DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS

Psychodynamic Psychotherapy *with the* HIV-Infected *Client*

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Table of Contents

Psychodynamic Psychotherapy with the HIV-Infected Client

HISTORY AND DEVELOPMENT

INCLUSION/EXCLUSION CRITERIA

DYNAMIC ISSUES IN HIV INFECTION

TREATMENT GOALS

THEORY OF CHANGE

TECHNIQUES

CASE EXAMPLE

TRAINING

EMPIRICAL EVIDENCE FOR THE APPROACH

REFERENCES

Psychodynamic Psychotherapy with the HIV-Infected Client

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Most recent estimates by the Centers for Disease Control (CDC) indicate that there are 1 million individuals living in the United States infected with the human immune deficiency virus (HIV). This works out to a rate of 1 in 100 men and 1 in 800 women (CDC, personal communication, January 9, 1995). Of these, over 130,000 have the acquired immune deficiency syndrome (AIDS); since the onset of the AIDS epidemic, over 200,000 deaths have been attributed to AIDS. The current rate of disease is 18 per 100,000 nationwide, with rates varying from 121 to 0.6 depending on the state (CDC, 1993).

These figures are certainly relevant for the psychotherapist: most of these individuals suffer significant emotional distress during the course of the illness, and many seek therapy at some point. The psychodynamic psychotherapist may very well be called on to offer treatment. Likewise, the therapist may find himself or herself treating a client who during the course of treatment learns that he or she is infected with HIV.

This is an extremely complex disease, one fraught with uncertainty and unpredictability, a significant degree of mythology, profound stigmatization,

irrational fears, and cumulative losses. The therapist unfamiliar with the disease may feel overwhelmed by its many unknowns and great complexity, a feeling that may cause him or her to avoid treating these individuals. It is hoped that this chapter will help to clarify some of the issues relevant to the psychodynamic treatment of persons infected with HIV and provide some guidance in approaching this difficult and sensitive area.

HISTORY AND DEVELOPMENT

The causative agent in the disease is virulent and lethal, but easily transmitted only under very specific circumstances. Infection, which requires the entry of contaminated body fluids from one host into the body fluids of another, occurs almost exclusively from sexual intercourse without barriers, the transfusion of contaminated blood and blood products, or the injection of contaminated blood such as occurs with the sharing of needles during the intravenous injection of drugs.

Once the virus enters the body, the immune system begins to produce antibodies to it. It is these antibodies that are detected when an individual is tested for HIV infection. After entry into the body, the virus can remain dormant for many years and the individual can experience excellent health during this interval. However, at some point the individual will develop opportunistic infections or AIDS-related cancers that officially classify him or

her as having AIDS. These illnesses are treated with varying degrees of success by medications or radiation therapy, but the invariable outcome is death.

A measure of the status of the disease from the time of infection to death actually reflects the status of one part of the immune system, a subset of the T lymphocyte, or CD4+. The total count of these vulnerable cells falls as the virus multiplies and kills them. The lower the cell count, the greater the risk of developing an AIDS-defining diagnosis as the immune system becomes unable to ward off infection. Infection is most likely to occur when the count falls below 200 per mm (Fauci & Lane, 1994).

One of the issues in psychodynamic psychotherapy with HIV-infected individuals is the potentially long period between the time of diagnosis of HIV infection to the time of expression of the disease. In fact, long-term projections of disease progression show that AIDS may not manifest itself until 10-15 years after initial infection with HIV (Chaisson & Volberding, 1990). HIV infection is perhaps unique in this respect: other life-threatening illnesses usually express themselves at the time of diagnosis or within a relatively shorter period of time. Likewise, extraordinary measures are often taken in other illnesses to attempt to arrest the progression of the disease, which may be asymptomatic (e.g., surgery for carcinoma of the bowel). The individual with HIV infection is often left with an extended period without

treatment and in relative health during which to deal with his or her illness, especially when the diagnosis is made soon after the infection. In fact, earlier diagnosis is becoming more and more common.

Review of the Literature

Most literature on the topic of psychotherapy with HIV-infected individuals suggests a broad-based approach, recommends a combination of supportive and expressive modalities, and encourages the therapist to develop a practical but flexible approach (Winiarski, 1991; Jacobsberg & Perry, 1992). However, few monographs deal with specific aspects of psychodynamic psychotherapy of persons with HIV infection.

Adler and Beckett (1989) address briefly such issues as the potential stigmatization of the client by the therapist and fears the therapist may have concerning potential contamination and/or ostracization by his or her colleagues. They also address some of the ethical dilemmas faced by the therapist in dealing with certain acting-out behaviors and the role of denial, which can put others, particularly sexual partners, at risk. They point out that the life-threatening nature of the illness may facilitate the work of therapy and that a dynamic understanding of the client and his or her place in relationships and society can make the therapist's work easier.

Sadowy (1991) discusses in a case report some of the dilemmas she

faced as an analyst who found herself in close proximity to the death of her client. She discusses each dilemma only briefly, but she does address the transferential and countertransferential aspects of the role omnipotence plays in defending the client and therapist against helplessness. She explores the role of projection: AIDS becomes a defense against angry feelings and a way of explaining behaviors and fantasies at the same time that it is experienced by the client as a punishment for sexual feelings. The author also addresses the very important role of the therapist in providing a dynamic understanding of her client even when the client is no longer able to make himself or herself understood. This role includes providing a soothing companionship based on an understanding of the deeper meanings of events to the client.

