

HIV/AIDS-Related Therapy — What my clients have taught me along the way¹

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With contributions from Frederick Haineault (Co-founder of "Healing Our Spirit B.C. Aboriginal AIDS Society"³ and "J.E." (long-term survivor living with HIV)⁴

¹*This is an updated version of the original article titled "HIV/AIDS psychotherapy: What psychologists need to understand" that first appeared in The Canadian Health Psychologist in 1996. For references and recommended readings, please contact the Author directly at: jweiser@phototherapy-centre.com or 604-689-9709.*

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³*Frederick Haineault was a close friend and colleague of Weiser's who died of AIDS-related pneumonia on December 6, 1995. Co-founder of "Healing Our Spirit B.C. Aboriginal AIDS Society", he was an AIDS Educator who blended traditional Cree teachings with his unique approach to educating First Nations people about AIDS. His comments included herein are from a transcription of a presentation he and Weiser gave together at an AIDS Conference in Prince Rupert, B.C., in September, 1995 — that they tape-recorded for the purpose of transcription for the authoring of this article for publication.*

⁴*"J.E." is the pseudonym requested by an ex-client of Weiser's who, when hearing she was writing this article (originally, in 1996), brought her a few pages he decided to write about his understanding of how therapy had helped him cope better. Although the years have been "bumpy", he is still alive and well after living with HIV for more than twenty years now. He asked to share his opinion in this updated version of this article that he believes his words are still timely and can hopefully help readers better understand what people like him are experiencing even while appearing to otherwise be in good physical health.*

Dealing with Diagnosis

Most people discovering they have been infected with HIV¹ quickly learn that this is not just solely a physical problem residing inside their body, but also that it comes with numerous complex mental, emotional, and spiritual aspects that will also directly influence the quality and direction of daily life lived through its always-present filter of related illnesses.

Usually it turns out that it is not AIDS² itself that is the problem (i.e., its medical definition), but rather what AIDS *means* inside a person's mind, feelings, and spirit, as well as in the reactions of others. Such psychosocial factors accompanying an HIV diagnosis can have much deeper influence than medical symptoms on the path each person's journey will take during the time they are living with the virus and trying to make sense out of it all.

"My very first response to being diagnosed with HIV was immediate [and] emotional: I burst out crying... That's certainly not the kind of response that I was used to having. I wasn't used to showing a lot of emotion in my life. I come from a background of abuse and I learned to shut my emotions off, [so] this immediate response was very surprising to me, but also, I guess, very necessary" [F.H., p.1].

"Twenty years ago I tested positive and was told to make my will because I was going to die.... The news I got that day has changed my life forever, and I wake up each day knowing it" [J.E., p.1].

I didn't set out to become a therapist counseling people with terminal illnesses but found myself becoming an early "expert" as HIV increasingly emerged as an urgent issue among clients I was already specializing in treating (primarily from cultural or sexual minorities, or societally marginalized populations such as Deaf, Aboriginal, gay and/or two-spirited men and street youth -- who were often also drug users and/or abuse survivors). Clients began to tell me about their own (or loved ones') infection with HIV, along with various fears and concerns relating to it all.

Revealing such things, even now years into the third decade of HIV, still remains risky in itself because there is still no way to know how friends and family will react. Once a person has divulged being HIV-positive (having the virus), perceptions and responses from others will never be the same -- *cannot* be the same because there's a new filter. As people are often cautioned at the time of first diagnosis, "Be careful who you tell and how you tell them, because once you tell, you can never 'un-tell' again", and once people know, they can never go back to not knowing...

1 "HIV" is an acronym for the "Human Immunodeficiency Virus".

2 "AIDS" is an acronym for "Acquired Immune Deficiency Syndrome". Contrary to general belief, AIDS is not an illness itself, but rather marks the point at which the HIV-positive person has acquired one or more of the illnesses that mark the advancement of the infection to a new level of sickness.

Because knowledge about AIDS and its various treatments is continually emerging, both medical and psychosocial truth is only situationally relative and prone to sudden changes or reversals without much advance notice. My clients find themselves frequently encouraged by their doctors to do things one way one day and then the next told to switch to something different. Some are told that early treatment (or even preventive treatment now) is best, while others are told to hold off all drug treatments until illnesses arise that require them. It's not that doctors are incompetent — they are doing the best they can when dealing with the unknown — it's just that new information keeps being discovered literally daily, and it seems that one day's news often contradicts the previous day's facts.

