The counseling relationship is an artificial one. For it to be most effective, clients must disclose intimate details about their lives, but the intimate role the counselor plays in the client’s life must not extend beyond the counseling session. The structural guidelines that govern this relationship are called “boundaries.” They are the rules by which counselors maintain this personal/impersonal dichotomy to ensure the client’s emotional safety and to facilitate the most effective outcome. This issue of PERSPECTIVES explores the meaning of boundaries, ways of setting and maintaining boundaries, and the boundaries that are important for HIV test counseling, particularly those relating to confidentiality, partner notification, and HIV surveillance.

Research Update

The relationship between counselor and client is a central component of the counseling process, and the quality of this relationship is a significant element in the success of a counseling interaction. The best outcomes tend to occur when a therapeutic relationship exists in which the counselor communicates respect, genuineness, and empathic understanding to the client.

Boundaries provide a way to conceptualize and maintain appropriate behavior and styles of relating for both counselor and client. Maintaining clear boundaries helps ensure that both the counselor and the client adhere to their distinct roles and limit opportunities for them to transgress those roles.

Boundaries are difficult to define because they are not a simple set of rules and ethics. Boundaries encompass the limits of the counseling relationship while ensuring the safety necessary for both client and counselor to be spontaneous in a session. Boundaries protect the client’s vulnerabilities and provide a framework for exploring his or her thoughts and feelings.

Although most of the research on boundaries applies to counseling and therapy in general, rather than HIV counseling in particular, it offers important insights for HIV test counselors.

Setting and Maintaining Boundaries

Counselors need to understand the rules and roles for both counselor and client, and it is important for counselors to communicate these rules to clients, by example and, if necessary, by explicit statements. However, counselors cannot expect clients to understand and maintain boundaries; it is the counselor’s responsibility to constantly and actively make judgements about where to draw boundaries and to do so with wisdom and compassion.

A boundary violation by a counselor can be harmful because it interferes with the basic structure of counseling that allows the client to feel safe. A boundary violation occurs whenever the counselor acts on the basis of his or her own needs or desires rather than on behalf of the client’s needs and best interests. Such boundary violations include participating in sexual activity with a client, lending or borrowing money, asking a client for advice, or trying to obtain other forms of help or support from the client.

Counselors must not take advantage of their expertise or position of trust to exploit clients. When coun-
selors consciously or unconsciously allow their needs to take precedence over the needs of the client, boundary violations are more likely to occur. It is important for counselors to be aware that they are in a position of authority in the counseling session, and the resulting power imbalance may increase the potential for inappropriate influence to occur.

Given that boundaries are limits that allow for a safe environment to address client needs, altering these limits creates ambiguity about what is allowed, which clients may interpret as an intrusion into their sphere of safety. In addition to harming clients, boundary violations can have detrimental effects on counseling and the broader therapeutic community, because the more clients have negative experiences with counselors, the less likely they are to trust counselors and test for HIV again in the future.

One boundary that counselors must never cross is that of sexual intimacy with a client. In addition to the potential harm and the exploitative nature of using the counseling setting for personal sexual gain, the counselor-client relationship is likely to change because for many people sexual intimacy is a defining feature of a relationship. Sexual interaction breaks the original contract and central boundary between counselor and client.

Although professional ethical codes provide important and useful guidelines for counselors, these guidelines are general and cannot possibly address every possible situation or dilemma that may arise in a counseling session. As a result, there may be situations in which a counselor may decide to cross certain boundaries for the greater good of helping the client. It is important to avoid extending a boundary impulsively. There must be sound reasoning behind such a decision that can stand up to peer scrutiny.

When faced with a decision to extend a boundary, a useful exercise is for the counselor to ask him or herself two questions: “Can I expect this boundary extension to further empower the client?” and “If the boundary extension turns out to be less helpful than expected, can the failure be used therapeutically to further empower the client?” Affirmative answers to both of these questions would suggest that the counselor is justified in extending the boundary, but it is important to approach these questions from an impartial, neutral stance and, if possible, after consulting a colleague.

