Human immunodeficiency virus and AIDS are established among the general population, and traditional notions of counseling, psychotherapy, and case management are being tested as never before.

Mental health practitioners have responded to the challenges presented by the medical, psychological, social, and spiritual aspects of HIV/AIDS by expanding their range of services and by combining professional roles, thus “bending the frame” of psychotherapeutic practice. In addition to making home visits (see chapter 14) and counseling clients on spiritual issues (see chapter 4) and safer sexual practices (see chapter 8), some practitioners speak at memorial services, serve as client advocates, and facilitate decisions about advanced directives or suicide. New for many therapists is the role of accompanying their clients to the ends of their lives, being one of few if any significant friends at the client’s deathbed. Challenging, frightening, and rewarding, AIDS-related mental health care pushes the limits of traditional practice as we enter the 21st century.

Traditional psychotherapy roles are delineated by what are called “frames” of practice, dictated largely by the theory—such as psychodynamic or cognitive—that guides one’s work. Bending the frame suggests that mental health providers not limit themselves to traditional roles but, as necessity demands, go beyond the ordinary limits and established
**TABLE 2.1.**
Comparison of Traditional Mental Health Services and “Bending the Frame”

<table>
<thead>
<tr>
<th>Topic</th>
<th>Traditional</th>
<th>Bending the frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home visit request</td>
<td>Decline visit</td>
<td>Consider visiting</td>
</tr>
<tr>
<td>Case management</td>
<td>Refer to case manager</td>
<td>May do varying degrees of case management, making contacts for client, etc.</td>
</tr>
<tr>
<td>Spiritual/religious issues</td>
<td>Refer to clergy</td>
<td>Sharing, disclosure, discussion</td>
</tr>
<tr>
<td>Self-disclosure</td>
<td>Usually very limited</td>
<td>Often more disclosive, mentoring, modeling</td>
</tr>
<tr>
<td>Medical information</td>
<td>Usually refer to medical worker</td>
<td>Often provide basic HIV information, educate and facilitate client’s medical decision making</td>
</tr>
<tr>
<td>Advance directives</td>
<td>Explore meaning of directives in context of therapy</td>
<td>Often educate and facilitate client’s decision process</td>
</tr>
<tr>
<td>Contact with family, partner, friends</td>
<td>Minimal or none</td>
<td>At client’s request: joint sessions, other meetings, grief work</td>
</tr>
</tbody>
</table>

boundaries. (For comparison of traditional and “bending the frame” responses, see table 2.1.) This requires:

- Development of a large repertoire of skills and resources with which to serve clients. Provider roles now encompass a field of skills as diverse as advocacy, case management, and existential psychotherapy.
- Deliberate, ethical, and theoretically sound selection of therapeutic responses to client needs. Bending the frame brings with it responsibilities. Its practice demands that professionals reexamine the legal and ethical aspects of their work, their real and therapeutic relationships, and the sources of personal authority from which they practice.

Winiarski (1991, 1993a, 1993b, 1995) conceptualizes the range of psychotherapeutic styles along a continuum of paradigms. At one extreme are therapists who maintain a friendship-like relationship with their clients. At the other are those whose therapy is not a dialogue and who are always neutral. Winiarski (1991) maintains that no single, unbending therapeutic frame can serve the HIV-positive client’s changing needs through the course of illness. Immediately after diagnosis, the client may require
shoring up, crisis intervention, and family intervention for support. Through the asymptomatic period, the patient may benefit from attention to preexisting problems and to short-term goals that reflect meaning in life. Toward the end of life, the client may require case management and assistance in obtaining services.

The preceding chapter noted that the issues relating to HIV/AIDS do not clearly sort into biological, social, psychological and spiritual components. Similarly, the mental health service needs of people with HIV/AIDS do not fall into well-circumscribed domains of counseling, psychotherapy, and case management. Many issues are addressed in service areas where all three disciplines overlap, a psychosocial Bermuda Triangle of sorts, where professional distinctions disappear. Still more work falls outside the traditional boundaries of all three fields. Mental health workers of the next century must develop the skills and the support networks to move in all three domains and beyond.

