigma in overt form, while felt stigma refers to the stigmatized people's internal feelings of shame and fear in relation to the experienced and anticipated discrimination (Scambler & Hopkins, 1986; Jacoby, 1994). In Scambler's later works, he extended this framework to conceptualize HIV stigma. He pointed out the importance of understanding the stigmatization process in the context of the changing dynamics embedded in social structures such as class, race, and gender (Scambler, 2004; 2009). According to this conceptualization, PLWHA can still experience the

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negative impacts of HIV stigma (felt stigma) without any actual discriminations (enacted stigma) occurring (Herek, 2002). Enacted and felt stigma has been investigated in research on PLWHA's experiences of HIV stigma, and results revealed that felt stigma is presented in three major domains – feeling, thinking, and fearing, in participants' daily lives (Block, 2009). PLWHA in this study used words such as leper, pariah, mutant, and freak to describe how they felt inside, and reported worries and concerns about how others might react to their HIV status.

Worries toward others' stigmatizing attitudes reported by PLWHA may not be unfounded. Even with the changing faces of infected and affected populations throughout the three decades of HIV epidemic, society's stigmatizing attitudes and behaviors toward PLWHA is still evident in literature. Based on national telephone surveys conducted in the United States, Herek, Capitanio, and Widaman (2002, 2003) found that several response patterns shown by participants indicated the prevalence of stigmatizing attitudes and belief toward PLWHA is still existing. For instance, participants may have knowledge about how HIV is transmitted, but they tended to exaggerate the risk by believing some forms of casual contacts to be high risk (Herek et al., 2002). They also found that nearly half of the participants agreed with the statement that "Most people with AIDS are responsible for having their illness" (Herek, et al., 2002). This result suggests that many people have the tendency to differentiate between "innocence" and "blame-worthy" PLWHA, and many PLWHA still tend to be blamed for their HIV infection (Hayes & Eriks, 2000; Herek & Capitanio, 1999). Participants who supported name-based but not anonymous reporting of HIV results to the government had significantly more negative feelings toward PLWHA, the gay community and IDU. These participants also perceived the issue of HIV stigma and discrimination as less extensive and serious (Herek et al., 2003).

Results from another national telephone survey further indicated the connection between people's negative attitudes toward homosexuality and stronger HIV stigma (Herek & Capitanio, 1999). In this study, results indicated that heterosexual participants who held stronger negative attitudes toward homosexuality also tended to associate AIDS with homosexuality or bisexuality more than other participants. Some participants equated any male-to-male sexual behavior with AIDS, even between two men who are both HIV negative (Herek & Capitanio, 1999). Researchers often use the term homophobia to describe people's negative attitudes toward gay and bisexual men in these studies. Homophobia is a word invented to address the oppression of lesbians and gay men. It refers to the negative beliefs and attitudes to lesbians and gay men, as well as the prejudice against them (Beverly, 2000). The damaging effect of homophobia can also be found among PLWHA. For instance, reports have shown that some heterosexual HIV-positive men are reluctant in reaching out to HIV-related service providers because in fear of being labeled as gay (Hoffman, 1993).

In conclusion, individuals' attitudes toward PLWHA are significantly associated with the HIV stigma beliefs that they hold. When working with PLWAH in a therapeutic relationship, clinicians' unchecked HIV attitudes and homophobia could precipitate negative consequences or even cause harm to the clients. Some researchers have used case vignettes to examine clinicians' reactions to HIV-positive clients. Results from these studies will be presented in the following section.

Clinicians' Reactions to HIV-positive Clients

In a study on people's help-giving behavior, results showed that among the 10 types of physically based and mental-behaviorally stigma, HIV stigma was the only onset-controllable and irreversible stigma identified by the participants (Weiner, Perry, & Magnusson, 1988). This

finding suggests that people are more inclined to attribute personal responsibility to the onset of

HIV, while at the same time they acknowledge that PLWHA are not held responsible for its

offset, since HIV is perceived as incurable (Weiner, 1993; Weiner et al., 1988). This onset-offset

disparity may evoke strong pity from people. Moreover, greater pity may be triggered when the

onset was presented as uncontrollable (blood transfusion), or when the HIV- positive people

were described as making an effort to do something about their condition (Schwarzer & Weiner,

1991). However, these clinician reactions may be based on assumptions that are very different

from the HIV-positive clients' experiences and understanding of their own issues. For instance, a

Black HIV-positive client may attribute his current difficulties to HIV stigma and racism

(external attribution), while the therapist may focus more on the motivation behind his high risk

sexual behavior (internal attribution).

Concerns regarding the impact of clinician bias in treatment with HIV-positive clients have

led several researchers to examine how clinicians' clinical judgments and reactions may differ in

response to diverse client characteristics. Crawford and his colleagues (1991) used case vignettes

to examine mental health professionals' stigmatizing attitudes toward HIV-positive clients. In the

vignettes, client's sexual orientation (gay or heterosexual) and illness (AIDS or leukemia) were

manipulated. Participants were randomly assigned to read one of the four vignettes and were

asked to complete questionnaires that measure their attitudes toward the hypothetical client.

Results indicated that some participants consistently held more negative attitudes toward persons

with AIDS than with leukemia. These participants were less empathic toward PLWHA and

attributed more responsibility to them for causing their illness. They were less likely to accept

PLWHA for treatment and make personal contacts with them. Furthermore, results suggested

that participants who held greater homophobia were more likely to deny the gay individual in the

vignette as a client, in both AIDS and leukemia scenario. Crawford et al. (1991) suggested that in addition to the attitudes toward PLWHA, mental health professionals' attitudes toward gay men and lesbians seem to play an important role in their reactions to the vignettes. Fliszar and Clopton (1995) also used vignettes featuring a HIV-positive or leukemia client to examine psychologist trainees' attitudes toward either client. Similarly, they found that participants had less positive attitudes toward HIV-positive clients.

Hayes and Eriks (2000) used vignettes depicting a male client living with HIV to examine psychologists' perceptions of the client. The scenario was the same except two client variables: client's sexual orientation (gay or heterosexual) and the cause of HIV transmission (sexual contact, blood transfusion, IDU, or unspecified). Results showed that participants attributed more responsibility to client who contracted the virus through sexual contact or IDU than through blood transfusion. Moreover, these attributions were associated with therapist homophobia, which means that therapists with greater homophobia attributed more responsibility to clients for causing their problems. Participants' responses to the vignette featuring a gay man showed that greater homophobia was associated with less empathy, attributions of lower client responsibility for solving his problems, worse rating for client's overall functioning, and less willingness to accept the client for treatment. Hayes and Eriks (2000) suggested that therapist with high levels of homophobia may still see HIV as a gay disease and therefore react toward HIV-positive clients more negatively.

Lastly, Hayes and Gelso (1993) used videos featuring a male actor to explore male counselors' comfort level with gay and HIV-positive clients. The videotaped client was portrayed as either gay or heterosexual and either HIV negative or HIV positive. Results showed that participants experienced higher levels of discomfort with HIV-positive than HIV-negative

client. Greater homophobia was found to be associated with participants' discomfort with gay clients.

Results from these studies demonstrate that clinicians are not immune to HIV stigma when responding to the HIV-positive client portrayed in the vignette. The potential impact to the therapeutic process is manifested in various forms such as less favorable evaluations of clients, blaming clients for causing their problems, and negative affective reactions toward clients. Perhaps because client's sexual orientation is often a research interest in these studies, results often indicated the connection between clinicians' homophobia and negative reactions toward HIV-positive clients. In these studies, clinicians with higher levels of homophobia held greater negative attitudes toward HIV-positive clients (Crawford et al., 1991; Hayes & Eriks, 2000; Hayes & Gelso, 1993). Clinicians' homophobia appears to have a significant impact on clinicians' reactions toward HIV-positive clients.

In addition to HIV status, another client variable that will be a focus of the present study is client's race. Issues pertaining to racial bias in therapeutic process will be presented in the following section.

Racial Bias in Therapeutic Process

In the United States, Whites are the dominant racial group in terms of both population numbers and social, political, and economic power. In clinical practice, it has been observed that many mental health professionals tend to hold a Western Euro-American worldview and practice psychotherapy from an ethnocentric monocultural stance (Sue et al., 1998). This observation raises the question of clinicians' competence in providing services to meet the needs of racially and ethnically diverse individuals. For instance, in a qualitative study on White counselor trainees' reactions to hypothetical cross-racial counseling and supervision dyads, Utsey, Gernat

and Hammar (2005) found that a common theme reported by the participants is struggle and discomfort with race issues. Utsey et al. (2005) suggested that if these intense reactions are not addressed in counselor trainees' training, clinicians may be unable to fully recognize the way they bring in racial bias into the therapeutic process.

In the mental health and counseling literature, racial bias refers to the phenomena of clinicians perceiving racial or ethnic minority clients (primarily African Americans), as compared to their White counterpart clients, as more disturbed and in greater need of treatment (Abreu, 1999). Research on racial bias and its impact on the counseling process has received increasing attention partly because of the demographic changes in the ethnic/racial makeup of the United States happening in the last few decades (Casas, 1985). Two types of research design are usually used in racial bias studies. In the first, data on clinical judgments from clinicians who are not aware their participation in a research study are analyzed. Results from these studies have consistently indicated clinicians' racial bias toward Black patients with regard to diagnosis and treatment decisions (Abreu, 1999). In general, African Americans are more likely to receive more serious diagnoses than Euro-Americans (Feisthamel & Schwartz, 2009). For instance, it has long been observed that Black patients have a higher chance to receive the diagnosis of schizophrenia than White patients in treatment settings (Flaskerud & Hu 1992; Garb, 1997; Minsky, Vega, Miskimen, Gara, & Escobar, 2003; Snowden & Cheung, 1990; Sohler, & Bromet, 2003). Pavkov et al. (1989) used data from a sample of mentally ill patients hospitalized at four Chicago metropolitan state mental hospitals to examine the connection between race and schizophrenia. They found that being Black is a significant predictor of a diagnosis of schizophrenia after controlling other variables such as their clinical status. Feisthamel and Schwartz (2009) found that compared to Euro-American patients, African American patients in a

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community mental health agency in a southeastern state were diagnosed disproportionately more frequently with disruptive behavior disorders. Higher rates of more severe mental disorder diagnoses may be a major cause of elevated number of inpatient admission among African American clients (Baker & Bell, 1999). Data on psychiatric hospitalization have shown that African Americans are considerably more likely to be hospitalized or to be involuntarily committed (Garb, 1997; Lindsey & Paul, 1989; Snowden & Cheung, 1990). These results suggest that noteworthy problems may still exist pertaining to treatment and diagnosis of minority groups.