"When first diagnosed, when people are experiencing that immediate reaction, there are also a lot of accompanying emotions that go along with it... I think the biggest one for me, and the most prolonged response, was the shock — it is really something to all of a sudden hear that you have in your body this virus. You don't really know what it is going to do to you eventually... There is this big unknown that is probably the most shocking thing about being HIV-positive". [F.H., p.1].

This lack of firm foundation and frequent readjustment of reality frameworks makes it difficult to keep updated while counseling people infected or affected by HIV — and it's even more slippery for people living with the virus themselves to somehow make sense of it all while trying to activate coping strategies or realize life goals — especially as AIDS seems to be turning into a long-term manageable chronic disease. It is not uncommon for clients to be living twenty-plus years being HIV-positive and still be healthy -- but it also happens that some will die the first year they are diagnosed. The fact that there is no dependable predictability makes life "crazy-making", as one client described it...

In HIV-related psychotherapy, clients are dealing not only with issues commonly expected by those facing death, but also often issues encountered by those who have experienced abuse. My clients often express feeling abused and disabled by their HIV diagnosis, by virtue of feeling they have lost the majority of their own personal power or their right to exercise any control over what is happening to their bodies and lives.

"There is still a stigma attached to being diagnosed with HIV [and] AIDS. And I did feel dirty. I did feel ashamed that I had this virus. And I wasn't really sure at that moment when I heard that I was HIV-positive exactly how I was going to deal with it" [F.H., p. 2].

This pervading uncertainty and lack of clear direction affects not just our clients, but also us therapists, who are used to working within fairly predictable outcomes, whereby if we do things a certain way, predictable results will likely happen. With AIDS, there has not been much sense of any consistent direction, of learning what will most help clients (and ourselves) survive the limbo and find meaning in the chaos. Hopefully this article will begin to shed some light on what HIV-infected (and also HIV-affected) clients are experiencing psychosocially, as well as suggest

some possibilities that might be of better help to them.

"I was twenty. I made a list of all the things I needed to do in order to be able to consider my life a success before I die, and set out determinedly to pursue them. I got my education and excelled in my career. I found a partner and had someone to love and love me. I made healthy changes in my lifestyle. I had success until one day I got sick and had to quit work. I dealt with HIV fine until I quit work, and then the problems started. I lost the validation of work, the financial reward of it, the status of it. My health had deteriorated, and the dream seemed to be coming to an end" [J.E., p. 1].

Psychosocial Consequences of Living with HIV

Frequently, only the medical aspects of treatment or prevention are given attention, as if maintaining the body's physical health is the patient's sole responsibility, while far too often there is much less preparation for encountering, understanding, or coping with the numerous psychosocial issues that also arise. But the consequences of living daily with HIV, and its resulting limitations not directly connected to medical problems (such as poverty, housing, or relationship difficulties), are sometimes harder to deal with due to their more subtle and socially-isolating nature, particularly for individuals without a strong emotional support system through friends or family.

In truth, for most HIV-positive people, the problems encountered during the first several years are usually not medical ones, but rather psychosocial in nature. It is common for my clients to explain that knowing they had tested positive was not the same as really *believing* it inside themselves — and thus the onset of their first HIV-precipitated illness often caused a second psychological crisis located somewhere midway between "positive visualization of ongoing health" and "denial" (with HIV these two attitudes are often hard to distinguish between).

With long-term survival becoming increasingly possible, most clients believe they will truly be the lucky one not going on to develop AIDS. And thus trying to get them to deal realistically with possible end-of-life issues may not be the goals most important to their health or stress reduction.

"To me, over the years, I had a lot of losses that I've had to deal with. Some of them were familiar... The hardest loss that I've had to deal with was the loss of ability... [like] when I was on my back because I was sick and I couldn't do anything. I couldn't pick up the phone. I just didn't have any energy. I couldn't think, because my energy was just gone. That to me was the hardest thing to deal with, because that was not my character, my usual 'modus operandi' — not me. Ever since I can remember I've been an active person. I was always doing something, like my grandfather used to do... [So] when I got to that point that doing anything was impossible, it was unbearable" [F.H., p. 5].

