formulation comprising the client’s actions, the client’s expectations of how others will act toward him or her, the acts of others in relation to the client, and the self-perception of the client and its corroboration by others. Psychotherapy using this approach attempts to raise the client’s awareness of how he or she actively participates in creating maladaptive cycles by behaving toward others in ways that precipitate reactions that, in turn, confirm the client’s expectations of himself or herself and of other people.

For example, Enrique tends to withdraw from or be unusually submissive around others because he expects them to take advantage of him and reject him if he were to be more assertive. Consequently, other people either ignore Enrique or take advantage of him, which confirms Enrique’s view of himself as a helpless person. The therapist explores this maladaptive cycle as it manifests in the relationship between the client and the therapist and the client and others.

**HIV Recedes into the Background**

In these cases, HIV remains a component of psychotherapy and a catalyst for change, but many times it recedes into the background while interpersonal, intrapsychic, familial, and societal issues come to the fore. In the interpersonal psychotherapy case, Albert has difficulties adjusting to being infected with HIV, yet the psychotherapy also deals with Albert’s change of careers, his setting of appropriate limits with friends, and his ability to express his needs to others. In the self psychology case, Anthony’s HIV infection confronts him with his substance abuse and helps him attain sobriety. Yet it is the couples’ intimate relationship and their self-esteem that becomes the focus of therapy.

The psychodynamic case deals with Robert’s difficulty asserting himself with his partner, which puts him at risk for HIV. However, therapy focuses on Robert’s difficulty asserting himself in everyday life. In the time-limited dynamic therapy case, Enrique’s unresolved anger toward his mother becomes the central issue of his therapy.

HIV disease always requires adjusting, but adjustment and change always occur in the context of other issues. Change is the result of the catalytic properties of HIV—and HIV-related concerns
are resolved as a result of this catalytic process. But the ultimate result seems to be a transformation of some kind that is more basic than an adjustment to the epidemic’s many challenges.

Other approaches may be used in conjunction with the approaches covered in this chapter. Among these are cognitive-behavioral therapy, existential therapy, object-relations therapy, other brief psychodynamic therapies, and group therapy and support groups. In addition, most therapists, even those whose practice is more insight oriented, employ supportive elements in their approaches.

There is not enough empirical research in the area of psychotherapies for HIV disease, yet clinical experience and the studies that do examine the relationship between psychotherapy and HIV confirm that psychotherapy can be enormously helpful for clients with HIV disease. With the awareness of special concerns that emerge in the treatment of people infected with HIV disease, most therapists can provide support and help as clients seek to work through the many issues they face. All of these approaches share the concern for the individual, the attempt to understand the individual and his or her relationships, and the effort to provide better coping tools for dealing with HIV disease.
Interpersonal Therapy: Albert

Kathleen F. Clougherty
John C. Markowitz

Albert, a forty-two-year-old divorced gay White Jewish male insurance adjuster, came to his therapist, Ron Hammond, L.C.S.W., complaining that he felt depressed and "overwhelmed" in his personal and professional life. Albert had tested HIV-positive two years before, and he had recently experienced a 300-point drop in his CD4+ cell count to 211, a jump in his viral load to 10,000, job dissatisfaction, the ending of a romantic relationship, and the death of his grandmother in the previous year.

Albert presented with complaints of depressed mood, loss of interest in activities he normally enjoyed, social isolation, decreased libido, difficulty falling and staying asleep, anxiety attacks, and suicidal ideation (without attempts). His initial Hamilton Depression Rating Scale score was 25, indicating significant symptom severity.

Albert told Hammonds he had no previous depression or psychiatric treatment but had a long history of alternative psychological treatments such as meditation, affirmation (chanting positive thoughts), and astrology. He had used alcohol and drugs socially in the past but not recently. He had no family history of psychiatric disorder, substance abuse, or suicide. Medically asymptomatic, Albert had refused antiviral medications, whose side effects he feared outweighed any possible benefits, but he did visit his physician regularly.

Personal and Psychiatric History

Raised in a major northeastern city, Albert was the middle of three siblings and the second son in a middle-class family. His father singled him out for physical
and emotional abuse from childhood through adolescence, calling him a "wimp" and a "fag" from early on. His father was close to Albert's elder brother, but without provocation hated Albert "from the day I was born." Albert was close to his mother, and particularly to his maternal grandmother, who died nine months before his presentation. His grandmother, but not his mother, protected him from his father.

Six months prior to entering treatment, when Albert's father forbade his mother to buy Albert a special birthday present, Albert stopped speaking to the father, even though his parents lived in his building and he saw them daily. This decision pleased Albert but did not diminish the rage he felt toward his father.

