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Counselors-in-Training Reactions to Clients Living with and without HIV

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An estimated one million people are currently living with HIV in the United States. Therefore, an important question remains pertaining to professional helpers' preparedness in working with people living with HIV/AIDS (PLWHA). This study ($N = 165$) utilized an analogue design, with participants receiving one of four possible clinical case vignettes, to determine the relationship of client HIV status and race with counselor-in-training self-efficacy, multicultural competency, and empathy. Results revealed that client HIV status was predictive of counselor self-efficacy, and that self-efficacy held relationships with multicultural counseling competency and empathy. Findings suggest multicultural skills training may be particularly important to increase CIT self-efficacy when working with PLWHA.

Keywords: HIV, analogue study, counselor training, self-efficacy

Introduction

The estimated number of new HIV transmissions in the United States has declined 18% within the last decade; still, nearly 40,000 individuals are diagnosed with HIV each year (Centers for Disease Control and Prevention (CDC), 2019). In addition, an estimated one million people are currently living with HIV in the United States (CDC, 2019). These numbers are particularly relevant to professional helpers and social service providers considering the breadth of mental health concerns and the importance of mental health intervention in the lives of people living with HIV/AIDS (PLWHA; Pence, 2009; Salters et al., 2016). For example, PLWHA reported greater rates of PTSD and depression than HIV-negative individuals (Benton, Ng, Leung, Canetti, & Karnik, 2019), and these diagnoses of PTSD and depression often co-occur with HIV within this population (Benton et al., 2019; Lu et al., 2018; Ng'ang'a, Mathai, Obondo, Mutavi, & Kumar, 2018). Unfortunately, the presence of HIV stigma further exacerbates the stress of living with HIV (Herek, 2014). In addition to these concerns, PLWHA report having a desire to speak about their emotional and mental well-being with care providers, highlighting the need for professional helpers to be knowledgeable about working with this population (Safran, Hoover, Tao, & Butler, 2013).

Given the presence of mental health concerns for PLWHA and the large number of PLWHA in the United States, professional counselors can expect to often work with this population in their practices or organizations. Therefore, professional counselors must be prepared to work with PLWHA. During a particularly grim period of the HIV/AIDS crisis, researchers found a great deal of counselors feel uncomfortable working with and potentially harbor negative feelings

towards PLWHA (e.g., Fliszar & Clopton, 1995; Hayes & Gelso, 1993). Contemporary research identifies potential biases within counseling students working with PLWHA (Joe & Foster, 2017). Additionally, master's level counseling trainees may enter the field having experienced little training during their graduate programs regarding HIV and its effects on clients' mental health (J. Campbell, Pietrantonio, & Miller, 2020; Rose, Sullivan, Hairston, Laux, & Pawelczak, 2015). Since the 1980s and 1990s, treatments for HIV/AIDS have improved greatly; notably, the 1996 introduction of antiretroviral therapy (ART; National Institute on Drug Abuse (NIDA), 2012) has drastically reduced the mortality rate associated with a HIV diagnosis (Coelho et al., 2018). Furthermore, ART has changed the diagnosis from a death sentence to an oftentimes manageable chronic disease (NIDA, 2012). Hence, an assessment of counseling trainees' outlooks on clients with HIV/AIDS is warranted to determine if past attitudes identified in the 1990s (e.g., stigma, decreased empathy; Hayes & Erkis, 2000) persist. The present study sought to conduct such an assessment by exploring coun-

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seling trainees' self-efficacy, multicultural competence, and empathy regarding working clients living with HIV/AIDS.

HIV and Mental Health Professionals

Stigma and lack of knowledge about HIV and methods of managing emotional responses to the illness are challenges to PLWHAs' mental health (Logie et al., 2018; Rinehart et al., 2018). HIV stigma can have negative psychological, physical, and social outcomes for PLWHA, and these negative impacts can manifest as anxiety, non-adherence to treatment, substance use, or isolation within PLWHA (Crockett, Kalichman, Kalichman, Cruess, & Katner, 2019). Moreover, PLWHA who also identify as a member of one or more marginalized populations (e.g., sexual minorities, people of color) may experience layered stigma associated with their HIV status as well as their cultural identities (Herek, 2014; Reidpath & Chan, 2005). Thus, the inclusion of race is an important piece of the present study. For instance, gay, bisexual, and other men who have sex with men (MSM) of color experience stigma associated with their sexual orientation and their race/ethnicity (McConnell, Janulis, Phillips, Truong, & Birkett, 2018), and they may experience HIV/AIDS differently than women of color (Colbert, Kim, Sereika, & Erlen, 2010). Unfortunately, stigma experiences are not reserved for outside clinical spaces and may occur within counseling relationships as well.

Mental health professionals and other service providers are not immune to the HIV-related biases and stigma that exist within the general population (Mehnert, Siem, Stürmer, & Rohmann, 2017), and many may be unaware of the cultural considerations of their work with PLWHA. To combat such biases, mental health professionals and other service providers must conduct competent and ethical practice when serving clients living with HIV/AIDS. Furthermore, counselors should practice self-awareness and the application of an intersectional lens during case conceptualization and intervention (Joe, 2018). Moreover, for counselors-in-training (CITs), the belief in their ability to provide appropriate, ethically and culturally sound services to clients living with HIV/AIDS can be critical to their success as mental health professionals.