**Background Reading**

Winiarski (1991) initiated the concept of flexible therapeutic frames and the need to move along a continuum of roles and therapeutic styles in accordance with a client’s changing circumstances. The term *bending the frame* appeared first in his description of integrated medical and mental health care for people living with HIV (Winiarski, 1993a). The American Psychological Association’s AIDS training curriculum appropriated the term to reinforce the necessity of using a flexible therapeutic frame in this work (Winiarski, 1993b).

Other authors have mentioned the concept of work beyond the traditional limits of their professions. When describing psychoanalysis with poor, urban clients, Altman (1993) emphasizes the multiple roles that therapists are called on to fill and notes that diverse worldviews challenge practitioners to differentiate pathology from cultural diversity. Blechner (1993) similarly observes that therapists with clients who have AIDS sometimes abandon their roles and become involved in their patient’s lives. When discussing the helplessness therapists feel, Farber (1994) acknowledges the biopsychosocial complexity of HIV/AIDS as well as the necessity for case management of HIV-related needs.

Of course, these stances have not been without criticism. In their review of Winiarski (1991), Wagner and Schell (1992) wrote, “It is generally believed that meeting the client’s ‘needs and desires’ is not the role of
the psychotherapist” (183). Rosica (1995) observes that the emotional aspects of HIV-related therapy are strong and that practitioners may avoid experiencing the pain that accompanies accurate empathy. This avoidance may be manifest as either emotional distance (excessive boundaries) or overidentification (loss of boundaries). Learning to sustain a balance between the two requires supervision and ongoing emotional support. Thus, practitioners need to be deliberate when tailoring and maintaining boundaries that are appropriate to each client’s needs. Still, as Curtis and Hodge (1995) note, AIDS work requires “new kinds of helping relationships for which traditional clinical boundaries provide little specific guidance” (5).

My Clinical Work

As a psychotherapist working with people with HIV at a large, inner-city medical center, I was frequently challenged by personal, professional, and ethical situations not addressed in my graduate studies. Almost daily I experienced anxiety about “bending the frame.” Later, as training director of the American Psychological Association’s HIV-related training program (the HOPE Program), I heard a secret held by most of the faculty experts: To practice effectively, these practitioners “bent” the frames of psychotherapy theory.

The faculty reported making home visits, bartering for services, eulogizing clients at memorials, facilitating decisions about suicide, and accompanying clients to AA meetings. These senior therapists reported a sense of relief once the group had shared its common “secret,” and a new sense of enthusiasm for the work ensued. The telling of our unorthodox stories was so powerful that we built it into the seven HOPE Program curricula.

Barriers to Bending the Frame

Those who choose to bend the frame of professional practice face at least four types of challenges: personal barriers, professional/ethical barriers, legal barriers, and systemic barriers.

Personal Barriers

The personal barriers are perhaps the most challenging and rewarding to overcome. Serving people with HIV, we are called on to confront our own attitudes, values, beliefs, traditions, habits and fears about our clients,
ourselves, and the ways we practice. A client once asked me: “Why do you think AIDS is here?” I responded that I thought it was “to show us where we need to love more.” Over the course of therapy, he taught me a great deal about the FFA (Fist Fuckers of America), and I had an opportunity to test my hypothesis. In supervision I learned techniques to notice but “bracket” or set aside my own feelings as a therapist. In my own therapy, I worked on those bracketed issues and explored my barriers to regarding clients positively.

Professional/Ethical Barriers

Many professional codes of ethics are general and difficult to apply to individual HIV-related cases. Even specific HIV-related policy statements yield conflicting interpretations. Practitioners may encounter codes of ethics that do not accommodate the nontraditional aspects of practice necessary to serve HIV-affected clients effectively.

Furthermore, professional codes of ethics and policies based in the dominant culture may be irrelevant to the worldviews of some clients. If a client’s culture holds that the only possession over which one has dominion is one’s body and that suicide, therefore, is acceptable, then requirements to prevent suicide may counter ethical principles such as autonomy.

Legal Barriers

Laws may pose real challenges, especially if they or their interpretations are unjust or unclear. Laws regarding suicide, duty to warn, right to know, and partner notification may prescribe practitioner behavior. Given the social-political climate in the United States in the 1990s, future laws or work place policies may contradict the therapist’s and the client’s personal values and beliefs about life, freedom, and justice.

