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Let's talk about sex: helping substance abuse counsellors address HIV prevention with men who have sex with men

Anya Y. Spector[*] and **Rogério M. Pinto**
School of Social Work, Columbia University, New York, USA

Abstract

Integrating HIV prevention into substance abuse counselling is recommended to ameliorate the health outcomes of men who have sex with men. However, culture-based countertransferences (CBCs) may hamper this effort. Using a case illustration, this paper will explain the manifestation of CBCs held among substance abuse counsellors and how they hinder counsellors' work with men who have sex with men. The following CBCs will be explored: distancing, topic avoidance, heteronormativity, assumptions and denying client strengths. These CBCs allow counsellors to avoid discussions about sexual practices and curtail HIV prevention counselling, while undermining the counsellor-client relationship. Based on the empirical literature on HIV and substance abuse prevention with men who have sex with men, we provide recommendations to help counsellors overcome CBCs and integrate HIV prevention consistently with men who are in treatment for substance abuse.

Keywords

counsellors; countertransference; men who have sex with men; HIV prevention

Introduction

Individuals who abuse substances are at high risk for HIV infection through unprotected sex and needle sharing (Center for Disease Control and Prevention 2009). While needle sharing is a vital area for interventions (e.g. needle-exchange), this paper will focus exclusively on individuals at risk for HIV through sexual transmission, in order to illustrate how this may affect the HIV prevention counselling that they receive in substance abuse treatment settings. Sex as it is represented in language is comprised of gender and anatomy, as well as descriptions of behaviour. For example, while counsellors may favour clinical terms like 'penis', 'oral sex', 'anal sex' and 'penetration', clients may use colloquial terms to describe the ways in which they engage in sex. Therefore, this paper uses the term 'sexual practices' to encompass sexual acts as well as myriad ways of speaking about, describing and understanding forms of sexual expression between men (Dowsett 1996).

[*]Corresponding author. ay2117@columbia.edu.

Clients in treatment for substance use disorders who engage in same-sex sexual practices have higher levels of substance use severity than their counterparts who exclusively engage in opposite-sex sexual practices (Cochran, Peavy, and Cauce 2007; Cochran, Peavy, and Robohm 2007). Often clients who engage in same-sex sexual practices do not identify as 'gay' or 'bisexual' and lack affiliation with or access to gay culture. This is often true for racial/ethnic minority men who may view 'gay culture' as not inclusive of racial/ethnic minorities and may consider it as being exclusively accessible to whites (Young and Meyer 2005). For the purpose of this paper, we will use the term 'men who have sex with men' as an umbrella term that encompasses men who identify as gay, bisexual or heterosexual and who engage in sex with other men.

Men who have sex with men represent 53% of new HIV infections in the USA (Centers for Disease Control and Prevention 2007) and have exhibited an increased prevalence of illicit drug use (Stall et al. 2001; Thiede et al. 2003). Men who have sex with men are at heightened risk for substance use disorders (US Department of Health and Human Services 2001) due to stigma and discrimination (McKirnan and Peterson 1989; Melendez and Pinto 2007), stress and depression (Hughes and Eliason 2002) and shame around same sex sexual practices (Diaz et al. 2001).

HIV prevention counselling and testing have been shown to be effective in reducing HIV risk (Stein et al. 2002) and can be integrated with substance abuse treatment (Melendez and Pinto 2009; Pinto, Melendez, and Spector 2008). Substance abuse counsellors ('counsellors') can help decrease HIV risk by providing information, counselling and referrals for HIV testing (Rotham and Tesorio 1999). Substance abuse treatment is an effective HIV prevention for men who have sex with men because clients in treatment tend to reduce sexual risk behaviours (Shoptaw and Frosch 2000). Safer sex counselling and condom demonstrations have also shown significant reductions in unprotected sex (Pendergast, Urada, and Podus 2001), while counselling with drug users has been shown to reduce the risk of transmission (Semaan et al. 2002).