Counselor Self-Efficacy

Counselor Self-Efficacy (CSE) has been thought of as an individual's ability to counsel a client in the near future effectively (L. M. Larson & Daniels, 1998), and can be considered a central trait that informs counselor training and selection (Beutler, Machado, & Neufeldt, 1994). Whereas Beutler et al. (1994) viewed CSE as stable, other researchers have indicated that CSE is circumstantial and can be related to the quality of one's supervision and work experience (Brown, Olivarez, & DeKruyf, 2017; Suh et al., 2018). Researchers

have identified that the benefits of CSE manifest both internally and externally. Internal benefits include greater counselor readiness and greater confidence in basic skills, including managing fundamental aspects of counseling (Lent, Hill, & Hoffman, 2003). External benefits of higher CSE include indirect effects on client outcomes (Kozina, Grabovari, Stefano, & Drapeau, 2010) and increases in service delivery (Mullen & Lambie, 2016). Specifically, as CSE increases, CIT anxiety decreases and levels of clinical judgment and performance increase, which in turn affects client outcomes (Goreczny, Hamilton, Lubinski, & Pasquinelli, 2015; Reese et al., 2009). Additionally, CITs with low CSE have a difficult time with case conceptualization, implement unproductive counseling strategies and interventions, and become more defensive in perfecting skills (L. M. Larson & Daniels, 1998). To date, researchers have not investigated the self-efficacy of CITs as it relates specifically to working with PLWHA, despite the relevance of this construct to counselor success.

Multicultural Competence

Like CSE, competence with respect to the social and cultural diversity of clients remains a key area of interest for CITs (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016), particularly the needs of PLWHA within their unique social and cultural contexts (Berger et al., 2016). The American Counseling Association (ACA; 2014) has identified "honoring diversity and embracing a multicultural approach" (p. 4) as one of five core professional values for the counseling profession. Additionally, the Council for Accreditation of Counseling and Related Educational Programs (CACREP; CACREP, 2016) has infused social and cultural considerations throughout their standards for counselor education. Efforts to meet these educational standards and uphold the values of the profession include both direct instruction and immersive experiences where trainees have direct involvement with culturally diverse individuals (Barden & Greene, 2014). Training and level of education have been found to be significant predictors of CSE levels; however, negative implications may be present in terms of lower self-efficacy for students in counseling programs with a limited multicultural training approach (Lopez-Baez & Paylo, 2009). Further, relationships exist between cultural competence and multicultural self-efficacy (Matthews, Barden, & Sherrell, 2018), suggesting that increasing students' multicultural training could bring about benefits in self-efficacy as well.

Whereas the competencies needed for working with clients living with HIV (e.g., empathy, genuineness, positive regard) are similar to those for clients who are HIV negative, there are additional knowledge and skills (e.g., grief and loss work, basic knowledge of HIV) that are relevant for working with PLWHA (Joe, 2018; Werth, Carney, & Mor-

ris, 1996). When guided by the Multicultural and Social Justice Counseling Competencies (Ratts et al., 2016), counselors should consider their client's worldview and experiences of marginalization. Specifically, counselors may better understand the lived experiences of marginalized individuals if they are aware and knowledgeable of diverse languages, sexuality and sexual orientation issues, and elements of drug culture as they impact PLWHA (Rozas & Smith, 2009). Furthermore, counselors and their patients benefit from cultural competence, both in their mental and physical health. Consequently, service providers with increased competence may mean greater medication self-efficacy and treatment adherence among PLWHA (Gaston, 2013).

Empathy

As a core condition in the counseling process, empathy fosters the therapeutic relationship as clients move toward their goals (Rogers, 1957). Defined as the emotional experience and comprehension of another's emotional state (Vossen, Piotrowski, & Valkenburg, 2015), empathy is necessary within the counseling context as evidenced by its byproducts of trust and an emotionally supportive environment. Regarding HIV/AIDS, empathy involves not only feelings for PLWHA, but also feeling with others, and connecting to their experiences (R. G. Campbell & Babrow, 2004). In an individual's response to PLWHA, elements of empathy include identification with PLWHA or the ability to take their perspective, understanding the context in which they live with HIV/AIDS, sharing emotions or maintaining emotional concordance with PLWHA, and having concern for PLWHA (R. G. Campbell & Babrow, 2004).

Within the clinical context, the presence of empathy as demonstrated by the counselor can promote trust, open communication, and improve client satisfaction and involvement in counseling (Elliott, Bohart, Watson, & Greenberg, 2011). In HIV-specific research of empathy, higher empathic concerns were associated with lower levels of stigmatization (Olapegba, 2010) and more favorable attitudes toward PLWHA. Additionally, PLWHA who were treated by counselors with higher levels of empathy disclosed more psychosocial and biomedical information and reported higher levels of medication self-efficacy (Flickinger et al., 2016). Although the Flickinger et al. (2016) study focused on professionals in a medical setting, the implications for counseling professionals is clear: empathy is central to open communication with PLWHA.

Purpose of the Study

Although extensive research exists regarding self-efficacy, multicultural competence, and empathy among CITs, none exists that explores these constructs together with respect to clients living with HIV/AIDS. The purpose of the present study was to address this gap in the literature and to inform

counselor training with respect to self-efficacy, multicultural competence, and empathy when serving clients living with HIV/AIDS. To engage these variables in the current study, we relied on an analogue design, in which CITs reviewed case vignettes of clients living with and without HIV. Therefore, we relied on the following research questions:

1. *Research Question 1:* What relationships exist between CITs multicultural competence, empathy, and counseling self-efficacy?
2. *Research Question 2:* Do multicultural competence and empathy serve as predictors of CIT self-efficacy when working with the client presented in the clinical vignette?
3. *Research Question 3:* Is client HIV status (as presented in a clinical vignette) predictive of CIT self-efficacy in working with this client?
4. *Research Question 4:* Does interaction occur between client HIV status and race in effecting CIT self-efficacy?