Albert was notably reliant on friends, calling many of them each day. Several had died of AIDS. He felt close to his friends, but remarked that although he willingly extended himself on their behalf, he worried that he could not expect reciprocal support and was reluctant to express his needs to them. This same pattern was evident in the three romantic relationships he had had. The last, a relationship that lasted two years, had ended about a year before treatment, when his lover became sexually involved with Albert's good friend and expected Albert to tolerate this situation. When Albert could not, his lover left him. Another close friend of seventeen years, whom Albert had supported through a series of crises, reacted to the news that Albert was seropositive by abandoning him. Albert commented that the emotional pain he endured in these relationships paralleled the abuse he had received from his father.

A college graduate, Albert had been reasonably successful in a variety of business ventures, and had worked at his current job for more than three years. Although the work was financially secure, Albert found it unstimulating, and he disliked his colleagues.

**Formulation and Initial Treatment Plan**

Albert met DSM-IV criteria for major depression without psychotic features. Having applied for treatment in a research program offering brief therapy for depressed HIV-positive clients, he was randomized to receive a course of sixteen weekly fifty-minute sessions of interpersonal psychotherapy. He was pleased by this selection, saying he might have refused antidepressant medication, which had been one of the other treatment alternatives.

Interpersonal psychotherapy (IPT) is a time-limited psychotherapy for treating depression, which has also been adapted to nonmood disorders. 
By ascertaining where a client's interpersonal functioning is impaired, determining what the client wants in affectively laden situations, and identifying what options the client has to achieve these desires, the therapist can help to resolve both the interpersonal problem and its associated symptoms of depression.

In obtaining a client's history, the therapist compiles an interpersonal inventory of key relationships, interpersonal patterns, and client expectations and outcomes. Therapists give clients the diagnosis of depression and with it the "illness" role. Seropositive clients are told they have two medical conditions, depression and HIV infection, and they are encouraged to become experts on both.

The therapist links the mood disorder to one of four interpersonal problem areas:

- Grief (complicated bereavement)
- Role dispute (disagreement with intimate partners or coworkers)
- Role transition (for example, the beginning or ending a relationship or job, a demotion or promotion, the loss of an ideal, or diagnosis of a significant medical illness such as HIV disease)
- Interpersonal deficits

The last, the least conceptually developed problem area and a residual category for clients who fall into none of the first three problem areas, defines clients with long-standing difficulties in maintaining relationships.

Once therapist and client agree on the focus of therapy, the therapeutic process involves using specific strategies to address the interpersonal problem area. Therapists are active, supportive, and non-neutral, and they address issues in the "here and now" rather than in terms of developmental antecedents. Albert's history suggests a role transition to accommodate to chronic infection with HIV: in his words, "making the most of the life I have left." Within that framework, there were also clear role disputes with friends and family. Albert found this formulation reasonable and helpful.

**Treatment**

Albert felt trapped in an unrewarding job at a point in life when he had no time to waste. Early in treatment, he explored his career options. Many years before, he had been active in the theater but left it for better pay. Now he
wanted to return to what had been a more fulfilling life. He pursued old contacts and was negotiating for a position at the time therapy concluded. This was a liberating decision that had a marked effect on his mood and depressive symptoms.

His success in changing careers and his increased self-esteem provided momentum to tackle his interpersonal disputes. Discussion and role playing with Hammonds helped him set appropriate limits with friends, even risking their anger and rejection. On dates, where he had previously “felt like damaged goods,” he learned when to express his needs and to initiate discussion of HIV status—both his own and the other person’s—at the appropriate juncture. Although not every encounter went smoothly, Albert recognized that addressing such issues early helped clarify whether a potential relationship was worth pursuing. Therapy also explored his dispute with his parents, including his mother's role in his abuse. He maintained his distance from his father but stayed in daily, intimate contact with his mother, albeit avoiding discussing his anger with her.

His Hamilton depression score dropped to less than 6, indicating remission of the depressive episode. Close friends remarked on how much happier he seemed to become during the sixteen weeks of treatment. Visiting a dying relative in a hospice raised issues of Albert's own mortality but did not hinder pursuit of his goals or cause a relapse.

On completing therapy, Albert faced the future with some excitement and anxiety, and he recognized that the role transition caused by HIV infection would be ongoing. During the final sessions, Albert and Hammonds acknowledged his considerable therapeutic gains, reviewed warning signs of depression, and discussed interpersonal maneuvers to avert its recurrence. This included setting clear expectations in relationships and asserting his own needs—for example, asking friends to call at least once a week so that he would not feel he was doing all the work in the relationships.