Despite the evidence suggesting that HIV prevention can be integrated into substance abuse counselling, many counsellors are not doing so due to biases toward clients with diverse sexual practices, particularly clients engaging in same-sex sexual behaviour (Mitchell and Oltean 2007). It is thus imperative that we understand how biases about same-sex sexual practices may hinder the delivery of HIV prevention within substance abuse treatment so that recommendations can be made to mitigate the problem.

This paper will advance this endeavour by using an empirically-based framework and a case illustration to explain how biases may inhibit counsellors' ability to integrate HIV prevention into substance abuse counselling. First, we will show how biases manifest within the counsellor-client interaction. Second, we will describe how these manifestations hamper the integration of HIV prevention into counselling. Third, we will make recommendations for reducing these manifestations and for promoting HIV prevention with men who have sex with men in treatment for substance abuse.

Homophobia, heterosexism and substance abuse counseling

Homophobia refers to discriminatory practices and negative attitudes toward individuals whose sexual practices differ from heterosexual norms (Hudson and Ricketts 1980). Moreover, heterosexism is a belief system that favours heterosexuality as superior to and/or more 'normal' and 'natural' than homosexuality (Morin 1997). Both homophobia and heterosexism have been documented among substance abuse counsellors (Cochran, Peavy, and Cauce 2007; Eliason 2000; Eliason and Hughes 2004; Matthews, Selvidge, and Fisher 2005). Many counsellors are less comfortable discussing sexual risk with clients who engage

in same-sex sexual activity than with their heterosexual counterparts (Mitchell and Oltean 2007). Counsellors also have negative and/or ambivalent attitudes (e.g. gay people should keep their sexuality to themselves and being gay is unnatural) toward gay and bisexual clients (Eliason 2000; Substance Abuse and Mental Health Services Administration 2001).

The counsellor-client relationship is the cornerstone upon which counselling interventions depend and without which a client is unlikely to remain and succeed in behavioural treatment (Ilgen et al. 2006; Joyce, Piper, and Ogrodniczuk 2007). Clients receiving medical treatments (e.g. methadone, buprenorphine) may in fact remain in treatment, despite lacking a strong counsellor-client bond, simply in order to obtain medications. However lacking engagement in counselling, it is unlikely that such clients would receive HIV prevention. Gay-affirmative practice, viewed as the gold-standard in counselling for men who have sex with men, is an orientation to clinical practice that upholds the value of same-sex sexuality, gay identity and humanity as equal to that of heterosexual individuals or those that do not engage in same-sex sexual activity (Davies 1996).

On the one hand, homophobic and heterosexist attitudes threaten the counsellor-client relationship when counsellors contribute to making clients feel judged, disliked, misunderstood and/or disrespected (Israel et al. 2008). On the other hand, positive treatment experiences for men who have sex with men have been shown to be strongly associated with counsellors' affirming attitudes toward their sexual practices (Eliason 2000; Eliason and Hughes 2004; Hughes and Eliason 2002). Clients who have positive experiences remain in treatment longer and are more likely to reduce HIV risk. Counsellors are ideally positioned to help decrease the spread of HIV by integrating prevention into counselling. A survey with substance abuse counsellors concluded that HIV knowledge was consistently low and that counsellors are hesitant to discuss with clients, sexual issues and specific sexual acts (Portnoff et al. 1996). Discussing sex with clients is a key skill for HIV intervention (Weiss and Gupta 1998). This requires frank discussions about clients' sexual practices and pleasure- and intimacy-seeking behaviours (Philpott, Knerr, and Boydell 2006), as will be discussed below.

Substance use counsellors' attitudes toward men who have sex with men

Counsellors often make assumptions about how clients behave sexually that reflect their personal values and attitudes. Often counsellors are not cognisant of their assumptions as these are embedded within their worldviews. Ecological theory suggests that experiences and perceptions are impacted upon and shaped by individuals' social environments (Bronfenbrenner 1989). Therefore, growing up in a society that is both homophobic and heterosexist impacts all individuals, including counsellors. The impact of homophobia and heterosexism is not limited to counsellors who identify as heterosexual. Biased attitudes may exist as a result of the ecological system, which sustains bias through institutionalised discrimination (e.g. marriage inequality, discrimination and violence). Social and political forces negatively impact counsellors, creating internalised homophobia, discrimination and hate crimes (Russell and Bohan 2007)