Stevens and Muskin (1987) explore the psychodynamic origins of the frequent failure of the capacity for empathy for persons with HIV infection. They attribute this failure to the process of unconscious identification and externalization, which ultimately leads to an emotional distancing from the infected individual and ultimately stigmatization.

Cohen and Abramowitz (1990) discuss a self-psychological approach to clients with HIV disease. They feel that self-object theory helps to explain the connection between the social consequences and the intrapsychic effects of HIV. They explore some of the ways in which HIV precipitates a destabilizing

crisis for the self and disrupts self-object functions. They also point out that some behaviors that help to meet self-object needs may lead to transmission of the virus.

Because of the paucity of literature addressing psychodynamic therapy in HIV disease, we have looked to related fields for some guidance. Searles (1981), for example, elaborates on issues relevant to cancer patients that are equally applicable to HIV/AIDS patients. He points out that the therapist can help the client to separate out the realistic physical threat to life from the primitive, distorted perceptions that have been projected onto it by the client or by others. Searles suggests that the terrible anxiety that accompanies the knowledge of having cancer is related more to these unconsciously threatening psychological contents than to the actual external threat. It then becomes the work of therapy to discover the defensive functions that the fact of the illness, or at least the preoccupation with the fact of the illness, is serving in the client's psychological life. The author eloquently describes how cancer can come to be viewed as a curse or punishment for unconscious aggression or as representing "oral, devouring, basically infantile-omnipotent demandingness" (p. 173). Other relevant issues include helping the client to differentiate himself or herself from the disease; the therapist's and the client's mutual envy of the other's position; the therapist's withholding in defense against anticipated loss; the importance of the therapist's grief in helping the client to grieve; countertransferential fears of making the client

more vulnerable in the course of treatment; and the therapist's fears of losing ego boundaries and the role of the fear of contagion in relation to this.

A critical aspect of therapy with clients with HIV disease is working through existential issues related to death and dying. Yalom (1980) identifies four primary concerns—fear of death, freedom, isolation, and meaning—and provides a readily accessible framework for the dynamic working-through of these important issues.

There are also certain dynamic issues relevant to this specific client population. In most areas of Canada and the United States, the majority of clients are gay men (CDC, 1993; LCDC, 1994). Historically, psychiatry has viewed homosexuality as pathological (Lewes, 1988). Fortunately, the American Psychiatric Association has officially supported the removal of homosexuality as a diagnosis suggesting psychopathology (Stein, 1993), and an expanding literature (Isay, 1989; Gonsiorek, 1982; Hetrick & Stein, 1984; Oldman, Riba, & Tasman, 1993) that explores the problems of gay men from a psychodynamic perspective does so from the premise that homosexuality can be viewed as a variant of normal. Such a premise allows the problems of gay men to be approached in a much more helpful manner, allowing, for instance, exploration of the effects of stigmatization and marginalization on the evolving sense of self.

INCLUSION/EXCLUSION CRITERIA

The Clinic for HIV-Related Concerns in the Department of Psychiatry at Mount Sinai Hospital in Toronto was established in 1986 in an attempt to address some of the mental health needs of the HIV-infected population in the city. Since that time, the clinic has assessed over 2,000 individuals and provides approximately 100 hours of service per week. The psychotherapy done in the clinic is informed by psychodynamic theory. Therapy may take the form of crisis intervention, brief psychotherapy, or long-term, open-ended psychotherapy. Over the years of our involvement with this highly troubled population, we have come to appreciate the tremendous value of a psychodynamic approach to treatment.

By far the majority of clients referred to our clinic are gay men. This reflects the demographics of HIV infection in the city of Toronto and in Canada in general. Therefore, without meaning to diminish in any way the importance of HIV in the lives of women or other special populations infected with HIV, this chapter will focus on issues relevant to gay men.

Each client referred to our clinic undergoes a psychiatric assessment by a small multi-disciplinary team. A diagnosis is formulated on the basis of *DSM-IV* (APA, 1994); treatment is prescribed based on that diagnosis and the psychodynamic formulation. Symptoms of depression and anxiety are practically universal in this population; most are diagnosed with depressive

spectrum disorders or anxiety disorders.

Clients are selected for a psychodynamic therapy in the manner in which such treatment is usually prescribed (Langs, 1982; Hollender & Ford, 1990). However, we are probably prescribing it liberally, based on our experience that the knowledge of having HIV seems to act as a catalyst to the work of therapy, helps to break through resistance, and in general motivates the client to explore unresolved issues in his or her life. The motivating force of HIV is sometimes quite surprising, and we have had the impression that even clients with difficult borderline or narcissistic personalities are able to make impressive gains in shorter periods of time than might have been expected. Extrapolating from Searles (1981), it is possible that paranoid defenses are not as important to such individuals, who realize that life is foreshortened, and they can enter into the therapeutic relationship with less fear of being overwhelmed by it. These clients' motivation may also relate to the fact that a terminal illness such as AIDS legitimizes the dependent role and help-seeking behaviors, which can easily be turned into sanctioned activities, such as frequent visits to the doctor.