*Discussion*

There is a risk that therapists may feel overwhelmed in treating depressed clients who are seropositive. Infection with HIV may appear to provide a concrete “reason” for being depressed, hopeless, and helpless. Yet it is important to recognize that most people with HIV are *not* depressed\(^{1,2}\) and that those who are often respond to treatment with antidepressant medication\(^{3,4}\) or psychotherapy.\(^{5,6}\)
Given the time pressure that many seropositive clients feel, brief, focused antidepressant therapies such as interpersonal psychotherapy are well suited for their treatment. Seropositive clients are also beset by the interpersonal problems that interpersonal psychotherapy addresses: they are frequently grieving many deaths, and adjusting to HIV disease defines an inevitable role transition.

Albert was pleased to have a time-limited intervention that offered him practical techniques to deal with his life. Returning for his second interpersonal session, he told Hammonds, “You won me over when you told me you’d give me tools for helping myself.” For him these tools eventually included the recognition of depression as a treatable medical illness rather than a characterological paralysis; recognition of the link between mood and environment; and the galvanizing demonstration that although depression made him feel helpless, he could in fact capably pursue his desires, choose among his options, and exercise effective control over his relationships, career, and life.

HIV disease does affect life course and outlook and necessitates reassessment of one’s priorities. Under the pressure of time and illness, people with HIV are often willing to make dramatic changes in the course of therapy, to transform their lives as Albert did. The success of interpersonal psychotherapy in addressing depression and HIV should alleviate feelings among psychotherapists that they have nothing to offer in treating such clients.
Self Psychology: Anthony and Helen

Sharone Abramowitz

Anthony and Helen, a couple in their thirties, began their relationship in the fog of Anthony's alcohol and drug use. They enjoyed passionate sex and good times as they kept their relationship casual. Married once, Anthony preferred keeping his commitments to a minimum, and he approached life with an ex-hippie "live and let live" philosophy. He offered Helen a pleasurable and undemanding escape from the pain of her recent divorce. For a while their casual lust was enough. Maybe it was the discovery of Anthony's seropositive status or a growing attachment, but each began to want something more out of the relationship.

Given his newly detected HIV status, Anthony was confronted with a stark choice. He could continue his drug-dependent lifestyle and die sooner, or stop and die later. He began to compare his lifestyle to Helen's ambitious writing career and full social life. Anthony's life of occasional landscaping and frequent drug use left him feeling inadequate beside this formidable woman. The choice became clear; he entered a twelve-step program. Recovery opened him to a profound spiritual awakening. A dream began to take hold of him. He envisioned designing, planting, and building a magnificent garden. With the program's philosophy guiding him, he entered into a "clean and sober" partnership with Helen. To be responsible and present in a relationship while not relying on the numbing effects of drugs challenged him. He worked hard at this new commitment, but the sizzle of passion died and his desire for sexual intimacy waned.

Anthony's transformation from a high and passionate lover to a sober man with low libido both encouraged and troubled Helen. She tremendously
respected Anthony’s efforts at recovery. His new ambition to create a wonderful
garden inspired her. She joyfully helped organize the garden’s plans, and
while he planted and cared for the garden, she paid the bills. Helen’s love for
Anthony grew as she saw his emerging depth of character. What pained her
was his sexual distancing. She wanted more, not less, intimacy as their rela-
tionship deepened.

Helen believed she could master all problems. At her urging, she and
Anthony joined a support group. Then, wanting more focused attention, Helen
searched for a therapist who had experience both with HIV issues and couples.
With great hope and a willingness to work hard, Helen and Anthony entered
psychotherapy.

Personal and Psychiatric History

Helen, born in South Africa, was the eldest child of an industrious mother and
an ambitious but less than successful painter father. In her White, middle-class
culture, appearances were all-important, a family’s value depended on profes-
sional and monetary successes, and vulnerabilities and excesses were private.

Helen’s mother carried out these cultural expectations. When her father’s
work did not sell, her mother supported the family. Helen was expected to help,
and under her mother’s tutelage she learned to manage a household effi-
ciently and keep up appearances. Helen gained her parents’ respect if she hid
her needs and remained productive. Forced out of childhood before it really
began, Helen grew up quickly.

Despite her father’s failure as a provider, he offered a route out from the
numbing conformity of their culture by encouraging Helen into the creative
arts. Through the arts, Helen met rebellious intellectuals and received affir-
mation for her individuality. This support enabled her to move to the United
States and distance herself from the suffocating expectations of White South
African culture.

