AIDS and Boundaries: Instinct versus Empathy
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There is a need for clear boundaries in all psychotherapeutic relationships, but for clinicians working with HIV disease, boundaries are especially important. Because HIV-infected clients usually do not get better, because they die, the emotional considerations of therapy far outweigh all others, including theoretical decisions and traditional treatment concerns.

Some of these reactions are a natural response to continuous exposure to the psychic trauma inherent in the HIV disease process. Most of the current AIDS literature on countertransference, both in qualitative and descriptive terms, deals with these emotional reactions.1,2,3

This article addresses a deeper aspect of the countertransferential response: boundaries, a concept that is often not explicitly named but one that is always present.* In HIV-related therapy, boundaries are either being lost or questioned.

It is no mystery why this occurs. The issues involved in death and dying will touch any therapist who is empathizing with his or her client. In fact, it is empathy—the mental and emotional connection to the spirit of another person that effective therapists employ to connect with and thereby help clients—that creates the ongoing need for clarification of boundaries.

Empathy

The term “boundaries” comes from the psychoanalytic concept of “ego boundaries,” defined by Paul Federn, an early psychoanalyst. He described ego boundaries as the “flexible boundaries that exist between the ego and the outside world (outer, external boundaries).”4 The most severe condition of external boundary loss occurs in schizophrenia when the parameters of the ego are lost and the individual is unable to distinguish the self from the outside world. For the therapist, the loss of ego boundaries leads to merging with the client and a conflict between an empathic approach and the preservation of self. It is this loss of self that raises much of the countertransference in psychotherapy. HIV-related counseling sorely tests basic boundaries of psychotherapeutic work, which can be expressed as three statements:

• I (self) am the therapist; he or she (other) is the patient.
• I do not have HIV disease; he or she does. This statement sounds somehow cold, but the separation of “I” from “he or she” is crucial. (With the therapist who is HIV-infected, this situation becomes vastly more complex.)
• I am not dying; he or she is. Once again, the factual labeling, the observation of literal reality “seems” cold, but it represents objective reality.

If these boundaries blur, both therapist and client suffer. The therapist loses his or her identity as clinician, objectivity and distance from the client, and the ability to keep reality in perspective.

The separation process required in the maintenance of boundaries raises feelings. An empathic clinician might rationalize that: “Everyone is dying. We’re all going to die sometime.” While ultimately true, usually the therapist survives his or her HIV-infected client. Time after time, year after year, the results are the same. So the feelings that arise—the mixture of empathic and hopeful ones with empirical, realistic, and self-preserving ones—

*Other theories of psychotherapy use different language to discuss the concept of boundaries. While this article applies a psychoanalytic perspective, its conclusions are relevant to other therapeutic approaches.
come into conflict. Inevitably the therapist feels guilt, rejection, abandonment, helplessness, loss, sadness, and mourning. He or she feels identification—the essence of empathy—but often this evolves into over-identification—the loss of the clinician’s self and, ultimately, of boundaries. Combined with these emotional responses is the psychic pain of the treatment conflict, the client’s traumatic response to the ongoing effects of the disease process. Each of the client’s losses is in turn experienced by the empathic clinician. Over time, these issues do not get easier for the clinician. The following case—taken from my clinical practice—conveys how boundaries come into play and complicate therapy.

Fleeing AIDS and Blurring Boundaries

It began conventionally enough: a gay man in his mid-thirties came in seeking help with a vocational decision. Brian had been in the theater for many years but had been fired from the national road tour of a Broadway play, and he had been angry and depressed for several months. He was having trouble getting a new acting job and was doing part-time work. All of this led him to the conclusion that show business wasn’t what “a real adult,” a “nearly middle-aged man” should be doing with his life.

Brian was a 38-year-old African-American man who was questioning his sexuality. While gay-identified, he had a history of and present attraction to women in his life.

Brian arrived at our fourth session sweating profusely, explaining that he had “the flu.” He said that if his fever continued, he’d go to a doctor, but it was clear that he’d been avoiding medical attention for some time. He raised the possibility of HIV infection, and then quickly buried it. The next time I spoke to him, he was hospitalized with PCP, calling from a mid-Manhattan hospital.

Just hearing the hollow sound of his words through his oxygen mask, I could picture the scene in his room: vapor coming out of the vent holes of his mask, the sound of the oxygen’s faint hiss, the I.V. running pentamidine into his arm; the flowers, cards and balloons that said: “Get Well Soon!” To Brian, I carefully presented the archetypal persona of a concerned, empathic therapist inquiring into his client’s medical situation, assessing and supporting, determining where to go next with treatment. What went on internally—what was not spoken nor meant to
be conveyed—was an entirely different matter.

