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Countertransference Issues in HIV-Related Psychotherapy

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Since Freud (1910/1959) first suggested the ideas of transference and countertransference, clinicians have learned to be especially aware of the ways their own emotional issues may influence the course of psychotherapy. While the debate about the validity and the application of these two concepts will never be completely resolved, contemporary practitioners are using terms such as boundaries (Rosica, 1995), overidentification (Caldwell, 1994), and compassion (Winiarski, 1995) to describe what is at least a similar phenomenon.

As the incidence of HIV infection has increased, mental health workers and researchers have reported the highly complex issues that force the practitioner to step beyond the traditional boundaries of the client/clinician relationship. This "stepping beyond" requires a creativity in treatment that can increase the likelihood of a dangerous countertransference (Macks, 1988; Shernoff, 1991).

Eversole, in the preceding chapter, writes about the necessity of "bending the frame" in HIV/AIDS-related psychotherapy. Stepping beyond the limits of the traditional psychotherapist's role is demanded by the need for home and hospital visits and the often close relationship that can develop between the clinician and the client, as well as the client's support system. Eversole explores specific behaviors such as attending funerals or
becoming involved in a client's support system as examples of tasks that
most would not include in a description of psychotherapy or counseling.
Nevertheless, these behaviors are often justified as the clinician faces the
stigma, rejection, and political debate that surround HIV treatment.
Working with clients who may have been rejected by their families or
who have no medical, financial, or social support systems brings the
practitioner face to face with human needs that demand attention.

Consider the situation of an HIV-infected mother of three young
children who has no money for basic needs. During a home visit the
counselor discovers that there is no food in the house and the mother is
too sick to go to the grocery. Obtaining some food for this family might
take precedence over becoming involved in interpersonal exploration.
Similarly, agreeing to take responsibility for planning a client's memorial
service puts the mental health professional in an entirely new role, one
that is likely to involve significant emotional responses. The clinician
“bends the frame” when direct involvement in such activities takes place;
the emotional responses to needs such as these constitute potential coun-
tertransference. Countertransference is a more internal process and can
certainly be positive or negative. Some clinicians react angrily to injection
drug users who present with HIV or refuse to step beyond their tradi-
tional role because of internal emotional responses that reflect unresolved
personal issues as opposed to appropriate clinical assessments.

This chapter reviews contemporary views of countertransference as
seen in HIV-related psychotherapy, summarizes a case that clearly reveals
the potential emotional difficulty that some practitioners experience, and
gives suggestions for ways to address the dangers posed by this phenome-
on. Let's begin by looking at what the literature tells us about counter-
transference.

Background Reading

Freud (1910/1959) provides the generative material on countertransference,
and more contemporary writers, using other terms, expand this concept.
Freud defined countertransference as the projection by the analyst of his
or her feelings, attitudes, or desires onto the patient. These projections
can take positive or negative forms but represent an unconscious desire to
satisfy the analyst's internal need. If left unaddressed, this process will
impede the analysis. Countertransference calls on the analyst to examine
internal material to understand self more completely. It can pull us more
fully into the patient’s life or push us away, but it also can provide an opportunity for much personal growth and increased appreciation for the richness of each person’s life experience.

In the case of the HIV-infected, issues such as death at an early age, family rejection, stigma, the often intense political debate, a reliance on experimental treatment, and other very complex issues, countertransference is likely to occur in the form of intense overinvolvement or distancing.

Genevay (1990) suggests that in working with elderly dying clients, many practitioners remain detached because of their own fear of helplessness and loss of control. The helplessness that many professionals report as they encounter the dying can generate fears of one’s own death that are intense enough to lead to denial and distancing. This denial can take the form of telling clients how well they look, encouraging them to consider participating in future events that clearly will occur after their deaths, and even staying away in the belief that there is no crisis.