Many clients express that it isn't being dead that worries them, as much as the dying process itself (and accompanying fears of being abandoned or consumed with pain in the process). During the therapy process, they journey through life-review and life-closure issues, along with grief, anger, shame, stigma, guilt (including survivor guilt), relationship difficulties, and resolution of "unfinished business" with family.

But these are also therapy topics with people who don't happen to be facing a death crisis at the moment — these are general health-enhancing explorations that can provide anyone with release from stress, and self-empowerment in their activation of self-advocacy and proactive self-care.

However, with HIV-positive clients, each goal successfully accomplished still leaves the client dangling in an unfinished "limbo" where it's unclear whether to pause or keep living. If they only could know how long they were likely to live, they could then make informed and sensible decisions; however, unlike cancer there's not such clear time-line expectations for prognoses.

In HIV psychotherapy, psychological distresses such as depression or watchful anxiety can be seen not just as symptoms needing alleviating, but might instead be good indicators of needed and healthy grieving — or necessary health vigilance in partnership with overworked doctors who must count on their patients to help keep track of all the details.

"People deal with HIV in different ways. Suicide..., denial..., [and] I experienced anger. HIV is not easy to deal with. There is quite a feeling of depression that lingered in my life for a while. Not a deep depression, not a disabling depression, but this low level depression that didn't quite come out to the surface. But I was aware of it; I knew it was there. I didn't immediately jump into acceptance — I had to go through quite a struggle to get to a point — to get to THAT point. To get to the point of acceptance, to the point where I could publicly say, 'I have AIDS'. I was ashamed about that. [And] to get to that point that I realized that, I don't know when, but I'm going to die" [F.H., p. 4].

The grieving for self and others never quite completes itself, as anticipatory grief and compassion fatigue can overwhelm any attempt at dealing with death and emotional loss on a one-by-one basis like pre-AIDS life, where there was time to get over one loss before another arrived. Loss of others is difficult enough; however, with HIV gnawing away at one's abilities and lifestyle, "loss" has deeper meaning and cuts a wider swath.

"Now that I was HIV-positive, believe me, this is a whole new journey in losses. That is probably the one concept that all of the emotional and psychosocial issues that I had to deal with — is that dealing with all the losses... First off, right at the point of diagnosis, is the loss of status. We may have a very high position... in society, but if you are HIV-positive, this is gone right now. You do not increase your status if you are HIV-positive" [F.H., p. 3].

Many clients tell me that it's hard to have AIDS-free time, that, as one client explained, "It's

always there on my shoulder, riding along with me wherever I go". AIDS "tenderizes" people, making them vulnerable in sudden unexpected ways, and yet often much less willing to again risk being open to feelings of intensity of *any* kind. Clients tell me that they feel more free being "out" with HIV, but that once they have announced their status, they often find it difficult to get others to treat them like ordinary people. A client told me that he feels his friends are watching him from behind glass.

"There are a lot more different aspects of who I really am. *I am not HIV. I am not AIDS.* I am a person who has had many many life experiences, and all of those life experiences and all of those talents and desires — is who I am. But most people don't know that [because] most people haven't experienced that with me, not the people who are in my life now. Most of them know me [only] as an AIDS activist and AIDS educator, yet that has only been a small part of my life. AIDS is a very important part of my life right now, and something that directs all of my activities, and I am very proud of doing the work that I have been fortunate to be able to do — *but that's not who I am!*

"I had lost a number of [longtime] friends to AIDS. I have a few new friends, but it is not easy at this point in my life to deal with things and start with new friends again. Some of the things that friendship requires aren't easy to establish again — not at this stage... [especially] because the people who know me now only know me as the person who is living with HIV — they don't know the me who has been really active and had a lot of energy, who discovered art work and explored artistic and musical abilities." [F.H., p. 5-6].