Systemic Barriers

Many providers work within systems that do not espouse a biopsychosocial/spiritual outlook on HIV/AIDS. AIDS work requires an interdisciplinary effort by the health, mental health, community, and social service members of a care team. Each discipline brings its own culture, values, rules, assumptions, and ethical practices to bear on the person with HIV and on other members of the team. The values of providers may, for
example, conflict with those of administrators regarding teaching safer sex negotiation skills to seriously mentally ill persons and making condoms available to them. It is doubtful that all interacting disciplines and personalities will arrive at the same solutions in response to the AIDS pandemic, and practitioners must learn to negotiate the differences.

**Recommendations for Future Practice**

Given the demands of working with HIV/AIDS clients, I offer the following recommendations to practitioners:

- It is important to develop a theoretical basis for practice that accommodates bending the frame. Unresolved role conflicts, limiting practice to a narrowly defined role, and focusing on knowledge, facts, and philosophical issues impede effective work with clients who have HIV/AIDS (Namir & Sherman, 1989). AIDS work has called on many of us to reassess the paradigms from which we practice in order to serve effectively the needs of our clients as they move across the spectrum of HIV/AIDS. A contemporary theoretical foundation forms the basis of one’s discernment and helps prevent making capricious decisions about when to bend the frame. It also demands continuing assessment of the implicit and explicit guidelines for practice.

- Ongoing supervision must be an integral part of HIV-related practice. Trying to do too much alone puts practitioners at high risk for unskillful practice and burnout. Many larger urban facilities provide supervision and peer consultation. Rural practitioners who work in relative isolation should find periodic supervision at metropolitan AIDS facilities. Telephone consultation, teleconferences and e-mail consultation are also advisable.

- Often mental health service workers are the only members of institutional staff who understand the full scope of issues facing the HIV-positive client and his or her feelings about them. With the client's permission, practitioners can serve as advocates for disenfranchised clients within complex medical-social service systems.

**Tools for Clinical Practice**

The following are my observations on critical aspects of working with HIV/AIDS clients:
• HIV/AIDS work requires a broad repertoire of professional role responses, skills, and therapeutic styles that allow practitioners to function in psychotherapist, counselor, and case manager roles.

The therapist must understand that to work with an HIV-positive client requires a broad range of professional skills. He or she must actively undertake to learn those skills, rather than work unknowingly and, likely, unethically with HIV-affected clients. Psychotherapists need to be knowledgeable about clients’ current and future likely situations and to enter into a contract based on the abilities of both parties to sustain this relationship. The practitioner must honor the therapeutic goals of the client, which may not be the goals the therapist would choose. Effective AIDS mental health work requires that practitioners be client-centered and serve the whole person.

• HIV work involves education and case management. Therapists who bend the frame find therapeutic moments while performing those services.

AIDS has disproportionately affected marginalized and stigmatized people in the United States. Reliable case management is necessary for most people with HIV/AIDS, because most will require a number of social services throughout their illnesses.

After the client undergoes HIV testing, part of the therapist’s work will entail educating the client about available resources as well as about HIV/AIDS itself. Adherence to medical recommendations may be an issue, and the clinician can explore what it means to the client to have so much time consumed by medical and social service appointments.

An issue that often arises in HIV-related therapy is the client’s frustration when negotiating the welfare system. People with AIDS need to make decisions about ceasing to work, getting Social Security benefits, and being designated “disabled.” Furthermore, clients receiving public assistance cannot move in and out of the wage-earning work force as their health fluctuates without losing medical coverage for the future when they may be sick again.

These case management issues have a therapeutic component. Consider such a disenfranchised client in therapy who needs to access social services. This is a client who lacks the social skills, emotional stability, and physical stamina to negotiate the social
service system independently. There may be a temptation to provide the client with appropriate phone numbers or to refer him or her to a case manager with whom he or she will have to establish yet another relationship.

Generally, a therapist who bends the frame might determine with the client what part of the task the client can perform successfully, such as obtaining initial information over the phone, and what therapeutic goals that might achieve. The therapist might assume an advocacy role, placing a call, negotiating with the social service worker, and putting the client on the phone all during the therapy session. The remainder of the therapy session might center around processing the interaction. Here the therapist has worn several hats: counselor, case manager, advocate, teacher, mentor, and therapist.