The second approach to the study of racial bias relies upon the use of vignettes in the form of case summaries or audiotaped interviews. The vignettes are presented to clinicians, who are then asked to respond to questions regarding their clinical judgments on either White or Black hypothetical patients identified in the vignettes. Inconsistent results have been found in these studies (Abreu, 1999). Findings from some studies have provided further evidence to clinicians' racial bias. For instance, Loring and Powell's (1988) found that Black male clients featured in the vignette were more likely to receive a diagnosis of paranoid schizophrenia by clinicians than were White patients. Participants also tended to identify both Black male and female clients in the vignette as having a paranoid personality disorder. However, other researchers have reported no significant difference was found in clinicians' perceptions of Black and White vignette patients (Bishop & Richards, 1987; Fisher, Matthews, Robinson Kurplus, & Burke, 2001; Kales, et al., 2005; Littlewood, 1992). Fisher et al. (1987), for example, asked counselor trainees to report their expectations of the personality and behavior of a male student who sought counseling for his issues regarding school work. Although results indicated some differences in perceived personality with regard to the race of the male student, the overall findings did not suggest

participants' different expectations and perceptions of the male student on the basis of his race. Bishop and Richards (1987) even found that counselors in their study on intake judgments of Black and White clients gave significantly higher ratings to Black clients with regard to their potential for change during the course of treatment.

Researchers have introduced several different perspectives to make sense of these conflicting results from racial bias studies. One assumption is that the changing face of contemporary racism (from overt to more subtle and covert forms) may have an impact on how racial bias is manifested in the therapeutic process. For instance, some researchers have examined how individual differences on color-blind racial attitudes are associated with clinicians' reactions and judgments in multicultural counseling (Gushue, 2004; Burkard & Knox, 2004). Burkard and Knox (2004) used case vignettes featuring different races (African American or European American) and client attributions of the cause of a problem (internal or external attribution) to examine how psychologists' color-blind racial attitudes are associated with their empathy and attributions of client responsibility for the cause of and solution to a problem. Findings revealed that participants with greater color-blind racial attitudes reported having significantly less empathy, while participants who were less color-blind showed more empathy toward the individual in the case vignette. Results also indicated that compared to participants with lower color-blind racial attitudes, participants with higher color-blind racial attitudes attributed more client responsibility to African American clients for solving their problems. In a similar study, Gushue (2004) found that White counselor trainees' color-blind racial attitudes were positively related to the impressions of symptomatology of a Black client but not a White client. Participants with higher color-blind racial attitudes judged the Black client in the vignette as more symptomatic than those with lower levels of color-blind attitudes did. Results from these

studies suggested that racial bias may still be manifested in many different forms to affect

clinicians' therapeutic impressions toward racial and ethnical minority clients.

Summary and Statement of the Problem

In summary, research has shown that stigmatized individuals can easily experience

stigmatization during social interactions with nonstigmatized individuals (e.g., clinicians) who

believe that they do not consciously hold any stigmatizing attitudes or belief. Empirical studies

on clinicians' reactions and clinical judgments have suggested that biased therapeutic

impressions may be caused by clinicians' reactions toward clients' HIV status and sexual

orientation. Moreover, in racial bias literature, scholars have argued that racial or ethnic minority

clients are often perceived by their clinicians as more disturbed as a result of clinicians' biased

racial attitudes (Abreu, 1999). Questions still remain, however, with regard to how clients' HIV

status and racial identity may operate in confluence, and to what extent, to influence clinicians'

therapeutic impressions. Specifically, an interaction of interest concerns the question of whether

the joint effect of client's HIV status and client's race will influence therapeutic impressions by

more than the simple effect of either the client's race or client's HIV status alone.

The answers to these questions have important implications for clinicians and researchers,

as well as educators. In a study on doctoral students' beliefs about their clinical competence in

working with HIV-positive clients, survey results showed that while there was a modest

correlation between the students' total past training in HIV issues and perceived competence, no

significant correlation was found between the multicultural emphasis in training received and

students' perceived competence in working with multicultural HIV-positive clients (Kindermann,

Matteo, & Morales, 1993). The authors of this article suggested that perhaps this result is a

reflection of how some counseling trainees underestimated the complexity of multicultural issues

and thought that issues regarding marginalized populations can be learned easily. Results of the present study may help educators' to provide more adequate HIV and multicultural training to increase counselor trainees' awareness and competence in providing treatment to HIV-positive individuals in multicultural populations. Knowledge about how different factors that may affect the therapeutic process can help clinicians increase their competence in developing treatment plans and intervention strategies that are sensitive to the needs of minority HIV-positive clients. Findings of this study may also help clinicians recognize how double discrimination/double jeopardy may be manifested in clinical impressions when working with HIV-positive individuals with multiple stigmatized conditions.

Research Questions and Hypotheses

The overarching question underlying the present study regards the influence of a client's HIV status and race (Black or White) upon counselor trainees' therapeutic impressions. In this study, therapeutic impressions include, but are not limited to, expected evaluation of the session, diagnostic impressions, and judgments of the client's overall functioning. In the present study, case vignettes featuring Black or White men who are either HIV-positive or HIV-negative will be present to the participants. The hypotheses of this study are as follows:

Hypothesis 1: Participants will report lower expectations of session depth and smoothness, lower assessments of overall functioning, and more negative impressions of symptomatology toward Black clients than White clients in the vignettes.

Hypothesis 2: Participants will report lower expectations of session depth and smoothness, lower assessments of overall functioning, and more negative impressions of symptomatology toward HIV-positive clients than HIV-negative clients in the vignettes.

Hypothesis 3: Participants will report lowest expectations of session depth and smoothness, lowest assessments of overall functioning, and most negative impressions of symptomatology toward Black HIV-positive clients in the vignettes.

Chapter III: Method

Participants

Participants were 861 graduate students enrolled in clinical or counseling psychology programs recruited across the United States. Participants who did not complete any of the three measures in the study were removed from the data analysis. Following this criteria of removal, five surveys were removed from the analysis due to missing data, leaving a sample of 856. Their mean age was 28.24 years ($SD = 5.81$ years, range = 21-60). Of the participants, 81.7% ($n = 699$) identified themselves as women, 16.9% ($n = 145$) as men, and 1.4% ($n = 12$) as transgender or other. Regarding racial identification, 690 (80.6%) identified "White," 56 (6.5%) identified "Asian," 46 (4.6%) identified "Black," 39 (4.6%) identified "Multiracial", 5 (0.6%) identified "Native American or Alaska Native," 2 (0.2%) identified "Native Hawaiian or Pacific Islander," and 18 (2.1%) identified "Other." With regard to participants' sexual orientation, 751 (87.7%) identified as heterosexual, 36 (4.2%) identified as homosexual, 47 (5.5%) identified as bisexual, and 22 (2.6%) identified as "Other."

The majority of the participants were enrolled in Ph.D. programs in applied psychology (either clinical or counseling psychology; participants were not queried as to which) at 58.6% ($n = 502$). The next most frequent enrollments reported by participants was Masters' programs in clinical or counseling psychology (29.4%, $n = 162$), clinical or counseling Psy.D. programs (10.7%, $n = 92$), and other (e.g., dual degrees; 1.2%, $n = 10$). With regard to having had previous experience in doing therapy or counseling, 731 (85.4%) indicated "Yes," and 125 (14.6%) indicated "No." Among the participants who reported "Yes" to experience in doing therapy or counseling, 75.8% ($n = 649$) reported previous experience of working with clients of color, and 15.1% ($n = 129$) reported previous experience of working with HIV-positive clients.

Frequencies and percentages for each of the demographic characteristics of the sample are summarized in Table 1.

Table 1

Demographic Characteristics of Participants

Characteristic	Frequency (*n*)	Percentage (%)
Age (years) (*n* = 856)		
21-25	294	34.3
26-35	496	57.9
36-45	40	4.6
46-55	19	2.2
56-60	7	0.8
Gender (*n* = 856)		
Male	145	16.9
Female	699	81.7
Transgender	6	0.7
Other	6	0.7
Race (*n* = 856)		
Native American or Alaska Native	5	0.6
Asian	56	6.5
Black	46	5.4
Native Hawaiian or Pacific Islander	2	0.2
White	690	80.6
Multiracial	39	4.6
Other	18	2.1
Sexual Orientation (*n* = 856)		
Heterosexual	751	87.7
Homosexual	36	4.2
Bisexual	47	5.5
Other	22	2.6
Current Degree Program (*n* = 856)		

Table 1 continued

Characteristic	Frequency (*n*)	Percentage (*%*)
M.A.	141	0.6
M.S.	68	6.5
Ed.M.	43	5.4
Ph.D.	502	58.6
Psy.D.	92	10.7
Other	10	1.2

Experience of Doing Therapy/Counseling (*n* = 856)

Yes	731	85.4
No	125	14.6

Experience of Doing Therapy/Counseling with Clients of Color (*n* = 731)

Yes	649	88.8
No	82	11.2

Experience of Doing Therapy/Counseling with HIV-positive (*n* = 731)

Yes	129	17.6
No	602	82.4

Procedures

All survey participants were recruited through advertisements on online social networking sites, emails, personal contacts, and solicitations sent to clinical or counseling psychology graduate programs across the United States asking permission for the study information to be disseminated to their students. Participants accessed the questionnaire through an online survey on the Internet. The online survey was made available to participants via the Qualtrics survey platform (http://www.qualtrics.com). Participants were first asked to read the Informed Consent and the Participants' Rights pages. Individuals who did not meet the minimum age requirement (18 years) and/or identify as trainees in clinical or counseling graduate programs were taken to

an exit page and excluded from this study. Once consent was given, participants were instructed to proceed with the study. Participants were advised that they were free to terminate the study at any time if they choose not to continue for any reason. Participants were asked to complete a brief demographic questionnaire. Next, participants were provided with one of four hypothetical intake summaries which differed only with regard to information about the client's race and HIV status. After reading the vignette, participants were asked to complete the *Session Evaluation Questionnaire* (Stiles, 1980; Stiles & Snow, 1984; Stiles et al., 1994), the *Clinical Features Questionnaire* (Abreu, 1999), and the *Global Assessment of Functioning Scale* (American Psychiatric Association, 2000). These measures were counterbalanced to minimize any potential order effect. Lastly, participants were asked to recall the vignette and answer several questions regarding the client presented in the vignette.

Case Vignette

Participants were provided with one of the four vignettes structured as an intake summary from a community counseling center client named "Michael." Michael was said to be a 30-year-old male who was encountering a series of issues with regard to mood, interpersonal relationships, work, and health. The vignettes distributed to the participants were identical in narratives. The only different information in these vignettes were Michael's HIV status and race. In the beginning of the first paragraph, the client was described as either (1) Black and HIV-positive, (2) White and HIV-positive, (3) Black, or (4) White. In the vignette, the information of Michael's sexual orientation was intentionally left out to reflect a scenario in which clients, particularly HIV-positive individuals who experience multiple forms of stigma and discrimination, may withhold disclosure of their sexual orientation during initial contacts with mental health professionals. The Black and HIV-positive vignette is contained in Appendix A.

Measures

Demographic questionnaire. The demographic questionnaire included multiple-choice items gathering information regarding each participant's gender, age, race, ethnicity, sexual orientation, education, years in current graduate program, as well as experiences of doing therapy/counseling with clients of color and HIV-positive clients.

