Counseling Men in the AIDS Crisis

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The AIDS crisis has affected men in many ways, ranging from massive denial to panic to devastation to death. While many diseases do not discriminate, AIDS is largely a disease of the disenfranchised and outcasts of society. Gay and bisexual men, IV drug users and multiple drug abusers, men of color, and hemophiliacs are the ones singled out for the tragedy of AIDS. This chapter will describe the psychosocial issues these men face as well as issues you may face as a therapist. AIDS has attacked the masculinity of these men and these effects will also be considered.

A Brief History

The AIDS crisis began in 1978 when doctors in large urban areas observed some young gay patients with unusual opportunistic infections. At first, it was believed some factor in the gay lifestyle caused AIDS—AIDS was often called the “gay plague.” Doctors hypothesized that the immune systems of gay men had become overloaded by multiple infections caused by having many sexual contacts, using large quantities of drugs, and having irregular eating and sleeping habits. Then in 1983, Dr. Luc Montagnier of the Pasteur Institute obtained a virus that he believed to cause AIDS. He named the virus LAV or Lymphadenopathy-Related Virus. In May 1984, Dr. Robert Gallo of the National Cancer Institute in Bethesda, Maryland, also isolated an AIDS-related virus, HTLV-III or Human T-Cell Lymphotropic Virus. After much scientific and political debate, it was agreed to call the virus Human Immunodeficiency Virus, or HIV. Since the crisis began, an alarming number of men and some women have come down with AIDS. By 1985, AIDS was the number-one killer of men aged 20-50 in New York City and San Francisco and was announced as the number-one health priority of the U.S. Public Health Service.

Epidemiology of AIDS

Nearly all people with AIDS are in one of the following seven risk groups: (1) homosexual/bisexual male— 66%; (2) intravenous (IV) drug abuser—17%; (3) homosexual male and IV drug abuser—8%; (4) hemophilia/ coagulation disorder—1% (5) heterosexual cases—4%; (6) transfusion, blood/components—2%; and (7) none of the above—3% (Centers for Disease Control, 1986). There have been no new risk groups identified since mid-1982. Almost 95% of people who have been diagnosed with AIDS are men. Of the cases, 22% are aged 20-29; 47% are aged 30-39; 21% are aged 40-49; 9% are over 49 years of age; and 1% of AIDS cases are children under the age of 13. In regard to racial/ethnic background, 60% are white; 25% are black; 14% are Hispanic/Latino; 2% are other or unknown. The overall mortality rate (death rate) is 54%, with most men dying within three years of diagnosis (Centers for Disease Control, 1986).

Belonging to one of these groups does not necessarily put a person at high risk for contracting AIDS. It is believed that other risk factors may influence and possibly weaken the immune system, either before or after exposure to the virus. These factors may include having a high number of sexual partners; poor personal and sexual hygiene practices; history of sexually transmitted diseases including parasites and hepatitis B; history of antibiotic use or heavy recreational drug use; persistently high psychological stress; social and emotional isolation; lack of self-acceptance; inability to express feelings and anger; and perhaps even genetic factors (Bahnson & Engelman, 1981; Cecchi, 1983; Guiot, 1984).

What Is AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome. A syndrome is a group of clinical symptoms that make up a disease or abnormal condition. A variety of symptoms are characteristic of the disease; however, not all symptoms appear in any one person. The virus causes breakdowns in the immune system, which then allows frequently occurring germs the opportunity to multiply freely, causing “opportunistic diseases.” Infection with HIV has varied body responses. Most people remain healthy but are carriers of the virus. Others with Lymphadenopathy Syndrome have swollen lymph glands but no other symptoms typical of AIDS. Some develop AIDS Related Complex (ARC), while others develop a full-blown case of AIDS.

The symptoms of AIDS include: unexplained fevers; shaking chills or drenching night sweats; persistent diarrhea; unexplained persistent fatigue; unexplained swollen glands; pink to purple flat or raised blotches occurring on or under the skin, inside the mouth, nose, eyelids, or rectum; persistent white spots or unusual blemishes in the mouth; and a persistent dry cough not caused by a common respiratory infection.