Several studies have sought to describe counsellors' attitudes, knowledge and sentiments towards men who have sex with men. A survey of rural substance abuse counsellors, for example, showed that nearly half reported negative or ambivalent views toward lesbian and gay clients with greatest negative views reported toward transgender clients (Eliason 2000). Rural and urban substance-use counsellors were compared and exhibited similar attitudes toward and knowledge about men who have sex with men (Eliason and Hughes 2004), despite the fact that urban counsellors reported more training and education about sexual diversity. Consistently lacking among counsellors was knowledge about internalised

homophobia, stress, coping, the coming-out process, domestic partnership and family issues. Being unaware of these issues presents a barrier to delivering culturally appropriate services.

Culture-based countertransferences

Countertransferenceis a term used in the psychodynamic literature to describe counsellors' unconscious and/or repressed feelings toward the client, possibly resulting from the counsellor's own history that may evoke various emotions (e.g. hostile, positive, ambivalent, parental etc.). However, this term has been broadened in the substance abuse literature to encompass counsellors' emotional responses to their clients in general (Najavitis, Crits-Christoph, and Dierberger 2000).

In this paper, we are using this term to describe specific emotional and behavioural counsellor responses that result from biases and culturally bound assumptions. In an attempt to advance knowledge about how these assumptions may damage the counsellor-client relationship, Stampley (2008) identified five critical behaviours often exhibited by counsellors when personal beliefs and assumptions interfere with their ability to provide culturally competent counselling. These behaviours are manifested when counsellors hold distinct assumptions/beliefs referred to as culture-based countertransferences (CBCs) (Stampley 2008). Below we describe CBCs in the context of HIV prevention counselling in substance abuse treatment settings.

First, *denial of clients' strengths* is a failure to recognise clients' life achievements, resilience and positive attributes. Counsellors may view their clients as unmotivated, resistant or making poor choices, rather than interpreting clients' behaviours as coping with stigma around sexuality or HIV status. For instance, for many men who have sex with men, being tested for HIV is daunting, because of having experienced the loss of friends and/or family members to AIDS, as well as experiencing the fear of additional stigma and discrimination. A counsellor may deny a client's strengths by not acknowledging the importance or difficulty of making the decision to be tested for HIV.

Second, *distancing* promotes unnecessary formality that is often used to assert authority. This results in counsellors not getting to know the client's needs, values and/or feelings. Counsellors may discuss program rules and policies excessively or offer unsolicited advice to clients in an effort to prevent the client from speaking about same-sex sexual practices or relationships. Counsellors engaged in distancing may hold superficial discussions with clients and have difficulty speaking about sensitive issues like sex and pleasure, which are all necessary for HIV prevention.

Third, *assumptions* may include preconceived expectations and prescriptions for clients. Counsellors may interpret their clients as sharing their worldview and therefore might not ask about sexual practices outside of the counsellors' purview if the client does not appear at risk through multiple sexual contacts. Counsellors may assume erroneously that clients are not at risk for HIV because they do not identify as gay or bisexual and that clients who identify as heterosexual do not engage in same-sex sexual practices. These assumptions curtail discussions about sex, since the counsellor is unaware of the questions that he/she ought to be asking about sexual practices.

Fourth, *heteronormativity* may cause counsellors to interpret same-sex sexual practices as deviant and heterosexuality as the only normal option for all clients. Counsellors who hold this belief may marginalise same-sex relationships. Counsellors who subscribe to heteronormative views may not hold same-sex partnerships in equal regard as heterosexual partnerships and may convey disapproval by dismissing a client's expressed feelings and

desires toward same-sex partners. Counsellors may view a client's sexual orientation rather than addiction as a problem.

Finally, the *avoidance of certain topics* refers to overlooking sexual matters or deliberately diverting conversations away from sexual practices or pleasure. For example, counsellors may not ask clients about whether they are using condoms because it may lead to the client disclosing sexual practices with which the counsellor is unfamiliar or uncomfortable. Counsellors may systematically avoid discussing sex because of not wanting to hear descriptions about same-sex practices.

