Serostatus and Counseling

Steven Ball, ACSW

To what extent must counselors share the characteristics of their clients and disclose these similarities in therapy? This question has received a lot of attention in the past few years, as issues of race, gender, and sexual orientation have become more prominent. Recently, this debate has encompassed the concepts of “seroconcordance”—sharing the same HIV antibody status—and "serodiscordance”—having different antibody status—prompting disagreement within the gay community and among HIV service providers.

At the same time as this social and political dialogue influences primary prevention and counseling targeted toward seronegative gay men, it raises important questions related to seroconcordance and discordance in other counseling venues. The answers to these questions are linked to contextual elements: individual versus group therapy; professional versus peer facilitation; private versus community-based practice; therapeutic goals; and primary theoretical orientation. Clarity about these factors provides essential tools to navigate the uncharted territory of seroconcordance/discordance in creating an effective therapeutic environment.

Firmly rooted in the legacy of gay affirmative psychotherapy, this article offers some guideposts for exploring the issue of seroconcordance/discordance, an issue that is as complex and multifaceted as the impact of AIDS on the gay community.

Gay Affirmative Therapy and Role Modeling

In response to the oppression of a homo-negative environment, in which gay men lack positive role models, gay affirmative psychotherapists have challenged traditional notions of psychoanalysis and used self-disclosure as a tool for modeling. In this context, personal disclosure is seen as critical in helping clients to feel understood and to gain a sense of interpersonal mastery and self-respect.

The disclosure of serostatus by social service providers might serve similar functions. The question of how to most effectively use role modeling has become, quite literally, a life-or-death dilemma. This tool has the potential to help uninfected gay men to stay uninfected, men with HIV disease to take care of themselves, and both infected and affected men to maintain a sense of hope, intimacy, and generativity.

One situation in which role modeling has been useful is in the context of groups for HIV-negative gay men. Many HIV-negative gay men have felt lost in a sea of choices for HIV-positive men that do not address their particular social and cultural concerns as uninfected men. This lack of appropriate resources hearkens back to a time when seropositive men were similarly overlooked and marginalized. Ironically, it is now uninfected men whose complex emotional reactions to the epidemic are denied or minimized not only by themselves, but also by their communities and the social service professionals intent on helping them. As seronegative men continue to struggle in a world that has long considered their difficulties to be inconsequential, childhood feelings of being "outsiders" are triggered and are reinforced, however unintentionally, by the external reality of a community consumed by AIDS. This is particularly true for those without the support of their families of origin, co-workers, friends, and sometimes even their therapists.

Some have argued that in the 1980s, gay men unconsciously colluded with the general public’s equation of a gay identity with AIDS. This evolution of identity limited the self-perceived roles of HIV-negative men.
Editorial: Cultural Competence

Robert Marks, Editor

Cultural competence in counseling requires providers to be aware of the effects of their biases on the therapeutic relationship. In response, providers need to resolve their prejudices and take active steps toward learning about and understanding other experiences. Over the past few years, some commentators have suggested that competence may not be enough—that to be most effective, therapist and client must share cultural experiences, whether it is being gay, or a woman, or African American.

As these ideas have been debated, serostatus has arisen as such an experience, and many seropositive and seronegative men have sought from therapy a mirroring of their realities. Yet, therapy is by nature an exploration, an unfolding of client to therapist; some mental health practitioners have suggested that this process can overcome difference, that it is even enhanced by difference.

This issue of FOCUS looks at seroconcordance and serodiscordance: how these circumstances inhibit or further therapy and the extent to which disclosure of serostatus is useful. Paul Plate discusses the challenges of being a seropositive therapist, the decisions to remain in practice and to disclose to both colleagues and clients, and the countertransference issues that arise when working with HIV-affected populations.

Steven Ball offers a brief history of gay-affirmative therapy and applies this approach to serodiscordance between therapist and client. Looking at seronegative clients in particular, Ball suggests that competence alone is not sufficient to respond to the shame and isolation faced by people who have been systematically marginalized by society.

It has been difficult for seronegative people living in communities hard hit by the epidemic to convince a skeptical public that they need emotional support to deal with multiple loss, post-traumatic stress syndrome, and survivor guilt. As incredible as it may seem to some, people who live through a plague face real psychological problems, and overlooking them poses a real threat to the community as a whole. Ball emphasizes the power of personal disclosure to caregivers, outsiders, and mourners. Many uninfected gay men felt unentitled to express the fears that they might become infected or to discuss loneliness or burnout when so many were dying around them. Others studiously avoided anything to do with AIDS and were ashamed to tell other gay men that they were afraid of being around illness or death. Many evaded opportunities to disclose their seronegative status and found themselves colluding with the misconceptions of others who assumed they were seropositive. Through role modeling, seronegative group leaders can evoke images of mastery and functionality.