In some cases, a clear focus for the therapy can be elaborated, and therapy ends when the issues involved have been addressed or when there is significant symptomatic improvement. In many other cases, the focus is less clear, and the therapy deals with the more open-ended issues of coping with

the diagnosis of a terminal illness and the existential issues involved, the pain of dealing with having a highly stigmatized illness, the shame associated with internalized homophobia, the isolation associated with other people's irrational fears of coming face to face with someone with HIV, and conflict over disclosure. Of course, the dynamic therapist quickly comes to realize that underlying the realities of the client's experience with HIV disease are conflictual patterns in interpersonal relating, unresolved intrapsychic conflicts, and a damaged sense of self.

DYNAMIC ISSUES IN HIV INFECTION

There are many dynamic issues encountered in the therapy of a patient with a life-threatening illness. The following section does not purport to explore all of them but focuses instead on certain issues that have been found to be particularly relevant in the treatment of HIV infection and AIDS.

Stigmatization

Perhaps the most pervasive, and one of the most insidious, is the issue of stigma. Stigmatization is the result of ascribing negative attributes and motives to individuals because they are associated with certain groups, a judgment that precludes the empathic understanding of the individual in any personal, sociopolitical, or sociocultural context. Clearly, gay men have been

stigmatized throughout history. From a psychodynamic perspective, stigmatization serves to distance the stigmatizer from feared elements of the self and society. The process also helps to protect the stigmatizer from the sense of his or her own vulnerability. In this context, the HIV-infected person suffers stigmatization as a result of society's fear of HIV, both as an infectious agent and as a metaphorical punishment for sexual feelings (Stevens & Muskin, 1987).

Homophobia is essentially a universal phenomenon, and it is well recognized that the fear of homosexuality is internalized by most, if not all, gay men. The resulting damage to a gay man's concept of self, sense of value, and capacity to have a compassionate relationship to himself is significant. Likewise, the internalization of "AIDS phobia" and stigmatization of those with HIV is practically universal. Intravenous drug users are stigmatized for what is commonly viewed as antisocial behavior. Likewise, women are often stigmatized owing to double standards applied to sexuality.

While the therapist must never dismiss the harsh realities associated with society's stigmatization of the gay man or any other person with HIV infection, it is important to keep in mind that a client's experience with stigmatization and its effects on him or her are highly individualized and determined by preexisting intrapsychic concepts of the self.

For example, Michael, an openly gay man who worked in the conservative environment of an accounting firm, reported that he rarely encountered overt homophobia or AIDS phobia. David, on the other hand, was a fairly "closeted" gay man who reported stigmatization at every turn. It became clear in the treatment of these two men that the difference lay in Michael's stronger sense of self and more trusting view of others, in contrast to David's highly vulnerable sense of self and rather paranoid attitude toward others. It is the work of therapy to help the client to explore issues beyond the realities of belonging to a stigmatized subculture and having a stigmatized disease—namely, the more important issues of the nature of the self and the resulting nature of his or her interpersonal relations.

Clearly, the therapist must remain vigilant for the emergence of transference in relation to stigmatization. Clients very often come to therapy expecting to encounter some form of stigmatization, whether they are gay men, intravenous drug users, or women with HIV.

The Metaphorical Meanings of Contagion

Another essentially universal phenomenon for therapy, and one closely associated with stigma, is the issue of contagion. We have seen that clients frequently view themselves as contaminated, dirty, and unlovable and as agents of death. The consequences of such self-perceptions include the

avoidance of telling others, isolation from others, and discomfort with sexual expression. Again, underneath such self-punitive views invariably lie attitudes and feelings about the self that antedate the knowledge of the infection. The therapy will uncover shame, guilt, mistrust, a sense of being unlovable, inadequacy, and other negative self-concepts. It is our clinical experience that the degree of shame and fear of rejection (and sometimes the degree of persistent emotional distress) that accompanies this disease is directly proportional to the intensity of these subconscious elements. AIDS is a very powerful metaphor. It becomes confirmation of the contaminated, unlovable self. It confirms the existence of an unsafe, hostile, and destructive environment. It is punishment for sinful behaviors, such as sexual expression, homosexuality, and behaviors that deviate from societal norms. It is confirmation of the fragility of ego boundaries and the threat of hostile, controlling intruders. In the transference, the client will project these issues onto the therapist, who must be vigilant for their emergence.

Rob is one client who illustrates how the projection of the self-concept of being unlovable creates an environment of mistrust and deception. He was desperate to enter into a long-term relationship and met a man with whom he quickly fell in love. Rob meticulously adhered to safer sex techniques, and it was not until the relationship had gone on for six months that he told his lover he was HIV-positive. His lover's reaction was a mixture of rage at the deception, extreme anxiety about his own health, fears for the future of the

relationship, and compassion for Rob's emotional state. Rob may have correctly assessed this particular lover as one who would have fled the relationship early on if Rob had not manipulated the situation so as to have his lover fall in love with him before he shared this essential bit of information. Rob's psychotherapy was itself associated with great resistance and withholding. He harbored profound unconscious fear of rejection by the therapist and defended himself through narcissistic grandiosity.

