

Male Counselors' Discomfort With Gay and HIV-Infected Clients

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This study examined male counselors' reactions to gay and human immunodeficiency virus (HIV)-infected clients in light of counselors' homophobia and death anxiety. After completing measures of homophobia and death anxiety, 34 male counselors viewed a videotaped, male client-actor in 1 of 4 conditions: either gay or heterosexual and either HIV negative or HIV positive. The dependent variable, counselor discomfort, was assessed through (a) the ratio of avoidance to approach verbal responses to the taped client, (b) self-reported state anxiety, and (c) recall of certain words used by the client. As hypothesized, counselors experienced greater discomfort with HIV-infected than HIV-negative clients, and counselors' homophobia predicted their discomfort with gay male clients. However, client sexual orientation did not affect counselor discomfort, and death anxiety was unrelated to discomfort with HIV-infected clients. Implications regarding countertransference and counseling were discussed.

More than 152,000 people have died in the United States as a result of acquired immunodeficiency syndrome (AIDS; Centers for Disease Control [CDC], 1992). Authorities have estimated that that number will nearly double in the next several years (Kaslow & Francis, 1989), and an additional 1.0 to 1.5 million U.S. citizens are thought to be infected with the human immunodeficiency virus (HIV), which causes AIDS (CDC, 1990; National Research Council, 1989). Given these grim statistics, counseling psychologists can expect to face increasing numbers of clients with HIV infection during the next decade. According to current projections (CDC, 1992), a large percentage of these clients will be gay men, and many will be confronted by their own, imminent death. To date, no empirical data concerning counselors' reactions to or effectiveness with HIV-infected clients have been published, although one survey suggested that clinical and counseling psychologists are not sufficiently trained to work with clients who are HIV positive (Campos, Brasfield, & Kelly, 1989). As a result of the lack of research on counseling HIV-infected clients, counselors who hope to improve their work in this area are left to draw on the separate literatures on counseling gay¹ clients and on counseling dying clients.

Although the concept of homosexuality as a mental disorder is now largely antiquated, counselors still experience considerable uneasiness working with gay male and lesbian clients (Garfinkle & Morin, 1978; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). Studies have sug-

gested that counselors' discomfort may arise from their lack of familiarity with gay men and lesbians (De Crescenzo, 1984; Gochros, 1984; Millham, San Miguel, & Kellogg, 1976), from counselors' conflictedness about their own sexuality (De Crescenzo, 1984; Messing, Schoenberg, & Stephens, 1984), or from counselors' homophobic attitudes (Casas, Brady, & Ponterotto, 1983; Garnets et al., 1991; Thompson & Fishburn, 1977). The relationship between counselors' homophobia and their discomfort with gay male and lesbian clients, however, has never been examined directly. *Homophobia* was originally defined by Weinberg (1972) as "the dread of being in close quarters with homosexuals" (p. 4), although the term has been used more broadly to refer to "any belief system which supports negative myths and stereotypes about homosexual people" (Morin & Garfinkle, 1978, p. 30) and "any of the varieties of negative attitudes which arise from fear or dislike of homosexuality" (Martin, 1982, p. 341).

Counselors' homophobia may manifest itself within the therapeutic relationship in various ways. Clinical writings have suggested that homophobia may be exhibited blatantly, as in the form of jokes or outright slurs (De Crescenzo, 1984), or subtly, through counselors' inquiries, silences, or interpretations (Martin, 1982) or through their tones or semantics (Moses & Hawkins, 1982). Homophobic counselors may discourage gay male and lesbian clients from revealing their sexual identities to others (De Crescenzo, 1984), question their clients' ability to function heterosexually (Martin, 1982), view gay male or lesbian identity as a transitory phase to be outgrown (Garnets et al., 1991), exaggerate or minimize the importance of one's sexual orientation (Messing et al., 1984), preoccupy themselves with the origins of a client's sexual orientation (Gartrell, 1984), or interpret nontraditional sex role behavior as indicative of pathology (Garfinkle & Morin, 1978). As De Crescenzo (1984) concluded, homophobia contributes to "behavior which is counter-therapeutic, counter-productive, or renders the worker less able to be effective with homosexual cli-

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¹ Throughout the text, unless otherwise specified, "gay" refers exclusively to gay men.

ents" (p. 120). Thus, the therapeutically damaging effects of homophobia may be conceptualized as countertransference reactions in that the behaviors stem from some conflictual area within the counselor (Gelso & Carter, 1985) and contribute to unsuccessful counseling outcomes (Singer & Luborsky, 1977).