Examining feelings like these can lead the psychotherapist to the realization that the real fear is of his or her own death and suffering. When the unconscious motivation for such behaviors is realized, there is the potential for a kind of honesty and realness that is rarely found in the workplace. Engaging such fears leads to a kind of personal development that enriches life. According to Genevay (1990), being helpless with the client empowers the client as well as the practitioner, but she warns that keeping clear the distinction between being a professional and being a friend is essential. This means that while the clinician may become more involved, limits must be clear between the client and the helper, and a constant eye must be kept on the ethical parameters of the relationship. Appropriate caring takes place within these limits. The trick is to learn to be present, to let the patient lead, but to also be clear about the limits of the relationship.

Federn (1952) was among the first to liken countertransference to boundaries. According to Federn, ego boundaries are flexible and serve to mark the limits of the ego and the outside world. When the therapist loses ego boundaries, he or she merges with the client and experiences a conflict between being empathic and preserving self. The potential loss of self increases the threat of countertransference in all psychotherapy, but especially in HIV-related psychotherapy. According to Rosica (1993), such blurring of boundaries leads to suffering by both the therapist and the client: “The therapist loses his or her identity as clinician, objectivity and
Such loss of boundary can lead to feelings of guilt, rejection, abandonment, helplessness, loss, sadness, and grief and a struggle among empathic identification, overidentification, and loss of self. Gabriel (1991) sees the bereavement reported by therapists who work with the HIV-infected in group settings as an example of countertransference. As they struggle with a wide range of internal emotional responses, helpers are called on simultaneously to help surviving group members live with these deaths and to face the threat of their own deaths.

Winiarski (1995) points out that HIV may elicit unsettling issues and feelings, such as "moral judgments regarding sex and substance use; psychological discomfort regarding alternative sexual practices and substance use, including but not limited to injection drug use; judgments regarding women, their sexual activity and childbearing responsibilities; racism and classism that include anger at disadvantaged urban minority culture members; feelings of helplessness, and seeming inevitable loss" (429). He points out that in HIV-related psychotherapy, provider attitudes often interfere with skillful practice. The effective use of compassion can become blocked by the practitioner's seeing clients as stereotypes and by his or her emotional reactions to the situation, ranging from viewing HIV-infected substance abusers as poor candidates for help because of perceived character deficiencies to the need for emotional distance because of fears of helplessness or death. Reactions like these are common for all professional groups involved in the treatment of persons with HIV disease (Silverman, 1993).

Caldwell (1994) uses the term "overidentification" to describe similar phenomena and sees gay psychotherapists as especially vulnerable. McKusick (1988) identifies common countertransference issues as fear of the unknown, fear of contagion, fear of dying and of death, denial of helplessness, fear of homosexuality, overidentification, anger, and need for professional omnipotence.

Other examples of potential countertransference include viewing HIV-infected children and hemophiliacs as most deserving of treatment because they are "truly innocent victims," to refusing to work with an HIV-infected drug user until the substance abuse is under control, to becoming overinvolved in one of the HIV-infected communities to the exclusion of others who are suffering. The problem posed in countertransference is not necessarily the action that one takes but the often unconscious personal issue that is serving as the disguised motivator. Certainly the prac-
countertransference who greets his or her emotional responses as an opportunity for further self-understanding will encounter the kind of growth that can lead to more competent practice.

Countertransference is thus a potentially powerful event that seems to permeate HIV-related psychotherapy and that can serve as a signal to the therapist that personal issues are present. While some, like Genevay (1990), may see this awareness as a call for growth and a potential enhancement for both the therapist and the client, others, such as Winiarski (1995), point out potential negative influences. In either event, the presence of countertransference demands that the practitioner proceed carefully. Before we examine ways to address this issue, let’s look at a case to get a feel for what might happen.

The Case of Mike

Mike was a twenty-nine-year-old gay man who had been rejected by his family and who had few friends. He initially consulted me because of depression related to chronic fatigue syndrome. As months passed he presented with symptoms of HIV disease but insisted that his physician had assured him that the proper diagnosis was chronic fatigue syndrome. Eventually at my urging he consulted another physician who diagnosed him with AIDS. I quickly became part of his primary support system, for his friends knew little about medical care and Mike’s resources were limited. Although I encouraged him to contact our local AIDS service organization, his social skills were such that he remained alone and agonized about being rejected by his family, who lived in another state. Without my knowledge he approached a fundamentalist church, hoping for acceptance and assistance but finding judgment and rejection. When he spoke to me about this, I was very distressed, and I quickly sought out a minister who agreed to visit him and simply listen to what he had to say.