Dan, on the other hand, after careful exploration of his feelings about himself and the meanings of HIV in his life and to his subconscious world, gave up withholding the realities of his HIV status from potential sexual partners. To his surprise, he tolerated the occasional rejection he met. More surprising for him, however, was the fact that most of his partners appreciated his honesty and often accepted his sexual advances with equanimity. The impact was significant for Dan's self-esteem and sense of personal control, and his general anxiety and depression diminished significantly.

We have observed many cases in which persons infected with HIV have been able to enter into mutually satisfying and mature relationships, thus confirming for us that the issues of unlovability, isolation, and fears of being perceived as contaminated and dangerous are very much associated with individual dynamics, personality structure, and ego strengths.

Another consequence of a negative self-perception as contaminated and thus hateful is unnecessary isolation from potential sources of support. Ken suffered greatly from the isolation he felt after finding out he was infected with HIV. He felt he could tell no one, owing to his fears that he would be rejected, that contracts in his work as a freelance artist would dry up, that his friends would abandon him, and, most important to him, that his parents would either reject him or be so horribly burdened by his illness that they would suffer greatly and add to his pain. Unfortunately, Ken died from the complications of AIDS before we had time to explore in more depth his feelings about himself as a gay man and his feelings about his relationship with his parents throughout his life. Ken told his family about his illness one month before he died, when he was developing HIV encephalopathy and losing his capacity to communicate meaningfully. His parents entered therapy in the clinic after Ken's death and are struggling with their guilt for not having accepted Ken's homosexuality more fully and with the issue of what it means that Ken did not feel he could share his illness with them. Clearly, Ken's parents are representative of the many families who are deprived of the opportunity to provide love and support in this difficult time because of the projections originating from unresolved intrapsychic conflict around the narcissistic injury associated with being gay.

Greg provides another example of how HIV infection can be viewed as punishment. Greg was emotionally, physically, and sexually abused by his

father throughout his early childhood. He was continuously humiliated and placed in double-bind situations. The profound damage to his sense of self from these experiences set him on a course of self-destructive behaviors, including multiple substance abuse and promiscuous, compulsive sex. A voice from the deepest parts of himself tells him that he is undeserving of any good thing coming to him, and consequently, it is profoundly difficult for him to view HIV as anything but a natural consequence of his absolute worthlessness.

Helplessness and Control

HIV as intruder and the subsequent loss of control over one's life is a frequent theme of therapy. In this context, the issue of suicide figures prominently with these clients; it is most often associated with maintaining control over the course of life and avoiding a helpless, dependent position.

Clients often seek to regain a sense of mastery and control by attending to those areas of life in which this is still possible. For some, this means becoming extensively educated about the disease, investigating alternative treatments, or organizing one's will and funeral. However, the work of therapy also includes careful examination of the metaphorical meaning of the disease in an effort to separate out the fantasies associated with the virus from the practical realities. Most clients are able to work through their

defenses to some extent and deal with the underlying anxieties frequently associated with a profound sense of aloneness or vulnerability originating from a lifelong history of uncertain attachment.

Doug dealt with his sense of helplessness by employing his characteristic narcissistic defenses: projecting his rage toward all aspects of the medical profession, society at large, the community-based AIDS support services, and the gay community, all receiving equal wrath. He vigorously controlled his medical (and psychiatric) treatment. However, gentle interpretations as to the source of his rage helped him to temper his destructive impulses and eased the burden of his final days in the hospital for all those involved, including himself.

In the transference, the issue of control often emerges in relation to the perceived power of the therapist over the client and the client's sense that the therapist is withholding something from him or her.

Omnipotence

In the first interviews with these clients, the therapist frequently encounters the hope that the therapist and the therapy will have some positive impact on maintenance of health and ultimately on longevity. There is a widely held belief in this client group that stress reduction, avoidance of depressed mood, and a generally optimistic approach to life will preserve

health. Therefore, psychotherapy is often viewed as an important adjunct to medical treatment. Rescue fantasies and belief in the therapist's omnipotence thus figure prominently early on. Careful exploration of the individual's hopes and expectations uncovers the dynamic issues associated with the tremendous fears of abandonment and existential aloneness.

Meaning and Fear of Death

Fear of death is essentially a universal phenomenon, and we all learn defenses against the anxiety associated with our mortality. These anxieties and associated defenses often inhibit our ability to life to its fullest extent. Obviously, the diagnosis of a terminal illness confronts our denial and presents the opportunity to work through the defenses, address the anxiety, and ultimately find a richer way of living.

This process runs parallel with questions about meaning in life. Meaning figures prominently in the psychotherapy of the gay man with HIV disease, for the search for meaning is complicated by repeated experiences of rejection, isolation, and marginalization, which lead to internalization of a punitive view of the self.