Anthony was the only son and youngest child of a lower-middle-class,
third-generation Italian American family. His mother and older sisters blan-
keted him with attention. He felt special but also smothered. Anthony’s father
was as distant as his mother was doting. Although Anthony wished he could be
closer to his father, his father’s strict Catholic morality alienated him. Living
up to these rigid expectations was a losing battle, and as a result Anthony fre-
quently felt inadequate.
As Anthony entered adolescence, America of the late sixties greeted him. “Sex, drugs, and rock and roll” promised an escape from his father’s bible and his mother’s hugs. Although the counterculture affirmed that which his father condemned, it could not completely repair his core sense of inadequacy. The problem became compounded by his growing involvement with alcohol and drugs. On the one hand, drugs offered self-enhancing functions: on cocaine, he could sexually dominate a woman, overcome his fear of female suffocation, and, until the high wore off, enter a moment of intense intimacy. On the other hand, drugs locked him into a meaningless life where his ambitions suffered, his values plummeted, and his self-esteem remained low, finally threatening his life—first by exposing him to HIV and then by compromising his infected immune system.

**Treatment**

Anthony and Helen entered couples therapy as they began the third year of their relationship and as Anthony entered the second year of sobriety. Their chief complaint was sexual dysfunction, a problem common among serodiscordant couples. Treatment was conducted in sixty-minute sessions, twice a month, for two years. Anthony remained free of HIV symptoms throughout the course of the therapy, and Helen remained seronegative. Their therapist, Renata Pascal, Ph.D., employed a psychoanalytic self psychological approach.

Rather than assume that the couple’s sexual symptoms were motivated by unconscious defenses against conflicts about HIV, self psychology emphasizes that it is first necessary to gain an empathic understanding of the clients’ subjective experience. One of the first therapeutic tasks was to explore how the couple saw the relationship of Anthony’s HIV infection to their sexual problems. Although they felt frustrated with how safer sex (which they assiduously practiced) interfered with spontaneity, neither believed that the virus was at the root of their sexual dysfunction: Helen wanted more sex, not less, and Anthony felt sure that his HIV status did not underlie his inhibitions.

The next goal of therapy was to assess Helen’s and Anthony’s stages of self-development. The self, according to self psychology, is the intrapsychic organization or internal structuring of subjective experience; it is the center of a person’s initiative and provides a sense of cohesion and an experience of continuity in space and time. To assess each client’s stage of self-development, it was necessary to determine which dimensions of self-experience were
most vulnerable to disruption and which were most secure. What complaints or successes did they each bring to the hour? It was also important to observe the types of selfobject experiences that the couple had of each other and of the therapist.

According to self psychology, the emergence and maintenance of the self require more than the inborn tendency to organize experience; they also require the presence of others. A selfobject experience is the intrapsychic experience of an “other” (a person, idea, or behavior) that provides nurturance and support to the self. To assess the partners’ selfobject experiences, Pascal sought to discover what most soothed or upset each partner about the other’s behavior. What behaviors did each rely on to soothe himself or herself after feeling injured? What was it that each most wanted from the other? In addition, Pascal explored how the couple’s dynamics recapitulated or repaired the successes and failures of the selfobject experiences that they had with their families as children.

As part of this process, Pascal assessed the transferences each partner had with the other and their transference expectations of the therapist. For self psychologists, transference has two dimensions: a repetitive aspect (the negative transference) and a restorative aspect (the positive transference). The repetitive dimension is the client’s fearful expectations that the partner or therapist will again fail to provide the selfobject functions that the client’s caregivers originally failed to provide. The restorative dimension is the client’s longing to receive from the partner or therapist the missing, insufficient, or once unavailable selfobject functions of the formative years.

The Intact Self and the Fragile Self

Helen presented with an intact self. Her ambitions were solid, and she was a strongly principled woman. What plagued Helen was a sense of insecurity concerning whether others would successfully provide her with idealized selfobject experiences. As a result, Helen followed in her mother’s footsteps, becoming involved with a man less outwardly organized and competent than herself.

When Anthony began treatment, his self state was fragile. He suffered from bouts of self-depletion and fragmentation anxiety, not infrequently requiring long hours of total quiet. At times he withdrew into transient depressive states accompanied by wishes to die. It was important for the couple for Anthony to discuss the self-disruptive events that precipitated these states and
to explore in what ways he then restored himself. Anthony needed mirroring (affirming affective attunement), and Helen needed to see the therapist model this. An appreciation of mirroring counteracted Helen’s belief that action is the cure for all ills. At the same time, the therapist was careful to validate how worrisome it was for Helen to see Anthony in these states. Over time, as Anthony’s sense of self strengthened, these states abated.

To break the cycle of discontent between Helen and Anthony, most graphically played out in their sex life, Pascal had to be the transferential repository of selfobject functions that the partners could not yet provide one another. By emphasizing process, not immediate behavior change, Pascal worked with each partner’s wish that the other would immediately gratify his or her unmet selfobject needs. As Solomon suggests, “If the goal is a healing of the central disturbance and development of a cohesive self, it is very important for the therapist to avoid instructions that suggest changes in actions or behavior toward each [partner of the couple].” Pascal initially offered a few suggestions, not as solutions but as a way to illustrate the dynamics of their relationship, particularly because sexuality is “the arena in which fundamental relational issues and struggles are played out.”