And for clients who are not doing so well medically, and have started into yet another health decline, all this talk about positive thinking and health activism can be tiring and produce feelings of failure. It is exhausting to have to keep up the image of a survivor when one no longer feels that way. Friends seem fine when a positive attitude is apparent, but sometimes get uncomfortable when the person is truly sick and weak. One client, who is a busy activist, told me that he felt so bad realizing death was near, because it would disappoint so many of his friends that he hadn't been able to beat it.

I find I frequently have to remind clients like him that dying is not failing, that not everyone gets to stay healthy, and that it really is normal to be sick once in a while without having to feel guilty about it. With HIV it is easy to appear attractive and healthy even while the body is being consumed by various infections, and so clients sometimes are accused of exaggerating complaints or using tiredness as an excuse.

One client described the "not-well-but-not-sick" feelings as being like forever treading water:

"You know how when you get sick? Well, with me "being sick" is never "over"; the best I can hope for is that it's just not getting any worse — I don't think I'll ever feel fine again. No, I'm not sick, but neither am I ever well... I'm just always very very

tired" [B.R.; private communication].

For both those infected and those affected by HIV in loved ones, grief and anger and desolate feelings must often be put somewhat "on hold", because the politically correct image currently in vogue is that of "survivor", rather than "victim", so one must be strong, keep a positive image foregrounded (which, as mentioned earlier, is often ironically seen by others as "denial"), and not allow thoughts of dying into the picture of self that is communicated.

This "survivor" image that keeps death further at bay makes it even more difficult for loved ones to breach that barrier into the more raw layers of painful emotions and fears, as the person often feels inappropriate (or not socially correct) when dwelling upon these thoughts. So loved ones are at a loss — and their own trauma and feelings frequently kept secret, a "conspiracy of silence" that is sometimes so deeply hidden in the unconscious as to be practically inaccessible. Political correctness sometimes overrides unmentionable thoughts. And so therapy with loved ones of the HIV-positive client also becomes complex.

Many people who go home to tell their families that they have tested HIV-positive must also at the same time explain how they got that way — and for people who have not explained their sexuality, drug use, or other risky behaviors, this is a big topic to cover in one visit. Sometimes families do reject the person and make it clear they are no longer welcome, and other times there is a surprisingly supportive reaction (often with those clients who had been most fearful that love would be terminated or turned conditional).

"I think the hardest aspect for me to deal with in the beginning was dealing with my family. I had this vision in my own mind about what my relationship was with my family. I knew the hardest thing for me to do was to go home and tell my mother that I was HIV-positive. It's the same thing as going to your parents and telling them that you are going to be dying of AIDS — it's one and the same thing in everybody's mind....

"I knew how she was going to react, and there was a part of me that said, 'I don't want to be the cause of my mother's grief. I love my mother and I know my mother loves me. Why do I need to go home and tell her that her favorite son is going to die of AIDS?' She broke down and cried like I've never seen her cry before. Then she gave me a hug, and said, 'I love you and I've always loved you, and I always will... I had never ever seen my family react like that before — I was not prepared for that. That was a very powerful emotional experience for me" [F.H., p. 8].

But families and friends are also human, and sometimes their fear or exhaustion hits a limit in the caring able to be provided. Clients who are ill expect to be taken care of, and issues can arise when caregivers can give no more. One woman who went home to die found her parents lovingly supportive — until she surprisingly improved, and found her welcome quickly chilled. There is often need to grieve the breaking of trusting expectations and assumptions that those who promise to always be there sometimes, in the end, simply cannot do it.

"Recently I realized that... I have reached out to my family [but] they did not return that. They did not pick up the telephone to give me a phone call, to see how I was doing. I had been living with this image in my mind that I had a close relationship with my family, and that they supported me. And when I came to the realization that they did *not* support me — not because they didn't say they loved me, but because they didn't follow through with their actions — this was a very big shock, and I have only recently discovered it. I'm still going through the grieving of this. In my culture, family is almost everything!" [F.H., p. 8-9].

HIV-Related Counseling Needs, Issues, and Techniques

"Very little of what is happening [in the early years], is what the virus is doing to the body at that time. You have to deal with emotional and mental issues as well as social issues... [Although] my culture and traditions gave me courage to deal with issues in my life... there are times when I am just going along doing my business, walking down the street... and all of a sudden, out of me comes all of these emotions" [F.H., p. 3].