My emotional response was to distance myself as much as possible from Brian, to separate I from him. What was happening was an instinctual boundary formulation, although it didn’t seem like that at the time.

What I recognized at the time were four strong feelings. First, I felt not just anger, but also rage. Brian had presented me with an interesting and complex case about a healthy person adjusting to an evolving sense of self; now it had become an AIDS case. Second, I felt a sense of having been “duped” by Brian and, as such, a feeling that he had breached the working contract.

Third, I felt resentment about having built and continuing to build a therapeutic relationship with someone who was going to die. That was entirely unacceptable. I had been through all of this before, had worked on AIDS units in two New York hospitals, and the general course of this disease was more than clear to me, well nigh certain, and only the specifics remained to play out. Finally, I felt a strong impulse to get rid of Brian while he was in the hospital—as soon as possible! I wanted this case to end!

Predictably, guilt—kept hidden from Brian—followed in the wake of this outpouring of emotion, raising questions like: What kind of therapist, would want to abandon a human being so in need? We can plot the course of these feelings: the therapist’s rejection of the client, a response to preserve the self, provokes a harsh ego-based response from the empathic professional and results in guilt.5

Confronting Denial

After he recovered from PCP, Brian regained his former energy, appearance, and functioning. Fortified with a charitable grant for a sum double the initial fee, Brian was able to come in for two sessions a week. This seemed beneficial to both of us, since he was interested and, frankly, the case warranted the extra sessions. It was here that one of the archetypal boundary issues—money—was introduced.

Money forms the fundamental boundary between therapist and client. If the client pays, then the relationship is about the exchange of professional services for a fee. So long as the client pays, he or she is in control of the services. If the money boundary blurs—if the clinician offers free service—the client may feel obligated to “be nice” to the clinician, or to continue with a clinician who is in fact more emotionally burdensome than helpful.

During this period, therapy progressed well. Sessions focused more on Brian’s presenting issues than on HIV disease. But it soon became apparent that Brian was firmly entrenched in denial of his condition. At regular intervals he would explain that there is no such thing as AIDS and that he was suffering only from curable opportunistic infections like PCP. Unconsciously, I joined him in his denial, focusing on Brian’s presenting issues and avoiding his deterioration and ultimate death. I wasn’t aware of it then, but I had crossed beyond empathy into over-identification.

Brian returned to show business, successfully landing good roles. After years of estrangement from his parents—due to his mother’s moral judgment of his sexuality—he reconciled with his family, satisfying his denial and, more especially, his family’s.

When Brian got spinal meningitis, my old rage returned: how dare Brian get sick! In building a close therapeutic relationship, I had blurred basic working boundaries. But now that Brian was so severely ill that his death appeared imminent, my instinctual process to distance myself from him reemerged. I maintained regular phone contact with him, but contrary to my usual policy for exceptionally ill clients, I allowed no hospital sessions.

After a few weeks, during which I conferred with colleagues, I realized that I was abandoning Brian. I began seeing Brian in the hospital, but in response to my guilt at trying to get rid of Brian, I refused my fee—a dramatic reaction formation, a defense mechanism where my actions contradicted my instinctual response. This response was also related to an impulse beyond empathy, a kind of altruism that was actually over-identification.5 I soon realized that in order to maintain professional boundaries, I had to charge my usual fee. Once I began charging, Brian appeared to be visibly relieved.

I continued to see Brian once a week for about three months in the hospital. When he was discharged, he was so ill that he

References
required 24-hour nursing care. At this point, Brian's denial, shattered by his 
rapid deterioration, gave way to a need for isolation, and he severed contact with me. 
He died about a month later.

The Lessons of Death

I learned of Brian's death by chance 
through the New York Times obituaries. Brian had probably declined into a 
profound depression, possibly so angry at me and at all the helpless, powerless authority 
figures who had been unable to save 
his life. In a rage, Brian cut himself off 
from the therapeutic relationship, 
the treatment and the therapist having lost 
their value to him. Possibly he had fantasized 
that were he a compliant patient, 
doing everything required of him, he 
would survive. With death imminent, this 
magical "bargaining" no longer worked.

Being cut off by Brian left me in an 
unresolved emotional state, myself aban- 
donated, with no closure to the treatment or 
the therapeutic relationship. In recalling 
these events, I find myself experiencing 
again the helplessness I felt as I watched 
Brian get sick and die and the rage of 
having been abandoned by him. I have not 
wanted to revisit this case or these feel- 
ings, and so have been drawn into a pow- 

erful conflict: on one hand, seeking to 
remember, to uncover their lessons; on 
the other seeking to repress, to veil their 
accusations.