Pascal initiated a basic self psychological technique: first the partners sought to empathically understand each other’s position; then, they explained why their respective positions were their selves’ best attempts to recruit what they needed. An important component of this process was helping the couple to see how their responses and expectations of each other reflected the dynamics from their early years. In this way, they began to view the inadequate responses of the other not as purposefully persecutory but as coming out of early developmental deficits. As each partner’s self strengthened through the therapeutic process, each could begin to provide the other with the needed selfobject functions.

**Discussion**

Self psychology views symptoms (for example, sexual dysfunction) and defenses not as “resistance” but as the client’s best attempt to maintain the cohesion of a threatened self. The therapeutic task in the case of Helen and Anthony was to understand how each partner threatened and supported the other’s sense of self, and how this was played out through their sexual dynamics.

While a part of Helen yearned to be taken care of, she also disavowed these needs. Disavowal is a defense prevalent in clients with the narcissistic
dynamics of overt self-competence hiding a fragile and shame-ridden inner self. Helen disavowed her dependency needs because she came from a family that discouraged her from expressing these needs. To contain the anxiety and shame that these unmet needs caused her, she consciously disavowed the unmet needs while unconsciously deceiving herself that she felt little about them. When Anthony was not there for her, Helen believed, “It doesn’t really matter, because I can take care of it.”

Helen’s yearning to be taken care of presented itself in the form of an idealized self-object transference. Feeling overburdened with her self-expectation to be a consummate caretaker, she wanted to lean on what she imagined to be the therapist’s omniscience. She often asked for direction and frequently commented on Pascal’s skill. By not undermining Helen’s idealized view of the therapist, the idealized self-object experience allowed Helen to accept encouragement to expose her disavowed vulnerabilities to Anthony. She began to trust that her dependency needs could also be responded to.

Therapy also allowed Anthony to provide important self-enhancing opportunities for Helen. As a seropositive man, Anthony was fighting for his life through his recovery process, while trying to create his dream garden and realize a life’s ambition before it was too late. By providing practical support to a man driven by such a quest, Helen could feel that she was an efficacious partner in a meaningful journey. Anthony also provided a vital counterpoint to Helen’s upbringing. He actively lived the philosophy of living life one day at a time. This view directly conflicted with Helen’s goal-directed upbringing. At times it made her insecure and pushed her to become more controlling. At other times, this philosophy, along with Anthony’s capacity to be open to her feelings, offered Helen a mirroring self-object milieu in which she could begin to integrate the vulnerability her background had forced her to disavow.

Helen’s self-assured style anchored Anthony, who experienced a confusing array of feelings. Relating to Helen was, in good and bad ways, like relating to the women in Anthony’s family. She played “the eldest sister” to his “youngest brother.” She provided him with idealized self-object functions such as guidance and structure, and modeled ambition. But her formidable will also easily overpowered Anthony’s fragile sense of self-assertiveness.

Fortunately the route away from drugs led Anthony to a twelve-step recovery program, a relationship that counterbalanced Helen—the kind of counterbalance to his mother that his distant father was unable to provide him.
as a boy. Although Anthony rejected his father's Catholicism, he did respect his father's love of Christ. The twelve-step movement provided the "twinship" self-object experience that Anthony yearned for as a boy but could not obtain from his father. He found a way to share in his father's spirituality while at the same time connecting to other men like himself. The pride he felt through his participation in the recovery program also allowed him to combat the shame that his father's religious dogma engendered.

Anthony's and Helen's sexuality played out the range of these inter-personal dynamics. Anthony's unavailability caused Helen to fantasize about Anthony dominating her. Embedded in this image was her wish to merge into the arms of a strong male figure and to be taken care of. The more she expressed this desire, the more Anthony felt unable to meet it. Because cocaine was no longer available to rescue him from his fear of female engulfment, he turned to fantasies of anonymous sex with distant men and objectified sex with diminutive women more passive than Helen.

Anthony's shame and guilt led him to request meeting with Pascal alone so that he could initially discuss these fantasies outside of Helen's presence. Helen consented to this arrangement. Although this technique is controversial, in this case it proved to be quite helpful. Because shame propelled Anthony to hide these issues from Helen, it remained inaccessible to the couple's work. For Anthony to deal with these fantasies and their implications, he required active encouragement from Pascal to expose this hidden material. After a few one-on-one sessions, Anthony was able to bring into the couple's work underlying interpretations of the fantasies without directly exposing their contents. This both saved face for Anthony and protected Helen.