Coming Out

Today, the presenting problems of many HIV-negative men illustrate this legacy of silence. Men are now reporting difficulty maintaining a commitment to safer sex over the long haul and a sizable number of gay men who became sexually active well after the onset of the AIDS epidemic have seroconverted despite a barrage of educational messages.

Feelings of isolation and disenfranchisement from the community bear a striking resemblance to the “closeted” period before a person comes out as gay. In order to be adaptive, coming out about negative serostatus should include opportunities for connection to others like oneself. These opportunities not only help eliminate isolation and normalize difference, but also reawaken the hope for further connection and self-expression.

The concept of identification is particularly important for clinicians working with HIV-negative gay men. Self-psychology, a psychodynamic approach through which the therapist uses the empathic relation-
ship to help clients fill the void of inadequate experiences in mirroring, idealizing, and twinning, offers guidance for addressing this issue. Organized around the healthy development of the self, a self-psychological, gay-affirmative model asserts that by revealing or confirming aspects of his identity, the gay male therapist functions as an “empathic twinning self-object.”

When he acts in this way, he can establish a sense of belonging; when he fails to, a client may feel self-conscious and alienated. Although these feelings—dismissed by others as self-indulgent in the wake of HIV-related grief—are often not freely acknowledged by uninfected gay men, the powerful need for belonging and fellowship usually arises when these men explore their anxiety and fear about their own futures.

Mental health and social service providers have begun to respond to this need for twinning by developing services specific to uninfected men. Clinicians working in AIDS service organizations on both coasts report that disclosing HIV-negative status has proved extremely effective in facilitating time-limited support groups for seronegative men. Gay Men’s Health Crisis (GMHC), one of the oldest HIV prevention organizations in the country, developed a 10-week support group model for seronegative men that draws on a synthesis of theoretical perspectives, most notably existential group work, gay affirmative self-psychology, and narrative techniques. The leaders of these groups acknowledge that since there are few real experts on the seronegative experience and only a rudimentary vocabulary to describe it, self-revelations and stories from group members must comprise the building blocks for defining approaches to their challenges and reconfiguring their inner resources.

These group leaders are advised to disclose their serostatus at the outset of the first group by employing the term “we” when discussing the group’s purpose. They introduce the group as a forum for normalizing fears, clarifying values, and building a community of concern to mitigate feelings of loss and isolation. Self-revelation by group facilitators helps members to work through subtle forms of denial, most often expressed in the beginning stages of groups by general statements like, “Gay men are selfish,” rather than subjective statements about their personal experiences like, “I hate using condoms.” Within self-governing peer-led groups, facilitators have often earned leadership over time and use self-disclosure as a catalyst for emotional sharing, affirmation, and group cohesion.

Just as the “out” gay therapist who discloses his sexual orientation might serve as a positive stimulus for expanding the self-expectations of gay clients, role modeling by seronegative group facilitators provides group members with a sense of permission to claim and explore HIV-negative identity. Seronegative role modeling ultimately offers some promise of safety, healing, and community; and it remains necessary as long as HIV-negative men are invisible and the trauma inherent in surviving a plague remains unacknowledged.

**Not Coming Out**

In support groups that include members who have undetermined HIV status or that are for both seropositive and seronegative men, the issue of self-disclosure and concordance/discordance becomes much more difficult to resolve. For instance, GMHC sponsors a series of 10-week groups for seronegative gay men, which includes men who have not tested, some of whom may test seropositive during the course of the group. Group leaders in these mixed groups are experimenting with not disclosing their serostatus, particularly in the early stage of group development, because such self-revelation could become either a symbolic support or a hindrance to the individual exploration of members. This avoids marginalizing uninfected men and gives group members the opportunity to explore the impact of knowing or not knowing serostatus on interactions with each other and the group leader.

Decisions about self-disclosure and matching providers and group serostatus ultimately depend on the characteristics and goals of the group, and the theoretical orientation of the therapist. For example, in a private practice setting, longer term groups, or more psychodynamically-oriented individual therapy, self-disclosure or the process of role modeling may be inappropriate. If a therapist sees a group as a setting for basic character change and for uncovering unconscious feelings, he or she may choose to remain more distant, separate, and interpretive. Employing a traditional, psychoanalytic interpretation of the transference relationship—in which a therapist uses neutrality and nondirectiveness

**References**


to avoid disrupting unconscious forces—a therapist would not disclose his serostatus or encourage an exploration of seroconcordance or discordance as an early stage group subject. However, even in this context, the therapist would further entrench a feeling of isolation and shame if he or she did not model an inquisitive stance toward the role of serostatus in building relationships, thereby giving group members permission to question among themselves how serostatus has affected interpersonal growth and development.