Witnessing this process, I have identi- 
ified three principles about boundaries. 
First, therapists must recognize and then 
accept the instinctual responses—however 
unpleasant—that occur naturally when 
doing AIDS work.

Second, the strong reflexive response 
to such instinctual feelings can follow two 
different paths. One path leads to hiding 
or erasing offensive thoughts or feelings; the 
other path to transforming these feel- 
ings—the desire to abandon, to reject, to 
be angry with—into their opposites. The 
first path leads to emotional distance, 
emotional boundaries replacing conceptu- 
al ones; the second leads to the absence of boundaries 
and the advent of inappropriate 
behavior such as seeing the client 
umerous times in a week, not charging a 
fee, and acting as a nurse.

Finally, clinicians need to foster some 
mediating agency within themselves to 
balance these two strong—and naturally 
 occurring—sets of responses, a middle 
ground that provides a realistic, emotion- 
ally-grounded base. Because HIV disease 
places such strong emotional demands on 
therapists, recognizing the need for help 
and outside support is essential. To take 
care of others well, one needs to take care of oneself first. Supervision is essential in 
mediating responses, and monitoring and 
maintaining boundaries.

Conclusion

The impulse to distance oneself from 
the sick and dying is basic to self-preser- 
vation. But it is too primitive and self- 
involved to well-serve the clinician. By 
invoking the neutrality rationale to aban- 
don patients or never to work with the 
dying, however, the clinician gives in to 
regression. On the other hand, to become 
over-identified with the client can help 
neither party.

Death and dying, disability, and HIV 
disease create a charged emotional con- 
text for therapy and make boundary mainte- 
anence difficult. The best perspective for 
the therapist is tolerance of the very real 
conflicts that occur in the work and 
understanding of our emotional responses and humanity.

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Boundaries and HIV-Related Case Management
Laurie C. Curtis, MA and Martha Hodge, MS

HIV-related mental health services frequently include a case management aspect that addresses basic needs for decent housing, food, and work. Such work often requires that staff have contact with a multitude of community organizations and individuals such as landlords, family members, neighbors, employers, and others. Mental health workers may be expected to be competent in community organizing, resource development and acquisition, advocacy and public education, mediation, and crisis prevention.

Such tasks take counselors into the daily lives of their clients to a far greater degree than occurs in traditional psychotherapy. To function effectively, providers must face the complex ethical dilemmas that impact day-to-day support and treatment of people with HIV disease. They must also sensitively navigate new kinds of helping relationships, for which traditional clinical boundaries provide little specific guidance.1

Ethics, Rights, and Boundaries
Boundaries are the highly personal translations of moral codes in our relationships with others. They are intrinsically neither negative or positive, but they exist in all relationships, expressed overtly or covertly by symbols and behavior.2 Two people may each subscribe to the same values or ethical codes, yet have very different boundaries in their relationships.

Similarly, personal boundaries may be different from one relationship to another, even from one situation to another.

A sports analogy can help clarify the difference between ethics and boundaries. Many writers and researchers have suggested that a close collaborative relationship between the mental health worker and the client is essential for treatment and rehabilitation.3 This relationship is the playing field and the goal is the intent or purpose of the relationship. Ethics are the rules of good sportsmanship by which the game is played. Boundaries establish the size of the field. An individual’s role in the game is not and should not be his or her sole identity. The key is the degree to which each individual is limited to playing only the assigned role.

Dilemmas in Relationship Boundaries
Relationship boundary issues raised by staff in community support services cluster around four key issues.

Professional Distance. Professional distance helps providers retain objectivity and ensure that it is the client’s needs, not the provider’s, that get met through the relationship. While there are certainly negative consequences of over-involvement for both the staff and the consumer, clients report that greater damage can be done by rigid enforcement of professional distance.4

Multi-Dimensional Relationships. Case management relationships are by definition multi-dimensional. In a single contact with a client, a community support worker or a practical support volunteer may help clean the client’s kitchen, supervise self-medication, teach problem-solving skills, demonstrate limit-setting, collect the rent, share a cup of coffee and a good laugh, and talk about the barriers to returning to school. In multi-dimensional relation-

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See also references cited in articles in this issue.
ships, the role of the staff may be unclear to both providers and clients and may even vary from contact to contact.