Confidentiality

Client confidentiality is one of the most important boundaries in the counselor-client relationship. Confidentiality is the ethical foundation of counseling that encourages client disclosure while protecting the client from having the disclosure revealed outside of the counseling context. The client is more likely to confide in the counselor with the knowledge that the sensitive information revealed during the session will remain confidential. Confidentiality is essential to establishing trust between counselor and client.

There are situations in which it is appropriate or necessary to break a client’s confidentiality. An important example of breaching confidentiality is the duty to warn when there is impending danger to the client or to other people. The 1976 legal case that set a precedent for the duty to warn is Tarasoff v. Regents of University of California, the first case to address the responsibility of practitioners to warn third parties of potential harm from their clients.

The Tarasoff case involved a client telling his psychotherapist that he was going to kill his girlfriend. The therapist notified the police, who detained the client but released him after deciding that he was not an immediate threat. The client later killed his girlfriend, and her parents sued the therapist for failure to detain a dangerous client and for failure to warn the victim and other people likely to have contact with her. The court decided that the threat of public peril outweighed the importance of client confidentiality. Although counselors and therapists have a responsibility to maintain client confidentiality, this confidentiality is not absolute because they also have a responsibility to protect public welfare.

The Tarasoff ruling stipulated that the “duty to protect” should exist in situations in which the following three conditions are met: a special relationship (as between therapist and client); a reasonable prediction of conduct that constitutes an imminent threat of violence; and an identifiable victim. The court also stated that it is the therapist’s obligation to break confidentiality only when it is necessary to avert danger to others. One interpretation of this statement is that there are various ways other than breaking a client’s confidentiality to protect potential victims. For example, encouraging behavior change may protect third parties while maintaining confidentiality.

The Tarasoff ruling—codified into California law—is widely cited as the precedent for cases involving the duty to warn, but it is legally binding only in California and
applies only to licensed therapists, not to HIV test counselors. There is no federal law addressing the limits of client confidentiality. While some states have laws pertaining to these issues, others do not, and laws in different states may vary dramatically.²

**Partner Notification**

Partner notification is the process of informing sexual or needle-sharing partners of clients who test positive for HIV or other sexually transmitted infections that they may have been exposed to infection. Partner notification has been controversial since the beginning of the AIDS epidemic because of the debate between the rights of the individual to confidentiality and the responsibilities of the state to protect public health.⁸ Although health care providers have an ethical responsibility to make sure sexual and needle-sharing partners are notified of exposure to HIV and other sexually transmitted diseases (STDs), doing so may compromise client rights to confidentiality.⁹

The goals of partner notification are: to provide services to sexual and needle-sharing partners of HIV-positive clients so they can avoid infection or prevent transmission to others if they are already infected; and to offer partners early access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services, as appropriate.¹⁰ In addition, partner notification, also called “contact tracing” or “partner counseling and referral services” (PCRS), provides an opportunity to educate both clients and their partners about risk-reduction strategies.⁹ Partner notification can also be an effective way of identifying sexual and drug-injecting networks at high risk for transmission of HIV and other STDs. This information can be useful for planning and directing prevention interventions to reduce risk within these networks.¹⁰

Different states have different laws regarding partner notification of HIV and other STDs. The Centers for Disease Control and Prevention (CDC) requires federally funded HIV testing sites to make partner notification programs available to clients who test HIV-positive. In addition, the World Health Organization and the United States Preventive Services Task Force recommend partner notification as a strategy to curb STD transmission.⁹

Partner notification benefits partners exposed to HIV whether or not they are infected. Those who are infected have the benefit of early diagnosis and, therefore, the opportunity to begin treatment. Those who test HIV-negative may become more aware of their risks and benefit from client-centered counseling, which research has shown to be effective at reducing the risk for STD infection.⁸