The Session Evaluation Questionnaire (SEQ). The complete SEQ (Stiles, 1980; Stiles & Snow, 1984; Stiles et al., 1994) is a measure of session evaluation, post-session mood, and therapist evaluation that consists of 27 7-point bipolar semantic differential style items. Ten items from the session evaluation section that corresponds to dimensions of session depth and smoothness were adapted and used in this study as an indicator of participants' perceptions of clients. Stiles et al. (1994) described the essence of session depth and smoothness as "psychotherapy sessions are simultaneously judged as good or bad in at least two distinct ways: (a) as deep (powerful, effective) or shallow (weak, worthless) and (b) as smooth (relaxed, comfortable) or rough (tense, distressing)." The Depth index consists of five items (powerful/weak; valuable/worthless; deep/shallow; full/empty; and special/ordinary) prefaced by the stem "This session was . . ." (Cronbach's alpha = .90; Stiles et al., 1994). The Smoothness index consists of five items (smooth/rough; comfortable/uncomfortable; relaxed/tense; pleasant/unpleasant; and easy/difficulty) also prefaced by the stem "This session was . . ." (Cronbach's alpha = .92; Stiles et al., 1994). In validation studies (Stiles et al., 1994), the Depth and Smoothness indexes were shown to be only moderately correlated. The use of SEQ has also been proved to reliably measure client's experience of psychological assessment (Ackerman, Hilsenroth, Baity, & Blagys, 2000) and client-related outcome in brief counseling (Mallinckrodt, 1993).

In this study, the verb tense in the item stem was modified to reflect the fact that participants were asked to imagine an upcoming session with Michael and to rate their expected evaluation of the session. Therefore the stem read ''I expect that a session with Michael might be. . ..'' instead of the original stem. Higher SEQ scores correspond to therapists' expectations of greater smoothness and depth. Smith, Mao, Perkins, and Ampuero (2011) used this modified Depth and Smoothness indexes for their study on the relationship between clients' social class and clinicians' therapeutic impression. Cronbach's alpha for the SEQ in this study was 0.86 (Smith et al., 2011). In the present study, Cronbach's alpha was .77 for the Depth index, and .83 for the Smoothness index.

Clinical Features Questionnaire (CFQ). The CFQ was developed by Abreu (1999) to measure clinicians' diagnostic impressions relative to a presenting case. The scale includes eight questions with regard to clinical diagnostic impressions of antisocial personality, malingering, delusions, substance abuse, anxiety, suicidality, impulsiveness, and depression (e.g., "How depressed would you estimate Michael to be?"). Each item was rated on an 11-point scale ranging from 0 (not at all) to 10 (extremely). The scores from the 8 items are computed to yield a mean score for initial impressions of symptomatology. The Cronbach's alpha was .70 (Abreu, 1999). This scale has been used or adapted in several similar studies on diagnostic impressions, and the reported Cronbach's alpha was between .77 and .85 (e.g., Gushue, 2004; Smith et al., 2011). In the present study, Cronbach's alpha was .80.

Global Assessment of Functioning (GAF) Scale. The GAF Scale (American Psychiatric Association, 2000) was used to measure clinicians' judgments of the client's overall functioning for the current study. The GAF is a numeric scale that ranges from 0 through 100, with higher scores reflecting better psychological, occupational, and social functioning.

Manipulation Check Questions. Three questions regarding Michael's race, age, and sexual orientation were used to evaluate whether the content of the case vignette has been experienced as intended by the participants. Of particular interest is the question about Michael's sexual orientation. Since Michael's sexual orientation was not specified in the vignette, answers to this question would provide additional confirmation that participants' therapeutic impressions were not the results of their assumptions regarding Michael's sexual orientation. The questions were (1) what is Michael's race, (2) how old is Michael, and (3) what is Michael's sexual orientation. These three questions were randomly arranged in each survey to prevent any potential order effect.

Chapter IV: Results

Preliminary Analyses

Data-cleaning procedures were conducted before the preliminary analyses. First, as stated

previously, five surveys were removed from the analysis due to missing data (participants failed

to enter a value to the GAF scale). In order to determine whether the data was suitable for

analysis via a multivariate analysis of variance (MANOVA), multivariate normality and

multivariate outliers were examined by calculating Mahalanobis distances, an analysis that

identifies any cases that have an unusual pattern of values across all dependent variables (Pallant,

2011). Results indicated the presence of multivariate outliers in six cases in the present study.

These data were further investigated to determine how different they were from the rest of the

cases. Findings suggested that these values did not differ significantly from the remaining cases.

Furthermore, these six cases represented less than one percent of the entire participants.

Consequently, it was determined that these cases were to be included in the main analysis. Based

on this result, it was also assumed that multivariate normality for the data of this study was not

violated.

Another assumption for use of MANOVA is that of homogeneity of variance for each

dependent variable. Levene's Test of Equality of Error Variance tests for homogeneity of

variance. Homogeneity of variance is violated for that variable if the test shows significance

levels less than .05 for any of the dependent variables. Levene's test was performed for each of

the four dependent variables in the study. Significance levels of .037, .082, .045, and .823 were

found for the SEQ-Depth, the SEQ-Smoothness, the CFQ, and the GAF, respectively. Since the

significance levels of the SEQ-Depth the CFQ are less than .05, a more conservative alpha level

(.025) is suggested for determining significance for these two variables in the univariate F-test

(Pallant, 2011). The assumption of homogeneity of variance-covariance matrices was also investigated by Box's Test performed by the data analysis software SPSS. The significance level for this test is normally set at 0.001 (Pallant, 2011). In the present study, the significance level was found to be 0.013, which supported the assumption of equality of covariance matrices.

Responses to the manipulation question about Michael's sexual orientation were also examined via response frequencies. In this question, six options were provided but only one of them was the correct response (It [Michael's sexual orientation] is not specified in the vignette). The majority of participants recalled this information correctly ($n = 625$, 73%), while 26.9% ($n = 231$) of participants did not recall it correctly. In the two vignettes featuring HIV-positive clients (Michael was described as Black and HIV-positive, or White and HIV-positive), percentage of correct responses were 71.4% ($n = 147$), 75.1% ($n = 175$), respectively. In the two vignettes that clients' HIV status was not mentioned (Michael was described as Black, or White), percentage of correct responses were 76.6% ($n = 167$), 68.3% ($n = 136$), respectively. Results are summarized in Table 2. A chi-square test of goodness-of-fit was performed to determine whether participants responded to the question about Michael's sexual orientation randomly, which would result in equal frequencies among the 6 options. In other words, if participants guess randomly, approximately 16.7% (one correct option out of the 6 options provided) would be correct responses. Results indicated that there was a significant differences in the proportion of correct responses to Michael's sexual orientation (73%) as compared with the assumed value of 16.7% based on purely guessing by participants, χ^2 (1, $n = 856$) = 1903.44, $p < .01$. This result did not suggest that the correct responses to Michael's sexual orientation were a result of random guessing by participants.

Table 2

Results of Manipulation Check Question on Michael's Sexual Orientation

Vignette	Incorrect Responses Count (% of total)	Correct Responses
Black HIV-positive (*n=206*)	59 (28.6%)	147 (71.4%)
White HIV-positive (*n=233*)	58 (24.8%)	175 (75.1%)
Black (*n=218*)	51 (23.3%)	167 (76.6%)
White (*n=199*)	63 (31.6%)	136 (68.3%)
Total (n=856)	231 (26.9%)	625 (73.0%)

Note. There are 6 options in this manipulation questions. "It is not specified in the vignette" is the only correct response for all vignettes.

Descriptive Analysis

Means and standard deviations for all variables for each vignette and for main effects (i.e., race and HIV status) are shown in Table 3 and 4. Bivariate correlation was conducted to examine if any significant correlation was found between variables. For each vignette, correlations among the dependent variables included in the main analysis and selective demographic variables (gender, race, sexual orientation, degree programs, experience of doing therapy/counseling with clients of color, and experience of doing therapy/counseling with HIV-positive clients) are shown in Table 5.

Table 3

Means and Standard Deviations for All Variables Across Four Vignettes

Vignette	1. Black HIV-positive	2. White HIV-positive	3. Black	4. White
	($n = 206$)	($n = 233$)	($n = 218$)	($n = 199$)
SEQ-Depth				
M	4.82	4.72	4.72	4.41
SD	0.77	0.72	0.77	0.66
Possible Range	1-7	1-7	1-7	1-7
Obtained Range	3.00-7.00	2.80-7.00	2.80-7.00	3.00-6.20
SEQ-Smoothness				
M	4.16	4.08	4.30	4.20
SD	0.79	0.78	0.86	0.75
Possible Range	1-7	1-7	1-7	1-7
Obtained Range	2.40-6.80	1.00-6.40	2.20-6.80	2.20-6.60
CFQ				
M	4.50	4.70	4.37	4.68
SD	1.32	1.35	1.17	1.08
Possible Range	0-10	0-10	0-10	0-10
Obtained Range	1.37-9.12	1.50-8.37	1.62-8.12	2.37-8.00
GAF				
M	61.67	61.13	63.62	62.34
SD	7.12	6.96	7.26	0.40
Possible Range	0-100	0-100	0-100	0-100
Obtained Range	35-81	40-81	38-85	13-92

Note. SEQ = Session Evaluation Questionnaire; CFQ = Clinical Feature Scale; GAF = Global Assessment of Function Scale.

Table 4

Means and Standard Deviations for Main Effects of Race and HIV Status

Main Effects	Race		HIV Status	
	Black	White	HIV-positive	HIV-negative
	($n = 424$)	($n = 432$)	($n = 439$)	($n = 417$)
SEQ-Depth				
M	4.77	4.58	4.76	4.58
SD	0.77	0.70	0.74	0.74
Possible Range	1-7	1-7	1-7	1-7
Obtained Range	2.80-7.00	2.80-7.00	2.80-7.00	2.80-7.00
SEQ-Smoothness				
M	4.23	4.14	4.11	4.25
SD	0.83	0.77	0.78	0.81
Possible Range	1-7	1-7	1-7	1-7
Obtained Range	2.20-6.80	1.00-6.60	1.00-6.80	2.20-6.80
CFQ				
M	4.43	4.69	4.61	4.51
SD	1.24	1.23	1.34	1.14
Possible Range	0-10	0-10	0-10	0-10
Obtained Range	1.37-9.12	1.50-8.37	1.37-9.12	1.62-8.12
GAF				
M	62.67	61.69	61.38	63.01
SD	7.25	7.18	7.03	7.34
Possible Range	0-100	0-100	0-100	0-100
Obtained Range	35-85	13-92	35-81	13-92

Note. Black = Vignette 1 and 3; White = Vignette 2 and 4; HIV-positive = Vignette 1 and 2; HIV-negative = Vignette 3 and 4; SEQ = Session Evaluation Questionnaire; CFQ = Clinical Feature Scale; GAF = Global Assessment of Function Scale.