The most common opportunistic diseases that occur in men with AIDS are a rare form of cancer called Kaposi’s Sarcoma, or KS, and a pneumonia called Pneumocystis Carinnii Pneumonia, or PCP. Both of these diseases are often treatable, as are virtually all opportunistic infections. The difference between AIDS and ARC is that persons with ARC have not yet been diagnosed with an opportunistic disease. With either diagnosis, it is possible to appear apparently well and work, be acutely ill, or be chronically ill and have great difficulties in daily living.

Neurological complications are estimated to occur in at least 30% of persons with AIDS (PWAs), and in 10% of PWAs these complications are the initial clinical problem (Bresden & Messing, 1983; Snider, Smith, & Nielson, 1983). Early symptoms include loss of concentration and recent memory, mental slowing, unsteady gait, un-coordination, social withdrawal, and apathy. Navia (1986) has found some clients may develop AIDS Dementia Complex without developing full-blown AIDS. A detailed neurological history and formal neuropsychological testing are necessary to establish a diagnosis.

Psychosocial Issues

Imagine yourself going to your doctor’s office and being told that you have a diagnosis of AIDS. Allow yourself to imagine the wide range of feelings you might have. Now consider you’re told you have ARC. Think about the tremendous range of feelings and thoughts you might be having. Now imagine being exposed to Human Immunodeficiency Virus, what is this like for you?

This portion of the chapter will deal with how men with AIDS, ARC, HIV Positive, and the rest of the “worried well” are affected by the AIDS crisis. Specific emphasis will be placed on how the disease affects us as men.

PSYCHOSOCIAL ISSUES OF PERSONS WITH AIDS

The best way to describe the process of counseling and dealing with a diagnosis of AIDS is the analogy of riding a roller coaster. Dealing with a diagnosis of AIDS has such tremendous and unsettling implications for any man that at times he will feel so overwhelmed that complete denial is necessary to function (Treese, 1983). At other times, he will experience deep depression, massive confusion, or great loss. Eight phases of counseling people with AIDS have been described by Lopez and Getzel (1984). This is not a stage model, but rather a descriptive model of the many phases, feelings, and interventions within the process of working with a PWA. As the model indicates, psychosocial intervention by counselors is important throughout this process (Christ & Wiener, 1985; Maylon & Pinka, 1983).

Phase 1: Engagement and assessment. The development of AIDS is totally unpredictable. Some men have been sick for some time before receiving their diagnosis. For others, the warning signs come only a short time before diagnosis. Therefore, it is hard to know what to expect in your initial interactions with a PWA. It is important to allow the client to ride on the roller coaster and just experience whatever feelings he may be having. This is not the time for confrontation, interpretation, or giving advice. Allow the dust to settle as the man begins to deal with the reality of his diagnosis. Denial may be present to a large degree. A man may talk with great bravado about how he is going to be the first one to survive and conquer this disease. Support the denial until your client is ready to face the range of emotions that come with such a devastating diagnosis.

Many issues will come to the surface in this early period. Most PWAs have led a fairly independent life prior to diagnosis, having their own apartments and working in careers or full-time jobs. These men may have to face dependency for the first time in their adult lives. There are often great fears associated with this as well as a loss of pride in being able to take care of oneself.

For men in committed relationships, the fear of becoming more dependent and possibly a burden on their partner is particularly difficult. The couple may face financial problems if the PWA is unable to continue working. The PWA may fear rejection from his lover or have to face the disturbing possibility he has transmitted the disease to his partner.

The issue of disclosure is a major one with regard to friends, family, and work associates. Employer reactions have varied from immediate firing to great compassion. Family reactions also vary from tremendous support to complete rejection. Within the gay community, “gay families” frequently have been extremely supportive, but there are also instances of rejection and stigmatization.

Another immediate reaction to diagnosis may be the belief that they are being punished. Many talk about being a “slut” or drug abuser and therefore deserving of AIDS. Some blame it on being gay or bisexual. Even previously well-adjusted gay men succumb to increased internalized homophobia. It is important to confront this judgment and help these men understand that they have a disease like any other disease. Self-loving, not self-loathing, is an important aspect of healing.