Perhaps this “overidentification” seems to have been executed easily and without thought. Each step I took was a troubling one. Aware of my own struggle with my father, now deceased, who failed to value me, I knew that some of my motivation was to show Mike that he was a person of worth and deserving of dignity and love. At the same time I carefully weighed the “cost” of moving beyond the traditional psychotherapy relationship into more of a nurturing friendship. Rarely did I step forward without hesitation and often intense internal debate. Knowing I could not
do as much for each of my clients, I attempted to identify the specifics that drew me to Mike. I tried to keep my focus on what might help him through each crisis and held on to a philosophical belief that all humans deserve to die surrounded by people who care for them. Unfortunately, Mike had virtually no one who understood his need for reassurance and love.

As his medical condition worsened, he was frequently alone for long periods of time, and I was one of the few who visited him. These visits began in his home but soon took place in hospital rooms and intensive care units. He spoke frequently about his fear of dying alone and his enormous sense of abandonment by his family. As he weakened, I assured him that someone would be present at his death. I spoke with his two friends about the importance of being there, and I instructed his nurses to call me if they failed to show up. The call came in the middle of a night marked by severe storms. Phone lines were down in various parts of the city, and his friends could not be notified. I went to the hospital and sat holding Mike's hand while he died. He was in a coma and unable to talk, so I spoke to him about his life and how much I had appreciated knowing him and told him it was OK to go, that he had finished his time with us. After some time he squeezed my hand twice and simply quit breathing.

When I left the room, his two friends appeared, and we shared some time together. Mike had not wanted to be buried in the local pauper's field. I was fortunate to be able to find a funeral home that donated services and a church to purchase a burial site for him. I gave his friends directions on what to do and tried to put them in charge, but they did not have a clue about how to make arrangements, and I found myself in an unexpected role as the key person in planning a funeral. I was amazed that people stepped forward with offers to help. A minister volunteered, Mike's former boss provided flowers, and, at the very end of the service, his family piled out of their car to attend the burial. On request, I made some comments at the grave.

What I had done was "bend the frame," maybe even twist the frame completely out of shape. At the same time, I was struggling internally, trying to figure out if I had totally lost my professional self and worrying that what I was doing was very wrong. For days I puzzled over my actions: Did I sit with him through the night for him or for me? Was this really a selfless act or was I reassuring myself that I would not be alone at my death? Was I in some twisted way trying to bank compassion so that I could draw on it from others when I was in need? Did his helplessness
and death in some strange way reassure me about my own power and future? Was I needing to witness his death so I could live more fully? What was I to do with all this sadness? Questions like these haunted me, and I felt very alone. To label these emotions as countertransference seemed at once appropriate and also demeaning.

As I struggled with these issues, I turned to colleagues for assistance. Most said to me, "What difference does it make? Mike had a companion when he died and that is what he wanted, and maybe you had an opportunity to work on one of your issues." While reassuring, these supportive comments did not end my self-examination.

Like most practitioners, my professional training was very traditional. The psychologist is supposed to be somewhat detached, should not reveal much personal information, and certainly is not supposed to have physical contact with the client. Psychoanalytic concepts such as transference and countertransference seemed of little use in my cognitive-behavioral world. Of course, over the years there have been those clients that I did not like and some who evoked intense compassion in me. And I would run across the occasional client who seemed unduly attached to me and curious about my personal life. But rarely did I conceptualize the dynamic in psychoanalytic terms. My training taught me to be a professional and to keep my personal feelings separate. I had accepted the role of a distant and personally uninvolved clinician without much question. That orientation began to change when I became a volunteer counselor with cancer patients. Suddenly I was in close contact with my client’s family members and a regular visitor in their homes. Helping a client tell his sons how sad he was that he would not live to see them graduate from high school evoked many emotions in me. My yearning for such a loving and courageous father and my sense of rejection by my own father was obviously present in that moment. Once I became involved in HIV work I knew quickly that my own feelings were going to a significant part of this experience.