Table 5

Correlations Among Dependent Variables and Selective Demographic Variables of

Participants for Each Vignette

Vignette 1 Black HIV-positive	1	2	3	4
1. Session Evaluation Questionnaire – Depth	—	.31[**]	-.06	.04
2. Session Evaluation Questionnaire – Smoothness		—	-.34[**]	.17[**]
3. Clinical Feature Scale			—	.29[**]
4. Global Assessment of Function Scale				—
Participants' age	.07	-.03	.20[**]	-.10
Participants' gender	.01	-.04	-.06	.00
Participants' race	-.10	-.05	-.03	-.01
Participants' sexual orientation	-.02	.07	-.13	.00
Participants' degree programs	-.05	.08	-.19[**]	-.08
Participants' Experience of Doing Therapy/Counseling with Clients of Color	.07	-.02	-.04	.00
Participants' Experience of Doing Therapy/Counseling with HIV-positive Clients	-.05	-.06	.03	.16[*]

Vignette 2 White HIV-positive	1	2	3	4
1. Session Evaluation Questionnaire – Depth	—	.32[**]	-.01	-.04
2. Session Evaluation Questionnaire – Smoothness		—	-.34[**]	.21[**]
3. Clinical Feature Scale			—	-.35[**]

Table 5 Continued

Vignette 2 White HIV-positive	1	2	3	4
4. Global Assessment of Function Scale				—
Participants' age	-.07	-.03	-.06	.01
Participants' gender	.03	-.01	.00	-.01
Participants' race	.00	.00	-.07	-.07
Participants' sexual orientation	.06	-.02	-.05	.08
Participants' degree programs	.06	.21**	-.24**	.09
Participants' Experience of Doing Therapy/Counseling with Clients of Color	-.03	-.08	.02	-.02
Participants' Experience of Doing Therapy/Counseling with HIV-positive Clients	-.10	-.13	.06	-.15*

Vignette 3 Black	1	2	3	4
1. Session Evaluation Questionnaire – Depth	—	.28**	-.14*	.08
2. Session Evaluation Questionnaire – Smoothness		—	-.36**	.23**
3. Clinical Feature Scale			—	-.36**
4. Global Assessment of Function Scale				—
Participants' age	.06	-.06	.02	.05
Participants' gender	.02	-.10	.10	-.03
Participants' race	-.18**	-.06	-.06	-.11
Participants' sexual orientation	.06	.00	.04	.00
Participants' degree programs	.07	.15*	-.19**	-.01

Table 5 Continued

Vignette 3 Black	1	2	3	4
Participants' Experience of Doing Therapy/Counseling with Clients of Color	.02	-.09	.01	-.02
Participants' Experience of Doing Therapy/Counseling with HIV-positive Clients	-.08	-.06	.00	.08

Vignette 4 White	1	2	3	4
1. Session Evaluation Questionnaire – Depth	—	.13	.08	.15*
2. Session Evaluation Questionnaire – Smoothness		—	-.22**	.18*
3. Clinical Feature Scale			—	-.17*
4. Global Assessment of Function Scale				—
Participants' age	-.07	.05	.18*	-.10
Participants' gender	.16*	-.13	.13	-.06
Participants' race	-.11	-.06	-.13	-.12
Participants' sexual orientation	-.02	.03	.01	.02
Participants' degree programs	-.15	-.08	-.09	.10
Participants' experience of doing therapy/counseling with clients of color	-.01	.02	-.04	-.09
Participants' experience of doing therapy/counseling with HIV-positive clients	.10	-.14	.07	.10

Note. Dummy codes were used for the following demographic variables:
Participants' gender – 1 = Female; 2 = Male.

Participants' race – 1 = People of Color (Native American or Alaska Native, Asian, Black, Native Hawaiian or Pacific Islander, Multiracial, and other); 2 = White.
Participants' sexual orientation – 1 = Heterosexual; 2 = Non-Heterosexual (homosexual, bisexual, and other).
Participants' degree programs – 1 = Masters' and other (M.A., M.S., Ed.M., and other); 2 = Doctoral (Ph.D. and Psy.D).
Participants' experience of doing therapy/counseling with clients of color – 1 = Yes; 2 = No.
Participants' experience of doing therapy/counseling with HIV-positive clients – 1 = Yes; 2 = No.
$^*p < .05.$ $^{**}p < .01.$

Test of Research Hypotheses

MANOVA were used to assess the data according to the three hypotheses of this study, as indicated below. The MANOVA results are presented in Table 6. The results of follow-up univariate analysis of variance (ANOVA) for main effects are presented in Table 7.

Table 6

Multivariate Tests for Race and HIV Status

Effect	Value	Hypothesis *df*	Error *df*	*F*	P
Race					
Wilk's lambda	.971	4.000	849.000	6.302**	.000
HIV Status					
Wilk's lambda	.959	4.000	849.000	9.035**	.000
Race x HIV Status					
Wilk's lambda	.993	4.000	849.000	1.407	.230

$^{**}p < .01.$

Table 7

Univariate ANOVA for Main Effects Summary Table

Source	Dependent Variable	df	F	η^2	p
Race	SEQ-Depth	1	16.234[**]	.019	.000
	SEQ-Smoothness	1	2.050	.002	.153
	CFQ	1	8.555[**]	.010	.004
	GAF	1	3.971	.005	.047
HIV Status	SEQ-Depth	1	15.652[**]	.018	.000
	SEQ-Smoothness	1	6.447[*]	.008	.011
	CFQ	1	.893	.001	.346
	GAF	1	8.327[**]	.010	.004

Note. SEQ = Session Evaluation Questionnaire; CFQ = Clinical Feature Scale; GAF = Global Assessment of Function Scale.
[*] $p < .012$. [**] $p < .01$.

Hypothesis 1: Participants will report lower expectations of session depth and smoothness, lower assessments of overall functioning, and more negative impressions of symptomatology toward Black clients than White clients in the vignettes. With regard to the first hypothesis that race of the clients in the vignettes would affect counselor trainees' therapeutic impressions, results of the MANOVA suggested a significant main effect for race, Wilk's lambda $F(4, 849) = 6.30$, $p < .01$. Follow-up univariate ANOVA tests, using a Bonferroni adjusted alpha level of .012 (.006 for SEQ-Depth and CFQ since homogeneity of variance for these two dependent variable were violated), indicated that of the four dependent measurements, SEQ-Depth and CFQ contributed significantly to the MANOVA effect, $F(1, 852) = 16.23$, $p < .001$, and $F(1, 852) = 8.55$, $p = .004$, respectively. An inspection of the mean scores revealed that participants expected slightly greater session depth for the Black clients in the vignettes ($M = 4.77$, $SD = 0.77$) than the White clients in the vignettes ($M = 4.58$, $SD = 0.70$). Participants' initial impressions of symptomatology were also slightly more negative toward the White clients in the vignettes ($M = 4.69$, $SD = 1.23$) than the Black clients in the vignettes ($M = 4.43$, $SD =$

1.24). SEQ-Smoothness and GAF did not contribute significantly to the MANOVA effect, $F(1, 852) = 2.05$, $p = .10$, and $F(1, 852) = 3.97$, $p = .04$, respectively.

Hypothesis 2: Participants will report lower expectations of session depth and smoothness, lower assessments of overall functioning, and more negative impressions of symptomatology toward HIV-positive clients than HIV-negative clients in the vignettes. Results of the MANOVA indicated a significant main effect for HIV status, Wilk's lambda $F(4, 849) = 9.03$, $p < .01$, which provides support to the second hypothesis that HIV status of the clients in the vignettes would affect counselor trainees' therapeutic impressions. Follow-up univariate ANOVA tests, using a Bonferroni adjusted alpha level of .012 (.006 for SEQ-Depth and CFQ since homogeneity of variance for these two dependent variable were violated), indicated that of the four dependent measurements, SEQ-Depth, SEQ-Smoothness, and GAF contributed significantly to the MANOVA effect, $F(1, 852) = 15.65$, $p < .001$, $F(1, 852) = 6.44$, $p = .011$, and $F(1, 852) = 8.32$, $p = .004$, respectively. An inspection of the mean scores revealed that participants expected slightly greater session depth for the HIV-positive clients in the vignettes ($M = 4.76$, $SD = 0.74$) than the HIV-negative clients in the vignettes ($M = 4.58$, $SD = 0.74$). However, participants expected slightly less session smoothness for the HIV-positive clients in the vignettes ($M = 4.11$, $SD = 0.78$) than the HIV-negative clients in the vignettes ($M = 4.25$, $SD = 0.81$). Participants also reported lower assessment of psychological, occupational, and social functioning toward the HIV-positive clients in the vignettes ($M = 61.38$, $SD = 7.03$) than the HIV-negative clients in the vignettes ($M = 63.01$, $SD = 7.34$). CFQ did not contribute significantly to the MANOVA effect, $F(1, 852) = 0.89$, $p = .34$, respectively.

Hypothesis 3: Participants will report lowest expectations of session depth and smoothness, lowest assessments of overall functioning, and most negative impressions of

symptomatology toward Black HIV-positive clients in the vignettes. No significant race ×

HIV status interaction effect was found, Wilk's lambda $F(4, 849) = 1.40$, $p = .23$; thus, no

follow-up tests were conducted. Results did not support this hypothesis.

Exploratory Analyses

In addition to the main analysis, further analyses were conducted to explore how various

demographic characteristics of participants, as well as their responses to the manipulation check

question of Michaels' sexual orientation, may have had an influence on the results of SEQ, CFQ,

and GAF scores. The following presentation of exploratory analysis will begin with the

examination of the implications of participants' responses to the questions of Michael's sexual

orientation on the results. Next, the effects of participants' race and gender on the results will be

explored.

Manipulation check: Michael's sexual orientation. The manipulation check question of

Michael's sexual orientation was used to examine whether participants were able to recall

correctly that this information was not mentioned in the vignettes they just read. Although results

from the analysis indicated that many participants responded to the question of Michael's sexual

orientation correctly, and that these responses were not a result of random guessing by

participants, there were still 26.9% ($n = 231$) of participants who failed the question. Separate

MANOVAs using participants who gave correct answers, and participants who gave incorrect

answers were conducted to examine whether the response patterns from these two groups may

confirm the original hypotheses.

For participants who were able to successfully recall that Michael's sexual orientation was

not mentioned in the vignettes ($n = 625$), the MANOVA results are presented in Table 8. The

results of follow-up ANOVA for main effects are presented in Table 9.

Table 8

Multivariate Tests for Race and HIV Status:

Correct Identification of Michael's Sexual Orientation

Effect	Value	Hypothesis *df*	Error *df*	*F*	P
Race					
Wilk's lambda	.958	4.000	618.000	6.761**	.000
HIV Status					
Wilk's lambda	.967	4.000	618.000	5.213**	.000
Race x HIV Status					
Wilk's lambda	.992	4.000	618.000	1.242	.292

**$p < .01$.

Table 9

Univariate ANOVA for Main Effects Summary Table:

Correct Identification of Michael's Sexual Orientation

Source	Dependent Variable	*df*	*F*	η^2	*p*
Race	SEQ-Depth	1	16.524**	.026	.000
	SEQ-Smoothness	1	1.941	.003	.164
	CFQ	1	9.723**	.015	.002
	GAF	1	5.261*	.008	.022
HIV Status	SEQ-Depth	1	12.390**	.020	.000
	SEQ-Smoothness	1	2.097	.003	.148
	CFQ	1	.958	.002	.328
	GAF	1	3.279	.005	.071

Note. SEQ = Session Evaluation Questionnaire; CFQ = Clinical Feature Scale; GAF = Global Assessment of Function Scale.
* $p < .05$. ** $p < .01$.