Along a similar vein, counselors' death anxiety has been implicated as a serious impediment to effective counseling with clients who are terminally ill. *Death anxiety* is a broad concept that may refer more specifically to any or all of the following: fear of suffering while dying, fear of punishment in an afterlife, or fear of annihilation (McKittrick, 1985). Scholars have posited that counselors' death anxiety often is stimulated when working with dying clients because clinical thanatology necessarily involves the client and counselor in a common though not usually contemporaneous problem, namely, death (Feigenberg & Shneidman, 1985). Whereas counselors may utilize their death anxiety constructively to maintain a healthy distance from and not overidentify with dying clients (McKittrick, 1985), if a counselor's death anxiety goes unchecked, the results can be damaging. The counselor may foster a client's denial of dying and death, regress to shared feelings of helplessness with the client (McKittrick, 1985), terminate counseling prematurely (Renneker, 1957), or engage in a type of magical thinking wherein death is viewed as reversible, counseling is seen as omnipotent, and longer, more frequent sessions are combined with pep talks in the belief that the client will be spared death (Charmaz, 1980; McKittrick, 1985). These clinical musings are heretofore untested and thus invite empirical investigation of the relationship between counselors' death anxiety and their discomfort with terminally ill clients.

Because the majority of people known to be infected with HIV are gay men and are likely to be confronting their own mortality (CDC, 1992), one might expect that counselors working with such individuals will experience discomfort commensurate with the counselors' own homophobia and death anxiety. In addition, because of the host of issues raised by homosexuality and death, counselors in general might be expected to experience greater discomfort with gay male and lesbian clients than with heterosexual clients, as well as more discomfort with terminally ill (e.g., HIV-infected) clients than with healthy (e.g., HIV-negative) clients. Thus, we hypothesized that (a) counselors' homophobia will predict their discomfort with gay clients better than their discomfort with heterosexual clients; (b) counselors' death anxiety will predict their discomfort with HIV-infected clients better than their discomfort with HIV-negative clients; (c) counselors' discomfort will be greater with gay clients than with heterosexual clients; and (d) counselors' discomfort will be greater with HIV-infected clients than with HIV-negative clients.

We chose to examine only male counselors in this initial study for several reasons. First, research has implicated gender as a moderating factor in countertransference reactions (Hayes & Gelso, 1991), so we wanted to isolate and study a single gender. We chose male counselors primarily because we thought that they would be more likely than female counselors to identify, and thus experience counter-

transference reactions, with the male clients we chose to use in our study. In addition, researchers have demonstrated consistently that men possess higher levels of homophobia than women (Hansen, 1982; Kite, 1984; Larsen, Reed, & Hoffman, 1980; Lumby, 1976; Millham et al., 1976; Thompson & Fishburn, 1977), and given our expectations that some of the male counselors would possess low levels of homophobia, we believed that we would find a wider range of homophobia scores with male counselors than with female counselors.

Method

Participants and Selection Procedures

Participants were 34 men who were either licensed, counseling center psychologists ($n = 4$) or doctoral students ($n = 30$) in clinical and counseling psychology from two large, public universities in the East ($n = 16$) and the Midwest ($n = 18$). Potential participants from each site were contacted by mail and asked to volunteer for a study examining male counselors' reactions to various clients. Participants were informed that the study would take approximately one half hour and that by returning a self-addressed, postage-paid card to the experimenter, they would be entered in a lottery for a \$100 savings bond. Of the 40 potential participants contacted, 34 (85%) volunteered for the study.

The 34 counselors (5 of racial/ethnic minorities, 29 White) ranged in age from 23 to 50 years ($M = 31.8$, $SD = 6.9$). Counselors' clinical experience from the onset of their training, including but not limited to practicums, externships, and other work commensurate with their level of training, ranged from 1 to 14 years ($M = 4.6$, $SD = 3.1$). It should be noted that counselors' experience was not found to correlate significantly with any predictor or dependent variable under any of the experimental conditions.