There are three main methods for undertaking HIV partner notification: client referral (also called self referral) involves the client agreeing to notify his or her partners of exposure and referring them to appropriate services; provider referral entails the test counselor or other provider obtaining consent from the HIV-positive client, then initiating the confidential notification process, which is usually carried out by the local public health department; and contract referral is a combination of the two by which the client agrees to notify partners with the understanding that the provider will take over notification responsibilities for partners who do not visit the clinic within a contracted time period.⁸ Research suggests that provider referral is more effective than client referral,⁹ but it also requires more staff training and is more costly and labor-intensive.⁸

Partner notification may also be especially difficult among hard-to-reach populations, including injection drug users and homeless people. As a result of these difficulties, there are often large differences between the number of partners identified, the number for whom adequate locating information is available, and the number successfully notified.⁸

Despite its benefits, partner notification may also lead to adverse outcomes, perhaps most notably, domestic violence against the HIV-positive client by the partner after being notified. Other potential adverse effects include stress, stigmatization, discrimination, loss of confidentiality, and emotional trauma. The potential for adverse effects highlights the need for caution and the importance of the training needed for safe and effective partner notification.⁸

Confidentiality is essential to establishing trust between counselor and client.
HIV Surveillance

Another challenge to confidentiality arises out of the process of surveillance that collects data to track the progression of the epidemic. In 1983, the CDC implemented a policy that requires states to report the names of all people diagnosed with AIDS. Although states have not been required to report cases of HIV infection, the CDC has recently given states a deadline of July 1, 2004 to implement a system of tracking HIV infection or risk losing substantial federal funding. Many states currently use a name-based reporting system, while a handful of states have chosen to use a code-based reporting system that maintains the confidentiality of the HIV-positive client’s identity.11

On July 1, 2002, California became the most recent state to adopt the policy of “non-names reporting.” Under the new system, every positive HIV antibody test at confidential test sites will be assigned a unique identifier code based on information about the client, including last name, gender, date of birth, and last four digits of his or her Social Security Number. The non-name code contains no information that can be used to trace the test result back to the client, thus protecting confidentiality of test results.11

Under the new California law, anonymous HIV test sites are not required to report HIV-positive test results because they do not collect any identifying information. However, when HIV-positive people seek medical care, including CD4+ count and viral load testing, medical providers are required to comply with the reporting process.12

Implications for Counseling

Within the context of HIV counseling and testing, many intimate conversations occur that challenge counselors to maintain professional boundaries, the ethical standards of behavior to which counselors must adhere in order to provide safety and focus in the session. Among these standards are avoiding self-disclosure, being aware of “countertransference” feelings and their effects on counseling, and maintaining confidentiality.

Self-Disclosure

Situations may arise in which counselors are tempted to disclose personal information about themselves to clients, sometimes in an attempt to display empathy. Although self-disclosure can be effective in certain therapeutic situations, it is generally not appropriate within the client-centered model of HIV counseling and testing. Self-disclosure should be used rarely and mindfully, if at all.

One reason for counselors to avoid self-disclosure is that doing so may give the client the opportunity to use the information to inappropriately shift the focus of the session onto the counselor. For example, if a counselor tries to place a client at ease and show empathy by disclosing that he or she also was terrified when first testing for HIV, the client may ask the counselor follow-up questions, including the counselor’s test results.

Self-disclosure should never include information about a counselor’s current sexual behaviors or substance use, largely because these behaviors are so closely related to the topics of the counseling session. There is also the potential for an emotional charge that would distract from the session’s goals by shifting the focus to the counselor instead of the client.

As another example, a counselor may be tempted to reveal his or her history of recovery from alcoholism in response to a client’s disclosure of a similar history. A more effective approach is to give clients positive feedback for taking care of themselves, perhaps by asking how long they have been sober and responding with supportive comments, such as, “That is quite an accomplishment. How are you doing with it?”

Before deciding to employ self-disclosure, the counselor must be certain there is no other way to achieve the desired purpose. Usually, there is another way that is more effective without undermining the dynamics of the session. The counselor must also be certain that the disclosure is in the interest of helping the client rather than serving the counselor’s own needs.