As I have spoken with other professionals who work with HIV-infected clients, I have asked what draws them into this difficult work. A usual reply is that in the work they find a kind of honesty and love that is rarely encountered. They speak of being moved by courage and commitment and of developing a keen awareness of the preciousness of life. They talk about the strength of family and support systems and of their growing spirituality. They report not fearing death so much and even discovering increased confidence about being alone.
Another group of professionals reports being angry all the time. They talk about the lack of resources and even the undependability of many of their clients. Their lives have become dominated by an insidious anger that destroys virtually all of their enjoyment of normal life activities. They are not just burned out; they are totally depleted and feel trapped in the work because “there’s no one else to do this if I give it up.” They have become professional and chronic victims. It is not hard for me to see that some have been drawn to the work because of previous feelings of anger and victimization and that they remain in the work in a futile attempt to deny their own issues with negative emotions. If their attachment to the work is pathological, what do I make of the more positive experiences I am having?

Naturally, the answers to questions like these are complex and are usually not readily apparent. The bottom line for me is whether I can defend my actions and find a sense of internal understanding and peace about what I am doing. For me, that is the crux of using my countertransference issues productively. And I have learned that I cannot reach such tranquility alone. Working with HIV-infected clients demands that I be willing to engage my emotional responses more fully and be alert to the ways that my own issues create potential pitfalls.

Not all countertransference is in the direction of compassion. One of the first HIV-positive injection drug users I treated had been brought to the clinic by his girlfriend. She had reported to her physician several horror stories about his suicide threats, disappearances, and abusive rages. She took his abuse and arranged for him to come to the clinic to talk to me. After waiting for him for twenty minutes, I was surprised to see his girlfriend open the door to my office. Startled because he was not there with me, she dashed about the clinic and found him in a restroom shooting up his drug. When she brought him to me he was high and unable to speak coherently, and I found myself thinking of ways I could terminate the case before it had even gotten started.

In supervision I learned that my resistance to working with him was created by my fear that I had nothing to offer that would help him control his drug habit. Once I recognized my reaction as my problem, I was able to interact with him more successfully.

The conflicts that arise in HIV-related psychotherapy or counseling demand careful attention. Often the clinician cannot resolve these issues alone. And sometimes there are few in our communities who understand the unique quality of this work. If unaddressed, countertransference can
lead to ineffective treatment. Fortunately there are ways to “turn up the volume” on these issues to guard against negative outcomes.

**Tools for Clinical Practice: Resolving Countertransference**

Clinicians working with HIV/AIDS clients may benefit from following these suggestions:

- **Don’t just do something; stand there.**
  
  Recently I co-led a workshop on living with a chronic illness. My colleague spoke about the kind of professional helplessness he often felt when faced with a dying client. He reported that he gained comfort in realizing that the old adage “Don’t just stand there; do something” could be changed to “Don’t just do something; stand there!” This change helped him understand that in being present, he was offering something very precious — his willingness to feel his own helplessness and not run away. In our outcome-oriented culture, it is difficult for many to continue to be involved in such difficult work when there are not always mileposts of progress to give reassurance of effectiveness.

- **Engage in case management.**
  
  Case management (Curtis & Hodge, 1995) is one of the means of dealing with countertransference. Learning about community resources and knowing when and where to refer clients can reduce the sense of helplessness reported by many practitioners. AIDS service organizations, social service departments, food banks, emergency housing, and the family and support systems that surround the client can be valuable resources. Getting to know the medical and social support systems reduces the sense of isolation that many clinicians experience. Such a “team approach” allows for consultation in a crisis and pools the talent for the protection of the client.