One barrier to bending the frame is the risk of “enabling” clients to maintain their pathology if the therapist performs duties outside the traditional role. The practitioner does not need to discontinue therapy in order to facilitate case management tasks; however, continued therapy might not be possible if such tasks are not performed. Effective clinicians will evaluate what they and their client feel is most helpful.

- HIV-related psychotherapy involves exploring a range of themes.

Adjustment to seropositive status is a process of integrating new information about oneself into one’s existing identity. It is nearly a developmental process of redefining oneself, and it takes time. The change involves a true grief/loss/rage response in many people. For some, dealing with guilt is an issue.

Other clients may have experienced a lifetime of discrimination and abuse as a result of their sexual orientation. Many gay men have considered or attempted suicide prior to acquiring the virus in part as a result of their own internalized heterosexism. Therapists do well to explore issues of unresolved childhood emotional, physical, and sexual abuse as well as rejection by school and family. Many clients have been disenfranchised from their families and have left home. When forced to return to their families due to their nursing needs, some find themselves in a reconstructed childhood role, and a host of unresolved family issues may come to the surface again.

For more psychotherapy themes, see Winiarski (1991) and Kalichman (1995).
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- **Legal and ethical dilemmas abound in AIDS-related work.**

  Practitioners need some framework or model for making ethical decisions that will sustain them even when some other parties are not pleased with it. They should rely heavily on consultation and documentation as necessary. Kitchener (1984, 1988, in press), Melton (1988), Reamer (1991, 1993, 1994, 1995) and Burris (in press) have written extensively about ethical and legal issues. The American Psychological Association’s Office on AIDS has developed a training curriculum (Jue & Eversole, 1996) to help practitioners apply a model for making ethical decisions related to HIV/AIDS.

  When confronted with an ethical dilemma, it is important to pause and deliberately identify one’s personal responses to the case (Jue & Eversole, 1996). The practitioner’s countertransference can greatly influence the decision-making process. It is helpful, then, to review the facts of the case and to conceptualize an initial plan on the basis of the clinical issues involved. While codes of ethics for the practitioner’s professional association may give additional guidance, evaluating the initial plan according to five ethical principles (i.e., autonomy, beneficence, do no harm, fidelity, and justice) provide a better understanding of the codes and how best to apply them. Practitioners may need to consult an attorney to identify the legal issues and risks in order to assess the options. In addition to considering all the personal, clinical, legal, and ethical perspectives, workplace policies and consultation with supervisors influence the decision. With careful consultation and documentation, practitioners can then choose a course of action and move forward with it.

- **AIDS work brings practitioners into the arena of sex, drugs, and death.**

  The traditional role that psychotherapists or counselors play doesn’t include demonstrating the use of a condom with a dildo. Consequently, few professional programs prepare students to deal with their own countertransference around sex and diverse sexual orientations. Practitioners of the 21st century must be able to talk freely with clients about sex. They must possess the information, skills, and language to teach safer sex techniques and especially the negotiation of safer sex. They must be comfortable taking a thorough, explicit sexual history with all clients in order to make accurate HIV risk assessments. Workshops and profes-
sional training should include experiences that normalize conversation to acquire explicit sexual information. Practitioners must be sensitive to any discomfort they experience with these issues and address them in supervision and in their own therapy.

AIDS work requires providers to be grounded in a framework for dealing with addicted clients and to be very aware of their feelings about individuals who continue to use substances. They must be competent to take a drug use history, to identify substance abuse, and to address its treatment. They must make decisions about treating clients who continue to use drugs or occasionally relapse. Since one policy may not serve all clients equally well, practitioners should decide whether therapy under such conditions helps move the client toward a healthier state and, if so, whether the situation is abusive to the therapist.

In addition, practitioners must understand their own issues around loss, grief, and bereavement. Many clients need to grieve the death of their partners, children, and many of their friends in rapid succession. Therapists should be cognizant of disenfranchised grief (mourning that cannot be publicly displayed and supported by the client’s family and friends, such as the loss of one’s lover). Often the therapist’s office is the only place the client has the opportunity to grieve, and the therapist is the only person trusted to witness and validate the client’s loss. Clients may need to grieve the loss of the healthy persons they used to be. They may need to grieve the loss of their dreams and aspirations. AIDS is a disease of loss after loss after loss, and it challenges good therapists to uncover sources of hope with the client.