Aloneness

Stigmatization, contagion, control, omnipotence, fear of death, and

meaning as dynamic issues relevant to the treatment of clients with HIV disease all have common elements. I believe that ultimately, much of the work involved in the therapy with these individuals centers on exploration of the profound sense of aloneness awakened by this disease. Our experience has demonstrated that this is of particular concern in the treatment of gay men. Most tell us that they were aware of their difference, even from a sexual perspective, at a very early age. Many recall alienation and isolation within their families, with consequent deficits in early nurturing relationships. Profound loss is also experienced during adolescence through failure to connect with peers; these individuals are also frequently victims of scapegoating. Persisting into adult life is marginalization, stigmatization, and persistent devaluation. Various defenses are called into play to deal with these reactions, and the individual copes as best he can. However, the appearance of HIV in his life takes on meaning that serves to confirm the internalized belief that he is unlovable and bad, and he feels the profound aloneness originating from childhood but hidden by his defenses.

Successful therapy frequently involves an exploration of the individual's experiences with rejection and isolation, a working-through of those elements that have been internalized, and paying careful attention to the transference, in which the therapist is seen as another potential abuser and abandoner of his or her vulnerable client.

Countertransference Issues

As might be expected, countertransference in the therapy with these clients can be particularly intense.

Stigmatization is a practically universal phenomenon, and the therapist must carefully explore his or her attitudes and preconceived notions about the group from which the client comes.

Unrealistic fears of contagion are extremely common among even medically knowledgeable therapists. The therapist must deal with these fears, as well as his or her own relationship to the metaphorical meaning of HIV.

The therapist frequently encounters his or her own sense of helplessness and hopelessness in the face of an illness that inevitably leads to death. The therapist must adjust his or her notions of success in therapy, particularly in therapy cut short by overwhelming illness and death.

The therapist inevitably comes to deal with his or her own fear of death and deals with barriers to empathic relationships with clients whose illness confronts the therapist's denial. Likewise, the therapist may need to deal with his or her relationship to aloneness, particularly in dealing with a disease as isolating as HIV infection.

Identification is an important countertransference issue. As suggested

above, we can easily become personally involved in a client's struggle with existential issues. We can find that working with terminally ill and dying clients from our own age group arouses difficult feelings; we can find it difficult to treat clients from the same age group as our children; and some therapists find it easy to identify with marginalized individuals. The possibility of over-identification with the client may be of particular importance for the gay therapist or the HIV-positive therapist. Unless the therapist understands clearly the inherent dangers in such situations, he or she may find it difficult to maintain boundaries with the necessary degree of objectivity.

Sometimes the therapist is faced with the ethical dilemma of having to deal with a client who presents a risk to others. The most common scenario is that of the individual who continues to seek sexual contacts without telling sexual partners that he or she is HIV-positive or has AIDS. The ethical dilemma may vary depending on whether the individual practices safer sex. It is essential that the therapist take the opportunity to understand the motives of the client in such situations. In the worst-case scenario, an individual is deliberately attempting to infect others through unsafe sex practices as an expression of rage. In such situations, the dilemma is perhaps less complicated: in the clear interest of protecting the public, the therapist can report the individual to local public health authorities. More commonly, however, the motives are less destructive and the behaviors less risky, as

suggested in the case of Rob described earlier.

The therapist must obviously attend to the countertransference evoked by such situations and seek to understand the role that his or her own personal morality, homophobia, AIDS phobia, or anger plays in the therapy and in understanding the individual. As suggested earlier, this issue, like all others, provides the opportunity for further dynamic understanding of the individual.

The question frequently arises as to the legal responsibility of the therapist in this context. It is important that the therapist explore this issue with his or her professional organization and to be aware of specific pertinent laws within his or her state or province. Clearly, the need to protect the public interest must be balanced against the need to preserve confidentiality.

TREATMENT GOALS

Goals of treatment with this client population vary with the individual and his or her issues and capacity for change. In general, however, the therapist hopes to achieve some symptom alleviation, to effect some change in the underlying intrapsychic conflict, to help the individual understand the meaning of the disease in his or her life, and to sort out the associations and projections from the realities of the disease. As mentioned, we frequently find that significant changes come about, not by addressing HIV directly, but by

focusing on interpersonal relationships, the view of the self, or apparently unrelated subconscious conflicts. This change in the individual translates into a different way of coping with the disease. It is tempting to advise caution in approaching the limitations of working with such a complicated client population, but in our experience, many of these clients are capable of significant degrees of success in working in a dynamic psychotherapy.

THEORY OF CHANGE

It has been the experience of the therapists in our clinic that this client population is, in general, quite capable of significant working-through of dynamic issues, despite the complexity of the issues involved. We hypothesize that the diagnosis of HIV has the power to motivate the individual to seek change in patterns of relating to the self or others, to work through defenses and anxieties associated with conflict, and to grapple with unconscious conflict. The individual experiences a sense of urgency that may manifest itself as a wish to find meaning in life, a wish to control emotional symptoms in order to enjoy time that is left, a wish to work through old feelings associated with past hurtful experiences, or to finally connect in meaningful relationships. Thus, the client is motivated to work on issues in a way that a physically healthy person who does not feel the urgency of time may not be. As mentioned, we have at times been quite surprised by the capacities of clients with fairly fragile personalities to make significant gains. Again, we

hypothesize that HIV acts with an overriding catalyzing effect on the individual, facilitating attachment and the development of a therapeutic alliance. In many cases, the therapist is treating an individual with HIV some years before the expression of the disease, and there is often sufficient time to deal with issues in a reasonable way.