Self-Disclosure. The conventional wisdom prescribes that workers reveal little about their personal values, problems, fears, and opinions.5 This stricture constrains staff to act as if they had no problems, emotions, or life experience, and inhibits a powerful aspect of the helping relationship. Self-disclosure by a worker—for example that he or she is HIV-infected or has been affected by the epidemic—can establish bonds of trust and understanding, validate the normalcy of client feelings, and model how to handle situations and express emotions. The fundamental question is “to what degree?” and “for what purpose?” The provider-client relationship does not exist to work out the problems of the staff person.

Reciprocity in Relationships. There is naturally a one-sided dimension to most paid helping relationships. However, when providers are always the “givers” and clients are always the “recipients,” we perpetuate the idea that providers have what is most valuable and the power to allocate it. But, most of us look for a kind of balance in personal and professional relationships, and often this balance is based on mutuality and reciprocity. Refusing offers of reciprocity—whether it is an offer of a cup of coffee or a small gift—may be as rejecting as outright stating to the person, “You have nothing of value to offer this relationship.”

The ultimate reciprocation is freely given friendship.6 If two individuals have ever played the roles of provider and client, are they forever precluded from a non-professional relationship? In the world of peer support “buddy” programs like the Shanti Project in San Francisco and the Gay Men’s Health Crisis in New York, what kind of boundaries are useful and appropriate? While buddies may share social interactions with clients, the intent of the majority of community support workers is not to be an individual’s friend, but to provide emotional and practical support in a friendly manner.

Accepting Ambiguity
Providers can sort out the nuances of ambiguous boundaries by reviewing situations in light of the following ethical guidelines for decision-making.

- Are there other, less problematic ways of achieving the same outcome?
- What are the benefits to the provider? What does he or she stand to gain?
- What are the possible problems that could occur for the client, community, or provider? How could the behavior be misconstrued by the client or by others?
- How comfortable would the provider be if this action were reported in the paper?

Three other factors can help ensure appropriate responses to ambiguous boundary questions, especially for practitioners who work in agencies. First, the culture of an organization determines whether it is safe for a staff person to exercise independent judgment, offer alternative suggestions, or express concerns about boundary dilemmas. Second, clarity and consistency in agency values and ethical expectations for both staff and clients help providers navigate ambiguity. Third, a safe forum for discussions of boundary and ethical issues enables providers to review agency values and ethics and compare them to real-world situations.7

Conclusion
HIV-related case management and mental health care place demands on staff to make independent judgments relating to ethics and boundaries. This work is growing more ambiguous as staff roles become increasingly multi-dimensional and public. But the challenge goes beyond codified statements of standards. To a degree, ambiguity is an inherent part of any individualized, consumer-driven, and community-focused service system. Providers need adequate tools and support to develop empowering partnerships with clients and to do so within a context of integrity, respect, safety, and advocacy. There is no right way to do a wrong thing.

Comments and Submissions
We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

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Dual Relationships
Kagle JD, Giegelhausen PN. Dual relationships and professional boundaries. Social Work. 1994; 39(2): 213-218. (University of Illinois at Urbana-Champaign.)

While they recognize the negative consequences of sexual relationships between counselors and clients, social workers generally underrate the harmful potential of non-sexual "dual" relationships, according to a review of the literature on this topic.

Health care professionals enter into dual relationships when they assume a secondary role as friend, employer, teacher, business associate or sex partner with a client. Most mental health professionals agree that sexual relationships between clients and therapists are unethical. Despite this, a national survey of mental health professionals found that 3.8 percent to 12 percent of men, and 0.2 percent to 3 percent of women admitted to having entered into a sexual dual relationship with a client.

Non-sexual dual relationships occur more commonly than sexual ones, and while less apparent, they can be equally harmful. A nationwide sample of 4,800 practitioners judged dual relationships with clients—as friends, employees, business associates, or students—to be more ethical than sexual contact.

The de-emphasis of psychodynamic theory, the lack of extensive supervised training of newer practitioners, and the adoption of empowerment models of therapy have confused the boundaries of the professional relationship between clients and therapists. New empowerment models seek to diminish the power discrepancy of the therapeutic relationship by encouraging therapist self-disclosure and contracting that gives the client more control over the therapeutic process and the outcome of services.

Some mental health professionals argue that dual relationships enhance the therapy process, opening avenues of communication and trust that otherwise would be inaccessible. The danger of extending professional boundaries in this way, however, is that treatment may suffer: equalizing the client-therapist relationship may shift the focus from the client’s needs onto the therapist’s needs. In addition, the power dynamic of the professional relationship will influence any secondary relationship. Whereas professional protocol regulates the therapeutic relationship, there is nothing in the secondary relationship to constrain the therapist’s potential, even unwitting, abuse of power.