Method

Participants

One hundred and sixty-five CITs, recruited from two separate CACREP accredited counseling programs in the Southeast United States, participated in this study. In total, 167 students were initially approached for participation, making for a 98.8% response rate. For those who reported gender, 80.6% identified as female ($n = 133$), 16.4% identified as male ($n = 27$), 1.2% identified as transgender ($n = 2$), and 1.2% identified as intergender ($n = 2$). Participants represented a number of counselor training programs, including mental health counseling ($n = 75$, 45.5%), school counseling ($n = 57$, 34.5%), marriage and family therapy ($n = 15$, 9.1%) and rehabilitation counseling ($n = 14$, 8.5%). Four participants (2.5%) did not complete this demographic item. Sexual orientation was also assessed, with 79.3% ($n = 130$) identifying as heterosexual, 7.9% ($n = 13$) identifying as bisexual, 4.9% ($n = 8$) identifying as gay, 4.2% ($n = 7$) identifying as pansexual or omnisexual, and 3.7% ($n = 6$) identifying as something other than the choices listed. Of those who identified their race, 54.5% ($n = 90$) identified as White, 21.8% ($n = 36$) identified as Black or African American, 9.1% ($n = 15$) identified as Hispanic, 6.1% ($n = 10$) identified as two or more races, and 2.4% ($n = 4$) were Asian or Pacific Islander. The majority of participants were in the first year of their counseling program ($n = 90$, 54.5%), followed by those in their second year ($n = 66$, 40%), third year ($n = 8$, 4.9%), and fourth year or later ($n = 1$, 0.6%). Participant ages ranged from 20-53, with a mean age of 26.16.

Research Design

Although a preliminary pilot study, this quantitative study utilized an analogue design to determine the effect of client HIV status on CIT self-efficacy. We created four nearly identical case vignettes, varying in terms of the client's HIV status and the client's race (i.e., the client was either identified as Black or White). Vignettes were informed by the Casebook for DSM-5 (Ventura, 2017). Details about the client, including his being 35 years old, heterosexual, and married, were kept the same in each vignette to ensure the only differences between vignettes were the clients' HIV status and/or race. By including other identities of power (i.e., the client being heterosexual and White), we were able to focus on the impact of two of the client's marginalized identities (i.e., race, HIV status). In each of the vignettes, the client is seeking counseling to better handle stressors in his life, including the potential threat to his job stability and finances due to health concerns. Although health concerns are mentioned in all vignettes, half of the case studies kept these health concerns neutral, while others explained these health concerns as a byproduct of the client living with HIV (i.e., "Mark has been experiencing health issues that may impact his ability to continue his physically demanding job" or "Mark has been experiencing HIV related health complications that may impact his ability to continue his physically demanding job").

Each participant viewed only one of these four scenarios, making the sample sizes for the four independent case vignettes as follows: client Black and HIV-negative ($n = 48$), client White and HIV-negative ($n = 39$), client Black and living with HIV ($n = 43$), and client White and living with HIV ($n = 35$). An a priori power analysis using G*Power software (version 3.1; Faul, Erdfelder, Buchner, & Lang, 2009) determined that a sample of 76 or more participants was appropriate for the analysis between the four groups at a .05 alpha level and a large effect size (0.4). Similarly, 74 participants were deemed necessary for the multiple regression analysis with five potential predictors.

Measures

Counselor self-efficacy. The Counselor Self-Efficacy Scale (CSES; Melchert, Hays, Wiljanen, & Kolocek, 1996) is a 20-item measure whose items are scored on a five-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). The CSES is designed to measure counselor self-efficacy in therapeutic skills and knowledge and, unlike other similar instruments, extends this measure to include self-efficacy in assessments, family interventions, and both individual and group counseling (L. M. Larson & Daniels, 1998). The instructions of the measure and the ending of the items were modified so the participants could answer the CSES items in reference to the case vignette they had just read. For example, sample items read as "I am able to ef-

fectively develop therapeutic relationships with this client" and "I can effectively facilitate client self-exploration with this client." Content-related validity was established for the CSES by asking expert judges to evaluate the instrument and look for agreement on the appropriateness of each item (Melchert et al., 1996). The CSES has further shown convergent validity through its correlation (.83) with other instruments of self-efficacy, such as The Self-Efficacy Inventory (Friedlander & Snyder, 1983). The normative sample of the CSES, comprised of graduate counseling psychology students, has a reported Cronbach's alpha of .93 (Melchert et al., 1996), and the current sample has an alpha of $\alpha = 0.88$.

Empathy. Davis's (1983) Interpersonal Reactivity Index (IRI) is a self-report measure comprised of four separate subscales, each including seven items. Each subscale (i.e., empathic concern, perspective taking, fantasy, and personal distress) serves as its own independent measure, and the scale does not result in a total score (Cliffordson, 2002). Further, each subscale aims to measure a separate aspect of empathy, with research most regularly using the perspective taking (PT) and empathic concern (EC) subscales (Hawk et al., 2012). Respectively, the PT and EC subscales measure the ability and tendency to adopt the viewpoints of others and experience warmth and compassion focused on others (Cliffordson, 2002). We administered only these two subscales in the present study, resulting in 14 Likert-type scale items representing two sub-constructs of empathy. These subscales are often used together for their ability to represent helping behaviors (Batson, 1997), making them particularly relevant for use in the current study. Scale items are presented on a five-point scale ranging from 1 (does not describe me well) to 5 (describes me very well). A sample item from the PT subscale includes "I believe that there are two sides to every question and try to look at them both" while the EC subscale includes items such as "I often have tender, concerned feelings for people less fortunate than me." The items of these two IRI subscales have shown adequate reliability in other studies looking at therapists in training ($\alpha = .73$ and $.71$; Jowers et al., 2019), with alphas in the present study being $.70$ (EC) and $.75$ (PT).