Phase 2: Assisting and supporting autonomy. Typical of men, it is often hard for PWAs to ask for help, whether it be financial, emotional, or to meet basic needs. Depending on the client’s physical condition, some PWAs may need a great deal of assistance with basic living skills, while others may be more independent. While it can be tempting for the counselor to preempt the autonomy of the client as a response to our own helplessness, it is important to encourage the client to be as autonomous as possible. Clients can get very angry when their autonomy is taken away.

Phase 3: Explaining the therapeutic relationship and meaning of AIDS. The issue of a PWA’s continuing dependence is important to address. The PWA is likely to feel ambivalent; while he may appreciate the counselor being there, he may also resent dependence on the counselor and envy the counselor’s health. The counselor may be pulled close and then pushed away. It is often difficult for men with AIDS to believe people could really care about them as human beings because of the stigmatization. In this weakened physical and psychological state, clients may internalize this stigmatization, leading to feelings of powerlessness and helplessness.

It is essential to empower the client in every way possible. Encourage him to confront people who withdraw, affirming his right for support. Encourage assertiveness in hospital settings. Help clients ask for explanations of tests and options, including alternative treatment modalities. Help them recognize and assert their right to be treated with respect, not as a freak or leper. Affirm the client’s right to determine his own limits and help him learn to listen to his body. Let him decide how much exercise and sleep he needs.

Empowerment includes letting PWAs know they can survive a diagnosis of AIDS. A New York study (Rothenberg, 1986) found people with AIDS who survive more than three years face a decreasing probability of dying from the disease. During the fourth year, there is a leveling off of the probability of dying, and after that time the probability appears to approach zero. The study also noted optimal survival occurred among young, white gay men with Kaposi's Sarcoma. Another study being promoted by the national PWA organization has found that 20% of people with AIDS live longer than the three years predicted as the average life span for those who are diagnosed (Lorenzini & Reynolds, 1982). The study found a number of characteristics of long-term survivors: the ability to externalize the disease, explore alternatives, take responsibility for their own health, say "no," and focus on making life productive. With this kind of information, some clients are able to mobilize their defense system more effectively.

Phase 4: Supporting the client in talking about death. At first, death may be referred to through indirect comments the client makes. For instance, he may say, "I don't know how much longer I can deal with this pain." Due to male socialization, it may be difficult for the PWA to give up because people would be disappointed in him and as well he would be disappointed in himself. It is hard even at this stage to acknowledge our limitations. Counselors may struggle with the same issue, wanting to support the client's exhaustion and desire to let go, but feel guilty or responsible for quickening the client's death. It is important to recognize that we are not responsible for our client's health or death. Our major function is to support the client wherever he may be in this process. Providing a good listening ear and offering neither optimistic nor fatalistic scenarios can be helpful as the client struggles to determine how he will continue his life.

During this phase, it is common for clients to spend time reminiscing about the past and contrasting the future as being very dim. The roller coaster effect is still noticed as clients range from laughing with friends to being deeply depressed.

Also during this time, clients may take a look at their present and past relationships and determine whether it is still possible to work on any of these relationships and resolve past problems. It has been hypothesized that such therapeutic work may enhance the immune competence of PWAs (Bahnson & Engelman, 1981).

Phase 5: Monitoring and maintaining health status. Regardless of whether a person with AIDS is hospitalized, it is important to monitor and maintain the health care received. Help the PWA advocate for quality care when possible. Lowered self-esteem and increased weakness may inhibit their ability to ask for care they deserve.

Anger is a normal emotion in any of these phases. The PWA may be angry at any number of things, from the injustice of the disease, the lack of governmental response, or concrete frustrations such as the doctor not having answers. It is important to validate the anger while helping the PWA vent it to help decrease anxiety and depression levels. Anger can also be channeled into constructive activities including work in PWA and AIDS organizations.