In response to the problem of dual relationships, the mental health community should take several actions including:

- Practitioner training should emphasize the dangers of dual relationships.
- Practitioners should inform clients at the outset of therapy about their rights as clients and the responsibilities encompassed by professional ethics.
- Practitioners and clients should report known violators of professional boundaries, and professional organizations should prosecute these violators.
- Professional organizations should develop services for therapists who engage in dual relationships or are in danger of doing so to assist them in avoiding this pitfall.

Boundary Issues for Dying Therapists

A case study—following the discussion between a therapist and her consultant—examines the motivations of a terminally ill clinical social worker who broke traditional boundaries to prepare her clients for the termination of her practice. Therapists facing the possibility of death cannot remain effective and, at a certain point, should not continue working. It is necessary to consult with a colleague to map out an effective plan of termination, so that the counselor may assist his or her client to internalize the loss and to let go of the relationship.

When initially diagnosed with cancer, the therapist did not disclose her illness to her colleagues or clients for fear of giving up her own identity and being trapped in a “sick role.” Four years later, her condition worsened, and she saw the need to disclose her illness. The therapist continued counseling after disclosure. In retrospect, the consultant and therapist agreed that earlier disclosure would have been more appropriate because it would have allowed clients more time to process and prepare.
After disclosure, her illness became part of the fabric of the sessions. She discussed with her clients some details of the illness, but felt uncomfortable revealing the part of her personal life and personality that had always been hidden by professional neutrality. At one point, the therapist lost neutrality with one of her clients, joking uncharacteristically. In consultation, the therapist analyzed the behavior: she had felt it signified a liveliness contradicting the deathlike silence of a restrained and self-effacing therapeutic stance, but in consultation she realized that the friendly behavior was a defense against the client’s anger and disappointment.

In another instance, the therapist reported dreaming of going to a client’s open house as a prospective buyer. The dream reflected ambivalence about remaining professional and feeling obligated to “be there” for her clients. Despite a healthy appearance, the therapist reported a withdrawal of energy from her work, loss of concentration, increasing fatigue, and the growing interference of medical treatments on her work schedule.

During consultation, the therapist recognized the need to terminate her practice while she still appeared vital and was able to concentrate on her work. She terminated it when her condition clinically worsened but the appearance of stable health remained. Nonetheless, termination for her meant exposure of her personal struggle; at the most fundamental level, she did not want to be viewed as sick.

Substance Abuse and Boundaries

Providing therapy to HIV-infected, chemically dependent individuals allows counselors to enrich the quality of their lives and work, establish true priorities, and develop intensely intimate relationships in the midst of the suffering, pain, and sadness. A commentary on this singular therapeutic relationship offers insights into balancing these feelings, professional objectivity, and the need to remain emotionally accessible to clients.

Effective, client-specific counseling in these settings requires overcoming countertransference at the same time as it necessitates breaking down some traditional barriers. For example, while expressing remorse or crying in the presence of clients is “inappropriate” in traditional counseling settings, emotional displays may benefit both HIV-infected chemically dependent clients and their counselors. Since many of these clients may be emotionally abandoned and physically shunned by their peers, such empathetic responses help clients feel human again.

In particular, counselors facing multiple losses need to grieve, rather than adhere to the standard of not visibly mourning clients or attending memorial services. Dealing with these losses allows the counselor to cope more adaptively, prevents burnout, and permits other clients to witness the counselor’s deep commitment to clients.

Counselors treating HIV-infected clients, particularly substance users, may need to be more tolerant of suicidal ideation. Instead of responding by administering psychotropic medication and placing them under surveillance, counselors should allow clients facing extreme physical and mental decline to discuss the option of rational suicide.

Finally, long-term substance abusers will not receive essential HIV-related services if counselors maintain the practice of not treating clients under the influence of drugs or alcohol. Drug users may never quit using, and denying mental health services to them because they refuse to abstain is as discriminatory as homophobia or racism.

Next Month
HIV prevention in the gay male community, one of the exemplars of effective public health efforts, has become the focus of criticism: it fails to reach gay men of color, young gay men, and men who relapse. In the February issue of FOCUS, Ron Gold, PhD, of Deakin University in Australia, continues in this tradition by calling into question three assumptions about HIV prevention for gay men. But he goes further than most by offering some ideas about developing a new paradigm.

Gold presented much of this material at the Conference on the Biopsychosocial Aspects of HIV Infection. We were so impressed with his conclusions that we have devoted the whole issue to his thoughts. In one article, Gold challenges the notion that we have created a “safe sex culture” in gay communities, and he critiques current HIV education materials and suggests alternatives. In the second article, Gold questions whether links to the gay community do, in fact, lead to behavior change.
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