Multicultural competence. The Multicultural Awareness, Knowledge, and Skills Survey-Counselor Edition (MAKSS-CE-R; Kim, Cartwright, Asay, & D'Andrea, 2003) is a self-report measure involving three subscales (i.e., participant's self-perception of multicultural awareness, knowledge, and skills) modeled after multicultural competency domains (Sue et al., 1982). The instrument is made up of 33 items, with 10-13 items in each subscale. The multicultural awareness subscale consists of items on a four-point Likert-type scale ranging from 1 (strongly disagree) to 4 (strongly agree), with items such as "the difficulty with the concept of integration is its implicit bias in favor of the dominant culture." Items for the knowledge subscale include the prompt,

“At the present time, how would you rate your understanding of the following terms,” followed by terms such as culture, racism, and pluralism. Participants respond on a 4-point Likert-type scale ranging from 1 (very limited) to 4 (very good). Last, the skills subscale includes items such as “how well would you rate your ability to accurately assess the mental health needs of lesbian women?” with possible responses ranging from (very limited) to (very good). Convergent validity of the scale has been confirmed through its relationship with similar scales such as The Multicultural Counseling Awareness Scale (MCAS; [Ponterotto, Sanchez, & Magids, 1991](#)). This scale has also shown adequate reliability in other samples of graduate counseling students, with scale alphas ranging from 0.80-0.87 ([Cartwright, Daniels, & Zhang, 2008](#)). For the present study, alphas for the three subscales are 0.65 (awareness), 0.84 (knowledge), 0.85 (skills), and 0.86 for the total scale.

Procedure

Approval to conduct this research was obtained through both participating Universities’ Institutional Review Boards (IRB). The researchers recruited CITs through counseling training courses, where participants were asked to complete the assessments using paper and pencil. Packets were numbered in order to account for which university they were collected, but no identifying information or names were collected throughout the process so that participants could not be identified. In accordance with IRB requirements, we presented participants with an informed consent prior to engaging in the research. Participants were then asked to read one of the four case vignettes, and then asked to complete the series of instruments and a demographic questionnaire. Included in the demographic questionnaire were items on gender, sexual orientation, counseling program type, year in school, relationship status, income level, religion, race, and age. Participants were directed to complete the questionnaires in relation to the client presented in the case vignette (e.g., reporting self-efficacy in working with that particular client). Research packets were administered by teaching assistants, rather than instructors of record, so that instructors could exit the classroom and students would not feel coerced to participate.

Results

Prior to data analysis, data were checked for missing data, outliers, and normality. Less than 3% of the data collected through the surveys were missing, leading the researchers to believe missing data would have no impact on results ([Schafer, 1999](#)). Following a missing data analysis, and Little’s MCAR test, data was also found to be missing completely at random ($p = .135$). With no concern present in relation to missing data, mean substitution was used. We assumed normality based on skewness and kurtosis levels rang-

ing from positive one to negative one ([Tabachnick, 2013](#)). Boxplots allowed the researchers to explore for outliers, and three cases were identified and removed, resulting in the final sample of 165.

Relationships & Predictors

To assess the relationships between self-efficacy, multicultural competence, and empathy (research question 1), we conducted bivariate correlation analyses. Correlations among these variables are presented in Table 1, along with means and standard deviations. Participant self-efficacy when working with the client in the clinical vignette had significant, positive ($p < .05$) relationships with multicultural knowledge ($r = .443$) and multicultural skills ($r = .588$). In addition, self-efficacy showed a positive significant relationship with perspective taking ($r = .281$). Significant relationships also existed between elements of empathy and multicultural competence. For example, empathic concern had a significant relationship with multicultural knowledge ($r = .161$), while perspective taking had significant relationships with both multicultural knowledge ($r = .255$) and multicultural skills ($r = .268$). Most demographic information (i.e., gender, race, sexual orientation, religion, counseling program) did not play a significant role in contributing to participants’ feelings of self-efficacy with their client, and therefore was not controlled for in subsequent analyses. However, students in their second year of their program ($n = 66$) reported significantly greater self-efficacy with the client ($M = 3.84$) than students in their first year ($n = 90$, $M = 3.51$), and students in their third year ($n = 9$) reported significantly greater self-efficacy ($M = 4.17$) than both these groups $F(2, 161) = 16.89$, $p = .00$, partial eta-squared = .173.

When answering our second research question, we explored additional predictors of counselor self-efficacy (through the use of multiple regressions), which for the present study specifically referred to participant self-efficacy in working with the client presented in their clinical vignette. Multicultural awareness, knowledge, and skills, as well as empathic concern, and perspective taking, were all considered as potential predictor variables of counseling self-efficacy. Of these predictor variables, only multicultural skills ($\beta = .588$, $p < .001$) significantly predicted variance in self-efficacy scores. The other potential predictors (i.e., multicultural awareness, ($\beta = -.017$, $p < .80$); multicultural knowledge ($\beta = .159$, $p < .06$); empathic concern ($\beta = -.071$, $p < .33$); and perspective taking ($\beta = .13$, $p < .09$), did not contribute in a significant way. Alone, multicultural skills predicted 34.4% of participant changes in self-efficacy scores when working with the client in their vignette ($F(1, 163) = 85.09$, $p < .001$, $R^2 = .344$).

Considering the previously noted relationship between year in the program and self-efficacy, we further controlled for this demographic variable to ensure the variance reported

Table 1
Relationships Amongst Variables: Correlations, Means, and SD

Variables	1	2	3	4	5	6
1. CSE	–					
2. Awareness	.068	–				
3. Knowled	.443**	.103	–			
4. Skills	.588**	.164*	.622**	–		
5. Concern	.047	-.020	.162**	.109	–	
6. Perspect	.281**	-.047	.251**	.263*	.420**	–
Mean	3.68	26.71	40.36	29.33	22.59	21.30
SD	0.47	3.48	5.25	4.60	3.48	3.82
Range	1-5	10-40	13-52	10-40	0-28	0-28
α	0.87	0.65	0.84	0.85	0.70	0.75

Notes. ** $p < .01$, * $p < .05$. CSE = Counselor self-efficacy, Awareness = MAKSS subscale, awareness, Knowled. = MAKSS subscale knowledge, Skills = MAKSS subscale skills, Concern = empathic concern, Perspect. = perspective taking.

was not being confounded with student year in the program. The variable of year in program was entered into the regression model in the first step, with multicultural skills then added in the second step. The hierarchical multiple regression revealed that the model was significant at step 1 ($F(1,163) = 33.94, p < .001, R^2 = .168$) and step 2 ($F(2,163) = 53.29, p < .001, R^2 = .391$), suggesting that even though year in the program was predictive of nearly 17% of the variance in self-efficacy, multicultural skills accounted for an additional 22% of this variance (see Table 2).