Phase 6: Supporting close relationships and grief-work. Generally the PWA has a sense of when death is near. Although the PWA may desire support from his closest friends and family, they may feel threatened and scared to come around. They may not want to face his impending death, or understand the PWA's sense of relief that the struggle is almost over. The PWA will also be dealing with much grief and loss, including the loss of respect and dignity, career, friends and lover, and bodily functions or mental functions.

Planning for death may occupy a lot of the PWA's attention. Some PWAs will want to die at home. With community task forces and health care, this often can be arranged. Referrals to lawyers and others who can assist in making final plans may also be needed. It is important to consider ahead of time whether and what kind of emergency life-saving measures are desired. These may be as simple as cardio-pulmonary resuscitation (CPR) or as involved as mechanical ventilation and drug modalities. Many PWAs prefer to plan their own funeral arrangements, which helps them feel they will die with dignity. Because this phase of illness can linger or be very quick, it is important to encourage the client as he is ready to make these plans.

Phase 7: Caring and advocating for the dying client. It is important to continue to advocate for the PWA in his last days and hours. If the person is at home, assure that adequate care is given. If the person is in the hospital, the therapist can help assure that the PWA will die with dignity. The PWA may be unconscious and unable to communicate directly. However, he may be able to hear and recognize voices. Take this time to say goodbye to the client. This is also a time to care for the significant others in the PWA's life. Frequently these people will have very intense feelings that need to be vented. Some may still be in denial and need assistance in letting go.

Phase 8: Grieving and mourning with the family and significant others. Even after the PWA dies, your role continues to be important as family and significant others grieve the loss. In the case of a gay man who dies, there may be significant issues and problems that arise during the planning of the funeral, the funeral itself, and the mourning time that follows. If the man had a lover, he may be excluded from giving any input regarding the funeral unless he has the power of attorney.

After the funeral, the family may want to blame the lover for the death of their son. It may be important to help the lover to stand up for himself and not allow family members to take advantage of him.

PSYCHOSOCIAL ISSUES OF MEN WITH AIDS-RELATED COMPLEX

A diagnosis of ARC can be just as devastating as a diagnosis of AIDS. For some men diagnosed with ARC, it comes after a longer period of seeing their health go downhill without doctors being able to diagnose them. It may be a relief to receive a diagnosis and know what they are fighting against. Others have confirmed their exposure to the virus through antibody testing and have felt like walking time bombs hoping they would not develop ARC, but expecting to be diagnosed. A diagnosis of ARC means an uncertain future. Some men will develop a full-blown case of AIDS. While some will remain in a very weakened state, others will recover.

One of the most comprehensive studies comparing affective reactions of men with AIDS and ARC found the psychosocial needs of people with ARC (PWARCs) have been greatly underestimated (Mandel, 1985).

PWARCs reported higher mean levels of emotional distress, as well as longer mean delay time in seeking medical treatment than men with AIDS. A total of 60% of PWARCs attributed their symptoms to some other disease and did not seek immediate physician care. The median delay for seeking care was about eight months. In the same study, 46% of PWARCs were unemployed due to severe physical problems.

Other factors contribute to greater emotional distress. Half of PWARCs had not discussed their health problems with one or more family members (Mandel, 1985). This was often associated with a lack of disclosure to their families with regard to their sexual orientation. For men who had disclosed their health, PWARCs reported more negative experiences in the disclosure than PWAs. Consistent with this, PWARCs feared rejection more than PWAs. Increased internalized homophobia was found in 25% of PWARCs (Mandel, 1985).

Working on developing a positive attitude can make a difference in how PWARCs cope with the disease. Hay (1984) talks about the importance of loving and forgiving oneself and working on positive, relationships. She encourages her clients to use self-hypnosis, meditation, creative visualization, and "mirror talk" to improve their abilities to love themselves. Men with ARC may believe their chances for intimacy are greatly decreased because no one would want to get close to them. While some men may reject them, others will want to get close and share in the experience of caring for and loving a man with ARC.