Offering psychotherapy to people living with HIV is a complex task, and it is extremely important to not perceive their HIV to be the defining problem until the client announces it as such. Good therapy involves co-constructing the mental reality that both client and therapist are participating in, and since it's the client whose needs are being addressed, it is very important to take cues from that person's own understanding and explanation of what is happening to them, how they make sense of it all, how they are coping with various big and small losses, and hearing each story without pre-judgment or external expectations.

"I knew that I couldn't change being HIV-positive, no matter how much as I wanted to. But what I could change about my situation, was the way that I was to deal with it" [F.H., p. 3].

Listening intently, reflecting back to be sure there is understanding, acknowledging feelings and trying to explore clients lives with them, in order to know them better, keeping hope without being condescending, respecting the right to choose one's own path and have it change as needed, and other such attitudes to the therapy session are goals that I think important not just for the client, *but also for the therapist*. My HIV-positive clients have taught me a lot and deeply affected the way that I try to help them.

"1995 was a time of grieving for me, trying to put the pieces together after losing two of the most important people in my life [my lover and my best friend]. [Then] in September, my mom was diagnosed with cancer... She died at the beginning of February [1996], and I was there with her at the end.... It was an agonizing and painful death... The shock of what I had seen lasted two weeks, and when I finally started to feel again, all there was was an empty black hole. I was very frightened. I hadn't been able to grieve my mother's death and I felt a large part of me had died

with her.

"I knew I was in trouble and called on my therapist again, as I had after my lover's and ex's deaths. She allowed me the safety to express all I was feeling. There was just a huge hole in my heart. I no longer felt [anything], and I was terrified to look into it for fear it would swallow me and I would lose sanity. She listened very well, repeating what I had said back to me to be sure she understood what I was saying, and then the probing would start.

"She has a way of questioning me that makes me look at the situation in a different light, or from a different angle. By urging me gently in certain directions, she brings up aspects of the pain I am in, allowing me to come to an understanding of the multitude of issues that are at work here.

"The uselessness, emptiness, confusion, the lack of strength I felt to continue, and how overwhelmed I am at grief and dying for family and friends, and for myself. *The validation of the normalcy of my emotional state is one of the best things I get out of it [counseling]*; the other is that as we explore all the issues I realize that taken one by one, I can deal with them. Like separating the trees from the forest, I am able to see far clearer.

"She does not do the work for me — she brings issues to light and from there the ball is in my hands. Another wonderful aspect is that as I am making progress, I can report back to her on my growth, and we can talk of the insights I've gained, of the stronger, wiser person I've become, and the implications these have on the rest of my life.

"I know I am a strong and courageous person, a 'survivor' if you will, but there are times I need help handling my life and its obstacles, and there are times when I act from the heart and end up overwhelmed and a bit lost. I really don't know where I would be today were it not for the help and safety that she has offered me in my times of crisis" [J.E., p. 2].

Sometimes the best thing I can do for my client is to honestly say I do not have answers and cannot give them any advice that will cure them. But healing is my business, and a safe comfortable private space in which to regularly explore what is happening to them is what my therapy tries to provide.

Much has already been written, by both professionals and also actual "long-term survivors" themselves about what seems to best help a person survive HIV/AIDS longer than predicted, and the reasons why these things help.

It is beyond the scope of this article to review all these different lists in detail, but they seem to all agree on some basic common goals that counselors should help their clients

work towards if they wish to more fully live until they die, instead of "dying before they die". These therapist-authors all seem to agree on much the same "survival techniques" as the list I myself developed for my clients, which includes:

- refusing to see AIDS as an automatic death sentence;
- taking more personal responsibility and becoming more self-directive with regards to one's own medical care (more active partnership with one's doctor, getting more informed about the actual facts of HIV, etc.);
- taking time to explore, experience, and learn from complex inner emotions;
- refusing to get stuck in helpless-hopeless attitudes;
- encountering one's own negative emotions rather than denying them or chemically numbing out to avoid them;
- improving personal coping skills so that small crises don't get any larger than they need to;
- reducing internalized racism and homophobia by learning to separate the disease from its stigma (separating the person from their illness) -- as Susan Sontag wrote, "[AIDS] is just a disease -- not a curse, not a punishment, not an embarrassment -- just an illness";
- finding as stable and healthy a living environment as possible under the circumstances;
- developing a support network where it's safe to ask for, and receive, emotional support;
- becoming more of an activist for oneself in "bearing witness" to wrongs even if unable to fix them (so that the resulting empowerment reduces the sense of victimization); and,
- finding some AIDS-free "down" time where HIV is not foregrounded (even though it never goes away; it can be "put aside" for a while so that the person can have a rest from it).