Providers who wish to avoid disclosure of negative serostatus to seronegative clients should first explore their own countertransferential issues in terms of over-identification with clients, seroconversion fears, and survivor guilt. In fact, any clinician working with gay men needs not only to learn more about HIV-related issues, but also to commit to an ongoing exploration of these issues as they pertain to his or her own serostatus and psychosocial functioning. Failing to do this or to resolve disruptive countertransference feelings may require clinicians to refer clients to other community resources.

The Counselor’s Task

Regardless of the sexual orientation or serostatus of the provider, a gay affirmative worker needs to become a social anthropologist. Prior to and while working with their gay clients, he or she must not only identify his or her own homo-negative attitudes and behaviors, but must also develop an understanding of, and belief in, the complexity of gay culture and experiences. As long as providers do this homework and are open to learning from their clients, there may be advantages in therapists being of different cultures from their clients.

In individual therapy, there is no serious harm in serodiscordance as long as therapists remain spontaneous in discussions about HIV disease, make room for their clients’ emotional experiences, and carefully explore their clients’ thoughts, behaviors, and motivations. With HIV-negative gay men, the most common mistake is to celebrate with too much enthusiasm a seronegative test result; this may promote feelings of invulnerability, increase feelings of guilt, and discourage clients from expressing less positive feelings.

In a long-term, HIV-negative or mixed-status group, an HIV-positive leader’s self-disclosure might open the door for a fuller exploration of the effect of differing serostatus on relationships and might stimulate dialogue about similarities and differences among members. In time-limited work, however, the exploration of the differences may sidetrack the stated purpose of the group and, in the case of HIV-negative support groups, could replicate the experience of being minimized by the community. This situation may change as uninfected gay men become more visible in the community and services for all men affected by HIV become the norm.

Any guidelines, particularly ones that address concepts as nascent as serostatus, are best viewed not as empirically tested rules but as summaries of recent experiences that have clinical value. When therapy includes themes of social oppression, the common ground of concordance between therapist and client can be powerful. By the same token, the process of therapy is an exploration that can use difference to achieve its goals. As with any client-focused intervention, what is most important is clinical judgment, creativity, and sensitivity to the client.


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Clearinghouse: Seroconcordance

References


Ten years ago, when I learned that I was HIV-infected, I stepped through a looking glass into a world where everything seemed both the same and different, where my clients were suddenly mirror images of myself. Because I was working with HIV-positive clients, I knew I had to resolve the denial, anger, and shame I felt so that I could maintain my professional responsibilities. As part of this process—which included therapy and clinical supervision—I had to ask myself some tough questions, questions that others before me had confronted. Should I continue to practice? What complications could I expect while conducting therapy? How could I deal with them?

**Should I Continue to Practice?**

As a person with HIV disease, I bring a special passion and expertise to the challenge of working with other people with HIV infection. I have personal knowledge of the impact of HIV infection and have become a motivated, educated consumer of HIV-related services. Perhaps most importantly, I have the opportunity to model a personal and professional life plan that incorporates my illness, continuing to do fulfilling work, being committed to goals, being involved, and making a contribution.

But desire was not the only criterion I considered when facing the question of continuing to practice. It was crucial for me to consider two other areas of my life: physical and mental health and the support of colleagues.

I realized early on that the decision to practice is not made once and for all. It is contingent on ongoing mental and physical health and my ability to deliver quality service. Before I could make a responsible decision about continuing to practice, I had to deal with depression; resolve feelings like anger, denial, and shame; and ensure that I was not facing organic decline or an illness that signaled incipient disability. To monitor my mental and physical health, I established relationships with several professionals, including an internist and a psychotherapist; to monitor my therapeutic work, I arranged for clinical supervision.

It is difficult to continue to work without the support of colleagues. A group practice can facilitate this support and the development of a therapeutic plan for clients. This can be done, for example, by introducing alternate providers who are available for short periods during a therapist’s illness or who may be able to continue with clients in the event of disability or death. In some cases, introducing a cotherapist may help in this transition.