Similar to the main analysis presented in the previous section, results of the MANOVA suggested a significant main effect for race, Wilk's lambda $F(4, 618) = 6.76$, $p < .01$, and HIV status, Wilk's lambda $F(4, 618) = 5.21$, $p < .01$; no significant race × HIV status interaction

effect was found, Wilk's lambda $F(4, 618) = 1.24$, $p = .29$. Follow-up ANOVA tests indicated that SEQ-Depth, CFQ, and GAF contributed significantly to the main effect for race, $F(1, 621) = 16.52$, $p < .01$, $F(1, 621) = 9.72$, $p = .002$, and $F(1, 621) = 5.26$, $p = .022$, respectively. SEQ-Depth was also found to contribute significantly to the main effect for HIV status, $F(1, 621) = 12.23$, $p < .01$. An examination of the mean scores revealed that participants who responded correctly to the manipulation check question of Michaels' sexual orientation expected slightly greater session depth for the Black clients in the vignettes ($M = 4.80$, $SD = 0.77$) than the White clients in the vignettes ($M = 4.59$, $SD = 0.70$); they also expected slightly greater session depth for the HIV-positive clients in the vignettes ($M = 4.78$, $SD = 0.73$) than the HIV-negative clients in the vignettes ($M = 4.60$, $SD = 0.75$). These participants' initial impressions of symptomatology were also slightly more negative toward the White clients in the vignettes ($M = 4.64$, $SD = 1.23$) than the Black clients in the vignettes ($M = 4.32$, $SD = 1.23$). Lastly, results showed that participants who responded correctly to the manipulation check question of Michaels' sexual orientation reported lower assessment of psychological, occupational, and social functioning toward the White clients in the vignettes ($M = 61.33$, $SD = 7.44$) than the Black clients in the vignettes ($M = 62.73$, $SD = 7.04$).

MANOVA was used to examine the results of participants who responded incorrectly to the manipulation check question of Michael's sexual orientation ($n = 231$). The results are presented in Table 10. The results of follow-up ANOVA for main effects are presented in Table 11.

Table 10

Multivariate Tests for Race and HIV Status

Incorrectly Identification of Michael's Sexual Orientation

Effect	Value	Hypothesis *df*	Error *df*	*F*	P
Race					
Wilk's lambda	.994	4.000	224.000	.312	.870
HIV Status					
Wilk's lambda	.926	4.000	224.000	4.485[**]	.002
Race x HIV Status					
Wilk's lambda	.991	4.000	224.000	.485	.747

[**]$p < .01$.

Table 11

Univariate ANOVA for Main Effects Summary Table

Incorrect Identification of Michael's Sexual Orientation

Source	Dependent Variable	*df*	*F*	η^2	*p*
HIV Status	SEQ-Depth	1	3.743	.016	.054
	SEQ-Smoothness	1	6.027[*]	.026	.015
	CFQ	1	.016	.000	.899
	GAF	1	5.475[*]	.024	.020

Note. SEQ = Session Evaluation Questionnaire; CFQ = Clinical Feature Scale; GAF = Global Assessment of Function Scale.
[*] $p < .05$.

Results of the MANOVA suggested a significant main effect for HIV status, Wilk's lambda $F(4, 224) = 4.48$, $p < .01$; no main effect of race or race $\times$ HIV status interaction effect was found, Wilk's lambda $F(4, 224) = .31$, $p = .87$, and Wilk's lambda $F(4, 224) = .48$, $p = .74$, respectively. Follow-up ANOVA tests indicated that SEQ-smoothness and GAF contributed significantly to the main effect for HIV status, $F(1, 227) = 6.02$, $p < .05$, and $F(1, 227) = 5.47$, p

< .05, respectively. An examination of the mean scores revealed that participants who responded incorrectly to the manipulation check question of Michael's sexual orientation expected slightly less session smoothness for the HIV-positive clients in the vignettes ($M = 3.99$, $SD = 0.77$) than the HIV-negative clients in the vignettes ($M = 4.25$, $SD = 0.84$). These participants also reported lower assessment of psychological, occupational, and social functioning toward the HIV-positive clients in the vignettes ($M = 61.18$, $SD = 8.08$) than the HIV-negative clients in the vignettes ($M = 63.57$, $SD = 7.35$).

Four two-way factorial between-group ANOVAs were conducted to investigate the impact of participants' responses to the manipulation check question of Michael's sexual orientation and vignette condition on SEQ-Depth, SEQ-Smoothness, CFQ, and GAF. Levene's test was performed for each analysis performed, and the insignificant results indicated that assumptions of homogeneity of variance were met. Of particular interest are the main effects of participants' responses to the manipulation check question of Michael's sexual orientation and the interaction effects between vignette condition and participants' responses to the manipulation check question of Michaels' sexual orientation. When CFQ was the dependent variable of the analysis, a significant main effect of participants' responses to the manipulation check question of Michaels' sexual orientation was found, $F(1, 848) = 9.41$, $p < .01$. Participants who responded incorrectly to the manipulation check question of Michael's sexual orientation reported more negative initial impressions of symptomatology toward the clients in the vignettes ($M = 4.78$, $SD = 1.23$) than those participants who responded correctly did ($M = 4.48$, $SD = 1.24$). No significant main effects of participants' responses to the manipulation check question of Michaels' sexual orientation were found when SEQ-Depth, SEQ-Smoothness, and GAF were the dependent variables of the analyses. Interaction effects were also to be found insignificant in all

analyses. The mean and standard deviations for each dependent variable according to participants' responses to the manipulation check question of Michaels' sexual orientation are displayed in Table 12.

Table 12

Means and Standard Deviations for Main Effects of Participants' Responses to the Manipulation Check Question of Michaels' Sexual Orientation

	SEQ-Depth		SEQ-Smoothness		CFQ		GAF	
	M	SD	M	SD	M	SD	M	SD
Participants' responses								
Correct ($n = 625$)	4.69	0.74	4.21	0.80	4.48	1.24	62.03	7.27
Incorrect ($n = 231$)	4.61	0.75	4.12	0.81	4.78	1.23	62.36	7.80

Note. SEQ = Session Evaluation Questionnaire; CFQ = Clinical Feature Scale; GAF = Global Assessment of Function Scale.

Effects of participant race and gender. ANOVAs were conducted to explore the effects of participants' race and gender on the results. For the analysis on the effects of race, participants who self-identified as Native American or Alaska Native, Asian, Black, Native Hawaiian or Pacific Islander, Multiracial, and Other on the demographic questionnaire were grouped together in a "People of Color" group. Four two-way factorial between-group ANOVAs were conducted to examine the impact of participants' race ("White" and "People of Color") and vignette condition on SEQ-Depth, SEQ-Smoothness, CFQ, and GAF. Levene's test was performed for each analysis performed. When SEQ-Depth was the dependent variable of the analysis, a significant main effect of participants' race was found, $F(1, 848) = 9.53$, $p < .01$. People of Color participants expected slightly greater session depth for the clients in the vignettes ($M = 4.80$, *SD*

= 0.84) than the White participants did (*M* = 4.64, *SD* = 0.72). When GAF was the dependent

variable of the analysis, a significant main effect of participants' race was found, *F*(1, 848) =

6.14, *p* < .05. People of Color participants assigned higher assessment of psychological,

occupational, and social functioning to the clients in the vignettes (*M* = 63.29, *SD* = 7.96) than

the White participants did (*M* = 61.84, *SD* = 7.26). No significant main effects of participants'

race were found when SEQ-Smoothness and CFQ were the dependent variables of the analyses.

Interaction effects were also found insignificant in all analyses. The mean and standard

deviations for each dependent variable according to participants' race are displayed in Table 13.

Table 13

Means and Standard Deviations for Main Effects of Participants' Race

	SEQ-Depth		SEQ-Smoothness		CFQ		GAF	
	M	SD	M	SD	M	SD	M	SD
Participants' race								
White (*n* = 690)	4.64	0.72	4.17	0.81	4.51	1.20	61.84	7.26
People of Color (*n* = 166)	4.80	0.84	4.25	0.78	4.77	1.39	63.29	7.96

Note. "People of Color" include Native American or Alaska Native, Asian, Black, Native
Hawaiian or Pacific Islander, Multiracial, and Other in the Demographics Form. SEQ = Session
Evaluation Questionnaire; CFQ = Clinical Feature Scale; GAF = Global Assessment of Function
Scale.

In the analysis on the effects of gender, participants were grouped according to their

identification as male of female; participants who self-identified as transgender and other on the

demographic questionnaire were excluded (*n* = 12). Four two-way factorial between-group

ANOVAs were conducted to examine the impact of participants' gender ("Male" and "Female")

and vignette condition on SEQ-Depth, SEQ-Smoothness, CFQ, and GAF. Levene's test was

performed for each analysis performed, and the insignificant results indicated that assumptions

of homogeneity of variance were met. When SEQ-Smoothness was the dependent variable of the analysis, a significant main effect of participants' gender was found, $F(1, 836) = 4.77, p < .05$. Male participants expected slightly greater session smoothness for the clients in the vignettes ($M = 4.32, SD = 0.84$) than the female participants did ($M = 4.16, SD = 0.79$). No significant main effects of participants' gender were found when SEQ-Depth, CFQ, GAF were the dependent variables of the analyses. Interaction effects were also found to be insignificant in all analyses. The mean and standard deviations for each dependent variable according to participants' gender are displayed in Table 14.

Table 14

Means and Standard Deviations for Main Effects of Participants' Gender

	SEQ-Depth		SEQ-Smoothness		CFQ		GAF	
	M	SD	M	SD	M	SD	M	SD
Participants' gender								
Male (*n* = 145)	4.56	0.75	4.32	0.84	4.47	1.18	62.57	8.98
Female (*n* = 699)	4.69	0.74	4.16	0.79	4.57	1.26	62.06	7.06

Note. SEQ = Session Evaluation Questionnaire; CFQ = Clinical Feature Scale; GAF = Global Assessment of Function Scale.

Since a significant number of participants identified themselves as White female (*n* = 561), MANOVA was conducted to examine whether the results from these participants may indicate any special patterns. The MANOVA results are presented in Table 15. The results of follow-up ANOVA for main effects are presented in Table 16.

Table 15

Multivariate Tests for Race and HIV Status:

White Female Participants

Effect	Value	Hypothesis *df*	Error *df*	*F*	P
Race					
Wilk's lambda	.976	4.000	554.000	3.412[**]	.009
HIV Status					
Wilk's lambda	.960	4.000	554.000	5.813[**]	.000
Race x HIV Status					
Wilk's lambda	.995	4.000	554.000	0.743	.563

[**]$p < .01$.

Table 16

Univariate ANOVA for Main Effects Summary Table:

White Female Participants

Source	Dependent Variable	*df*	*F*	η^2	*p*
Race	SEQ-Depth	1	6.292[*]	.011	.012
	SEQ-Smoothness	1	1.463	.003	.227
	CFQ	1	5.607[*]	.010	.018
	GAF	1	4.444[*]	.008	.035
HIV Status	SEQ-Depth	1	14.078[**]	.025	.000
	SEQ-Smoothness	1	2.616	.005	.106
	CFQ	1	.223	.000	.637
	GAF	1	2.929	.005	.088

Note. SEQ = Session Evaluation Questionnaire; CFQ = Clinical Feature Scale; GAF = Global Assessment of Function Scale.
[*]$p < .05$. [**]$p < .01$.

