HIV test counselors, perhaps more than most other providers, come face-to-face with the full range of HIV risk behaviors and responses every day. Through this continual process of assessing risk behavior and conveying HIV-related information, counselors are forced to consider the role of HIV risk in their own lives.

In discussing HIV risks, counselors may confront uncomfortable feelings if they, themselves, are engaging in risky behavior, if they have in the past, or if they are unsteady in their resolve to maintain safer practices. These feelings often concern the process of “countertransference,” the thoughts and feelings about a counselor’s own life that occur to the counselor in response to a client. To deal appropriately with countertransference—a concept that has its basis in psychotherapy—it is important for counselors to be aware of their own psychological issues, especially those that may be stimulated by interactions with clients. Without this awareness, counseling may inappropriately relate more to the counselor’s than the client’s needs.

This article addresses some common countertransference issues that arise in the course of counseling. It presents ways counselors can recognize and respond to countertransference, and highlights these approaches with case presentations.

Feelings and thoughts may emerge in response to any aspect of the client’s communication, including both non-verbal and verbal cues. For instance, a client’s description of engaging in unprotected sex may evoke a range of countertransference feelings: shame, as a counselor remembers his or her own recent lapse; anger, if the counselor thinks the client’s lapses are going to result in more transmission of HIV; or resentment, if the counselor has practiced safer sex yet wants to engage in unprotected sex. Having these feelings is natural, but when these feelings interfere with focusing on the client, they may inappropriately guide the session. For example, in order to protect his or her own self-esteem, the counselor might suppress the memory of having engaged in risky sex, and either judge or dismiss the client’s activities or collude with the client in minimizing negative consequences of unsafe behavior. To consider whether this is occurring, the HIV counselor can, during the session, ask him or herself what feelings are “coming up” and why this might be happening. For example, if a client’s communication style engenders familiar feelings of discomfort in the counselor and the counselor is able to understand in the moment the roots of these feelings, he or she can avoid counseling on the basis of those feelings. Identifying these roots is crucial to resolving feelings and re-focusing on the client.

The Context of Countertransference

As the mantra goes, information alone does not change behavior; beyond knowledge, behavior is motivated by feelings, thoughts, and experiences, and the relationships among these. This becomes especially clear when a colleague seroconverts, sometimes after years of AIDS work, after testing seronegative, and after reporting that he or she has adopted safer activities. The reality is that counselors are as capable as clients of taking risks, whether it be engaging in unprotected anal or vaginal intercourse, sharing needles without cleaning them, or drinking alcohol prior to sex—a secondary risk factor in transmitting HIV. But, counselors who engage in risk behaviors often have trouble acknowledging this to themselves or to co-workers. Working in the AIDS field sets up an assumption that counselors know about safety and have the capacity and commitment to remain safe.
Sometimes, compassion for oneself—and one’s colleagues—is the most difficult feeling to access, yet it is important for counselors to remember their own humanity and vulnerability.

**Identifying Countertransference**

Feelings that arise for a counselor in HIV testing and counseling in response to a client are neither good nor bad. Like any feelings, they result from human experience, they are not something to judge, and their existence is not something to deny. On the contrary, they are something to recognize and acknowledge, because they can improve test counseling by giving counselors insights into clients’ responses and in turn help clients work through issues more productively.

The process of noticing and responding to countertransference involves several internal steps. During the counseling session, the counselor begins by approaching his or her own feelings with a willing curiosity and in a non-judgmental and empathic way, much as he or she responds to the client’s feelings. Detachment becomes an important tool as the counselor experiences the feelings—a prerequisite for learning more about them—and begins to separate from them. To the extent possible, the counselor must step back from his or her feelings and reflect upon them and their meaning in the context of the issues the client presents. This is a difficult task, especially when the counselor’s feelings are strong.