Disclosure is essential to develop collegial support, but this experience is always emotional and sometimes disappointing. While colleagues may be verbally supportive, they may also be reluctant to refer

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See also references cited in articles in this issue.
new clients or to participate in collaborative activities. In thinking about this possibility, it is important to distinguish between the irrational fears of colleagues and the predictable human response that an HIV-infected therapist is potentially a disabled therapist. It has been useful for me to consider how I would deal with this kind of response if it was presented to me by a client rather than a colleague, responding, as I outline below, to vulnerability with reassurance.

Disclosure to Clients

The decision to disclose or not to disclose to clients is perhaps the most difficult one faced by HIV-infected therapists. Unlike the situation with colleagues, when I believe disclosure is absolutely necessary, deciding to disclose to clients is more complex.2 For some providers, however, the decision is obvious, either because these providers consider the information to be entirely personal or because the disclosure is contrary to their theoretical approach. For example, for a provider with a psychoanalytic orientation, disclosure will impede therapeutic neutrality and possibly lead to a reversal of roles.4 Other therapists choose to disclose precisely because of personal conviction or theoretical approach. Being willing to disclose opens up the possibility for the therapist to be a kind of role model for the client. It is important to note that therapists choosing not to disclose must consider the risk of disclosure from other sources in the community.

One way of framing disclosure is for the therapist to discuss plans to support clients should he or she become temporarily or permanently unable to continue the therapeutic relationship. All clients need reassurance that providers will be there for them and will be available for as long as they need them. A collaborative plan developed by the therapist and the client helps to prevent the client from feeling or being abandoned. It also illustrates that the therapeutic relationship is not exclusive and dependent.

The Dynamics of Therapy

Countertransference feelings for HIV-infected therapists can lead to contrasting reactions.4 For example, a provider who is experiencing powerlessness, frustration, and anger in his own life may be overly sensitive to the helplessness of his or her client and may end up working harder than the client. On the other hand, the same provider—driven by a sense that time is short—may be excessively confrontational and intolerant, and may push the client to work harder than the client is prepared to work.

A provider who is feeling a loss of control or the imminence of his or her own death might try to keep the client focused on living despite clear indications that the client’s physical and emotional conditions have progressed to the point where it is necessary to prepare for dying. In contrast, the provider might seek to prepare for dying before it is indicated. In both cases the client’s image is obscured by the provider’s own reflection in the mirror. Sometimes the mirror the client holds up does not reflect where a therapist is, but where he or she wants to be. A client who seems in control of his or her own illness may engender resentment in a therapist who feels unready to deal with his or her own HIV infection. As a result, the therapist may pull back from the client, miss appointments, or even terminate the relationship. In all of these cases, consultation and supervision can provide the insight to protect clients and enhance therapy.

Conclusion

Many therapists work with the terminally ill. Some face the prospect of incapacity from an illness of their own. All therapists struggle with countertransference reactions. What makes the experience of the HIV-infected provider working with the HIV-infected clients unique, or nearly so, are not the issues themselves, but the fact that these issues are concurrent and compressed into a period of exaggerated and unpredictable time.5,6 But while HIV disease has made my clinical practice more intense, complex, and uncertain, it has also made it more rewarding for myself and, I like to think, for my clients—bringing to them a deeper dimension of healing and hope.

References


Authors

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Heterosexual Therapists and Gay Groups

Heterosexual therapists may fail to facilitate lesbian and gay groups effectively when they both identify with group members’ rage at heterosexual society and fear being the object of that rage. According to a pilot study of gay and lesbian groups at a Pennsylvania college campus, self-disclosure by heterosexual therapists of their concerns regarding sexual orientation discordance creates an environment that allows confrontation as well as self-development and maturation.

A student counseling center offered two therapy groups, one for gay men and one for lesbians. Each group was led by a heterosexual therapist who disclosed his or her sexual orientation in a pre-screening session. The groups met every week for 90 minutes and initially were comprised of five members each.

Initially, the therapists felt accepted by group members. The difference in sexual orientation was noticeably downplayed by members; the female therapist, for instance, was heralded an “honorary lesbian.” By the fourth or fifth session, however, these conscious attempts to create environments that excluded conflict by minimizing differences in sexual orientation were also inhibiting the goals of therapy, primarily, to develop the resources for interpersonal growth.

The groups succeeded in exploring the gay male and lesbian experiences when two things occurred: first, at the point that the facilitators disclosed that they intended to offer input and confrontation, in addition to validation and support; and later, at the time that group membership changed. Because new members were older, more isolated, and more alienated than current members, group discussions began to focus on differences in the gay and lesbian experience as well as on frustrations with the straight world. In addition, group facilitators led sessions exploring issues that arose out of straight leadership in a gay group. For example, discussions about the gay social and political scene excluded the straight leader, and, in one case, when the leader showed up late and was unintentionally locked out, the “accident” was plumbed for its deeper meanings, that is, the group’s attempt to lock out the heterosexual world.