Results of the MANOVA suggested a significant main effect for race, Wilk's lambda $F(4, 554) = 3.41$, $p < .01$, and HIV status, Wilk's lambda $F(4, 554) = 5.81$, $p < .01$; no significant race × HIV status interaction effect was found, Wilk's lambda $F(4, 554) = 0.74$, $p = .56$. Follow-up ANOVA tests indicated that SEQ-Depth, CFQ, and GAF contributed significantly to the main

effect for race, $F(1, 557) = 6.29$, $p < .05$, $F(1, 557) = 5.60$, $p < .05$, and $F(1, 557) = 4.44$, $p < .05$, respectively. SEQ-Depth was also found to contribute significantly to the main effect for HIV status, $F(1, 621) = 14.07$, $p < .01$. An examination of the mean scores revealed that White female participants expected slightly greater session depth for the Black clients in the vignettes ($M = 4.72$, $SD = 0.74$) than the White clients in the vignettes ($M = 4.60$, $SD = 0.769$); they also expected slightly greater session depth for the HIV-positive clients in the vignettes ($M = 4.76$, $SD = 0.72$) than the HIV-negative clients in the vignettes ($M = 4.56$, $SD = 0.69$). White female participants' initial impressions of symptomatology were also slightly more negative toward the White clients in the vignettes ($M = 4.66$, $SD = 1.25$) than the Black clients in the vignettes ($M = 4.41$, $SD = 1.17$). Lastly, results showed that White female participants reported lower assessment of psychological, occupational, and social functioning toward the White clients in the vignettes ($M = 61.17$, $SD = 6.82$) than the Black clients in the vignettes ($M = 62.48$, $SD = 6.86$).

Summary of exploratory findings. Overall, the exploratory analyses revealed that participants' responses to the surveys were to some extent different based on whether or not they had correctly identified Michael's sexual orientation. In participants who had correctly identified Michael's sexual orientation, significant main effects for race and HIV status were found. In participants with incorrect recall, a significant main effect was found for HIV status. Several findings were similar to the main findings: in the correct identification group, SEQ-Depth and CFQ contributed significantly to the main effect for race, whereas SEQ-Depth was found to contribute significantly to the main effect for HIV status. In the incorrect identification group, SEQ-Smoothness and GAF contributed significantly to the main effect for HIV status. Other explorative findings differed from the main findings: in the correct identification group, GAF was found to also contribute significantly to the main effect for race, while SEQ-Smoothness and

GAF were found to be insignificant to the main effect for HIV status. In the incorrect

identification group, SEQ-Depth was found to be insignificant to the main effect for HIV status.

With regard to the impact of participants' correct identification of Michael's sexual orientation

and vignette condition on all measurements, a significant difference was found among

participants' responses to CFQ. Participants who correctly identified Michael's sexual

orientation reported more positive initial impressions of symptomatology toward the clients in

the vignettes.

Findings from the exploratory analysis also showed slightly different response patterns

based on participants' race and gender. Participants who identified as people of color (compared

to those who self-identified as White), gave more positive SEQ-Depth and GAF scores overall to

the clients in the vignettes. Male participants expected slightly greater session smoothness

overall.

Lastly, in participants who self-identified as White female, significant main effects for race

and HIV status were found. Similar to the main findings, SEQ-Depth and CFQ contributed

significantly to the main effect for race, whereas SEQ-Depth was found to contribute

significantly to the main effect for HIV status. Different from the main findings, GAF was found

to also contribute significantly to the main effect for race, while SEQ-Smoothness and GAF were

found to be insignificant to the main effect for HIV status.

<center>**Chapter V: Discussion**</center>

The primary purpose of this study was to use case vignettes to explore the potential impact of client's race and HIV status on counselor trainees' expectations of treatment process and perceptions of symptom severity. Specifically, the research questions that guided the study were:

Hypothesis 1: Participants will report lower expectations of session depth and smoothness, lower assessments of overall functioning, and more negative impressions of symptomatology toward Black clients than White clients in the vignettes.

Hypothesis 2: Participants will report lower expectations of session depth and smoothness, lower assessments of overall functioning, and more negative impressions of symptomatology toward HIV-positive clients than HIV-negative clients in the vignettes.

Hypothesis 3: Participants will report lowest expectations of session depth and smoothness, lowest assessments of overall functioning, and most negative impressions of symptomatology toward Black HIV-positive clients in the vignettes.

In this chapter, the implications of the study's findings for each of these hypotheses will be presented in the context of extant scholarship. Next, relevant limitations of the study will be discussed, followed by suggestions for future research and practice.

Hypothesis 1

The study's first hypothesis concerned the potential impact of the hypothetical client's race upon participants' clinical impressions. Contrary to the hypothesis, significant greater levels of session depth for the Black clients and more positive impressions of symptomatology toward the Black clients were reported by the participants. These results may suggest how contemporary racism (e.g., color-blind racial attitudes and aversive racism) influences clinicians' clinical impressions and judgments when working with racial minority clients. For instance, some

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participants may have evaluated the Black clients in an overly positive way as an attempt to demonstrate their nonracist attitudes (Dovidio & Gaertner, 2004). Another possible explanation is based on the theory of shifting standard. Biernat, Manis, and Nelson (1991) proposed that individuals adjust their reference points when making subjective judgments toward members of stereotyped social groups. For instance, Gushue (2004) found that White counseling and clinical psychology students perceived the Black clients in the vignettes as more healthy. In other words, these participants may have evaluated the racial minority client as "healthy" based on their lower expectations of the psychological well-being of people of color. Similarly, in the present study, counselor trainees may have used different standards, based on the race of the client in the vignettes, to make clinical evaluations. Thus, participants' more positive diagnostic impressions toward the Black clients than the White clients may be associated with participants' implicit racially biased attitudes or racist stereotypes.

Since it is assumed that many counselor trainees are trained from a Western Euro-American and ethnocentric monocultural stance view (Sue et al., 1998), higher expectations of session depth toward the Black clients may also be caused by participants' belief that they can learn more from a client whose racial and cultural backgrounds are so different from the training model they have received. Moreover, the majority of participants in the present study identified themselves as Caucasians (80.6%, $n = 690$). Research has suggested that in cross-racial counseling scenarios, White counselor trainees reported higher levels of discomfort and struggle with race issues (Utsey et al., 2005). Perhaps to the Caucasian participants in the present study, reviewing the vignettes feature a Black client may have represented as a hypothetical chance for them to learn and improve their clinical skills on race issues. Therefore, these participants may have reported higher expectations of session depth with the Black clients. On the other hand, the

assumed similar cultural and racial experiences may lead the Caucasian participants who

reviewed the vignettes feature a client of the same race to believe that the clients' issues would

be easier to understand, and thus reporting lower expectations of session depth.

Hypothesis 2

The second hypothesis of the present study concerned the potential impact of the

hypothetical client's HIV status upon participants' clinical impressions. As hypothesized,

participants reported lower expectations of session smoothness and lower assessments of overall

functioning toward the HIV-positive clients than HIV-negative clients in the vignettes. As

discussed previously, literature on clinicians' reactions to HIV-positive clients have shown that

some clinicians held less positive attitudes and higher levels of discomfort toward PLWHA

(Crawford et al., 1991; Hayes & Eriks, 2000; Hayes & Gelso, 1993). Results of the lower

expectations of session smoothness toward the HIV-positive clients appear to be consistent with

the findings of these studies. Moreover, it is reasonable to assume that counselor trainees who

have more experience of treating HIV-positive clients may have higher levels of confidence and

skills than the counselor trainees with less or no experience of working with this population.

Since the majority of the participants in the present study reported no previous experience of

treating clients who are living with HIV (85.0%, $n = 732$), it is possible that these participants'

lack of confidence in treating HIV-positive clients contributed to the overall lower expectations

of session smoothness results. Working with PLWHA who may have experienced greater levels

of stigma, clinicians need to be more aware of and sensitive to their reactions and expectations so

the therapeutic relationships would is not compromised (Earnshaw & Quinn, 2012 ; Earnshaw,

Quinn & Park, 2012).

Results also supported the hypothesis that the HIV-positive clients in the vignettes received lower ratings than the HIV-negative clients in the vignettes with regard to their psychological, occupational, and social functioning. However, significant differences were not found in participants' diagnostic impressions between the HIV-positive and HIV-negative clients. These findings suggest that despite of the similar evaluations of symptomatology assigned to all clients in the vignettes, participants in this study gave lower ratings to the overall functioning of the HIV-positive than the HIV-negative clients in the vignettes. How can this finding be explained in the context of HIV stigma? One explanation is that this result suggests participants may hold HIV stigma so that they expected the HIV-positive clients in the vignettes to have worse psychological, occupational, and social functioning even though similar diagnostic impressions were made to both HIV-negative and HIV-positive clients in the vignettes. Another possible explanation is that counselor trainees in this study are aware of their HIV stigma and its potential impact on the PLWHA. Thus, their diagnostic impressions were not biased, as reflected in the non-significant different results found in their diagnostic impressions toward the HIV-positive and HIV-negative clients. The lower ratings of overall functioning assigned to the HIV-positive clients in the vignettes may reflect how participants consider the potential negative impact of HIV stigma on PLWHA's daily life.

However, contrary to the hypothesis that HIV-positive clients would receive lower expectations of session depth, results showed that participants expected slightly greater session depth for the HIV-positive clients than the HIV-negative clients in the vignettes. As mentioned previously, the majority of the counselor trainees in the present study reported no previous experience of treating clients who are living with HIV. It is possible that in response to a vignette featuring a HIV-positive client, participants with no experience of working with PLWHA may

expect to learn more from this experience, and therefore reporting higher expectations of session depth. In other words, responses to the questions of session depth may in fact reflect the participants' belief that they may learn more from working with a client who is "atypical" from the ones they have been exposed to in their previous clinical experiences.

Hypothesis 3

The study's third hypothesis examined the potential interaction of the hypothetical client's race and HIV status and its effect upon participants' clinical impressions. The insignificant result derived from this study's findings did not provide support for this hypothesis. To examine the layering of HIV-related stigma, Reidpath and Chan (2005) proposed the concepts of *shared stigma* (when the characteristics of two forms of stigma overlap) and *synergistic stigma* (when the effects of two forms of stigma combined are worse than the simple addition of the stigma associated with each characteristic separately). The non-significant interaction result found in the present study did not suggest the synergistic stigma based on clients' race and HIV status. It appears that racial bias and HIV stigma may function more similar to the simple addition model to affect counselor trainees' therapeutic impressions. But to what extend does racial bias and HIV stigma separately influence clinicians' clinical judgments when working with racial minorities living with HIV/AIDS, and to what degree do these two forms of stigma overlap? The findings of the present study suggest that more research should be conducted to further examine the complex intersections of different stigmas.