Clients may want to talk about death and what they perceive it will be like. They may want to make preparations for death, including completing relationships with significant people in their lives. Practitioners must be prepared to facilitate clients’ decisions about wills, living wills, do-not-resuscitate orders, durable powers of attorney, guardianship of children, suicide, and funeral arrangements.

Practitioners also need to know their own “trigger issues” related to grief and loss and to learn techniques such as “bracketing” or putting their own issues on hold in order to remain faithfully present for their clients. It is incumbent on helping professionals to do their own work on grief issues once they identify them. Grief work can involve identifying one’s own
losses, relating them to the tasks of grieving (Worden, 1982), and taking steps to move toward completion of those tasks. Finally, they must actively attend to their own methods for effectively grieving new losses associated with their work. Grieving requires some way of externalizing the emotion and the pain of loss (see chapter 5).

- **Bending the frame requires practitioners to reevaluate their notions about “compliance.”**

Many clients move in and out of therapy over the course of their illnesses, not wanting to be reminded about their disease when they feel well. Therapists may find themselves angry with clients who only come for therapy when things are not going well. Clients who are very ill may not be able to come to therapy sessions at all but may need it most at that time. First and most of all, the therapist should try to help the client understand the meaning of the “noncompliant” actions. With understanding, a client has more freedom to make choices rather than being limited by reflexive, unconscious responses.

In response to the client’s inability to attend sessions, bending the frame might include making home or hospital visits and conducting therapy sessions at the client’s bedside in a semiprivate room or literally spoon-feeding the client throughout a session.

- **Counselors can help clients deal with issues of disclosing their HIV status.**

Clients must make decisions about informing sexual partners and people with whom they may have shared injection equipment. Disclosure may involve considerable risk for clients. It may entail disclosing their sexuality, adulteries, or addictions as well as notifying significant others that they may be infected with the virus. Clients may risk physical harm, death, eviction, rejection, and loss of children or jobs by disclosing their serostatus to others. Counselors and therapists can assist clients in assessing the real and perceived dangers of disclosure.

- **Bending the frame sometimes involves an untraditional degree of self-disclosure and mentoring.**

The real relationship may be therapeutic. Once, when a long-term client told me that he had been diagnosed with a terminal cancer, an involuntary tear rolled down my face. My client asked, “Why are you crying?” and I answered him honestly: “Because
you told me you have cancer, and I am feeling sad." Practicing a relationship of fidelity and honesty had been a therapeutic goal, so it was important for me to be congruent when asked about our real relationship.

Clients with AIDS may ask therapists directly about their sexual orientation. Some sexual minority clients, lacking role models and mentors, ask their lesbian or gay therapists how they manage certain aspects of their lives. Here again the real relationship is called on to be therapeutic. Therapists need to understand their own internalized oppression and to make choices that benefit the client. In bending the frame, the boundaries between client and therapist may shift, but a sound rationale for how and why the frame is bent can keep providers from falling into an unhelpful relationship. Boundaries may be more flexible at the therapist’s discretion; however, the therapist is no less aware of or responsible for them.

• AIDS work lends itself to a transpersonal approach.

Perhaps one of the greatest honors for therapists is the journey they take with a client up to and through the client’s death. Therapists may notice themselves becoming more transpersonal in their approach as the roles of learner and teacher change over the course of therapy. In essence, the therapeutic relationship becomes one of two partners in a shared covenant (Driscoll, 1992; May, 1983). The counselor agrees to serve as a guide whose faithful presence, honesty and boundaries will be therapeutic. For practitioners who bend the frame, that agreement includes a commitment to continue with a patient through death or cure. A mental health professional may be the only friend the client expects to outlive him or her, and the therapeutic relationship may be the only trustworthy relationship in the client’s life. Kain (1996) observes:

We must become good guides. We must be willing to ride the rapids of our HIV-positive clients’ lives without complaining about the cold temperature of the water or the heat of the sun. We must remain present at our clients’ side from the time they first set into the water until the time they are lifted out. (xxvi)