The CBCs described above are often a product of feelings or beliefs also known as biases. We acknowledge the vast literature on countertransference; however, in this paper we are focusing specifically on the manifestations of CBCs in counsellors and how CBCs may prevent them from integrating HIV prevention. Attitudinal issues may result in counsellors unintentionally conveying disapproving or unsupportive non-verbal signals through body language, tone of voice, subtle speech patterns and disrupted eye contact. This may be disruptive to establishing rapport. Culture-based countertransferences are reactions towards clients whose sexual practices counsellors may perceive as too risky, disgusting, inappropriate, deviant or not worth discussing. These perceptions can limit objectivity and effectiveness (Forrest 2002). Furthermore, the authors are using the CBC framework to illustrate specific counsellor behaviours vis-à-vis HIV prevention.

We acknowledge that the psychodynamic orientation is not utilised by many substance abuse counsellors both because counsellors are often not trained to do so and because modalities such as cognitive-behavioural, motivational interviewing and relapse prevention are considered evidence-based (Miller, Zweben, and Johnson 2005). Therefore, we are not suggesting that counsellors adopt a psychodynamic approach to treatment of clients in substance abuse settings. Rather we are demonstrating how counsellors may use this model, which happens to be grounded in a psychodynamic theory, to understand their own behaviour.

Case illustration

Because of the heightened risk for HIV infection among men who have sex with men who abuse substances, there is an urgent need to integrate HIV prevention into substance abuse counselling. However, CBCs may hamper this effort and thus necessitate empirically drawn strategies for reducing barriers to HIV prevention during substance abuse counselling. Therefore, below we illustrate a selected interaction between a client and counsellor to show how CBCs hinder HIV prevention. The interaction highlighted is not meant to cast a negative light upon counsellors, but to illustrate the points made above. It would be nearly impossible for anyone counsellor to exhibit all of these CBCs. We will indicate in brackets each CBC as it appears in the counsellor-client interaction. The case will be followed by an explanation of how CBCs impacted negatively upon counselling.

The case of Kris

Kris is a 57-year-old, married, biracial man who has sex with men, who recently tested HIV-positive. Kris' boss suggested that he attend treatment for his drinking because it was affecting his performance at work as an ophthalmology technician. Clara, his counsellor, is a 32-year-old, white heterosexual female. Here we illustrate Kris' second session with Clara:

Clara: Good morning! It's great to see you again. Have a seat.

Kris: Thanks. [Sits down]

Clara: How have you been since the last time we saw each other, last Wednesday?

Kris: Well I haven't had a drink … yet.

Clara: I'm glad to hear that you have not been drinking. But, it sounds to me like you are having a tough time. Has anything changed this the last time we saw each other?

Kris: You could say that something has changed. I'm not sure that I'm ready to talk about it though.

Clara: You don't have to tell me anything that you don't want to. This is your session. I'm on your side, Kris. What you say tome stays here. What's going on for you? You don't look too good.

Kris: Not feeling too good. It's been a really bad week. [Looking down at his feet]

Clara: How come?

Kris: Well, my church was having this health fair, and my wife; she's like, 'Come on, Kris. We need to go to this health fair. The Pastor is expecting us' and all that mess. So I said, 'Fine.' It's not like I go to church every Sunday but she has stuck by me through thick and thin and I figure, I owe her, right?

Clara: That's very generous of you.

Kris: So they are offering HIV tests at this thing and she says, ' Lets do this.' 'This is something we need to do together since we are starting over again. ' Trying to make it work. So I said, 'Ok', thinking, 'I got nothing to worry about' … but then the man comes back and says, 'I'm sorry to inform you that you tested positive for HIV'. Then my whole world just stopped. I couldn't hear anything he said after that. All I could think was, 'How am I going to tell my wife, my kids, my job. … What am I going to do?'

Clara: Well, that is a lot to handle. So how did you tell your wife? [denying strengths]

Kris: I didn't.

Clara: It's very important that you tell her as soon as possible. [assumptions]

Kris: Yes, I just haven't figured out how just yet.

Clara: You have to be honest because this is a serious health issue. How long have you been married?

Kris: 26 years in March.