Exploratory Findings

The exploratory analyses revealed that participants' responses to the surveys were somewhat different based on whether they correctly identified Michael's sexual orientation. Results of the separate analyses comparing participants who gave correct answers to participants

who gave incorrect answers showed no common measurements that contributed to the main effects of race and/or HIV status between these two groups. Specifically, significant results based on participants who correctly identified Michael's sexual orientation were similar to those main findings that are contrary to Hypotheses 1 and 2 (e.g., SEQ-Depth and CFQ to the main effect for race, SEQ-Depth to the main effect for HIV status); significant results found among participants who incorrectly identified Michael's sexual orientation were similar to the main findings that are in line with Hypothesis 2 (e.g., SEQ-Smoothness and GAF to the main effect for HIV status).

These findings invite speculation as to whether assumptions regarding Michael's sexual orientation might have affected participants' clinical impressions. Among participants who were able to recall that Michael's sexual orientation was not specified in the vignettes, biases and stigma related to sexual orientation might have been kept at a minimal level so that their clinical impressions were not affected when reading the HIV-positive vignettes. On the other hand, participants who gave incorrect answers may be more possible to assume Michael's sexual orientation, which in turn activating their biases and stigma related to sexual orientation. These participants' clinical impressions might have been influenced, and hence contributing to the different results between participants who correctly or incorrectly identified Michael's sexual orientation.

Findings from the exploratory analyses also indicated different response patterns based on participants' race and gender, and several interpretations may account for these differences. For instance, participants who are people of color, based on both their professional and personal life experiences, may have higher levels of awareness on how racial or ethnic minority clients may be judged as more disturbed and in higher need of clinical treatment by clinicians (Abreu, 1999).

As a result, participants who are people of color may have given more positive evaluations to the clients in the vignettes, as shown in the significant difference in SEQ-Depth and GAF between participants who are people of color and White. In addition, since the vignettes feature male clients, male participants may have expected the session to be more comfortable due to the gender match. Female participants, on the contrary, may have expected the process to be more uncomfortable and anxiety-provoking due to the gender mismatch.

Lastly, findings based on participants who self-identified as White female showed some similarities and differences to the main results. Discussions on the possible explanations to the results for Hypotheses 1 and 2 may also be applied here; specifically, the shifting standard may explain the more positive evaluations to the Black clients in the vignettes, and the higher expectations of session depth toward Black and/or HIV-positive clients may be related to White female participants' motivations to learn through working with Black and/or HIV-positive clients. However, comparing to the original results, among the female participants, GAF was found to also contribute significantly to the main effect for race, while SEQ-Smoothness and GAF were found to be insignificant to the main effect for HIV status. These differences might possibly be related to characteristics of White female participants that were not measured in the present study. Findings from elsewhere in the literature may provide some potential explanations for these different results. For instance, in a study that included mostly White female social work students, results showed that participants demonstrated adequate understanding about oppressed groups, but they were unable to connect their knowledge to the overall impact of oppression on the daily lives of people (Bronstein & Gibson, 1998). In the present study, if White female participants shared the similar pattern, they may have had a difficult time to apply their knowledge on tasks that required consideration of the impact of stigma and discrimination on the overall daily

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functioning of clients in the vignettes. Therefore, they may not have adjusted their diagnostic impressions even when the clients in the vignettes were specified as having stigmatized conditions. This effect may explain why CFQ and GAF were both found insignificant to the main effect of HIV status.

On the other hand, as previously mentioned in the discussions of the results in Hypothesis 2, similar diagnostic impressions made to both HIV-negative and HIV-positive clients in the vignettes could also be explained as the non-biased attitudes toward HIV shown by the participants. Literature on clinician gender has provided some possible explanations for this assumption. For instance, in a study on the association between physician gender and the quality of HIV care, results showed that HIV patients working with a male physician were more likely to report having problems with feeling respected by their physicians (Beran, Cunningham, Landon, Wilson & Wong, 2006). Moreover, literature has found that greater levels of homophobia were found among men than women (Hayes & Gelso, 1993), and that there is an association between higher levels of homophobia and greater negative attitudes toward HIV-positive clients (Crawford et al., 1991; Hayes & Eriks, 2000; Hayes & Gelso, 1993). Overall, these results suggested that certain characteristics of female clinicians may contribute to the way that they treat and perceive HIV-positive clients. It is possible that female participants sampled in the present study may also have shared these characteristics.

Limitations

This study has several limitations that must be considered in interpreting its results. First, case vignettes were used and participants were asked to imagine a clinical scenario. The impact of reading a case summary is, of course, not identical to a clinical situation; it is almost certainly much less powerful than meeting with a client face-to-face. The results of the present study may

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not, therefore, be entirely applicable in a real clinical setting. Moreover, literature has suggested that individuals may display avoidant behavior when interacting with PLWHA (Mooney, Cohn, & Swift, 1992). Therefore, the design of this study may not be able to capture the full impact of stigma on the counselor trainees when working with individuals who are racial minority and/or HIV-positive.

Second, counselor trainees participated in this study through an online survey on the Internet. Participants were instructed to stop anytime if they chose not to continue; some individuals may therefore have terminated the study due to discomfort or personal reactions regarding working with racial minority and/or HIV-positive clients. It is also possible that some people may simply have not wanted to spend time retaining the case information or filling out the questionnaires, and thus gave up in the middle of the study. Therefore, participants of the present study may represent a select group of counselor trainees whose composition affects the findings in some way. For example, they may represent individuals who are more aware of and interested in clinical issues pertaining to working with stigmatized individuals.

Furthermore, it is not clear how other stereotypes associated with the clients in the vignettes may have affected the results. For instance, how may Michael's gender have interacted with racial stereotypes and HIV stigma in influencing participants' therapeutic impressions? Literature has suggested that some people may still equate any male-to-male sexual behavior with AIDS (Herek & Capitanio, 1999). Therefore, it is probable that the male character in the HIV-positive vignettes may trigger stronger reactions than originally intended, particularly to those with homophobia. Furthermore, although the manipulation questions were used to examine participants' recall of Michael's sexual orientation, it was unclear that how participants' responses may be affected if they have assumed Michael's sexual orientation. This is particularly

relevant for participants who may have stronger degree of homophobia. If these participants reviewed the HIV-positive vignettes and assumed Michael is gay, their homophobia may have influenced their responses. Lastly, participants may have come up with their own hypotheses about Michael's social class. It is possible that such associations affected participants' evaluations of Michael's symptom severity and functioning level. For example, participants with greater levels of racial prejudice may assume that the Black and HIV-positive client is from a lower social class, and therefore give higher GAF scores in accordance with a shifting-standards bias, i.e., Michael is healthy for a Black HIV-positive person with lower social class.

Finally, the vast majority of the participants self-identified as White and/or female. In one regard, this sample serves as a fitting representation of the shifting demographic trends in the field of psychology. A recent report showed that women make up more than 70 percent of the new psychology doctorates (Willyard, 2011). However, it also suggests a limitation of this study, in it limited the exploration of the impact of racial and gender differences between clinicians and the clients. Furthermore, there are other participants' characteristics that were not controlled in the study, which may have affected the results. For instance, it is possible that differences in the number of multicultural and/or HIV knowledge among participants could have influenced responses to the surveys.

Implications for Future Research

Findings of the present study have several important implications for research in counseling psychology. First, the results reported here support the contention that counselor trainees' therapeutic impressions may be influenced by the clients' race and HIV status. This finding suggests that participants' attitudes and beliefs toward race and HIV may play a role in their clinical judgments when working with racial minority and/or HIV-positive clients. Future studies

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could further examine this question by measuring participants' attitudes, beliefs, and stereotypes toward racial and sexual minority groups to provide a richer theoretical understanding of how clinicians' internal processes may be connected to their external behaviors. For instance, it was previously mentioned that the concept of shifting standards (Biernat, Manis & Nelson, 1991) may account for the impact of contemporary racist attitudes among counselor trainees. Measures of participants' color-blind racial attitudes or aversive racism might usefully be included, therefore, in future research on this topic. In addition, it was previously suggested that the use of case vignettes in this study may have lessened the impact of variables of interest upon the participants. It is possible that in future studies, photos, video clips or actors could be used to elicit reactions that are closer to those that emerge within a real clinical setting. In so doing, researchers could also observe and measure participants' physical reactions (e.g., avoidant behaviors such as physical distance and eye contact) as indicators of attitudes and biases toward clients with stigmatizing conditions.

Researchers could also explore how counselor trainees' stigma may be manifested in different processes or aspects of the therapeutic relationships. For instance, literature on stigma has suggested that in addition to the overt form of stigma, *felt stigma* (Scambler & Hopkins, 1986; Jacoby, 1994) and *anticipated stigma* (Earnshaw & Quinn, 2012 ; Earnshaw, Quinn & Park, 2012) are commonly found in the life experiences of people living with stigmatizing conditions. It is possible that racial minority and/or HIV-positive clients may experience stigma through their interactions with the clinicians, such as their tone on the phone when making the first appointment, non-verbal behavior during the session, or how treatment plans and interventions are presented and delivered. It would be helpful for future studies to examine how these clinician behaviors might differ when working clients of different race and HIV status.

Results of the present study may also pertain to future research on clinicians' biases when working with people living with different forms of chronic and/or life-threatening illness (e.g., heart disease, diabetes, stroke, cancer). Literature has suggested a strong association between stigma and various type of illness. As discussed earlier, the stigma associated with HIV has a unique set of patterns that sets it apart from other types of illness-related stigma. For instance, people tend to perceive HIV as an onset-controllable and irreversible stigma, and this kind of attribution and reaction (e.g., a "blame-the-victim" ideology) is not commonly found among other types of physically based and mental-behaviorally stigma (Weiner, Perry, & Magnusson, 1988). The stigma associated with HIV/AIDS has been blatant due to its association with homosexuality and IV drug use – social groups that are considered to be morally blameworthy; while the stigma associated with other types of illness, such as cancer, has been less overt and operating in the context of the people's irrational thoughts that "it could happen to me" (Fife & Wright, 2000). These research findings suggest that the impact of perceived stigma on the individuals with HIV/AIDS and other type of illness might be different, but such differences have not been studied systematically. In the meantime, it is important for clinicians to understand how their biases and knowledge related to various types of illness might influence their therapeutic and diagnostic impressions. Therefore, future research could be benefit from examining the topic of how clinicians make clinical judgments, and what factors influence their clinical decisions when working with clients living with various types of chronic illness.

Furthermore, a review of health psychology literature on chronic illness in recent years suggests that race and patients' other potentially stigmatizing conditions have rarely been included in the scope of research questions (e.g., Cantisano, Rimé, & Muñoz-Sastre, 2013; Earnshaw & Quinn, 2012; Earnshaw, Quinn & Park, 2012). If this study were replicated with

vignettes in which clients were living with a different kind of chronic illness, would the race of the clients make a difference in counselor trainees' therapeutic impressions? Researchers may also want to compare different chronic illness conditions to expand knowledge on the layering of HIV-related stigma. For instance, vignettes featuring clients with no chronic illness conditions, various types of chronic illness, HIV, and different races could be compared. Differences in participants' responses would further expand our understanding of the shared and unique characteristics of HIV stigma and race-related stigma.