A rare case in which self-disclosure may be appropriate is if a counselor is working with a client who is grieving the loss of a loved one and feels isolated, is difficult to reach, or is having trouble opening up. If nothing else seems to be working, a counselor who has had a similar experience may disclose this as a way to normalize the experience, to make it easier for the client to open up, and to put him or her at ease.

“Third personing” can accomplish goals similar to self-disclosure without risking the integrity of client-centered principals. Rather than disclosing personal experiences, counselors may refer to “other clients” or “a friend” as a reference. For example, the counselor might say, “Other clients have also said that it is difficult to consistently use condoms,” and then follow up with some of the approaches “these clients” have found useful.

Countertransference

“Countertransference” is a psychological term referring to feelings or thoughts a counselor may have for a client that have less to do with the client and more to do with the coun-
Within HIV counseling and testing, countertransference often involves erotic feelings the counselor has for the client. Whether a counselor is attracted to a client is not problematic in itself. Given the context of intimate sexual discussion, it may be understandable that such feelings occasionally arise. What can cause problems is how counselors react to these feelings. Some counselors may find themselves asking questions about or steering the session into areas that have more to do with the counselor’s personal interests than the client’s risks. This is an infraction of professional boundaries.

For example, it is a gross violation of boundaries for a counselor who is attracted to a client to give the client his or her home phone number or to make a date with the client. Such behavior could lead to the counselor’s dismissal. To help reinforce professional boundaries, many HIV testing agencies have policies against counselors having social contact with clients for several years after counseling them. These policies protect clients as well as counselors from creating relationships that have dual, often conflicting purposes, are almost always damaging to the client and counselor, and are unethical.

If erotic feelings arise during a session, it is essential for counselors to find ways to put them aside. Learning to recognize and observe with detachment one’s own thoughts and feelings towards a client is the mark of a good counselor. For example, a counselor may develop an internal monologue that says, “I find this client very attractive, and I want to know more about his relationship difficulties. It is okay for me to find him attractive, but I’m not going to act on it, and it is none of my business what his relationship difficulties are unless they contribute to his HIV risks.” This kind of exercise may help enable the counselor to remain appropriately focused. However, it is important for counselors to maintain a balanced perspective so that attempts to avoid topics that may raise countertransferringal feelings do not overshadow the goals of the counseling session to provide an accurate risk assessment.

Discussing one’s attraction to a client with a colleague or supervisor is an appropriate way for counselors to release an erotic charge. Additionally, counselors may consider referring the client to a different counselor for the disclosure session, although this may not be possible at all test sites.

Confidentiality

Within the context of HIV counseling and testing, the term “confidentiality” has two connotations. One connotation refers to the type of HIV testing service an agency offers, meaning that “confidential” testing differs from “anonymous” testing in that it involves collection of client names and other identifying information. The other connotation refers to professional boundaries and the requirement that all client information remain private to enhance the safety of the session. This aspect of confidentiality applies to both anonymous and confidential test sites.

The safety created by confidentiality within a session is crucial.
agency keeps client files.

According to state laws, there may be exceptions to confidentiality. Those exceptions are usually in the areas of providing information that is subpoenaed by a court of law; reporting child abuse, elder abuse, or domestic violence; and informing endangered third parties of an imminent threat. When medical records are subpoenaed, the prevailing state law holds precedence. At anonymous test sites there are no records kept and, therefore, none to subpoena. For counselors at confidential sites, the procedures on reporting laws are established by their agencies. Counselors should always consult their supervisors on how best to handle these issues if they arise.

Standard child abuse reporting laws apply at confidential, but not anonymous, test sites. A counselor who has reason to believe that a client is involved in child abuse must, in collaboration with agency supervisors, report this to child protective services or the local police. However, it is important to keep all references to HIV confidential. If a client is 18 or older and was the victim of child abuse before the age of 18, it is the responsibility of the client—not the counselor—to make the report.