Clara: That's a long time. You have been through so much together and raised a family together. Heck, you told me she was your high school sweetheart. That's a strong bond. I'm sure if she stuck by you through your drinking, she will stick by you through this. I mean, after all, how do you know that she isn't the one who gave it to you? You know, women can also pass HIV to men. [assumptions]

Kris: Because, I haven't always been faithful, you could say.

Clara: Oh, but how do you know that she has … all I'm trying to say is that you shouldn't blame yourself. Marriage is hard work and just because you've been intimate with women

outside of your marriage doesn't make you a villain. It's very common for both men and women to be unfaithful, even though it isn't right or fair. But you need to speak to your wife and to any women that you have had sexual contact with recently so that they get tested too. [heteronormativity] That is your responsibility. You and your wife will both need to see a doctor to find out how you can protect yourselves and stay healthy. [topic avoidance]

Kris: Right … I need to think about it. I don't want to drink behind all this.

Clara: May be we should increase the number of groups you are attending to twice a week so that you can have some extra support. [distancing]

Kris: Ok.

Clara: If you want to bring your wife in for a counselling session we can all sit down together and discuss this. I would be happy to support you in telling her in any way I can. The most important thing is that she protects herself and that you continue to work on your marriage. Don't worry, Kris. It's going to be ok.

Kris: Thanks

Culture-based countertransferences in the case of Kris

Denying strengths—The counsellor, Clara, assumed rather quickly that Kris told his wife about his positive HIV test. She ignored his self-protective response to hold onto the information until he felt ready to discuss it with his wife. This is a failure to recognise Kris' strength in processing the diagnosis with his counsellor before taking the difficult action of revealing his HIV status to his wife. In fact, Kris initiated the conversation with the counsellor as a preliminary preparatory step to talking about his HIV status with his wife and others in his life. Kris' openness with Clara could have prompted her to strategise with Kris about how to talk about HIV with his loved ones. Instead, Clara demonstrated disapproval of Kris' not disclosing his diagnosis and, ultimately, failed to see his strengths in coping with a difficult situation by speaking to his counsellor instead of 'using' or 'picking up'. This may have increased Kris' defences and made him feel less able to reveal his own vulnerabilities, making a frank discussion about HIV prevention less likely.

Assumptions—Clara's assumption that Kris already disclosed his HIV status to his wife and her insistence that he do so immediately revealed her assumptions about what a client should do when they discover that they are HIV-positive. Clara took an authoritative stance to convince Kris that he must disclose his status. This is an example of how assumptions reveal biases and curtail candid discussion of sex and HIV transmission. Clara revealed that she held biases toward Kris for not being responsible and telling his wife that he had tested positive. Clara missed an opportunity to find out about Kris' sexual risk practices and help him find ways to reduce risk of HIV transmission.

Topic avoidance—Clara did not ask any questions about Kris' HIV risk such as how many partners he has had, whether he has sex with men and whether he uses condoms. This reflects the strategy of avoiding discussing sexual practices. When Clara told Kris that he would need to talk to a doctor about staying healthy, she created a barrier that hampered Kris' ability to talk with her about staying healthy, signalling that he ought to discuss sexual health with a physician instead. Clara's discomfort resulted in a confrontational approach that may have threatened the counsellor-client relationship in its nascent stages by denying Kris an opportunity to explore his concerns about HIV and his sexual relationships, including his sexual practices with his wife.

Heteronormativity—Clara assumed that Kris was 'unfaithful' to his wife with other women because he is married and viewed his marital status as an indication that he was having sex exclusively with women. This is a common heteronormative assumption that impedes counsellors from considering that clients in heterosexual relationships may also engage in same-sex practices. She missed an opportunity to explore Kris' sexual preferences and find out what having unsafe sex with men meant to him. Clara was unable to address HIV because Kris' sexual practices remained undisclosed. Clara's lack of awareness prevented her from asking about what types of sexual practices Kris was engaging in with other men such as if he was the receptive or insertive partner and whether he was using condoms.