This list points out some important counseling goals, such as finding a way of lessening fear and anxiety, increasing self-direction and self-control, finding a sense of purpose and meaning, exploring the range of memories, feelings, spiritual beliefs, and enhancing supportive relationships (people who matter to the client, as well as who they themselves are important to).

Interestingly, this list works just as well for those "long-term surviving" caregivers and family members as being useful recommendations for improving their own health, even if not living with HIV themselves! Anyone can improve their life by using this list to get it into better balance -- even counselors.

In summary, all the studies in the world will not explain how people came to the point where they decided to go to their first counseling session, how they decided it was time to shift from the position of being a "powerless victim" to that of having the first seed of hope. But once a person finally finds some reason to live, something that gives their life meaning and purpose, something that makes their feelings worth exploring and encountering, then that person has begun the path of healing inside their heart and spirit. Only then will they have a reason to begin to take care of themselves physically, and hopefully live long enough that a cure is found.

The counseling journey can be a long one sometimes, but it has a simple beginning: deciding it's time to do something about one's life. People can move from being passive victims to active participants in their own life, thereby gaining more control over what is being done (or not done) to their body. Rather than just floating along in defeat, powerlessness, resignation and apathy in reaction to life's circumstances, they can begin to actually live the rest of their life more fully and hopefully, as its gifts become more appreciated the more they are explored -- but this also means accepting its emotional, mental, and spiritual (as well as cultural!) parts.

It is my position that people may not be able to do anything about the circumstances of their life, but they can find ways to improve how they respond to those circumstances. People may well have HIV, but it can be made to take a back-seat rather than running their life for them. As James Baldwin said, "If you don't live the only life you have, you won't live some other life; you won't live life at all!"...

Issues for Psychologists Ourselves

As AIDS continues to selectively devastate certain parts of the population more than others, in something resembling a plague or genocide, HIV infection can also easily become a very personal issue for those therapists trying our best to help. No psychologist specializing in HIV-related psychotherapy remains untouched by the numerous deaths of clients and friends (and colleagues!).

Despite a lot of new promising treatments, permanently surviving AIDS is a client concern where there is presently very little hope, when even the dreaded word cancer is losing its throat hold due to increased survival rates. Clients *can* survive AIDS, but in the earlier years, few did — and for those who are now living a lot longer than expected, survivor guilt is another major issue that arises (along with poverty and its mandate of poor housing and job insecurity).

Trying to help clients deal with their own imminent death, and/or the guilt/pleasure of not dying (yet) — while still managing to beat very heavy odds — can be a heavy load for any therapist. However, if we have also not yet dealt with the inevitability of our *own* death (and how confronting it can actually be very empowering), then we are likely not going to be able to help other people clear away the numerous issues around their own. This is a place where transference and counter-transference can easily and fluidly intrude, especially if the therapist is living with HIV her/himself.

If psychologists, doctors, and other people who provide help to those with HIV have themselves lost friends, family, or lovers to AIDS, we may be wearing our own subtle layers of anger, grief, frustration, and so forth, during the time we are trying to help others who are experiencing these same things — and those personally-selective filters are almost impossible to set aside. In this, there is not only the danger of personal burnout as the diagnoses increase, but also that in the numbers' multitude, therapists might find ourselves innocently resorting to functional generalizations, categorical labelings, and other consequences of AIDS' increasingly large numbers — and thus reduce the client to less than a full complex human being.

There are clients dealing with AIDS to try to help, as well as their own families, friends, lovers (or those who reject them) to help them communicate with. There are also simple medical consequences such as dementia or incontinence, which can test the therapist's own limits of tolerance. Sometimes our own mental stability becomes increasingly overwhelmed by something that is just too complex to encompass therapeutically and/or with medical odds too small to keep continually extending our hopes (and our clients') toward the ongoing goal of surviving day after day, client after client.