The AIDS antibody test. Men can now go to an anonymous, confidential clinic to find out if they have been exposed to HIV. It is important in counseling individuals about taking the test to help them look at the potential consequences both emotionally and behaviorally. For some clients, taking the test may be contraindicated because of the extreme anxiety they already feel without knowing their antibody status. For others, it may help to decrease their anxiety if there is little reason to believe they have been exposed and they find out they are negative. The results of testing have been studied by the San Francisco AIDS Health Project. They found 57% of men tested indicated they had improved risk reduction at least somewhat, while 35% said their behaviors had not changed since taking the test (Dlugosch, Gold, & Dilley, 1986); 1% of the participants said their activities had become somewhat less healthy since taking the test. With regard to mood changes, the authors concluded, "Taking the test has a powerful impact on the emotional state of a person, with the expected outcome of great relief and mood improvement for those receiving negative results and heightened anxiety and depression for those with positive results" (Dlugosch et al., 1986, p. 2).

Ongoing counseling either individually or in groups may help men learn more positive ways of coping with the natural stress of being exposed to AIDS. It is important to help these men establish a positive outlook because of the danger of setting themselves up to get the disease. Maintaining a positive approach is also a way of keeping the immune system strong and preventing further deterioration of health (Coates, Temoshok, & Mandel, 1984; Hay, 1985). Just as with PWAs and PWARCs, men who are

HIV positive often have to deal with other underlying conflicts that have been unresolved from the past, including homophobia, drug addiction, negative self-esteem, poor relationships, and poor coping mechanisms in general. Clinical syndromes reported in this group include panic disorders, insomnia, depression, and hypochondriasis (Forstein, 1984).

While the gay community appears to be responding more positively to safe sex guidelines, the greater concern arises about the spread of the disease in the heterosexual and the IV drug community. These communities have been more difficult to reach and it is important for all men who are sexually active or involved within the drug subculture to recognize the great risks they are taking.

Psychosocial Issues of Special Populations

BISEXUAL MEN

The AIDS crisis has presented some unique issues for bisexual men, particularly those who have ongoing relationships with women. Many bisexual men have lived on the fringes of the gay subculture, resulting in a lack of access to appropriate information, resources, and support for themselves. With the onset of the AIDS crisis, these men may not have appropriate information about safe sex and other precautions that could help them protect themselves and their partners.

Many bisexual men in the past have been able to rationalize their outside relationships by telling themselves they posed no danger to themselves or their partners. But now, facing the reality of possible infection often leads to increased anxiety and guilt. Some bisexual men have chosen to cope by refraining from any further activity with other men, causing them to feel unfulfilled and depressed.

The crisis that bisexual men face when they test positive for the HIV virus or are diagnosed with ARC or AIDS can be quite traumatic. Frequently, many of these men have not been open with their partners about the extent of their homosexual activity. Therefore, they face a dual “coming out” to their partners.

THE WORRIED WELL

As the AIDS crisis progresses, the worried well comprise a greater number of people in the community. The worried well include: (1) people with nonspecific symptomatology or people who have a few symptoms for ARC but not enough to make a diagnosis; (2) people with intimate exposure to someone with AIDS or ARC or a person who is HIV positive; (3) people with no known intimate exposure, but who are at risk because of past or present sexual activity and / or past or present drug usage; (4) gay persons who are just coming out; (5) persons not at risk who incorporate anxiety about AIDS into preexisting psychosomatic disorders or other nervous disorders; (6) people not at risk who have been misinformed about AIDS with regard to means of transmission; and (7) any service provider.

The impact of AIDS crisis on the worried well has been incredibly dramatic. For gay men, it has meant a total reevaluation of the gay lifestyle. For many, the 1970s represented a time when gay liberation was at its height and gay men were beginning to feel positive about themselves for the first time. The AIDS crisis hit at the end of this period, causing many gay men to take a hard look at how they were living their lives. Jim is a typical example.