Procedure

Each counselor participant completed a brief demographic questionnaire along with a 31-item scale composed of the 15 items from Templer's (1970) Death Anxiety Scale and 16 items from Daly's (1990) Homophobia Scale. Upon completing these inventories, each counselor was asked to assume the set of an ongoing (i.e., six previous sessions) therapy relationship between himself and the videotaped client. Each counselor then watched and listened to one of eight randomly assigned videotapes (two actors, four conditions), responding verbally to the client into the microphone of a continuously operating tape recorder during pauses in the client's speech. These pauses were controlled by an experimenter who manually stopped the videotape at five predesignated points in the client's speech. At the conclusion of the videotape, counselors completed a state anxiety measure, followed by a cognitive recall index.

Instruments

Counselor homophobia was assessed with a 16-item Homophobia Scale developed by Daly (1990). Daly's operational definition of homophobia was that of prejudicial attitudes toward and negative stereotypes about gay men, similar to Morin and Garfinkle's (1978) definition. Daly's instrument requires respondents to rate scale items along a 5-point continuum ranging from *strongly agree* (1) to *strongly disagree* (5). For the present study, items were

scored such that higher scores reflect greater homophobia. In developing the scale with a sample of 441 college students, Daly (1990) found an average item-total correlation for the 16 items of .76, an internal consistency (α) of .93, and a test-retest reliability over a 4-week interval of .93. Also, consistent with prior research (Hansen, 1982; Kite, 1984; Larsen et al., 1980; Lumby, 1976; Millham et al., 1976), men scored higher than women. Thus, Daly's instrument was chosen on the strength of its reliability and validity data in relation to other indices of homophobia.

Templer's (1970) Death Anxiety Scale (DAS) was used to assess counselors' death anxiety. The DAS contains 15 items designed to be rated either "true" or "false" by respondents. In response to a suggestion by Kurlycheck (1978), a 5-point scale ranging from *strongly disagree* (1) to *strongly agree* (5) was used instead of the true-false format to increase the scale's sensitivity to subtle individual differences. (Changing the response format of the DAS did not violate assumptions of homogeneity of variance, as evidenced by a nonsignificant Cochran's test, $C = 0.54, p > .05$). The DAS has shown a 3-week test-retest reliability of .83 (Templer, 1970), and Kuder-Richardson coefficients ranging from .65 to .76 have been reported (McMordie, 1979; Templer, 1970; Warren & Chopra, 1978). Support for the scale's construct validity has been established through a series of studies involving college students, psychiatric nurses (Templer, 1970), retirees, psychiatric aides (Templer & Ruff, 1971), cigarette smokers (Templer, 1971), husbands and wives, and gay men (Templer, Veleber, Lovito, Testa, & Knippers, 1983). Data also provide evidence for the scale's concurrent validity (Vargo, 1980) and discriminant validity (Templer, 1970).

Manipulation of the Independent Variable

Client sexual orientation and HIV status were manipulated through the use of client actors on videotape. Each of two experienced, White male actors in their 20s role played a client in scenarios corresponding to the four client conditions of interest (either HIV infected or HIV negative and either gay or heterosexual). The design of the study involved two actors to allow detection of a possible actor effect. In the four client-actor conditions, similar scripts were followed in which the client-actors discussed their AIDS antibody tests, sexual activities that led to the tests, emotional reactions to the tests, and subsequent relationship issues. Efforts were made to hold constant across conditions factors other than client sexual orientation, HIV status, and germane semantics (e.g., reference to either a male or female partner) and emotional content. The emotional content of the scripts was manipulated in accordance with realistic differences between gay clients' potential therapy material (e.g., fear of parents finding out about client's sexual orientation through romantic relationship with same-sex roommate) and heterosexual clients' parallel situations (e.g., fear of parents finding out about client living with female partner). The emotional content of the scripts was guided by literature on common psychological reactions to testing HIV positive (Campos et al., 1989; Grant & Anns, 1988; McKusick, 1988; Morin, Charles, & Malyon, 1984).