HIV Status, Race, and Self-Efficacy

To understand the influence of client HIV status on CITs self-efficacy (research question 3), the researchers performed a linear multiple regression with the dummy coded client HIV status variable as a predictor of self-efficacy. We used variance inflation factors (VIF) to assess issues of multicollinearity and deemed this not a concern (i.e., $VIF < 10$). Client HIV status served as a significant predictor, accounting for 3.4% of the variance in participant self-efficacy scores ($R^2 = .034, F(1, 164) = 5.79, p = .02$).

Last, we completed a factorial ANOVA to compare the interaction effect between client HIV status and race on CIT self-efficacy when working with this client (research question 4). Although clients reported higher mean CSES scores when presented with clients not living with HIV ($n = 87, M = 3.75, SD = .43$) in comparison to clients living with HIV ($n = 78, M = 3.58, SD = .49$), the main effect for HIV status yielded an F ratio of $F(3, 162) = 2.50, p = .062$. The observed power was .667. The main effect for race yielded an F ratio of $F(1, 163) = .724, p = .40$, indicating that the effect of race was not significant. This interaction effect between HIV status and race was also not significant ($p > .05$). The observed power was .262.

Discussion

The purpose of this study was to determine if client HIV status influenced CIT's self-efficacy when working with clients. We used four separate clinical case vignettes to assess these differences, in addition to instruments measuring counselor self-efficacy, multicultural competence, and empathy. Results from this study help to provide insight into how CITs feel with health-diverse clients, as well as how those training professional counselors can better prepare CITs in working with clients living with HIV. Results from this study suggest that despite the changing face of HIV, CITs still feel less efficacious counseling people living with HIV, regardless of the race of this client. Although a small effect size, these results serve as preliminary findings in an often-neglected research area and aim to serve as pilot work for future research expanding on these topics. Results also indicated significant relationships between multicultural competency factors (knowledge, skills) and self-efficacy, and the predictive influence of multicultural skills on CIT self-efficacy.

Our findings indicated that client HIV status was significantly predictive of CIT self-efficacy, albeit a small contribution explaining 3% of the variance in self-efficacy scores. This finding supports the notion that CITs may continue to feel less confident when working with clients living with HIV. Two potential explanations for this finding may be on-

Table 2
Hierarchical Regression Predicting Self-Efficacy

Variable	B	β	t	p	R ²
Step 1					.168
Year	.329	.416	5.83	< .001	
Step 2					.391
Year	.194	.245	3.77	< .001	
Skills	.051	.504	7.76	< .001	

Notes. Year = year in counseling program; Skills = MAKSS subscale skills

going bias and lack of education related to HIV in general, and counseling people living with HIV specifically (Mehnert et al., 2017). Counselor educators may consider utilizing tools that bring additional exposure to PLWHA into their classrooms (e.g., interviews or videos of the experiences of PLWHA) to increase often-limited exposure, and perhaps therefore increase self-efficacy (Rowan, Kabwira, Mmatli, Rankopo, & Long, 2012). CITs may further have misperceptions about PLWHA, which affects their ability to feel prepared or competent in working with such clients. Similarly, the narratives of PLWHA may not be present in service-provider training programs, or students may not be taking advantage of continued learning around this population, as is needed in order to allow CITs to feel confident in working with such clients (Rose et al., 2015). This finding supports previous research showing CITs often lack training in their graduate programs surrounding PLWHA (J. Campbell et al., 2020; Rose et al., 2015). It also updates research from a different era of HIV (e.g., Fliszar & Clopton, 1995; Hayes & Gelso, 1993) that suggests professional counselors may not be completely comfortable with clients living with HIV. To correct misconceptions and allow CITs to feel more prepared through increased knowledge, counselor education programs should consider partnering with local HIV/AIDS organizations to supplement existing curriculum with additional HIV/AIDS information. Likewise, the mental health needs of PLWHA have a place in multiple counseling courses, including multicultural courses, trauma-based courses, and rehabilitation counseling courses. Last, including clients with HIV in class role plays (e.g., clinical skills courses) will allow students more practice in this area to build additional efficacy. Adding experiential training approaches (e.g., the aforementioned role plays of clients living with HIV or in a theories-based course practicing different theoretical approaches with clients living with HIV) may be of particular importance in training programs considering our findings point to multicultural skills being more predictive of self-efficacy than knowledge or awareness. In other words, knowledge surrounding PLWHA may not be sufficient enough to boost CIT self-efficacy, and skill-based opportunities should be offered.

Knowing which variables had relationships with, and served as predictors for, self-efficacy, leads to better understanding of which areas of counselor training we can enhance to leave CITs feeling better prepared for working with these clients. The positive significant relationships between counselor self-efficacy and multicultural knowledge, and skills, demonstrates the strong link between each of these variables. Therefore, knowing that CIT self-efficacy was lacking when working with clients living with HIV, self-efficacy may increase as multicultural knowledge and skills increase (Matthews et al., 2018). Likewise, if CITs were able to gain additional self-efficacy in working with these clients,

we would hope to see an increase in their overall multicultural competence as well (Barden & Greene, 2014). Most notably, multicultural skills served as a predictor of participant self-efficacy, suggesting this area of multicultural training (e.g., experiential skills activities such as culturally based role plays and practice sessions) may be particularly important in increasing CIT self-efficacy.