With the twelve-step program and therapy bolstering him, Anthony increasingly asserted himself with Helen. Helen, at first unsure of her value to Anthony if he did not need her directiveness, felt relieved that he was becoming a stronger and more dependable figure. In the meantime, Anthony acquired a more empathic understanding of Helen's background and grew less reactive to her directiveness. Helen responded by acknowledging that she, and not only Anthony, needed recovery. She joined Al-Anon and retreated from only focusing on what Anthony should and should not do. She began to pay more attention to the vulnerable states that her other-directedness was defending against. As Helen backed off, Anthony moved forward. Finally, Anthony could feel like a grown man when facing Helen's "big sister" persona; and Helen could stop being the only adult. Needless to say, their sex life improved.
Psychodynamic Psychotherapy: Robert

Israel Katz

Robert was a twenty-four-year-old White gay man, the son of a Russian immigrant mother and a German American father. A few months before he started therapy, he had relocated from the Midwest to Southern California to join his thirty-four-year-old Asian American lover. Robert sought treatment because he was scared that his feeling down all the time was threatening his relationship with his partner.

Robert had a hard time enjoying himself with his partner and didn’t quite believe that he deserved a loving relationship. His partner, Frank, in turn withdrew from Robert and got irritated when Robert berated himself and his life. Robert worried that he was not attractive enough and was not satisfying Frank sexually. He was afraid that Frank would abandon him or look for outside sex and bring HIV into the relationship. He was also afraid that if his current relationship did not survive he would become a “sex-starved cruising junkie” who would contract HIV and be doomed to loneliness for the rest of his life. Finally, Robert felt “out of sync” with gay people and intimidated by “handsome buffed men,” whom he believed looked down on him.

Robert had a lot of difficulty asserting himself and verbalizing his desires to Frank. He was afraid that he would sacrifice the relationship if he did assert himself and did not please Frank. Robert wanted to understand why he felt so bad about himself even after moving away from his religious family, whom he perceived as being very homophobic and judgmental. He wanted to feel better and more confident.

Martin McCombs and Graciela Morales developed an earlier version of this case, for which the author is indebted to them.
Personal and Psychiatric History

On arriving in the United States, Robert's family joined relatives in Ohio and became active in the leadership, administration, and management of the local evangelical church. Robert's father was a middle-management supervisor at an auto parts plant; his mother was a homemaker. Both parents had finished high school and worked hard to ensure that their children succeeded.

Robert's parents already had a fifteen-year-old daughter when they decided to have Robert, a second child. Robert perceived both parents as strict and withdrawn people who expected him to be powerful and masculine in fairly stereotypical ways; his father encouraged him almost unceasingly to play sports and to keep a lid on his feelings.

As a child, Robert was withdrawn and isolated, had few friends, was obese, and felt alienated from his peers, partly because his mother did not speak English proficiently and his community had very few "foreigners." Despite his father's pressure, Robert did not like to play sports, and he avoided male friendships. He recalled adolescent homoerotic fantasies, which were extremely painful and disconcerting to him; homosexuality had been so unacceptable that it was an inconceivable alternative to these fantasies.

During his adolescence, Robert had fantasies of suicide as a relief from his psychological pain, but he never acted on them because of his fears of afterlife damnation. Robert did not date in high school, although he maintained social contact with girls through the youth activities at his church. After he graduated from high school, Robert lived at home with his parents and worked as an administrative assistant in his father's company—so assiduously that he successfully avoided having a social life. Robert met Frank while Frank was visiting Ohio on a business trip. The two men stayed in contact for several months before Robert decided to move to Los Angeles to join Frank and get away from his parents. Robert had not come out to his parents and, in fact, secretly doubted his homosexuality.

Once in Los Angeles, Robert sought treatment from Jonathan Cooper, L.C.S.W., a therapist he had found listed in a gay newspaper. Robert told Cooper that he felt bad about his sexuality and was terrified that he would contract HIV.

Formulation and Treatment Plan

During his first session, Robert talked about "feeling down," his inability to assert himself, and his terror that one way or another he would get HIV. Because
he had the capacity to look at himself and was motivated to try to understand why he felt so bad about himself, he connected well with his therapist. During the initial visit, Cooper concluded that Robert did not have problems with impulse control, suicidality, homicidality, or substance abuse, any of which would have made it more difficult for Robert to respond to an insight-oriented approach. Cooper also noted that Robert could tolerate some anxiety and could focus on himself and his internal world. For all these reasons Cooper believed that a psychodynamic approach could help his client.