Lastly, as shown in the exploratory analyses, additional variables that were not part of the present study merit further examination. Results showed that participants' responses to the surveys were slightly different based on whether they successfully recalled Michael's sexual orientation. This finding raises the question of how counselor trainees' perceptions and memories of case-related information may be associated with stigma and their responses to the surveys. Moreover, findings from the exploratory analysis also showed slightly different response patterns based on participants' race and gender. In future studies, researchers may want to control for participants' race and gender to further investigate the role of clinicians' characteristics in the association between stigma and therapeutic impressions. In addition, the target participants of the present study are counselor trainees. It would be helpful to determine whether practicing clinicians might have different responses to the vignettes. Information gathering from such comparisons could help educators to develop strategies to provide effective training to prepare counselor trainees in working with clients of different racial background and HIV status.

Implications for Practice

Results of the present study showed that counselor trainees' expectations of therapeutic process and evaluations of the clients' symptomatology might be influenced by the clients' race and HIV status. This finding highlights the important role of multicultural awareness and competence in counselor trainees' clinical training. Regardless of clinicians' good intentions when working with a stigmatized client, without a proper understanding of the cultural frame of the client, clinicians still risk making biased clinical judgments. Along these lines, multicultural training has been found to be related to increasing levels of awareness to the trainees' implicit racial prejudice (Castillo, Brossart, Reyes, Conoley, & Phoummarath, 2007). In addition, clinicians' awareness of social justice was found to be associated with more positive prognoses of clients (Hays, Prosek, & McLeod, 2010), and higher levels of HIV knowledge have been associated with counselor trainees' more positive attitudes toward PLWHA (Carney, Werth, & Emanuelson, 1994).). In light of such findings, counselor educators must apply a multidimensional approach that includes not only facts and information, but also training opportunities that would assist trainees in increasing awareness of their racial-cultural development, racial prejudice, and attitudes regarding HIV.

Another relevant implication is that clinicians' multicultural awareness and competence could not only benefit their clinical work with racial minority clients, but also their White clients. In a study on the role of culture in clinicians' clinical judgments, results indicated that race/ethnicity issues were rarely explored and talked about when the clinicians and clients are both White (Hays, Prosek, & McLeod, 2010). Clinicians may miss a significant aspect of clinical information by ignoring the racial and cultural experiences and development of their White clients. This issue may also relate to the findings of the present study in which a significant

number of White counselor trainees reported lower expectations of session depth for the White clients in the vignettes.

Educators and clinicians should also continue to work on improving their awareness of the different sources that may trigger clients' experience of stigma, and to improving their clinical interventions targeting reducing clients' anticipated stigma. When working with racial minority and/or HIV-positive clients, clinicians are encouraged to considerate how clients' stigmatizing conditions may influence the diagnosis or diagnoses (Hays, Prosek, & McLeod, 2010). Moreover, within the therapeutic process, clinicians should be mindful that stigma that may impact their demonstration of the understanding, caring, and compassion that are particularly important in establishing and maintaining a therapeutic patient-provider relationship with people living with stigmatizing conditions. Furthermore, some researchers have argued that the clinical diagnoses used by clinicians may reinforce the public's stigma and stereotypes of mental illness (Corrigan, 2007). Findings from the present study suggest that clinicians should incorporate considerations of of HIV stigma into clinical judgments to make an appropriate clinical diagnosis. Clinicians are recommended to conceptualize the impact of HIV stigma within their overall clinical evaluations to ensure that HIV-positive clients receive proper treatment without inadvertently being stigmatized in the therapeutic process.

Conclusions

People living with stigmatizing conditions often experience exclusion, rejection, blame, and devaluation in their daily lives, which can lead to psychological distress (Scambler, 2009). Counseling psychology and related specialization, including vocational psychology, health psychology, multicultural psychology, and rehabilitation psychology, can provide much-needed services to these individuals (Chwalisz, 2008). Therefore, it is vital that counselor trainees

understand the characteristics of stigma, how it affects these individuals' lives, and how it may influence clinicians' therapeutic impressions and clinical decisions. In the present study, hypothetical clients of different race and HIV status were presented via case vignettes to examine counselor trainees' responses. Findings provided some evidence that participants' therapeutic impressions were influenced by the race and HIV status of the clients in the vignettes. Consistent with the hypothesis, it was found that participants reported lower expectations of session smoothness and lower assessments of overall functioning toward the HIV-positive clients. However, contrary to the hypotheses (and contrary to results from some existing literature), participants reported lower expectations of session depth regarding both the HIV-negative and White clients in the vignettes. In addition, Black clients in the vignettes received higher ratings on diagnostic impressions –they were viewed as less likely to have clinical disorders. These findings suggest a complicated picture of how different factors may intertwine to affect the therapeutic process and outcomes when providing treatment to clients who are racial minority and/or PLWHA. Results of the present study highlight some challenges for educators who work with counselor trainees, which relate not only to professional development, but also to personal growth and self-awareness regarding issues of race, HIV, prejudice, and stigma. It is hoped that the present study will contribute to ongoing research that expands clinicians' understanding of multiple layers of stigma and its impacts on people living with stigmatizing conditions.

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Appendix A

Case Vignette

Michael is a 30-year-old HIV-positive Black male who presented for therapy with feelings of stress associated with issues around his current job and interpersonal relationships. Michael has never been in therapy before. Michael reported experiencing financial pressure because he has been worried that he may lose his part-time job at a retail store. He has found himself becoming less interested in engaging in conversations with his clients at the store, and his job performance has not been satisfactory for a while. Michael also reported that he noticed himself becoming impatient and edgy when walking on crowded streets. He reported that sometimes he almost wanted to push the people around him who were walking too slowly. However, Michael said that this never actually happened and that he immediately felt guilty when he had this thought. Michael is currently single. He reported that he has never been in a successful relationship, and his relationships always turn into friendships in the end. Michael denied any past history of alcohol or drug abuse. He reported that he is a social drinker and sometime smokes marijuana with his friends during the weekends. Michael identified a small group of good friends but reported an estranged relationship with his family members. Michael reported that he sometimes attends the Sunday service at a local church. However, he stated that he was not an active member and did not socialize with any church members.

Demographics Form

1. What is your age? _____

2. What is your gender?

□ Male
□ Female
□ Transgender
□ Other (Please specify) _____

3. What racial group best describes you?

□ Native American or Alaska Native
□ Asian
□ Black
□ Native Hawaiian or Pacific Islander
□ White
□ Multiracial
□ Other (Please specify) _____

4. What is your ethnic background? _____

5. Which best describes your sexual orientation?

□ Heterosexual
□ Homosexual
□ Bisexual
□ Other (please specify)_____

6. What degree are you currently working towards?

□ M.A.
□ M.S.
□ Ed.M.
□ Ph.D.
□ Psy.D.
□ Other (please specify) _____

7. Years in current graduate program. _____

8. Do you have any experience of doing therapy/counseling?

□ Yes
□ No

If you answer 'Yes" to question 8,

9. How many years of experience of doing therapy/counseling do you have? _____

10. Do you have any experience of doing therapy/counseling with clients of color?

□ Yes
□ No

11. Do you have any experience of doing therapy/counseling with HIV-positive clients?

□ Yes
□ No

Session Evaluation Questionnaire

Instructions: Please respond to the following questions to evaluate the client in the vignette. For

each item, please circle the number on the scale that most accurately reflects your beliefs.

1. I expect that a session with Michael might be

  1   2   3   4   5   6   7

Shallow   Deep

2. I expect that a session with Michael might be

  1   2   3   4   5   6   7

Weak   Powerful

3. I expect that a session with Michael might be

  1   2   3   4   5   6   7

Empty   Full

4. I expect that a session with Michael might be

  1   2   3   4   5   6   7

Ordinary   Special

5. I expect that a session with Michael might be

  1   2   3   4   5   6   7

Worthless   Valuable

6. I expect that a session with Michael might be

  1   2   3   4   5   6   7

Rough   Smooth

7. I expect that a session with Michael might be

1	2	3	4	5	6	7
Uncomfortable						Comfortable

8. I expect that a session with Michael might be

1	2	3	4	5	6	7
Tense						Relax

9. I expect that a session with Michael might be

1	2	3	4	5	6	7
Unpleasant						Pleasant

10. I expect that a session with Michael might be

1	2	3	4	5	6	7
Difficult						Easy

Clinical Features Scale

Instructions: Please respond to the following questions to clinically evaluate the client in the vignette. For each item, please circle the number on the scale that most accurately reflects your clinical evaluation of the client.

1) How antisocial would you estimate Michael to be?

0	1	2	3	4	5	6	7	8	9	10
Not at all					Moderately					Extremely

2) How likely is Michael to intentionally exaggerate physical and psychological symptoms (malingering)?

0	1	2	3	4	5	6	7	8	9	10
Not at all					Moderately					Extremely

3) How delusional would you estimate Michael to be?

0	1	2	3	4	5	6	7	8	9	10
Not at all					Moderately					Extremely

4) How likely is Michael to be an alcohol/drug abuser?

0	1	2	3	4	5	6	7	8	9	10
Not at all					Moderately					Extremely

5) How anxious would you estimate Michael to be?

0	1	2	3	4	5	6	7	8	9	10
Not at all					Moderately					Extremely

6) How likely is this Michael to entertain suicidal behavior?

0	1	2	3	4	5	6	7	8	9	10
Not at all					Moderately					Extremely

7) How impulsive would you estimate Michael to be?

0	1	2	3	4	5	6	7	8	9	10
Not at all					Moderately					Extremely

8) How depressed would you estimate Michael to be?

0	1	2	3	4	5	6	7	8	9	10
Not at all					Moderately					Extremely

Appendix E

Global Assessment of Functioning (GAF) Scale

Instruction: Please use the Criteria below to determine Michael's current functional status.

Assigned GAF Rating: _____

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Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)

100 | 91	**Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**
90 | 81	**Absent or minimal symptoms** (e.g., mild anxiety before an exam**), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g. an occasional argument with family members).
80 | 71	**If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational or school functioning** (e.g., temporarily failing behind in schoolwork).
70 | 61	**Some mild symptoms** (e.g. depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household)**, but generally functioning pretty well, has some meaningful interpersonal relationships.**
60 | 51	**Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g.. few friends, conflicts with peers or co-workers).
50 | 41	**Serious symptoms** (e.g.. suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).
40 | 31	**Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 | 21	**Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).
20	**Some danger of hurting self or others** (e.g., suicide attempts without clear

| 11	expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).
10 | 1	**Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**
0	Inadequate information.

Appendix F

Manipulation Check Questions

1. What is Michael's race?

□ Native American or Alaska Native
□ Asian
□ Black
□ Native Hawaiian or Pacific Islander
□ White
□ Multiracial
□ Other (Please specify) _____
□ I don't remember
□ It is not specified in the vignette

2. How old is Michael?

□ 20
□ 30
□ 40
□ Other (Please specify) _____
□ I don't remember
□ It is not specified in the vignette

3. What is Michael's sexual orientation?

□ Heterosexual
□ Homosexual
□ Bisexual
□ Other (Please specify) _____
□ I don't remember
□ It is not specified in the vignette