Counselors can use their feelings to examine the “pull,” that is, the sense a counselor might have that a client is seeking a specific kind of response from the counselor. While detaching from feelings and assessing their meaning, the counselor might reflect on the client’s communication both in terms of what is being said and how it is being communicated. For example, a client who complains about not getting adequate emotional support from a partner may evoke the counselor’s own feelings of his or her relationship. Aware of this, the counselor can step back from his or her reaction to the client’s communication and form a reply such as: “How do your friends respond when you ask them for support?”

When the session is finished, the counselor must then determine how he or she is going to process his or her feelings further, and in what venue, be it psychotherapy, supervision, or with peers. At that point, the counselor’s observations of his or her feelings become important tools. When these feelings and concerns speak directly to HIV risk, the counselor becomes, in a sense, a client. It is wise at this point for the counselor, both as an HIV service provider and as a person living somewhere along the risk continuum, to explore these feelings. This is important so that these feelings do not impede future counseling and to ensure that the counselor gets the support necessary to make or sustain behavior change for him or herself. In some cases, identification of countertransference issues, which can occur during supervision or with peers, may be enough for a counselor to resolve these issues. In instances where further exploration of these issues is necessary to reach resolution, psychotherapy may be useful.

The following case studies show how countertransference can affect test counseling, how counselors may or may not notice countertransference that is occurring, and how they may respond appropriately or inappropriately.

**Rhonda and Mary: Affinity for a Client**

Mary is a 32-year-old heterosexually identified woman who is seeking HIV testing because she “just thought it was time.” Upon further exploration, Rhonda, her counselor, learns that Mary has had three sexual partners in the past six months and, while Mary discussed condom use with one of the partners and has used condoms in the past, these three partners did not use condoms.

Mary has accurate information about condom use and HIV transmission risks, but she believes that within her circle of friends, she is not at risk. She describes this group as professional people who frequent a particular bar after each workday. She says she drinks a little, but does not believe her alcohol use plays a significant role in her choices about either sexual partners or condom use.

Rhonda also identifies as heterosexual and sees herself as knowledgeable about safer sex. She, too, has had several sex partners in recent months and has not used condoms consistently. While Rhonda has felt some guilt about not using condoms—she thinks that she should “know better”—she rationalizes that those in
Rhonda likes Mary, and thinks she is making understandable choices regarding safer sex, or, more accurately, not feeling a need to use protection given her peer group. As the discussion progresses, Rhonda notices herself minimizing Mary’s risk, as she fails to pursue discussion of the specifics of Mary’s sexual activity. Rhonda finds herself concluding that since Mary is intelligent, her assumptions must be reasonable. She asks herself if she is rationalizing simply because Mary’s behavior is so similar to her own, and further if this similarity is evoking in herself feelings of friendship and camaraderie, and the inclination to defend or justify Mary’s choices. Rhonda catches herself just in time to shift her approach with Mary.

Counseling Response. Rhonda might intervene in several ways, all of which depend on an acknowledgment of how “close” Mary’s situation feels to her own and how necessary it is to set aside the feelings that this affinity inspires. When Rhonda recognizes how she may be identifying with Mary, she responds by returning to the issue of safer sex in a more in-depth manner. She does this by addressing apparent contradictions between the accurate information Mary has about HIV risk and the possibly dangerous assumptions Mary is making about her circle of friends.

Rhonda uses her feelings to neutralize the countertransference, saying, “I can understand how you might feel the way you do considering that you believe your friends are not at risk of having HIV.” This approach allows Rhonda to name her bias and at the same time validate and empathize with Mary’s belief.

From this point, however, it is important for Rhonda to step back from her “understanding” and assist Mary by injecting some objectivity into the discussion. She says, “I’m wondering what information you have about your circle that makes you so certain,” in this way challenging both Mary’s and her own assumptions. She then listens to Mary’s rationale and points out contradictions or rationalizations in a manner Mary might understand.