TECHNIQUES

The usual techniques of a dynamic therapy apply for this psychotherapy (Langs, 1982; Hollender & Ford, 1990). However, therapy with HIV-infected clients is complicated by a number of factors. First is the aforementioned unpredictability and irregular course of the disease. It is characterized by the sudden onset of often bizarre, frightening, life-threatening illnesses that may lead to death or may be followed by long periods of relatively good health. We feel that any therapist who undertakes a psychotherapy with these individuals must be familiar with the medical aspects of the disease and be prepared to work in a flexible manner. The therapist may need to rapidly shift focus as the disease progresses, or regresses.

Our therapists have had to address the important issue of boundaries and the implications of changing the venue of therapy, entering the intimacy of the home environment, cleaning up vomit, urine, or feces during a home visit, involving family members and caregivers in sessions, and attending at

the deaths, funerals, and memorial services of clients. Obviously, it is important to ensure that boundaries are not loosened to the extent that over-identification with the client and a wish to be too gratifying occurs. It is possible to interfere with important work in the last stages of life if boundaries are loosened inappropriately.

On the other hand, boundaries can be too rigid if the therapist resists entering into the client's experience because of the painful issues involved for both the client and the therapist. Sadowy (1991) makes the observation that even if the client becomes unable to speak, the therapist can still use dynamic understanding of the client to his or her benefit by anticipating the meaning of events that are occurring. We have had the experience that extending the dynamic understanding of the client into other venues has been helpful for both the clients and their caregivers, as illustrated in the following examples.

Phil was seen in weekly psychotherapy for two years. We explored in depth his sense of vulnerability related to having been adopted, to having lost his adoptive father to cancer when he was seven years old, and to having had to cope with being gay. HIV was clearly a motivating force in bringing him to therapy but was not a primary focus in the therapy until he developed a large Kaposi's sarcoma lesion on his face after the first year of therapy. A prominent theme was highlighted by this event: his fragile sense of his lovability and his compulsion to attend to the needs of others in order to feel

he deserved their love. He developed great skill in covering his facial lesions with makeup and wearing clothes that hid his progressive weight loss. He also went to great lengths to reassure friends and work associates that any changes they observed in him were insignificant. He was consciously making an effort to avoid upsetting others and to avoid the guilt of having to burden them with his illness.

The therapy focused on his sense of vulnerability and feeling that his value to others was measured by what he could do for them and how little of a burden he could be. Gradually, as he developed insight and was able to address these issues, he was able to tell people of the true nature of his illness and was surprised to find that support and love came to him more or less unconditionally. He eventually abandoned the makeup and was less obsessive in his dress. Consequently, we were able to deal more directly with his feelings about his impending death. After approximately two years of therapy, Phil became homebound due to pain in his legs from extensive Kaposi's sarcoma lesions. Therapy continued in his bedroom on a weekly basis for some months. The proximity of death naturally moved the therapy toward more existential issues, but we continued to explore his discomfort with the role of having to receive help and his anxiety about not having the energy to entertain visitors. Ongoing attention to these issues facilitated the implementation of home care and visiting nurses, a more relaxed attitude toward his friends' visits, and also the change in venue of the therapy. (When

presented with the option of my coming into his home as his health deteriorated, he had been terrified by the prospect, for much the same reason.)

As he continued to decline, he developed a secondary infection in his leg and became delirious. The themes of his psychosis were perfectly within the context of the issues we had dealt with in the therapy. Although Phil's interactions with visitors were consistently pleasant, he developed delusions that he angered them with his behavior. He believed that some people actually became physically abusive, including his lover, whom he believed to have struck him on several occasions. Phil naturally assumed all blame for this, feeling that others "abused" him because he was such a tremendous burden. While interpretation was, of course, unhelpful to Phil at this point, his lover found the dynamic understanding of the themes immensely helpful and was able to view the situation with a little more objectivity.

Max was treated in a psychodynamically informed supportive psychotherapy for approximately two years before he became home-bound owing to progressive weakness associated with wasting syndrome. He had a paranoid personality; while interpretation of his projections was often unhelpful, he seemed to value the therapeutic relationship, and the transference was largely free of paranoid projections. I took this as a reflection of his need to preserve some links with an empathic relationship in

the face of his deteriorating health, even though virtually all his other relationships had been influenced by his defenses. As his health deteriorated, he was, of course, pressed into the position of accepting increasingly intimate care from his family and from strangers, such as those from a visiting hospice service. Attention to the dynamic meaning associated with my visits to his apartment, I believe, helped to preserve his contact with the real elements of his relationships. For example, he was upset during one visit that I had declined a glass of juice at the previous visit; he had assumed I did so because I feared catching HIV from him. We talked about his fears, and he seemed reassured. On other occasions, it was necessary to deal with the implications of cleaning up spilled urine and holding his basin for him while he vomited. The easing of boundaries in situations such as this may very well have precipitated angry, paranoid feelings in this individual, but I believe that the relationship we had established, with its honesty and respect for his person and self for who he was, helped to preclude such feelings. Likewise, in meetings with his family and caregivers, who were often angered and distressed by his rage and rejection, the sharing of a dynamic understanding of his behaviors helped them to develop tolerance and to strategize to provide him with optimal care.