• A practitioner is only one player in the client’s larger physical-spiritual phenomenon and comes to understand his or her own life-death transition differently.
In some theories, the client is expected to internalize the healthy aspects of the therapist, and there may be an implicit (or explicit) assumption that the therapist will remain unchanged. The therapeutic covenant, however, is created in a closed vessel, a crucible, in which both the therapist and the client are exposed to the energy of living and growth. As the client transitions from an incarnate being to a spiritual being, the therapist is exposed to a changing life energy and perspective that is operationalized in the client's behavior, emotion, and insight.

Many therapeutic frames are based on ego and healthy differentiation of self. While the therapist usually does not die during the covenant, the HIV-positive client usually does. In the later stages of the client's life, there may be an unspoken conflict in therapy if the therapist tries to strengthen ego and differentiation while the client, who is moving from an incarnate being to a spiritual oneness, is attempting to lose it.

As clients move toward death, some constrict their circle of relationships, and the counselor or therapist may be terminated before he or she is ready. Ordinarily, one might explore the client's reasons for terminating, but dying people move to another set of priorities and may not "process" this change with their therapists. Practitioners may experience a feeling of being left behind. We cannot repeatedly walk this transitional path from body to spirit with clients and remain unchanged.

- **Effective AIDS-related practitioners clarify their spiritual beliefs.**

If mental health service providers are not comfortable bringing the genuine and spiritual aspects of themselves into therapy, they may not serve clients fully. Therapists must be willing to sit with a client through conversations about spiritual issues and experiences. Discomfort with the topic and quick referral to a cleric or medical practitioner can betray the fidelity of the relationship. The practitioner's spiritual beliefs often expand and strengthen as a result of doing AIDS work, and these beliefs can serve as a true resource when cases seem confusing or overwhelming (see chapter 4).

- **HIV/AIDS creates more need than any one person can supply, and practitioners need actively to address their own tendencies to burn out.**

Garfield (1982) notes that some of the factors promoting burn-out include isolation, lack of support, unrealistic self-expectations, lack of self-monitored time out, and excessive responsibi-
ties. Furthermore, the stigma associated with AIDS and dying compounds all other stressors and denies caregivers external reinforcement. Mental health service providers, in systems unsympathetic to substance users and HIV-affected persons, often are caught in the middle of conflicts, negotiating the dilemmas between client rights and the needs of clients, their families, significant others, staff, and self. Practitioners need to develop strategies in their personal lives and at work to address the exhaustion and disenchantment common in HIV/AIDS work. These ways include:

— Appreciating all the successes or “wins” practitioners can find in their work, such as facilitating a decision about treatment so that a client lives long enough and well enough to complete an unresolved relationship or goal.

— Clarifying those things in which we have faith. Faith isn’t discussed much as a therapeutic tool in graduate and professional training. It can be extremely sustaining to know that the ordinary and unspectacular moments in sessions serve a purpose. A client, who I feared was benefiting little from our work, once told me before he died that the insights he’d gained in therapy were instrumental in reconciling his relationship with his family. The value of our efforts may not always be made clear to us, but we need to have faith that they are worthwhile.

— Reviewing our motivations for doing AIDS work and making sure we get those needs met. Practitioners should monitor their tendencies toward work addiction and routinely evaluate whether they want to continue doing this work. A hallmark of “AIDS burnout” is the belief that leaving this work is not acceptable.

Conclusion

Providing mental health services to people with HIV requires practitioners to bend the frame. Bending the frame is a paradigm shift from traditional service delivery (“doing to”) toward facilitating empowerment of clients (“doing with”) as successful consumers of mental health services. To make the shift, practitioners need a wide range of psychotherapeutic,
counseling, and case management skills and the ability to move easily from one mode to another as the client’s situation requires. In addition, the work requires us to be very deliberate in managing our professional relationships with clients and to value our real relationships with them as well. As for our clients, AIDS calls on us to reexamine the sources of authority in our professional and personal lives and to respond in a way that is true for us. AIDS work compels us to look at our own issues and to grow as professionals. It reminds us to live fully. It shows us where we need to love more.

REFERENCES