A more specific description of the content of each script may be helpful at this point. For both HIV-negative clients (gay and heterosexual), the particular relationship issues discussed included being in love, fear of rejection, living with one's partner, parental disapproval, and uncertainty about the future. The two HIV-positive clients discussed relationship issues, such as fear of infecting one's partner, changes in sexual practices, guilt over dying early, and fear of isolation. The two HIV-positive scripts, one for the gay client and one for the heterosexual client, were virtually identical

except for the names of the clients' partners. The same was true of the scripts for the two HIV-negative clients, with the additional exception that the gay client talked about coming out to his parents, whereas the heterosexual client discussed his parents' probable reaction to his moving in with his partner.

The content of each script was judged by three counselors, each with more than 2 years of experience working with gay male clients and AIDS-related concerns. Along a 5-point continuum of plausibility, the four scripts had an average rating of 4.67. In addition, a comparison of the two client-actors revealed no significant differences on any of the dependent measures.

Dependent Variable

Counselor discomfort, the dependent variable, was assessed with three separate procedures. Each was designed to measure an affective, a cognitive, or a behavioral aspect of counselor discomfort. A multivariate approach to discomfort was chosen because previous studies on counselors' countertransference or other reactions (cf. Yulis & Kiesler, 1968) have tended to examine only one aspect of a counselor's reaction to a client. In the present study, we attempted to capture "more slices of the countertransference pie" with three dependent measures.

The affective component, counselor state anxiety, has been found to relate negatively to perceptions of counseling performance (Bandura, 1956), ratings of counselor empathy (Bergin & Jasper, 1969), and outcome ratings (Kelly, Hall, & Miller, 1989). We measured counselor anxiety using the State Anxiety scale of the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970). The scale consists of 20 items rated on a scale ranging from *not at all* (1) to *very much so* (4). Participants were instructed to respond to the items in accordance with how they felt while viewing the client videotape. The inventory has shown internal consistency ranging from .83 to .96 (Dreger, 1978) and predictably low (since state anxiety is situational) test-retest reliabilities: between .16 and .33 for 1 hr, between .27 and .54 over 20 days, and between .31 and .33 over 104 days (Dreger, 1978). Furthermore, the State Anxiety scale "is a sensitive indicator for the transitory anxiety that is experienced . . . in counseling" (Spielberger, 1976, p. 9) and has been used successfully in previous related research (Hayes & Gelso, 1991).

The cognitive component of counselor discomfort was defined as inaccuracy in recalling client material. Although little empirical research has been conducted on memory processes in counseling, at least one study (Gardner, White, Packard, & Wampold, 1988) found that ratings of counselors were more favorable when counselor recall was highly accurate than when recall was less accurate. Furthermore, most theorists would agree that "the counseling process itself is heavily dependent upon the memory functions of both the client and the counselor" (Kraft, Glover, Dixon, Claiborn, & Ronning, 1985, p. 122). The present study used an accuracy of recall method stemming primarily from Cutler's (1958) work. Cutler found that when clients discussed material that was related to areas of conflict within counselors, the counselors tended to overestimate or underestimate the frequency with which the client discussed such material. Therefore, to the extent that death and homosexuality are conflict relevant for counselors, one can expect that they will recall the frequency with which clients mentioned these topics with a high degree of inaccuracy. Thus, an index of cognitive distortion was calculated with percentages in which the numerator was the absolute difference between the actual and estimated number of times words related to death (e.g., "die") and sexuality (e.g., "gay") were mentioned by the client, and the denominator was the number of times the words were actually men-

tioned by the client. The number of times the words were mentioned by each client was derived directly from the stimulus tapes by the first author; this procedure was straightforward and factual to the point that interjudge agreement data were thought to be unnecessary. Furthermore, it should be noted that counselors in all four client conditions were asked to estimate the frequency of the same set of words, although the clients used the words with varying frequencies across the conditions. That is, each of the two HIV-negative clients (gay and heterosexual) mentioned words related to death 6 times and words related to sexuality 14 times. Each of the two HIV-positive clients mentioned words related to death 18 times and words related to sexuality 9 times.