Naturally in these situations the therapist must have the client's consent for discussion of his or her intrapsychic world, but I have found that invariably the client not only can understand the importance of such

discussion but experiences relief from the knowledge that people understand him or her in this way.

Some attention has been given to the possibility of formally adapting short-term models of psychotherapy to this client population. Our therapists have felt uncomfortable with anxiety-provoking methods, such as those outlined by Sifneos (1992), given the nature of the issues we are dealing with. It could be that Mann's (1973) model is applicable, given its focus on anxiety related to termination, but again, our concern is that we may be dealing with issues beyond the scope of that form of therapy.

However, the concept of developing a focus is applicable, and these clients are often able to participate in this process and generate a clear focus for the therapy. Common foci are fears about disclosure, unresolved interpersonal difficulties, and barriers to intimacy. Luborsky's (1984) supportive-expressive method of brief psychotherapy holds promise, and we have recently begun to explore its utility with these clients.

In any event, we have been impressed by our clients' capacity to work effectively with a focus. Our practice in many cases has been, in fact, to develop a focus with a patient, work on that issue toward resolution, and terminate the therapy, making further therapy available at a later date to work on other issues as they become important for the client. Clients for

whom this practice works are obviously those who can tolerate adhering to a focus; these are usually individuals who fit the criteria for candidacy for short-term psychotherapy, as set out in the literature on the subject (Crits-Christoph & Barber, 1991).

Most, if not all, models of brief psychodynamic psychotherapy explore in varying degrees of depth the issues of transference and countertransference reactions to termination. While there is real concern for not wanting to harm a person facing death, we speculate that formally dealing with termination in a brief psychotherapy can be an immensely helpful experience. It can provide a sense of mastery and competency with respect to separation. In so doing, the therapist would have to confront his or her own death anxiety and other countertransference issues, such as fears of being perceived as cruel and rejecting and personal fears of abandonment and aloneness. Our therapists generally apply an "open-door policy": a client is told that, while the therapy is formally terminating, he or she may return at a later date to take up other issues. At this point in the evaluation of our approach to these clients, this appears to be the most appropriate intervention, primarily because HIV disease is a disease of continuum that ultimately leads to death. New issues inevitably arise or previously treated issues become increasingly complex as the disease progresses, and a return to therapy can be most appropriate.

Clients taken on in long-term therapy are those who require more

support or are unable to focus, owing either to difficulty with affect regulation or personality structure. Likewise, ill clients are rarely if ever terminated in their therapy.

CASE EXAMPLE

Following is a summary of a psychotherapy with a man who presented to the clinic with a request for help dealing with feelings he was having about his HIV diagnosis.

History

Mark was a 50-year-old gay man who presented with a major depressive syndrome and concomitant panic disorder that seemed to start shortly after moving in with a lover of four months. The depression and anxiety had progressively worsened over the eight months prior to presentation. Mark had been diagnosed HIV-positive three years prior to presentation, and his latest CD4+ cell count of 310 indicated that his disease was progressing, although it was not yet in a critical stage.

Mark was born while his father was overseas with the armed forces, and he felt that he was probably illegitimate. His father was absent for the first three years of his life, and during this time he was raised by his grandmother, whom he remembered as acting dutifully toward him rather than with love.

He had very little memory of his mother from this time. Mark's father returned home when he was three, divorced his mother, and put Mark and Mark's one-year-old brother in the care of Children's Aid. Apparently his grandmother had wanted to keep the children, but his father would not permit this, and Mark remembered a traumatic separation from her. Between the ages of six and fifteen, Mark was placed in three separate foster homes. In one, he was neglected and physically abused, and in the others he received little emotional nurturing.

Between ages 15 and 20, he lived with a maternal aunt. After successfully completing high school, he obtained a good job and went through a rapid series of promotions. He said that at age 20 he had everything he could hope for and was quite comfortable financially. He remained close to his aunt until she died when he was 33. He had since had little contact with any of his family: "It's as though the whole family died when she died."

He married in his early twenties and was happy for the first three years, until his wife had an affair and he left her and his two-and-a-half-year-old daughter. Mark had been aware that his brother was homosexual and began accompanying him to gay bars, although he did not identify himself as homosexual at the time. He found that he enjoyed the attention of men and began to enjoy sex with them, but he believed that it was not possible for men to love each other. He had two brief relationships but terminated both of

them because he felt he was hurting his partners with his lack of commitment.

He decided to go back to his wife, out of a sense of pity for her, he said. He reported being content for the following year and enjoying his daughter, who was six years old at the time. However, he precipitously left the marriage when he learned that his wife was five months pregnant and had not told him. He viewed her not telling him as a breach of trust and a lack of commitment. He had never seen either his wife or daughter since.

At this point, Mark believed he could no longer trust women and returned to a homosexual lifestyle. Over the years, he was in and out of relationships with men. When he developed feelings of love, he responded by leaving. His longest relationship lasted four years. He reported that he had not found men any more trustworthy than women but felt he had been able to exercise more control over men. He left his last relationship three years prior to the assessment after discovering that he had HIV. At that point, he made up his mind that he would give up on relationships altogether.