Distancing—Clara suggested that Kris attend more support groups in response to his assertion that he is at risk of relapse. While intensifying care by increasing group counselling is a recommended strategy to help prevent relapse, in this instance the counsellor made the recommendation too soon. By offering a solution (more groups), she missed an opportunity to explore Kris' feelings about HIV, his health and his wife, all of which may lead to relapse. This may have been interpreted by Kris as the counsellor suggesting that he talk about his feelings with the group and not with her. By creating distance, Clara signalled a lack of interest and potentially reduced the likelihood that he will talk to her about HIV in the future. This hampers prevention because if Kris does not feel that his counsellor is interested in or willing to discuss his sexual behaviour, he may not broach the subject, impeding efforts to plan risk reduction strategies.

The impact of culture-based countertransferences on counseling

This case illustration shows how CBCs hampered the counsellor's ability to integrate HIV prevention. Like Clara, counsellors working in substance abuse treatment settings may employ topic avoidance with men who have sex with men by choosing to focus exclusively on their drug use and avoid discussions about sexual practices. Counsellors may rationalise this by considering that they are attending to their clients' presenting issue, which is their substance abuse. However, for many men who have sex with men, substance abuse and sex are inextricably linked, so much so that drinking or using drugs assumes an organising role in sexuality and identity. Counsellors who appreciate and explore the connection between sex and substance use demonstrate understanding and openness to their clients. Avoiding the topic of sex likewise results in avoiding key aspects of clients' substance use. Therefore, in light of the plethora of evidence that suggests a strong association between substance use and HIV risk, counsellors who do not prioritise HIV prevention are not making good use of the available evidence and are thus providing substandard treatment.

Heteronormativity can also result in omissions that impede HIV risk assessments. For example, in cases where counsellors assume that married male clients only have sex with women, the counsellor is omitting the question about whether the client also has sex with men. This strategy results in counsellors lacking crucial information about HIV risk and therefore being unable to intervene appropriately. By assuming that marital status is indicative of exclusively heterosexual practices, counsellors may fail to assess clients' needs for HIV counselling about prevention and exploring the connection between substance abuse and risky sexual behaviour.

Denying clients' strengths inhibits discussion about clients' resilience and achievements. By ignoring or pathologising clients' coping strategies or neglecting to examine clients' cultural values, counsellors may be neglecting a source of protection against HIV. This is particularly important when working with individuals whose sexual practices may have exposed them to stigma and shame. When the counsellor expresses judgment or assumes an

authoritative stance, the client is less able to disclose sensitive sexual information. Without such information, counsellors cannot intervene to help clients prevent HIV transmission.

Distancing, or avoiding clients by referring them elsewhere or engaging in a teaching role in order to avoid discussing sexual practices creates an artificial barrier between the counsellor and the client, drawing attention to the difference in status between them and discouraging clients from discussing sexual issues. This may result in prescriptions via 'should' statements, such as 'you should not have had sex outside of your primary relationship' or condemning statements such as, 'I'm warning you that you should not engage in sex work because it is illegal and if you are found to be HIV-positive, you could be arrested'. Unrealistic expectations may cause counsellors to harshly judge clients' for not measuring up to preconceived standards.

Culture-based countertransferences pertain to race, ethnicity, education, social class and age as well and can cumulatively impact the quality of counselling. Other CBCs may exist and those ought to be studied further to reveal how they hinder counselling. However, the CBCs highlighted here, which relate to sexual practices, are detrimental to HIV prevention because they curtail discussions about sexual risk and risk reduction. We are also aware that myriad contextual factors may influence how counsellors treat their clients and may ultimately result in diverse outcomes. For example, counsellors working in faith-based substance abuse programs may be prohibited from addressing same-sex sexual practices and therefore may be unable to deliver HIV prevention to men who have sex with men.

Counsellor disclosure: an ethical and legal issue

The case exemplified above involves a complex ethical and legal issue for Clara, known as 'duty to warn'. In cases where a counsellor is aware that a client may be knowingly exposing his/her spouse/partner to HIV and is unwilling to disclose his/her status to the spouse/partner, the counsellor may be legally responsible to do so (Säfken and Frewer 2007). In the case of Clara, this would mean that she would be obligated to inform Kris' wife that Kris tested positive for HIV. Conversely, if Clara breaches client confidentiality, she risks both the consequence of permanently and irreparably severing the client-counsellor, as well as being sued for breach of confidentiality for disclosing Kris' personal medical information. Ethically, Clara encounters the challenge of deciding whether her duty to warn Kris' wife supersedes her duty to protect her client's confidentiality and the sanctity of the client-counsellor relationship. She must determine whether Kris intends to take precautions to protect his sexual partners from becoming infected.