If a client tests HIV-positive, it is important to notify his or her sexual or needle-sharing partners because they may have been exposed to infection. The preferred method of informing partners is for the client to disclose his or her test result. If the client is unwilling or unable to inform his or her partners, the counselor can refer the client to the local health department for assistance. Most health departments have trained health officers who gather information from the HIV-positive client about past partners and notify them without using the client’s name or other identifying information.

If the client remains unwilling to inform past and current partners, work with the client to explain the importance of notifying partners, and refer him or her for counseling. Some clients need time after the shock or anger of hearing an HIV-positive disclosure to integrate the test results before they are able to tell others about their diagnosis. Anecdotal experience from agencies that provide follow-up counseling to clients who test HIV-positive suggests that within a few weeks of receiving medical and social services and with supportive counseling, clients who were previously unwilling or unable to inform partners become more receptive to doing so.

**HIV Surveillance**

Since 1983, the Centers for Disease Control and Prevention (CDC) has required states to report all cases of AIDS, the disease characterized by HIV infection, opportunistic conditions, and low CD4+ cell counts. However, AIDS statistics do not give an accurate representation of an epidemic that includes increasing numbers of people who are HIV-positive but do not have AIDS. Many states have implemented programs that report the names of all people who test HIV-positive, but a handful of states have decided on a policy that reports HIV infections to the CDC using a unique code—rather than a name—that cannot be linked back to the HIV-positive person.

On July 1, 2002, California became the most recent state to adopt the policy of “non-names reporting.” Non-names reporting uses a mechanism that prevents reporting a case of HIV infection more than once and distinguishes one case from another. A non-names report is generated when a client tests HIV-positive at a confidential test site—but not at an anonymous site—or when a client receives medical care for HIV infection from a medical provider.

To generate the unique identifier code that is reported with an HIV-positive test result, testing agencies collect a client’s last name, complete date of birth, gender, and the last four digits of a client’s Social Security Number. Additionally, confidential test sites ask for contact information from a client, usually a telephone number or address, to be used separately from the reporting information and only to contact the client if he or she fails to return for test results.

![Image](https://example.com/image.png)
If clients express concerns regarding the collection of personal data that will be sent to the CDC, explain that the personal information is converted into a “Soundex” code, an eight-digit code that does not contain their name or any other identifying information that can be traced back to them.

If clients do not want to disclose their personal information, counselors at confidential test sites may refer them to an anonymous test site, which does not collect personal information. However, it is important to explain that even if they test anonymously, if their test result comes back HIV-positive, a non-names code will be reported to the CDC by their medical provider when they seek medical treatment or diagnostic tests.

If non-names reporting proves to be an effective system for providing accurate HIV surveillance data, HIV testing agencies and clients in states with names-reporting policy may pressure their elected officials to adopt a non-names system. This may increase HIV testing among people at risk for HIV who feel uncomfortable with names reporting.

**Case Study**

Dan is a 38-year-old heterosexual HIV test counselor who, until recently, had been married. His marriage ended five months ago, and he is now dating women and trying to apply the safer sex messages he has always conveyed to his clients. The last time Dan had used condoms, however, was about 20 years ago, and he finds it difficult to implement the new behavior. Dan’s client is Jackie, a woman in her mid-thirties who is also newly divorced and new to the dating scene. She is testing because she is concerned about having unprotected sex.

**Counseling Intervention**

From the beginning of the session, Dan is aware that he is attracted to Jackie. He finds himself wishing he could meet a woman like her who seems to have so many of the qualities she values. At various times during the session, Dan takes a deep breath as a way to re-focus himself so he can concentrate on providing a thorough risk assessment.

As Jackie begins talking about being new to dating and the difficulties of meeting people with whom she is compatible, Dan is tempted to tell her that he has first-hand knowledge of how difficult dating can be after many years of marriage. Instead, Dan gathers himself and talks about how other recently divorced clients have also found dating and safer sex to be difficult issues.