One year prior to presentation, he met John. Mark tried very hard to resist a relationship with him but came to care for John a great deal. After four months, the two decided to move in together. At the time of assessment, Mark described John as honest, and paradoxically, he said that he trusted him

implicitly. He felt that John was totally committed to him and would be available when Mark needed him, even as his health deteriorated. However, Mark worried about the burden that he would become for John and at a more preconscious level worried that he did not deserve John. Sex was a major area of difficulty for them. Mark consciously experienced this difficulty as a fear of infecting John, even though he was fully aware of ways they could make love while absolutely minimizing the risk to John.

The Treatment

Mark clearly identified HIV as giving him a sense of urgency and was also highly motivated by the intensity of his depression and anxiety. Given the degree of his symptomatology, it was decided to treat him with a combination of lorazepam and trimipramine, which provided moderate results with maximally tolerated doses.

I decided to treat Mark with a brief psychotherapy utilizing Luborsky's (1984) supportive-expressive method and the core conflictual relationship theme (CCRT). I was aware that in many ways Mark was not an exceptional candidate for brief psychotherapy, but he was able to fairly rapidly develop a focus for the therapy and was very motivated for the work. This particular technique seemed well suited to his therapy given its relationship themes.

In this method, the focus develops from a formulation that is generated

from a series of anecdotes from the client's interactions with others, referred to as relationship episodes. The therapist explores with the client the wish associated with these relationships. Consideration is then given to how the client expects the other to respond (response of other). Finally, the response of self is generated based on how the client expects to respond to the anticipated response of other. This formulation, which is referred to as the core conflictual relationship theme, becomes the focus of the therapy, and anecdotes, unconscious material, and transference are interpreted in this context.

It was hypothesized that Mark's anxiety was associated with unconscious fears reactivated by his developing intimacy with John. Given the serious nature of his repeated early abandonment experiences, Mark had come to expect that he would always be abandoned by anyone for whom he cared. Therefore, it felt safer for him to abandon the other before he himself could be hurt. This feeling seemed operative both times he left his wife, particularly the second time, and in his succession of homosexual relationships.

The CCRT developed for the therapy was as follows:

Wish: To be in a relationship in which he could feel safe

Response of other: To abandon him

Response of self: To leave the relationship

Mark accepted the CCRT as the focus for the therapy and settled into the contracted 16 sessions. He readily generated relationship episodes, which were interpreted in the context of this theme, and he quickly developed insight into the origins of his anxiety. His comfort with John increased significantly, and he had many fewer episodes of panic, although he was not able to resume a comfortable sexual relationship with John. It seemed that sex made him too vulnerable, that it was too intimate to enter into with ease. Clearly, he also experienced his infection as a metaphor for his contaminated, unlovable self.

It was obvious from the outset that the transference involved in termination would further evoke anxiety related to the theme of abandonment. Mark resisted exploration of his feelings about termination. He denied that termination had much significance for him and expressed relief at the idea of being able to have one less doctor to see. Without having fully explored the termination issues, the therapy ended at the contracted time. When he returned in follow-up several months later, it was obvious that he had continued to explore relationships utilizing the insight he had gained in the therapy. One of his most impressive gains was the development of a mutually satisfying sexual relationship with John. However, he was distressed by a recent exacerbation of anxiety, which we were able to understand as

related to returning to the intimacy of the therapeutic relationship and the unexplored unconscious fears associated with it. He was engaged in an additional brief course of therapy in an attempt to further elaborate these issues, and his anxiety level decreased markedly. During this time he reunited with his brother, whom he had been estranged from for eight years over an objectively minor breach of trust. The brothers developed a very close bond that persisted despite several significant conflicts that Mark realized would in the past have precipitated his leaving the relationship. In each case, Mark was able to evaluate his feelings in relation to the CCRT and preserve the relationship.

Case Summary

This case illustrates several points: (1) the potential for overcoming barriers to intimacy in the face of the existential crisis associated with the profound aloneness accompanying HIV disease; (2) the role HIV plays in bringing a person to therapy to deal with issues that become pressing in the face of terminal illness; (3) the facilitating effect of HIV in helping a person attach and engage in the therapy; (4) the catalyzing effect of HIV on the therapy; (5) the potential for doing good work in the face of a complex set of circumstances, including the dynamics associated with repeated abandonment in critical developmental periods, the dynamics associated with homosexuality and the presence of a life-threatening illness associated with

profound stigma; and (6) the value of approaching the crisis of HIV from the perspective of unresolved intrapsychic conflict.

TRAINING

A psychodynamic approach to the client with HIV disease naturally requires familiarity with the principles and techniques of dynamic therapy. However, given the complexity of the disease, its unpredictable course, and it's devastating effects, the therapist must also have a basic understanding of the disease itself. It is most helpful to have a good working relationship with the medical doctors treating the individual. Supervision from therapists with experience treating these clients is helpful to those taking these clients on for the first time, as is ongoing discussion with peers who provide similar treatment.

EMPIRICAL EVIDENCE FOR THE APPROACH

I am not aware of research addressing the psychodynamic treatment of individuals with HIV disease. The Clinic for HIV-Related Concerns continues to explore the relevant issues, particularly the applicability of brief forms of dynamic therapy, and we have recently begun planning for preliminary research into practical applications of brief models of psychotherapy with our client population.

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