The behavioral component of counselor discomfort was measured by analyzing counselors' verbal responses to the videotaped clients. The analysis is based on the research of Bandura, Lipsher, and Miller (1960), who categorized counselors' responses in terms of approach and avoidance. Those counselors' responses judged to "elicit from the patient further expressions of . . . feelings, attitudes, and behavior" (Bandura et al., 1960, p. 2) were classified as approach responses. By contrast, those responses judged to inhibit, discourage, or divert the client from further exploration or expression of a theme were classified as avoidance responses. Approach responses have been found to relate positively and avoidance responses negatively to counseling outcome with hostile (Varble, 1968), dependent (Caracena, 1965; Schuldt, 1966), and mentally retarded clients (Campbell & Browning, 1975).

For each counselor, a cumulative ratio of the number of avoidance responses to the number of approach and avoidance responses was calculated. Ratings were conducted by three 2nd-year doctoral students in counseling psychology who were not aware of the study's hypotheses. The pairwise correlations among the three raters for the cumulative ratio of avoidance responses to approach and avoidance responses were .60, .66, and .79 ($p < .01$ for each). In addition, measures of interrater agreement were calculated to reflect agreement as to whether a counselor response was an approach response, an avoidance response, or neither. The proportions of ratings on which pairs of judges agreed were .67, .69, and .73. Furthermore, J. A. Cohen's (1960) K coefficients, which indicate "the proportion of agreements between two raters after chance agreement has been removed from consideration" (Tinsley & Weiss, 1975, p. 370), were .42, .48, and .48, each significantly different from 0 at the .05 level and considered satisfactory, given the stringent nature of the statistic.

Results

To test the hypotheses that client HIV status and sexual orientation would affect counselor discomfort, a 2×2

multivariate analysis of variance (MANOVA) was conducted with affective, cognitive, and behavioral counselor discomfort measures as the dependent variables. Results of the MANOVA revealed that counselors experienced more discomfort with HIV-positive clients than with HIV-negative clients, Wilks's lambda $F(3, 28) = 7.15, p < .01$. Post hoc univariate F tests indicated that of the three dependent measures (state anxiety, approach-avoidance, and cognitive recall), only state anxiety contributed significantly to the MANOVA effect, $F(1, 30) = 13.67, p < .01$. The behavioral and cognitive measures of counselor discomfort did not contribute significantly to the MANOVA, $F(1, 30) = 0.20, p = .66$, and $F(1, 30) = 1.59, p = .22$, respectively.

Results of the MANOVA further indicated that counselors' discomfort with gay clients was not significantly different from their discomfort with heterosexual clients, Wilks's lambda $F(3, 28) = 0.67, p = .58$. The lack of a main effect for client sexual orientation demonstrated that no significant differences existed between the gay and heterosexual client conditions on any of the dependent variables; thus, no follow-up tests were conducted. In addition, the interaction between client HIV status and sexual orientation was not significant, Wilks's lambda $F(3, 28) = 0.21, p = .89$. Table 1 presents a summary of relevant means and standard deviations. The means for state anxiety are scores on the STAI State Anxiety scale (possible range = 0-80; actual range = 26-59); for cognitive recall, the means represent the proportion of error in estimating the frequencies of certain words used by clients (possible range = 0-∞; actual range = 5-35); the means for approach-avoidance reflect the percentage of avoidance to approach and avoidance verbal responses (possible range = 0%-100%; actual range = 0%-80%).

As hypothesized, counselors' homophobia predicted their discomfort with gay clients better than their discomfort with heterosexual clients. A comparison of the Pearson product-moment correlation coefficients between homophobia and each dependent variable revealed that the correlation between counselors' homophobia and behavioral response (i.e., approach-avoidance) scores was greater for the gay ($r = .78$) than the heterosexual ($r = -.23$) client condition, $z = 3.38, p < .01$. The correlations between homophobia and each of the other two dependent variables did not differ significantly across the gay and heterosexual client

Table 1
Means and Standard Deviations for Main Effects of Client Human Immunodeficiency Virus (HIV) Status and Sexual Orientation on Measures of Counselor Discomfort

Dependent measures	HIV status				Sexual orientation			
	HIV neg		HIV pos		Heterosexual		Gay	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
STAI State Anxiety	37.8 ^a	8.4	48.1 ^a	7.4	40.7	9.3	45.1	9.2
Cognitive recall	68.3	36.0	56.0	16.4	61.7	34.9	62.6	20.6
Approach-avoidance	30.2	25.4	27.2	15.0	26.4	17.3	31.0	23.5

Note. The state anxiety measure is from the State Anxiety subscale of the State-Trait Anxiety Inventory (STAI). Neg = negative; pos = positive.