Limitations and Future Research

Like all studies, the current pilot study is not without limitations. Although providing initial support for continued bias in helpers-in-training, the study relied on self-report measures, so social desirability may be present. We have considered that the presence of social desirability may have affected the lack of interaction between HIV status and race and student's overall efficacy in working with Black clients (K. E. Larson & Bradshaw, 2017). Future studies exploring topics of CIT self-efficacy, multicultural competence, or empathy, would be wise to rely on client or faculty ratings to more accurately assess these areas, or to include a measure of social desirability. Some of the measures used in this study also had lower alpha levels than desired (i.e., IRI, .70 and .75; multicultural awareness, .65), suggesting more consistent results would come from more reliable instruments. Further, all participants are from the Southeast region of the United States. Future research should be more inclusive and expand to establish a larger, more representative sample. Additionally, exploration of the regional differences regarding this topic might yield interesting results, given the prevalence of HIV in the South, in California, and in major metropolitan areas in the North and Midwest. Last, the clinical vignette used in this study solely explored differences in race and HIV status. Given the existing research on HIV stigma, and its relation to route of transmission (e.g., drug use, sexual behaviors, diagnosed at birth, blood transfusion), as well as research citing additional stressors of holding multiple marginalized identities (e.g., race, gender, sexual orientation), future research should expand the case vignette to include this information. Additionally, stigma related to same-sex relationships might warrant vignette manipulation in terms of the clients' sexual orientation.

Conclusion

The current study is one of the first of its kind to examine the influence of client HIV status and race on CIT self-efficacy in working with that client. In addition, we explored relationships between this self-efficacy, multicultural competence, and empathy. Previous research notes the biases and lack of cultural awareness of helpers-in-training working with clients living with HIV (e.g., Fliszar & Clopton, 1995), but these studies have failed to be updated along with changes in HIV treatment and prognosis. Additionally, these studies have solely focused on practicing professional counselors,

and not on CITs. Results from this investigation provide initial support for previous research and suggest that CITs continue to lack self-efficacy in working with PLWHA despite the changing face of HIV. Furthermore, this level of self-efficacy has relationships with aspects of self-perceptions of multicultural competence and the ability to take others' perspectives. This pilot study aims to be a precursor for future research focusing on pre-service providers' comfort in working with PLWHA and how this comfort potentially interacts with other marginalized client identities.

References

- American Counseling Association. (2014). *Code of ethics*. Author.
- Barden, S. M., & Greene, J. H. (2014). An investigation of multicultural counseling competence and multicultural counseling self-efficacy for counselors-in-training. *International Journal for the Advancement of Counselling, 37*(1), 41–53. doi:10.1007/s10447-014-9224-1
- Batson, C. D. (1997). Self-other merging and the empathy-altruism hypothesis: Reply to neuberg et al. (1997). *Journal of Personality and Social Psychology, 73*(3), 517–522. doi:10.1037/0022-3514.73.3.517
- Benton, T. D., Ng, W. Y. K., Leung, D., Canetti, A., & Karnik, N. (2019). Depression among youth living with HIV/AIDS. *Child and Adolescent Psychiatric Clinics of North America, 28*(3), 447–459. doi:10.1016/j.chc.2019.02.014
- Berger, M. B., Sullivan, K. A., Parnell, H. E., Keller, J., Pollard, A., Cox, M. E., ... Quinlivan, E. B. (2016). Barriers and facilitators to retaining and reengaging HIV clients in care. *Journal of the International Association of Providers of AIDS Care (JIAPAC), 15*(6), 486–493. doi:10.1177/2325957415616491
- Beutler, L., Machado, P., & Neufeldt, S. (1994). Therapist variables. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 229–269). New York: Wiley.
- Brown, C. H., Olivarez, A., & DeKruyf, L. (2017). The impact of the school counselor supervision model on the self-efficacy of school counselor site supervisors. *Professional School Counseling, 21*(1), 1096–2409–21.1. doi:10.5330/1096-2409-21.1.152
- Campbell, J., Pietrantonio, Z., & Miller, A. (2020). Counselors' knowledge about HIV transmission and prevention. *Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education, 1*–9. doi:10.34296/02011019
- Campbell, R. G., & Babrow, A. S. (2004). The role of empathy in responses to persuasive risk communication: Overcoming resistance to HIV prevention messages. *Health Communication, 16*(2), 159–182. doi:10.1207/s15327027hc1602_2
- Cartwright, B. Y., Daniels, J., & Zhang, S. (2008). Assessing multicultural competence: Perceived versus demonstrated performance. *Journal of Counseling & Development, 86*(3), 318–322. doi:10.1002/j.1556-6678.2008.tb00515.x
- Centers for Disease Control and Prevention. (2019). *Hiv surveillance report*. Author. Retrieved from <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2018-vol-30.pdf>
- Cliffordson, C. (2002). The hierarchical structure of empathy: Dimensional organization and relations to social functioning. *Scandinavian Journal of Psychology, 43*(1), 49–59. doi:10.1111/1467-9450.00268
- Coelho, L., Rebeiro, P. F., Castilho, J. L., Caro-Vega, Y., Mejia, F. A., Cesar, C., ... and, P. M. L. (2018). Early retention in care neither mediates nor modifies the effect of sex and sexual mode of HIV acquisition on HIV survival in the americas. *AIDS Patient Care and STDs, 32*(8), 306–313. doi:10.1089/apc.2018.0028
- Colbert, A. M., Kim, K. H., Sereika, S. M., & Erlen, J. A. (2010). An examination of the relationships among gender, health status, social support, and HIV-related stigma. *Journal of the Association of Nurses in AIDS Care, 21*(4), 302–313. doi:10.1016/j.jana.2009.11.004
- Council for Accreditation of Counseling and Related Education Programs. (2016). *2016 CACREP standards*. Author. Retrieved from <https://www.cacrep.org/for-programs/2016-cacrep-standards/>
- Crockett, K. B., Kalichman, S. C., Kalichman, M. O., Cruess, D. G., & Katner, H. P. (2019). Experiences of HIV-related discrimination and consequences for internalised stigma, depression and alcohol use. *Psychology & Health, 34*(7), 796–810. doi:10.1080/08870446.2019.1572143
- Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology, 44*(1), 113–126. doi:10.1037/0022-3514.44.1.113
- Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy, 48*(1), 43–49. doi:10.1037/a0022187
- Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using g*power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods, 41*(4), 1149–1160. doi:10.3758/brm.41.4.1149
- Flickinger, T. E., Saha, S., Roter, D., Korthuis, P., Sharp, V., Cohn, J., ... Beach, M. C. (2016). Clinician empathy is associated with differences in patient-clinician