Jim has been an active man in the New York gay community for many years. In 1978 his physician was one of the first to hear about the incidence of Kaposi's Sarcoma and expressed concern to him. Jim told his friends and they labeled him an alarmist. His physician updated him, but his friends continued to discount him. Several years later, Jim and his friends began to face the reality of AIDS. Some chose to become celibate, while others denied the danger. Jim decreased the number of his sexual partners. A year later, some of Jim's friends were diagnosed with ARC and AIDS. Jim learned about safe sex, but found it difficult to change his behavior. He'd never used condoms before and felt awkward talking to his partners about using condoms. At a seminar, he learned safe sex is equal to caring about yourself and your partner. He began to approach sex with a more positive attitude, and recognized that AIDS was probably going to be a part of his life forever. It is eight years since his doctor's first warning; now when he visits friends who have AIDS, he knows just by looking in their eyes when they are going to die. Some of his friends are just going crazy bouncing back and forth between wanting to take care of themselves and being self-destructive. He ranges from anxiety and panic to feeling like a hypochondriac to depression and severe anger and rage at the government's inability and unwillingness to put all their resources together to fight this disease. He's also frustrated because he really doesn't know who to believe in regard to the facts about AIDS.

MINORITY MEN

AIDS as an issue in the black and Latino communities has been kept in the closet, largely due to the myth that AIDS is a white man's disease (Gerald, 1986). In reality, 39% of people with

AIDS are black or Hispanic even though these two groups only comprise 19% of the U.S. population. Of people with color with AIDS, 53% are gay or bisexual and 42% are IV drug users. The biggest reasons for this myth are the homophobia within the black and Latino communities and the problems with access to proper health care. The existence of homosexuality is often denied, making it difficult for men with AIDS or ARC to identify themselves and ask for services. Because of generally poor and discriminatory health care as well as lack of trust in the health-care system, it is typical for blacks and Latinos to delay seeking treatment until they may be very sick. Whereas the general mortality rate for all people with AIDS is roughly three years after diagnosis, many blacks live only eight months after diagnosis (Gale, 1986).

The most important issue to encourage treatment as soon as symptoms are apparent. Saxon (1986) describes the "post-diagnosis syndrome" in which blacks are very angry about their diagnosis. AIDS is particularly difficult for a professional black man because he may feel "They finally got me." It is important to validate this anger while being compassionate and patient with the PWA. It is typical for minority PWAs to be very confused and frightened, partly due to inadequate explanations from their physicians. It is important to support the PWA in helping him get needed medical information to ease his confusion.

In regard to the reactions of families, Latino families tend to give support once they get over the initial shock (Paniagua, 1986). This family acceptance is true only for Hispanics who are acculturated. Hispanics who are "undocumented" have generally left home to be free and do not contact their family upon diagnosis. In the black family, the PWA may die alone. Frequently the black mother is afraid to let her son come home or feels unable to provide financially for the son because of already strained resources (Paniagua, 1986; Saxon, 1986). It is common with the black PWA to claim to be an IV drug user rather than gay or bisexual because he perceives this may be more acceptable to his family.

In terms of ongoing care and financial support for both black and Hispanic PWAs, it is important for therapists to recognize the likelihood of institutional racism affecting the quality of care. The therapist needs to be an advocate for the PWA when the possibility of such discrimination occurs. State disability is limited by what the person paid into it, and typically blacks and Latinos have paid in less and therefore receive even fewer benefits than the typical white client.

IV DRUG AND MULTIPLE DRUG USERS

There is still a controversy over whether multiple drug abuse is a major causative factor in the development of AIDS. Krieger and Caceres (1985) maintain that at least 79% of PWAs have been drug abusers. They maintain that since drugs damage the immune system, it is drug abusers who are at highest risk for developing AIDS.

CLINICAL ISSUES WITH DRUG ABUSERS

Spiegel (1986) argues it is important for PWAs to have a choice as to how to live their life, including whether to become sober. She sees substance abuse treatment as a quality-of-life issue, and emphasizes that although there are many issues for a PWA to face, the therapist may need to deal with chemical dependency before the client can be helped to deal effectively with other psychosocial stressors. Timing is an important issue, particularly because the PWA at diagnosis may already be in the denial mode and therefore be hard to confront about a chemical dependency problem.