^a These means are significantly different from each other at $p < .01$.

Table 2
Bivariate Correlations Among Predictor and Criterion Variables Within Client Conditions

Predictor variable	Criterion variable: Counselor measure		
	State anxiety (r)	Cognitive recall (r)	Approach-avoidance (r)
Homophobia			
Heterosexual client	-.08	.08	-.23
Gay client	.27	-.18	.78*
Death anxiety			
HIV-negative client	-.07	.19	.07
HIV-positive client	.35	-.01	.15

Note. HIV = Human immunodeficiency virus.

* $p < .01$.

conditions. (See Table 2 for a summary of correlation coefficients.)

Last, no support was found for the hypothesis that counselors' death anxiety would predict their discomfort with HIV-infected clients better than their discomfort with HIV-negative clients. None of the Pearson correlation coefficients between death anxiety and the dependent variables differed significantly across the HIV-negative and HIV-positive client conditions. The Pearson correlations between dependent variables for all client conditions were as follows: State Anxiety scale with approach-avoidance, $r = .19$; State Anxiety scale with cognitive recall, $r = .02$; approach-avoidance with cognitive recall, $r = -.28$.

Discussion

Contrary to our hypotheses, the results indicated that clients' sexual orientation did not affect counselor discomfort. Consistent with the hypotheses, however, clients' HIV status did appear to influence discomfort. That is, clients who were HIV positive evoked more discomfort in counselors than did HIV-negative clients. In particular, counselors felt more anxious with HIV-infected clients than with HIV-negative clients. Thus, on an affective level, counselors experienced more discomfort with HIV-infected clients than with HIV-negative clients.

What can be concluded from the absence of a main effect for client sexual orientation on counselor discomfort? At least in terms of counselors' reactions to clients, this finding runs counter to the literature suggesting that male counselors are inadequately prepared to work with gay clients (Buhrke & Douce, 1991; Graham, Rawlings, Halpern, & Hermes, 1984; Thompson & Fishburn, 1977). At the same time, it should be noted that cultural diversity is emphasized strongly in the training programs at both universities from which counselors were drawn. Thus, the findings may be most generalizable to counselors who receive training that emphasizes work with culturally diverse populations.

In seeking to explain the negative results of sexual orientation on counselor discomfort, a clue may be gained from our findings regarding the homophobia variable. The mean score on the homophobia scale for our subjects was 22.9 ($SD = 9.2$), whereas the mean for 218 men in the

normative sample was 52.6 ($SD = 17.4$). Thus, our sample was 1.7 SD below the mean for men in the norm group. This low level of homophobia, coupled with the finding that homophobia was highly predictive of counselor discomfort, at least at a behavioral level (verbal approach-avoidance), suggests that the counselor participants in general were able to interact comfortably with a gay subject-client as a result of these counselors' low levels of homophobia. Future research could profitably address the question of how to affect homophobia when it is present.

The question of how to influence homophobia is particularly salient given the fact that, as noted above, this variable was highly correlated with our behavioral index of discomfort for gay clients. Thus, it appears clear that homophobic reactions, when present, are highly problematic in counselors when interacting with gay clients. Just how high homophobia needs to be in order to interfere with counseling cannot be answered from the present data. Our clinically based impressions are that even moderate levels of homophobia will be disruptive, but this is clearly a question requiring additional research.

Although support was found for the hypothesis that counselors would be more uncomfortable with HIV-positive than with HIV-negative clients, contrary to expectations, counselors' death anxiety was not predictive of their discomfort. One possible explanation is that counselors' death anxieties may not have been provoked sufficiently by the HIV-infected clients in this study. Even though each HIV-infected client mentioned the word *death* six times, the clients' deaths were not portrayed as imminent. The clients had just discovered their HIV status and showed no physical manifestations of HIV infection. It is possible that counselors' death anxiety would become a factor in their level of discomfort when working with clients who actually have AIDS and are closer to dying.