Cooper developed a psychodynamic formulation, which included a conflict among three elements: Robert's wanting to express his assertiveness, anger, and sexual impulses toward others; his fear that if he showed these impulses he would be punished, damaged, and abandoned; and the defense of turning his aggression on himself and hating himself as a way to deal with the anxieties connected to being more sexually confident with his partner and being more assertive with his parents and with other people. In some ways Robert exhibited a classical Oedipal conflict: he feared the expression of aggressive and sexual instincts toward his father (and other important figures in his life) because of fears of the bodily damage and punishment that would follow were he to express these instincts. He also had pre-Oedipal fears of abandonment and loss of the "object" (mother or father or both) if he expressed his sexuality and aggression.

Cooper believed that Robert could benefit from exploring the conflict between his need to assert himself and his fear of being punished or abandoned. Perhaps if Robert experienced and understood this anxiety within the context of the therapeutic relationship, he could come up with better ways to assert himself appropriately and feel better about himself.

Treatment

Cooper saw Robert once a week for forty-five-minute sessions in an office setting over the course of twenty-one months. During this period, Cooper tried to establish a therapeutic alliance by listening attentively to Robert and empathizing with the difficulties he presented. However, because Robert felt bad about himself and because he had internalized a disapproving father, he saw male figures as condemning. As a result, Robert often interpreted Cooper's empathy as condescension, feeling that Cooper was judging him as not being "good enough" instead of trying to understand his life. At one point Robert said to Cooper, "You don't really care about me. All you want is to judge me." Cooper tolerated these attacks and tried to explore Robert's perception of the
therapist as judgmental. Cooper pointed out the connection between Robert's childhood experiences and his assumption that the therapist would behave as Robert's father had.

Cooper also was attentive to material that centered on the theme of Robert's anxiety about asserting himself in his outside relationships, in the therapeutic relationship, and, to a limited extent, with his parents. Robert had an easier time talking about his difficulties asserting himself with his partner, Frank. For example, Robert recounted the time he wanted to go to a particular restaurant that Frank did not like. Robert backed down because he believed that Frank would punish him by withdrawing if Robert asserted himself. Robert described such scenarios often, even though he was never able to offer an example of this feared result having occurred.

Cooper tried to explore Robert's anxiety and fantasies about asserting himself with Frank. Whenever he was questioned in this way, however, Robert changed the subject, saying that he did not want to "talk about it." At times Cooper persisted, which made Robert irritable. However, Robert had difficulty expressing this irritation toward Cooper and was able only once to let Cooper know how upset he was during therapy. When encouraged to elaborate on his feelings, Robert stated that perhaps something "bad" would happen if he were to be more assertive with the therapist. When Cooper asked Robert what he meant by "bad," Robert said that he was too nervous to discuss the subject anymore. Robert successfully rebuffed Cooper's further attempts to talk about the therapeutic relationship, instead focusing discussion on his relationship with Frank.

After about a year of psychotherapy, Robert shamefully acknowledged that he had been lying to Cooper about practicing safe sex with Frank and that neither partner had been tested for HIV. Robert and Frank frequently had unprotected anal intercourse, and Frank never used a condom. Robert also had lied to Cooper about successfully and assertively communicating either his discomfort with this practice or his suspicion that Frank may be having sex with other men. Robert was afraid that if he "removed" the "special offering" of unprotected sex, Frank would punish him, spending more time with other men outside the relationship or leaving Robert altogether.

Cooper confronted Robert about the riskiness of his behavior. Robert's lack of self-respect was palpable as he stated with all sincerity that he believed if he complained, he would lose Frank or be punished for speaking out about his own needs. Cooper pointed out the price Robert was paying—possibly get-
ting HIV—and described it as “self-destructive.” He and Robert discussed that it was possible to refuse to have unsafe sex and yet maintain a relationship; it was possible to have a good relationship in which both partners communicated and in which one of the partners did not have to suffer or be afraid of asserting himself. Robert began to practice safer sex even though he continued at times to have sex without a condom. He tested HIV-negative and continued to be HIV-negative during the remainder of therapy.

Robert decided to stop therapy after twenty-one months. From Cooper's perspective, Robert had made some modest gains and still had several areas to work on. Robert felt a bit more comfortable asserting himself with Frank, had a better sense of self-esteem, and could enjoy sex more. He still struggled with his passivity and tended to go along with others a lot of the time, but he was more aware of this pattern. Robert and Frank practiced safer sex most of the time, and Robert felt less depressed overall. (Robert also said that Frank had become a little more patient with Robert's downswings now that Robert was more assertive and less self-denigrating.)

Cooper believed that Robert became more anxious as their relationship grew closer, but Robert did not agree with Cooper's interpretations that Robert was seeking to flee psychotherapy in order to avoid confronting Cooper.