- communication behaviors and higher medication self-efficacy in HIV care. *Patient Education and Counseling*, 99(2), 220–226. doi:10.1016/j.pec.2015.09.001
- Fliszar, G. M., & Clopton, J. R. (1995). Attitudes of psychologists in training toward persons with AIDS. *Professional Psychology: Research and Practice*, 26(3), 274–277. doi:10.1037/0735-7028.26.3.274
- Friedlander, M. L., & Snyder, J. (1983). Trainees' expectations for the supervisory process: Testing a developmental model. *Counselor Education and Supervision*, 22(4), 342–348. doi:10.1002/j.1556-6978.1983.tb01771.x
- Gaston, G. B. (2013). African-americans' perceptions of health care provider cultural competence that promote HIV medical self-care and antiretroviral medication adherence. *AIDS Care*, 25(9), 1159–1165. doi:10.1080/09540121.2012.752783
- Goreczny, A. J., Hamilton, D., Lubinski, L., & Pasquinelli, M. (2015). Exploration of counselor self-efficacy across academic training. *The Clinical Supervisor*, 34(1), 78–97. doi:10.1080/07325223.2015.1012916
- Hawk, S. T., Keijsers, L., Branje, S. J. T., der Graaff, J. V., de Wied, M., & Meeus, W. (2012). Examining the interpersonal reactivity index (IRI) among early and late adolescents and their mothers. *Journal of Personality Assessment*, 95(1), 96–106. doi:10.1080/00223891.2012.696080
- Hayes, J. A., & Erkis, A. J. (2000). Therapist homophobia, client sexual orientation, and source of client HIV infection as predictors of therapist reactions to clients with HIV. *Journal of Counseling Psychology*, 47(1), 71–78. doi:10.1037/0022-0167.47.1.71
- Hayes, J. A., & Gelso, C. J. (1993). Male counselors' discomfort with gay and HIV-infected clients. *Journal of Counseling Psychology*, 40(1), 86–93. doi:10.1037/0022-0167.40.1.86
- Herek, G. (2014). Hiv-related stigma. In P. Corrigan (Ed.), *The stigma of disease and disability: Understanding causes and overcoming injustices* (p. 121-138). Washington, DC: American Psychological Association.
- Joe, J. R. (2018). Counseling to end an epidemic: Revisiting the ethics of HIV/AIDS. *Journal of Counseling & Development*, 96(2), 197–205. doi:10.1002/jcad.12192
- Joe, J. R., & Foster, V. A. (2017). Moral development, HIV/AIDS knowledge, and attitude toward HIV/AIDS among counseling students in the united states. *International Journal for the Advancement of Counselling*, 39(3), 295–310. doi:10.1007/s10447-017-9299-6
- Jowers, C. E., Cain, L. A., Hoffman, Z. T., Perkey, H., Stein, M. B., Widner, S. C., & Slavin-Mulford, J. (2019). The relationship between trainee therapist traits with the use of self-disclosure and immediacy in psychotherapy. *Psychotherapy*, 56(2), 157–169. doi:10.1037/pst0000225
- Kim, B. S., Cartwright, B. Y., Asay, P. A., & D'Andrea, M. J. (2003). A revision of the multicultural awareness, knowledge, and skills survey-counselor edition. *Measurement and Evaluation in Counseling and Development*, 36(3), 161–180. doi:10.1080/07481756.2003.11909740
- Kozina, K., Grabovari, N., Stefano, J. D., & Drapeau, M. (2010). Measuring changes in counselor self-efficacy: Further validation and implications for training and supervision. *The Clinical Supervisor*, 29(2), 117–127. doi:10.1080/07325223.2010.517483
- Larson, K. E., & Bradshaw, C. P. (2017). Cultural competence and social desirability among practitioners: A systematic review of the literature. *Children and Youth Services Review*, 76, 100–111. doi:10.1016/j.childyouth.2017.02.034
- Larson, L. M., & Daniels, J. A. (1998). Review of the counseling self-efficacy literature. *The Counseling Psychologist*, 26(2), 179–218. doi:10.1177/0011000098262001
- Lent, R. W., Hill, C. E., & Hoffman, M. A. (2003). Development and validation of the counselor activity self-efficacy scales. *Journal of Counseling Psychology*, 50(1), 97–108. doi:10.1037/0022-0167.50.1.97
- Logie, C. H., Wang, Y., Lacombe-Duncan, A., Wagner, A. C., Kaida, A., Conway, T., . . . Loutfy, M. R. (2018). HIV-related stigma, racial discrimination, and gender discrimination: Pathways to physical and mental health-related quality of life among a national cohort of women living with HIV. *Preventive Medicine*, 107, 36–44. doi:10.1016/j.ypmed.2017.12.018
- Lopez-Baez, S. I., & Paylo, M. J. (2009). Social justice advocacy: Community collaboration and systems advocacy. *Journal of Counseling & Development*, 87(3), 276–283. doi:10.1002/j.1556-6678.2009.tb00107.x
- Lu, H.-F., Hsiao, F.-H., Sheng, W.-H., Liao, S.-C., Wu, P.-Y., Yang, Y.-L., & Chang, N.-T. (2018). Prevalence and predictors of depression among people living with HIV/AIDS. *Nursing Research*, 67(5), 379–386. doi:10.1097/nnr.0000000000000288
- Matthews, J. J., Barden, S. M., & Sherrell, R. S. (2018). Examining the relationships between multicultural counseling competence, multicultural self-efficacy, and ethnic identity development of practicing counselors. *Journal of Mental Health Counseling*, 40(2), 129–141. doi:10.17744/mehc.40.2.03
- McConnell, E. A., Janulis, P., Phillips, G., Truong, R., & Birkett, M. (2018). Multiple minority stress and LGBT community resilience among sexual minority men. *Psychology of Sexual Orientation and Gender Diversity*, 5(1), 1–12. doi:10.1037/sgd0000265
- Mehnert, L., Siem, B., Stürmer, S., & Rohmann, A.