Jackie says she feels awkward bringing up condoms with her partners, and because her partners have never initiated condom use, she has never used them. This makes Dan think about his own experiences with condoms, which have been mostly unsuccessful. Whenever he has tried to use condoms, his sexual functioning has suffered. Dan recently discovered that his own difficult experiences with condoms allowed him to make empathic statements during counseling sessions, whereas in the past he would simply educate clients on the need to practice safer sex.

Dan directs the discussion into risk reduction methods Jackie can use if she has sex without condoms. He discusses the hierarchy of risk and, while talking about oral sex as a less risky alternative to unprotected vaginal intercourse, he realizes for the first time that he should apply the same advice to himself when he is unable to use condoms.

Jackie then says that she wishes she could meet a man like Dan who is so nice and handsome. Dan feels flattered but also nervous because he is unsure of his ability to handle this situation appropriately. Jackie asks Dan if he is single, and Dan feels conflicted about revealing that he is also newly divorced and finds dating difficult. He is tempted to say that he also wants to meet someone just like her, but he has enough presence of mind to realize that pursuing his own feelings would damage the integrity of the counseling session, especially at a time when Jackie is feeling vulnerable.

With a deep breath Dan fumbles for composure and words. The best he can manage is saying thank you as he averts his gaze from hers. After recomposing himself, he brings up the issue of support, asking her, “Do you have anyone you can talk to who can support you while you are out there dating and trying to be safe?” Jackie says she has a girlfriend with whom she can talk about these things. Dan encourages her to seek her girlfriend’s support, adding that it is difficult to make significant changes without this kind of support. He also offers Jackie a referral to a women’s support group.

After the session, Dan meets with his supervisor to discuss his feelings about Jackie and what Dan should do if he meets Jackie outside of the clinic. With the supervisor’s help, Dan realizes that he would need to be polite in such a situation but remain detached from any involvement with Jackie for two years, according to the agency’s policy.
Test Yourself

Review Questions

1. True or False: A client is more likely to confide in a counselor with the knowledge that the sensitive information revealed during the session will remain confidential.

2. Under which circumstances is it acceptable for a counselor to make a date with a current or former client? a) during a counseling session; b) during a social occasion outside of the counseling environment; c) after a period of time stipulated by the rules of the testing agency; d) never.

3. True or False: A boundary violation occurs whenever a counselor acts on the basis of his or her own needs or desires rather than on behalf of the client’s needs and best interests.

4. What are the goals of partner notification? a) to provide services to sexual and needle-sharing partners of HIV-positive clients so they can avoid infection or prevent transmission to others if they are already infected; b) to offer partners early access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services; c) to identify sexual and drug-injecting networks at high risk for transmission of HIV and other STDs; d) all of the above.

5. True or False: Partner notification is controversial because of the debate between the rights of the individual to confidentiality and the responsibilities of protecting public health.

6. What are the main methods for undertaking HIV partner notification? a) client referral; b) provider referral; c) contract referral; d) all of the above.

7. True or False: Boundaries protect the client’s vulnerabilities and provide a framework for exploring his or her thoughts and feelings.

8. True or False: Under California’s non-names reporting law, all HIV test sites are required to report HIV-positive test results to the CDC.

Discussion Questions

1. What are professional boundaries for HIV test counselors?

2. What are some alternatives to self-disclosure?

3. What are local referrals for confidential HIV testing and anonymous HIV testing?

4. What are the procedures at your agency for child abuse reporting?

5. What are the procedures for the local partner notification service?

6. Which local laws may potentially affect client confidentiality?

7. What are the pros and cons of HIV partner notification?

Answers

1. True.

2. c.

3. True.

4. d.

5. True.

6. d.

7. True.

8. False. Anonymous test sites in California are not required to report HIV-positive test results because they do not collect identifying information about clients. However, when people who test HIV-positive anonymously seek HIV medical treatment or diagnostic tests, their medical providers will report their serostatus to the CDC.
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