Also there are numerous therapeutic issues that my clients try to deal with, the likes of which I never dealt with in my graduate school training; for example, what can I tell a client who finds that people are unwilling to become sexually intimate or even emotionally committed with him because he might die soon (but then again, he might not), or because one tiny error or sloppy sexual practice might result in a possible death sentence? How do you recommend condoms to rural Aboriginal youth who come from a community that accepts all out-of-wedlock babies with no judgment or stigma because "the more children we have, the better we re-populate from the earlier effects of genocide"??

And then there is one more issue which is not so frequently mentioned: Psychologists who are themselves HIV-positive or who have arrived at the full diagnosis of "having AIDS" (or who love someone in this situation). These are professionals who are quite competently doing just fine, but for whom the clients' issues suddenly connect them with their own. Transference/counter-transference issues become even more complicated when those psychologists who are in some of the same situations as their clients are nevertheless still some of the very best people to be able to help.

Therapists who are themselves HIV-positive have personal dilemmas that were likely not even conceived of when they were receiving training that could never have prepared them for some of the choices they must now make about self-disclosure or not (What about duty to inform the client? If the client seems to be AIDS-phobic, should the therapist reveal their HIV-positive status?), taking on new clients or not (what if the therapist gets sick and can't work before this client is finished with therapy?), telling colleagues (they say they're comfortable with clients having AIDS, but what about a colleague — is this threatening or too close for comfort?), and other more complicated issues which just didn't exist in the days I received my training. But I do find myself wondering sometimes how could a therapist who has HIV (but is not "out" about it), ever counsel a client to "confront the fears and get on with life"? Yet "outing" oneself is not necessarily a safe thing to do yet in our Profession...

If clients are hospitalized for solely-medical, but not mental, reasons (like drug infusions) is it ethical to continue to see them inside their own hospital room instead of their office? If they are home-bound, is a home visit acceptable? Can I gently touch a client to offer comfort or communicate caring, without this signally mothering/smothering/ transference issues (or even worse, ethical breaching?). These sorts of boundary dilemmas arise from yet another kind of

"closet", one which is inside the emotional house of all of us doing this work, and there are no simple clear answers.

Conclusion:

From all these years of doing this work, one thing has become very clear in my mind: Reviewing various lists describing "the characteristics of long-term survivors of AIDS" such as I included above, it is quickly evident that these are very much the same characteristics of long-time-surviving psychologists who do the counseling of these people! What activates the immune system and enhances emotional health in one person can also work well for others, so the guidelines for helping people living with HIV to avoid burn-out or emotional overload, will certainly be equally good directives for caretakers or therapists.

To end on a more personal note, I share below my own list of what helps me emotionally survive this work and find it still enjoyable and worthwhile despite the pain of many losses. It is the same credo I try to encourage my clients to adopt:

- 1) Believing in the value of my own future, whatever it may be — along with my right to direct that future as I see best,
- 2) Remaining willing to live very intensely and vulnerably and avoid shutting down my feelings except when I need privacy in order to heal,
- 3) Doing what I believe is right and ethical in my actions so that I have choice and control over what I do (as long as I am willing to accept that the resulting consequences are no one's fault but my own!), and finally,
- 4) Remembering that to avoid burnout, I must be willing to take as well as give, to play and relax more with less guilt, to ask for help myself sometimes — and thus recognizing that I, too, have needs and the right to have them acknowledged and fulfilled, and that I do not always need to be the "strong knowing one" in a relationship.

This list has served me well, and many of my clients have found it helpful too.

Ten years ago, when this article first appeared, there was very little hope of surviving AIDS. Today there is more hope, based on newer treatments, yet this is a bittersweet hope because these are not universally accessible to all and don't always produce the same success, especially if the client is from a population or culture that the tests were not "normed" on.

It seems to me that we therapists have a large role to play in helping clients find ways to nurture and sustain their hope, in the trust that some day this will all be only a bad memory. I hope this article has helped provide some understandings that can assist that process...