- **Form peer supervision groups.**
  
  Some practitioners report forming peer supervision groups to address individual situations and to allow for the ventilation of emotion. These groups can meet weekly or monthly and serve as a major source for emotional exploration and support. Delgado and Rose (1994) encourage the use of informal helping networks like peer groups to help caregivers cope with the stress.
Gabriel (1991) outlines a model of group supervision that focuses on therapists' unconscious communications, defensive functioning, and resistances, as well as on countertransference issues. Her model helps the counselor develop an increased intellectual and emotional comfort with issues like facing a deteriorating illness, accepting death, and dealing with survivors. She believes that such groups reduce the likelihood that helpers will be overwhelmed by feelings of helplessness, anger, and loss, especially the pain of multiple loss.

- **Get a buddy.**

Some practitioners contract with a professional colleague to create a peer supervision team. Whenever either of the pair determines the need to process what is going on in a particular case, the other partner agrees to meet, listen to the dilemma, and suggest possible alternatives. With such an ongoing relationship, partners can check each other on possible countertransference issues. Such conversations also serve as checkpoints when bending the frame and help ensure more competent care. They also help reduce some of the isolation and helplessness that characterize this work. Arrangements with a buddy can last the duration of one case or extend over several years.

- **Schedule regular clinical supervision.**

Another way to surface countertransference issues is through regular clinical supervision. Contracting with an HIV-wise clinician who understands the complexities can help practitioners provide more competent treatment. Several authors stress the importance of clinical supervision in dealing with countertransference issues. When the supervisor is competent and unafraid to confront the practitioner with instances where attitudes and values are interfering with competent treatment, there is an immense opportunity for personal growth and improved service delivery.

Winiarski (1995) suggests that the supervision must deal with rescue fantasies ("A cure is just around the corner"), instill a belief in the effectiveness of ongoing treatment, encourage more direct intervention when the practitioner is withdrawing, and reduce feelings of despair and demoralization. The supervisor needs to be particularly alert to unexposed and unexpressed anger. Further issues of burnout prevention are essential if the
helper is to continue to provide competent treatment. Bell (1992) believes this is especially true when working with substance-abusing clients.

- Be in psychotherapy.

Perhaps the most powerful means of understanding individual countertransference issues is for the practitioner to enter psychotherapy. Facing one’s fears of death, helplessness, anger, rejection, lack of confidence in treatment skill, and the many other emotional responses that accompany HIV-related psychotherapy may demand more individual attention than can occur in group or individual supervision. Individual psychotherapy suggests that the clinician is taking responsibility for his or her professional and personal growth and development and may be the best arena for conflict resolution.

- Pursue additional training and balance in life.

Other approaches include clinical training and continuing education, use of the professional literature, and common burnout prevention techniques such as exercise, journal writing, reflection on meaning, and the pursuit of personal interests and hobbies (Imhof, 1995). Above all, the maintenance of predictable life structure will help the clinician retain balance in life. Unfortunately, all too often, this is the first quality-of-life component to go when faced with the overwhelming needs presented by persons with HIV.

Conclusion

Perhaps the most difficult issue in determining whether countertransference is present, in either positive or negative form, is that many of our responses to suffering reflect a deep human compassion that is not pathological. Caring for the sick and dying does offer the opportunity for increased meaning in life and often an enormous sense of fulfillment. When Mike died, I went through days and weeks of turmoil. While his death was easy, his dying was difficult, and I believe that my presence made some slight difference to him. I also know that my presence reflected in part some of my own fears of abandonment and death. Under supervision and in psychotherapy I have learned more about my personal issues. That has been Mike’s gift to me. As I bent the frame and worked through some of my fears, I can now work with human suffering by being
more fully present. And when I find myself distancing from a difficult situation, I know to start examining what is going on inside me, to see if there are personal issues that are getting in my way, to lean into the discomfort these issues generate, and to learn, once again, that both positive and negative emotional responses can serve as reminders of my own frailty and incompleteness as a human being. Through engaging my own suffering I can more fully understand the struggles of my clients. I can “just stand there” and recognize that my willingness to be present may be the most significant and helpful action.

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