US state law in 37 states and the District of Columbia stipulates that a counsellor's first course of action ought to be to persuade the client to notify his partners of his HIV status and only if such persuasion is unsuccessful to notify the authorities. However, the law is not clear about how long a counsellor ought to work with a client before concluding that the client will not notify partners. In order to determine how to proceed, Clara, or any counsellor, should openly address the issue with his/her client in order to assess how the client would like to proceed. Also, a counsellor would need to assess for any risks of domestic or partner violence. It is imperative to know whether informing a partner about testing positive for HIV could result in physical, emotional or financial harm. Therefore, Clara should inform Kris that she has a duty to warn and allow him to determine how to proceed. Clara ought to assess for the threat of any violence or retaliation if Kris discloses his status. Then, Clara and Kris may decide upon a plan for disclosing his status to his wife and any other partners that he is able to contact.

Implications for training and practice

Case illustrations offers a brief glimpse into one or few counselling sessions; nonetheless, they are helpful for demonstrating client-counsellor interactions (see, for example, Pinto 2006). Since the above case illustration was conceived by the authors, it does not reflect an actual interaction, but rather highlights salient concepts in order to emphasise the CBCs discussed in this paper. Perhaps using actual representations of interactions from audiorecorded sessions would offer a different understanding of CBCs. Therefore, the authors recommend that future research be conducted that focuses on gathering data from counsellors to more thoroughly describe how CBCs manifest with regard to HIV prevention in substance abuse counselling. Future research should analyse transcribed sessions with substance use counsellors for evidence of CBCs to better understand how they manifest in different clinical situations and their impact upon different types of client-counsellor interactions.

Table 1, summarises a number of empirically informed recommendations for counsellors to reduce CBCs and ameliorate the integration of HIV prevention in substance abuse counselling with men who have sex with men. Counsellors who exhibit CBCs are likely to overlook important assessments that are pertinent to HIV risk, such as history of sexual abuse, partner violence, hidden same-sex sexual practices, non-disclosure of same-sex sexual practices to opposite sex partners and/or sex work. In the USA, men who have sex with men who have a history of childhood sexual abuse and/or sexual coercion are more likely to become infected with HIV (Jinich et al. 1998). Counsellors who are unwilling to discuss clients' sexual practices are also unlikely to ask about clients' sexual history, therefore missing an important opportunity to assess HIV risk related to having been a survivor of childhood sexual abuse or coercion. However, the inability to assess sexual abuse history also impacts the quality of substance abuse counselling since sexual abuse history is often a precursor to problems with drugs and/or alcohol (Briere and Elliott 1994). Therefore, by improving communication and awareness about understanding a client's sexual history, counsellors will be better equipped to address substance abuse along with HIV.

Partner violence between men who have sex with men is associated with elevated risk of HIV transmission due to relationship dynamics that render individuals powerless against their abusive partners (Craft and Serovich 2005). Counsellors who overlook issues of relationship dynamics because of CBCs like heteronormativity may fail to identify partner violence and therefore overlook an important predictor of HIV risk that requires attention and intervention. Men who have sex with men who identify as heterosexual, and particularly African Americans, are likely to hide their same sex sexual behaviours from their family, friends, female sex partners and healthcare providers, including counsellors (Millett et al. 2005). Stigma and shame leading to hiding sexual practices is strongly associated with elevated risk for HIV and is likely to go undetected by counsellors who are not sensitive to the needs of this population. Counsellors making assumptions that their clients are only having heterosexual sex may inadvertently prevent disclosure by discouraging men who have sex with men who identify as heterosexual from discussing their same sex sexual practices. Substance use often accompanies and fuels partner violence (Coker et al. 2002), increasing the severity of violent incidents, therefore, counsellors ought to consider assessing for partner violence as a key aspect of addiction counselling as well.