Following the session and as a learning tool, it will be important for Rhonda to discuss this case with someone—perhaps her own psychotherapist, her supervisor, or a counseling-site team consultant—to clarify the appropriateness of her counsel-

### Noticing and Responding to Countertransference

There are six steps that will help counselors respond to countertransference:

1. Be willing to be aware.
2. Notice feelings, stepping back from them in order to gain perspective.
3. Examine feelings for their relevance to the issues a client brings to the session and to shaping appropriate interventions.
4. Shape interventions using these insights.
5. Implement interventions, always continuing to notice these feelings.
6. Attend to countertransference feelings after the session, with colleagues, peers, or supervisors, in personal psychotherapy, or through other resources.
not over, and that there is, in fact, no cure for HIV. Still, he longs for what he has referred to with friends as the "great unknown" of having sex without protection. In addition, while he knows his role as a counselor precludes having any personal relationship with a client, Sam is aware of being attracted to Joshua.

Counseling Response. Sam catches himself emotionally affirming to himself Joshua's hope and optimism about promising HIV treatments and his desire to have unsafe sex. At this moment of understanding, Sam has to make an important choice. If he is to unquestioningly accept his own responses, he will risk colluding with and directly or indirectly supporting the fantasy aspects of Joshua's feelings.

Instead, Sam uses his feelings in a way to help Joshua sort through these hopes and fantasies in the context of HIV risk reduction. He does this by observing the thoughts and feelings he is experiencing, while recognizing that his task is to help Joshua deal with his desire to engage in unprotected sex. It is appropriate for Sam to acknowledge out loud that he can understand Joshua's hopes and desires. Then, Sam must again step back from these hopes and desires in order to intervene objectively and with neutrality. He does this by exploring the reality of HIV risks and the harm of becoming infected, and contrasts between Joshua's desires and the consequences of unprotected sex.

As to his attraction to Joshua, Sam does not begrudge himself these feelings; they are pleasant and natural. He does, however, recognize his role in this context, and focuses on the counseling task, remaining aware that it is inappropriate for him to disclose his attraction to Joshua.

Steve and Christine: Keeping Secrets

Steven, who is 43 years old, seeks counseling and testing because he wants to enter a drug treatment program and has been "encouraged" by the program's intake worker to test. His primary drug was heroin, and although he has friends who use heroin and are okay with their use, everything has become unmanageable and he wants to give up drug use to save his life.

His counselor, Christine, is closeted about her own heroin use. While she sees that at one time drug use was a problem for her, she now believes herself to be a responsible user. Steven has a scruffy look, one Christine associates with "druggie losers." She has never liked the language of 12-step recovery programs, and she does not like Steven, although she is unclear why this is. She wants the session to end.

Counseling Response. Christine's stereotypes and judgments about "druggie losers" in general and Steven in particular clearly interfere with her ability to counsel him. Her lack of self-awareness, defensiveness, and contempt for Steven may mask her uncertainty. While she may see herself as a "functional" and responsible heroin user (since she does not share her works and is not putting herself or others at risk), her need to maintain that she is a reasonable or good person may set the stage for a poor intervention. She may lack the empathy to validate Steven's situation and fail to offer him the support required by someone seeking recovery.

Unfortunately, Christine is not able to recognize her countertransference. In an unconscious effort to get through the session quickly, she asks only closed-ended questions, for example, how many times he has had unprotected sex and when he last injected drugs. In doing this, she succeeds in gathering facts but fails to understand the issues Steven faces or to support his motivation to take care of himself.

Given the intensity of her feelings, Christine would have needed to assess her ability to achieve an objective, neutral, and supportive counseling posture. If she could not do this, the only responsible course would have been to find a different counselor for Steven. However, while referral to another counselor is sometimes the most valuable response to countertransference, it is not a permanent solution, and counselors who use this approach with any frequency must assess this pattern. Finally, if Christine were interested in improving her ability to counsel, particularly for people with substance-related issues, it would be wise for her to use supervision to further detach herself from the session.

Conclusion

When HIV counselors are themselves at risk for HIV infection, internal conflicts—whether they are conscious of them or not—complicate counseling sessions. If counselors are aware of their conflicts and can step back from their own feelings, they have an opportunity to enhance their responses not only to the client in question, but also to all clients they will counsel.
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