Spiegel also suggests discussing the increased risk that drug abusers face, including the danger of blood-to-blood contact and the immunosuppressant qualities of drugs, particularly amyl nitrate (poppers). Heterosexuals need to know the AIDS virus is highly transmissible to unborn children.

AIDS education organizations have been very divided in terms of their approach to reaching the drug abusing community. While Spiegel argues that the number-one priority should be to stop drug abuse, it is important to recognize that drug abuse will continue. Therefore, it is important to provide education about safe needle practices and how to “clean the works.” Teaching drug agencies about AIDS is important so that in-house education to clients can be provided.

Issues for Therapists

The therapist who chooses to work in the AIDS crisis will face some of the biggest challenges in his or her career. The ability to remain open to our feelings is extremely important in this work. Difficult feelings such as helplessness, anger, and fear are necessary to work through in order to stay open to our clients (Forstein, 1984; Romano, 1985). Without working through such feelings, it is likely the therapist may tend to smooth over the pain of the client in order to smooth over his or her own pain.

A number of other abilities are desirable for the therapist. It is important to have a comfortable respect for the human spirit and be able to accept and discuss spirituality. It is important to be comfortable with death and dying issues. Regardless of orientation, it is important to be open to the use of medication and alternative treatment approaches. Clients tend to be very needy, requiring the therapist to be clear about issues of dependency. Another area for therapists to explore is their own attitude toward sexuality. Homophobia and sex-negative attitudes may affect a therapist’s ability to discuss specific sexual practices with clients without appearing judgmental or motherly, as well as to interface with relationship building. For therapists in a high-risk group, the tendency to identify with clients may lead to minimizing the seriousness of the client’s situation or, at the other extreme, lead to depression and feelings of helplessness for the therapist.

Most important for any therapist is the necessity to arrange for some type of supportive therapy or networking in order to assist with the healing process of this work. Therapists often experience the same roller-coaster phenomenon as clients. With supervision, it is possible to determine what may be healthy coping mechanisms and what dynamics may be getting in the way. The need to mourn a number of deaths in a relatively short time can be difficult and painful. When mourning is not successfully completed, the dangers of burnout are very real.

Resources for Counselors

In most larger cities, a counselor will be able to draw on the resources of local AIDS task forces

(Furstenberg & Olson, 1984). These task forces, which include both health professionals and laypeople, have organized and trained groups of volunteers and "buddies" to reduce the isolation of people with AIDS and provide basic assistance to them with daily living skills and emotional support. Many task forces have employed social service advocates who have experience and connections with the health-care system and economic assistance programs. Such task forces may also provide groups for people with AIDS, their significant others, and groups for the worried well. A listing of all existing task forces is available through the Shanti Project in San Francisco (1986). The same document also lists a number of groups that have been established for PWAs.

There are several useful guides for people with AIDS as well (Los Angeles AIDS Project, 1985; O'Hara, 1984). These publications provide guidelines for how to live a better-quality life. Most AIDS organizations have also developed pamphlets that can be useful in direct work with PWAs as well as with the community. A number of videotapes have also been developed for training purposes. The Shanti Project has videotaped their entire training program, which is tremendously useful as an adjunct to local trainers. Also recommended is "Aids: Care Beyond the Hospital," developed by the San Francisco AIDS Foundation (1984), and training workshops from the AIDS Health Project (1984).

Many governmental economic assistance programs are available to PWAs and PWARCs. I suggest developing a liaison with professionals within these agencies to assist in getting aid as quickly as possible for clients.

Summary

It has been difficult to present all of the immensely complex issues surrounding this crisis adequately. Clearly, a mutli-disciplinary, multidimensional approach is necessary in order to meet the needs of the many thousands of people who have been and will be affected by this crisis. While there is hope on the horizon that medical progress will be made, the psychosociological aspects of the AIDS crisis will have an impact on our society and particularly on men's lives for many years to come. The AIDS crisis provides an opportunity for men to work through a number of difficult issues. It is hoped that through this process we will increase our ability to relate more openly to all men and women.

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