- (2017). The impact of client-counselor similarity on acceptance of counseling services for women living with HIV. *AIDS Care*, 30(4), 461–465. doi:10.1080/09540121.2017.1381329
- Melchert, T. P., Hays, V. L., Wiljanen, L. M., & Kolocek, A. K. (1996). Testing models of counselor development with a measure of counseling self-efficacy. *Journal of Counseling & Development*, 74(6), 640–644. doi:10.1002/j.1556-6676.1996.tb02304.x
- Mullen, P. R., & Lambie, G. W. (2016). The contribution of school counselors' self-efficacy to their programmatic service delivery. *Psychology in the Schools*, 53(3), 306–320. doi:10.1002/pits.21899
- National Institute on Drug Abuse. (2012). *Nida research report: Drug abuse and HIV*. Author. Retrieved from <https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/rrhiv.pdf>
- Ng'ang'a, P. W., Mathai, M., Obondo, A., Mutavi, T., & Kumar, M. (2018). Undetected psychiatric morbidity among HIV/AIDS patients attending comprehensive care clinic (CCC) in Nairobi Kenya: towards an integrated mental health care. *Annals of General Psychiatry*, 17(1). doi:10.1186/s12991-018-0179-1
- Olapegba, P. O. (2010). Empathy, knowledge, and personal distress as correlates of HIV-/AIDS-related stigmatization and discrimination. *Journal of Applied Social Psychology*, 40(4), 956–969. doi:10.1111/j.1559-1816.2010.00606.x
- Pence, B. W. (2009). The impact of mental health and traumatic life experiences on antiretroviral treatment outcomes for people living with HIV/AIDS. *Journal of Antimicrobial Chemotherapy*, 63(4), 636–640. doi:10.1093/jac/dkp006
- Ponterotto, J., Sanchez, C., & Magids, D. (1991). Initial development and validation of the multicultural counseling awareness scale (MCAS)..
- Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, 44(1), 28–48. doi:10.1002/jmcd.12035
- Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisholm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology*, 3(3), 157–168. doi:10.1037/a0015673
- Reidpath, D. D., & Chan, K. Y. (2005). A method for the quantitative analysis of the layering of HIV-related stigma. *AIDS Care*, 17(4), 425–432. doi:10.1080/09540120412331319769
- Rinehart, R., Rao, D., Amico, R. K., Ruiz, E., Brandes, P., Correa, C., ... Molina, Y. (2018). Experienced HIV-related stigma and psychological distress in Peruvian sexual and gender minorities: A longitudinal study to explore mediating roles of internalized HIV-related stigma and coping styles. *AIDS and Behavior*, 23(3), 661–674. doi:10.1007/s10461-018-2348-2
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21(2), 95–103. doi:10.1037/h0045357
- Rose, J. S., Sullivan, L. T., Hairston, T., Laux, J. M., & Pawelczak, M. (2015). HIV/AIDS knowledge among professional counselors and counseling students in Ohio. *Journal of LGBT Issues in Counseling*, 9(1), 2–16. doi:10.1080/15538605.2014.997333
- Rowan, D., Kabwira, D., Mmatli, T., Rankopo, M., & Long, D. D. (2012). Using video as pedagogy for globally connected learning about the HIV/AIDS pandemic. *Journal of Social Work Education*, 48(4), 691–706. doi:10.5175/jswe.2012.201100113
- Rozas, L. W., & Smith, E. (2009). Being on this boat: The provision of culturally competent mental health services to people living with HIV/AIDS. *Journal of HIV/AIDS & Social Services*, 8(2), 166–187. doi:10.1080/15381500903077911
- Safran, M. A., Hoover, K. W., Tao, G., & Butler, M. O. (2013). Sexual behaviour and desire to discuss mental health as reported by HIV-infected men who have sex with men. *International Journal of STD & AIDS*, 24(2), 93–99. doi:10.1177/0956462412472307
- Salters, K. A., Irick, M., Anema, A., Zhang, W., Parashar, S., Patterson, T. L., ... Hogg, R. S. (2016). Harder-to-reach people living with HIV experiencing high prevalence of all-type mental health disorder diagnosis. *AIDS Care*, 29(6), 696–704. doi:10.1080/09540121.2016.1227763
- Schafer, J. L. (1999). Multiple imputation: a primer. *Statistical Methods in Medical Research*, 8(1), 3–15. doi:10.1177/096228029900800102
- Sue, D. W., Bernier, J. E., Durrant, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist*, 10(2), 45–52. doi:10.1177/0011000082102008
- Suh, S., Crawford, C. V., Hansing, K. K., Fox, S., Cho, M., Chang, E., ... Lee, S. M. (2018). A cross-cultural study of the self-confidence of counselors-in-training. *International Journal for the Advancement of Counselling*, 40(3), 255–266. doi:10.1007/s10447-018-9324-4
- Tabachnick, B. (2013). *Using multivariate statistics*. Boston: Pearson Education.

- Ventura, E. (2017). *Casebook for DSM-5®: Diagnosis and treatment planning*. New York: Springer Publishing Company.
- Vossen, H. G., Piotrowski, J. T., & Valkenburg, P. M. (2015). Development of the adolescent measure of empathy and sympathy (AMES). *Personality and Individual Differences, 74*, 66–71. doi:[10.1016/j.paid.2014.09.040](https://doi.org/10.1016/j.paid.2014.09.040)
- Werth, J. L., Carney, J. S., & Morris, E. (1996). Supervision of counselors-in-training working with clients with HIV. *Counselor Education and Supervision, 36*(1), 37–47. doi:[10.1002/j.1556-6978.1996.tb00234.x](https://doi.org/10.1002/j.1556-6978.1996.tb00234.x)