The results of this study point to several implications for counseling and counselor training. First, given that counselors experienced discomfort with HIV-infected clients on an affective level beyond that experienced with HIV-negative clients, and considered in conjunction with the growing numbers of HIV-infected persons in the United States, the results of this study underscore the need for counselors to be trained to work with clients who are HIV positive, as a

possible means of decreasing counselors' discomfort. Training that addresses counselors' own fears of HIV infection and death (Johnston & Manese, 1990) may be of particular importance.

Second, whereas counselors' homophobia was significantly lower than that found among a general population of male college students (Daly, 1990), the significant relationship between counselors' homophobia and verbal avoidance behavior strongly suggests that supervisors and counselors themselves need to be closely attuned to counselors' feelings in general about sexual orientation and, in particular, their potential homophobic reactions. In essence, the findings imply the need for counselors to examine closely their own beliefs, attitudes, and biases toward gay men. As Shannon and Woods (1991) stated: "The demands of working with gay men can be a challenge to both gay and nongay therapists. Without question, we must confront and work through our own homophobia and the many myths and stereotypes about gays" (p. 213).

The results of the present study also broaden the existing empirical base for understanding countertransference. If counselors' verbal avoidance of client material is construed as a form of countertransference behavior, as a number of studies have suggested (Bandura et al., 1960; Cutler, 1958; Hayes & Gelso, 1991; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968), then our data indicate that male counselors' homophobia strongly predicts their countertransference behavior with gay clients. That is, counselors' stereotypes about, fears of, and negative attitudes toward gay men seemingly contribute to counselors' circumventing gay clients' clinical content and affect. Similarly, if counselors' anxiety is viewed as indicative of countertransference (see M. B. Cohen, 1952; Freud, 1926/1959; Hayes & Gelso, 1991; Sullivan, 1954), then our findings imply that counselors experience more countertransference with HIV-positive clients than with HIV-negative clients. Furthermore, the positive relationship between state anxiety and death anxiety in the HIV-positive client condition ($r = .35$), though not statistically significant, hints at the theoretically sound conclusion that counselors' countertransference reactions with HIV-positive clients are rooted in counselors' anxieties about death. This is a potentially fertile area of research awaiting investigation with a larger sample.

Several limitations to this study must be kept in mind in drawing conclusions from it. As with any laboratory study, one must question how well the results generalize to actual counseling settings (Gelso, 1979). Of primary concern here is the external validity of data gathered largely from counselors in training and the accuracy with which the analogue counseling situation resembles genuine client-counselor interaction. A second, potentially restrictive qualification of the study is that the clients depicted within the scripts were atypical in certain regards. That is, all four clients had concerns related to HIV, the HIV-infected clients had just discovered their conditions, and the gay clients certainly could have discussed more aspects of being gay than they did. For instance, the gay client who was HIV negative only briefly mentioned coming out issues, whereas the HIV-positive gay client did not mention coming out issues at all.

Last, the limitations of certain instruments used in this study affect the conclusions that can be drawn from it. For example, Daly's (1990) Homophobia Scale was designed to measure people's prejudicial attitudes toward and biased beliefs about gay men; it does not, however, assess the extent of one's internalized homophobia (e.g., fears that oneself may be gay), which certainly may affect counselors' discomfort. Furthermore, because competing definitions of homophobia exist (cf. Lehne, 1976; Martin, 1982; Messing et al., 1984; Morin & Garfinkle, 1978; Pharr, 1988; Weinberg, 1972), the findings of the present study regarding homophobia do not agree with all of the various ways in which the term is used.

Limitations notwithstanding, the present findings provide support for clinical theories that underscore the difficulty of counseling HIV-infected clients and that implicate homophobia as a source of countertransference behavior for male counselors working with gay male clients. Future research that examines counselors' death anxiety with clients who are closer to dying, perhaps in a field setting, would be valuable to counseling psychologists in their work with clients who have AIDS.

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