Homogeneity or Heterogeneity of Groups

Heterogeneous characteristics among members of a therapy group enhance the therapeutic tension deemed necessary for change, while homogeneous characteristics allow for the group cohesiveness crucial to building rapport and support. According to an essay, counselors should consider the goals of the group and the optimal balance of heterogeneity and homogeneity to achieve those goals.

Homogeneous groups share not only individual characteristics such as age, gender, ethnicity, and cultural background, but also common problems or linked issues that reflect the focus of the group. Depending upon the issue, different levels of homogeneity and heterogeneity are appropriate. For example, a group of people with an age-specific concern may not need to be of the same race, but depending upon the level of development of group members, cohesiveness may be heightened if members are of the same gender.

Therapeutic groups that are aimed toward achieving personal change in group members are more likely to benefit from a climate that evokes therapeutic tension, thus including members with diverse conflicts and coping strategies as well as diversity in individual characteristics. For example, an age-specific group whose members are seeking to resolve issues with their personal relationships may benefit from having an age-heterogeneous group. At the same time, counselors should seek homogeneity that will allow the group task to be achieved, specifically, clients should share similar abilities to tolerate anxiety, motivation for change, acceptance of the group’s ambitions, and general mental and social abilities.

Gay Therapists and HIV-Infected Clients
Cadwell SA. Empathic challenges for gay male therapists working with HIV-infected gay men. In
Gay male therapists strongly identify with the fear of contagion, death and grief, and homophobia experienced by their HIV-positive clients, according to a small Boston study. In addition, therapists may react to a seropositive client’s risky behavior as a personal threat.

The study comprised 15 White, gay male therapists ranging in age from 32 to 55. All were uninfected or of unknown serostatus.

Many of the therapists had experienced HIV-related multiple loss in their social and professional circles. Some of these therapists numbed themselves to avoid feelings of loss and grief; they became “machine-like” and were not effective in dealing with their clients’ problems. When seropositive clients discussed the shame of being infected, personal experiences of being oppressed and stigmatized for being gay were triggered for therapists.

All of the therapists experienced difficulty when clients—whether seropositive or seronegative—expressed unsafe sexual impulses. In one case, a therapist’s own fear of contagion entered the therapy session when he strongly cautioned a patient against becoming sexually involved with a seropositive.

Self-Disclosure in the Analytic Session
Renio O. The ideal of the anonymous analyst and the problem of self-disclosure. Psychoanalytic Quarterly. 1995; 64(3) 466-495. (San Francisco Psychoanalytic Institute.)

By eschewing the pretense of anonymity and making self-disclosures in the psychoanalytic session, the analyst facilitates the therapeutic process, establishing a healing, collaborative atmosphere between the client and therapist. According to an essay focusing on psychoanalysis, the contemporary bias toward anonymity is an impossible goal. Instead, psychoanalysts should articulate any thoughts and feelings that contribute to a client’s self-investigation.

The traditional principle of anonymity holds that an analyst will avoid all deliberate input of his or her own personality in an effort to maintain the ideal of “analyst as reflecting mirror.” Analysts disclose only information that is crucial, for example, only what is necessary to establish a rapport with the clients.

However, the therapeutic relationship consists of constant—usually inadvertent—disclosure from therapist to client. For instance, the empathy central to therapy communicates a therapist’s personal knowledge of the client’s experience. Clients may also infer meaning from a therapist’s lack of disclosure. They may think that the therapist is being sadistic or controlling by not giving opinions or answering questions. Alternatively, clients may fantasize that the analyst is suppressing self-expression as a form of selfless devotion to the client.

The effort to avoid disclosure and to remain anonymous also invites the client to idealize the analyst as an objective authority. Idealization may be inevitable, and is not necessarily counterproductive when initiated by the patient, but it is problematic when it is solicited by the analyst. By not disclosing the observations and assumptions that underlie an intervention, for example, an analyst may lead a client to guess about the therapist’s reasoning, distracting the client from reflecting on his or her own issues.

Self-disclosure of the therapist’s rationale—even when this reasoning is not perfectly clear to the therapist—helps dispel the analyst’s mystique as an objective authority. In doing so, the analyst conveys respect for the client as a collaborator and the client feels more comfortable expressing concerns about therapy. This enables the identification and correction of unproductive patterns.
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