Counsellors would benefit from a thorough examination of their CBCs in each encounter. Through self-reflection, supervision and checking with the client, counsellors may be able to detect the areas where they are having difficulty relating to their client. Counsellors self-reflection may include developing awareness about one's own limitations in talking to clients about sex, difficulties in accepting the important and joyful role that sexual practices

play in clients' lives and counsellors' own levels of internalised homophobia/heterosexism. This type of thorough self-exploration will better prepare counsellors to recognise CBCs and overcome them. Counsellors who have not had extensive training in sexuality and the interconnectedness of sexuality with substance abuse must do so in order to effectively address HIV transmission with those who exhibit sexual behaviour that may be different from that of the counsellor. Training must include a thorough understanding of sexuality, discrimination, stigma, homophobia and how the social environment impacts the self-concept, coping and defences among men who have sex with men. Specific issues like sexual abuse history, partner violence and hidden same-sex practices and vulnerability to HIV should be well understood by counsellors. In order for counsellors to avoid perpetuating myriad social inequities faced by men who have sex with men, they must first become aware of how CBCs manifest and where they originate. This can be done through training that is focused upon reducing CBCs. Counsellors need ongoing supervision to monitor for CBCs in their practice. When feasible, counselling sessions should be observed by a supervisor or expert peer in order to assess for CBCs. Counsellors who consult with other professionals may gain knowledge and new perspectives on counteracting CBCs. Role-plays where counsellors rehearse sessions with clients can be useful educational tools in practicing HIV prevention counselling skills. In addition to training, supervision, education and reading relevant literature about CBCs, counsellors would benefit from self-reflection about their own biases so that they may address CBCs in practice (Maldonado 2008; Westefeld 2009).

Conclusion

This paper demonstrates that CBCs hamper HIV prevention efforts. Applying Stampley's framework of CBCs helped the formulation of how counsellors' beliefs produce particular behaviours that undermine efforts to integrate HIV prevention into substance abuse counselling. Counsellors who are not able to initiate and maintain dialogue about sex and HIV distance themselves from clients, avoid discussing sexuality, take on an authoritative or instructive role to avoid emotion, pathologise clients' coping responses, omit questions about sexual behaviour and fail to see clients' strengths. This paper is meant to raise awareness among counsellors, supervisors and administrators working in substance use settings about the urgency of being able to recognise and identify CBCs so that we may work to eliminate them and successfully integrate HIV prevention into substance abuse counselling. We recommend extensive training in sexuality, collaboratively designed with substance abuse counsellors, for all counsellors, supervisors and administrators. Training should focus on recognising and reducing CBCs through role-plays, supervision, educational programs and exposure to information about HIV, diverse sexual practices and how stigma affects coping strategies.

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Table 1

Recommendations for professional development.

CBC	Impact on counsellor	Impact on client	Recommendation
Distancing	◆ Counsellor is unable to conduct risk assessment or discuss transmission	◆ Client may feel that counsellor has own agenda and is not listening or interested in what the client has to say	◆ To train counsellors to recognise distancing patterns within sessions, non-verbal signs that create distance and reduce them by asking exploratory questions and staying with issues related to sex
Preconceived expectations	◆ Counsellor is unable to assess sexual risk (e.g. sex abuse, partner violence, unsafe sex, sex work)	◆ Client may feel that counsellor is judging him	◆ To train counsellors to understand men who have sex with men sexual practices and recognise differences between these and their own
Heteronormativity	◆ Counsellor is unable to plan risk reduction because he/she minimises the importance of same sex sexual relationships and sexual pleasure between same sex partners	◆ Client may feel judged, disliked or disrespected	◆ To train counsellors to challenge their assumptions about sexuality and to embrace a broad range of sexual expression as healthy and functional
Topic avoidance	◆ Counsellor is unable to assess sexual risk, plan risk reduction strategies, or refer for HIV testing	◆ Client may feel silenced or discouraged from discussing sexual issues	◆ To train counsellors to practice speaking candidly about sexual practices, particularly same-sex practices in colloquial and technical terms