Robert was able to make some gains in the psychotherapy while still struggling with his fears of assertiveness and sexual confidence. Through psychotherapy, Robert gained a better understanding of his fears of assertiveness and sexual confidence and grew to appreciate how these issues affected other areas of his life, largely through the repeated experiences of analyzing his transference feelings toward Cooper and his expectations of him.
Time-Limited Psychotherapy: Enrique

Israel Katz

Enrique was a thirty-five-year-old seropositive Mexican American man who entered therapy under court mandate. His story began as he was helping to clean a local park. An older woman approached him and started yelling at him, telling him not to pick up the trash. Enrique and the woman got into an argument, and he ended up pushing the woman twice and calling her names. Enrique was arrested for battery and did not defend his actions at that point. Furthermore, he did not go to court to follow up on the charges, because he “did not feel like it.” The court found him guilty but agreed to a plan of requiring at least twelve sessions of psychotherapy rather than sending Enrique to jail.

Enrique started therapy with Mark Krimsky, M.D. He reported no history of violence and said that this was the only time in his life in which he had fought with someone; he described himself as always being “in control” and peaceful and basically in good health despite his HIV status. Initially, his only motivation to attend therapy was the court order, but soon he said he was looking forward to understanding his behavior in the park. He was puzzled and wanted to understand why the altercation occurred. He wanted to feel less irritated about this incident, to be happier, and feel better about himself.

Personal and Psychiatric History

Enrique was born in San Francisco, the seventh of eight children. Both parents were Mexican. His father developed leukemia when Enrique was nine months old, and he decided to move the family back to Mexico to be closer to their extended family. Enrique’s father had a series of low-paying, blue-collar jobs, while his mother stayed at home taking care of the children. His parents did
not get along with one another; his father drank a lot of alcohol and beat up his mother. Enrique got along much better with his father, who died when Enrique was eleven years old, than he ever did with his mother.

Enrique said that he was never a “masculine” boy and that his mother disliked him because of this, preferring his older brother, who was more conventionally “macho.” Enrique remembered having erotic fantasies involving men since the age of eight and felt that he had never been typically male. He was not out as a gay man to any of his family, and he feared that if he told his mother he was gay it would kill her. Enrique’s mother did not go to his elementary or high school graduation ceremonies, never hugged him or touched him, and neglected him emotionally. He felt that he could never express any feelings toward his mother, because she would respond by telling him that men “were not supposed to go on about their feelings.”

Enrique left Mexico at the age of eighteen and came back to San Francisco for a better life. He worked as a bartender for a few years, when he developed major depressive symptoms: depressed mood, anhedonia, difficulty sleeping, low energy, low self-esteem, and psychomotor retardation—but no suicidal or homicidal ideation and no psychotic or manic symptoms. There was no medical cause, substance abuse or dependency, or acute psychosocial stressor that could account for Enrique’s depression, so he started seeing a psychiatrist, Celia Hauser, who prescribed Zoloft. At the time of the incident in the park, Enrique had been in complete remission from his depression for several months. He had no history of psychiatric hospitalizations, suicide attempts, homicide, or any other troubles with the law.

After he was mandated by the court to seek psychotherapy, Enrique saw two other therapists, both of whom were women. He did not like either of these therapists because “they were women and reminded me too much of my mother.” He said that they only pretended to be caring but in fact were just doing their job. In both cases, he quit therapy without talking to the therapists about his dissatisfactions. He had no other experiences in psychotherapy.

Enrique believed that he got HIV from Bob, a White man from Texas whom he met in 1985. Enrique and Bob were together for one and a half years. In late 1986, Enrique noticed that Bob had an eye infection and suspected Bob was HIV-positive. However, he did not want to “hurt” Bob by asking him about this and so withdrew from him, never seeing him again. Enrique was angry with Bob but did not want to speak to him. Several years afterward, Enrique saw Bob in the subway but fled before his former partner could reach
him. He later found out that Bob died from AIDS. Enrique had been seropositive since 1986; his CD4+ cell count was in the 400s, his viral load was less than 5,000, and he had no history of opportunistic infections.

Enrique had one other relationship that lasted for six months in 1997. Enrique was not attracted to Randy, a White man who also had HIV, but was afraid to let him know this, because it might “hurt him.” Enrique said that he was also uncomfortable with Randy's frequent insistence that they have unprotected anal intercourse, something that Enrique felt was terribly risky, even though they were both seropositive. As a result, Enrique drew back from Randy. Enrique also described a pattern of interaction with his friends and lovers in which he would try very hard to please others but would end up “being taken advantage of;” at which point he would become angry and then withdraw from these relationships.

Formulation of a Treatment Plan

After hearing this history and listening for behavioral and psychological patterns, Krimsy, who was trained in the use of time-limited dynamic psychotherapy (TLD), conceptualized Enrique’s interpersonal style as follows:

- Acts of self. In general, Enrique withdrew from others; when he was around others he was overly compliant—acting submissive, then resenting the other, becoming angry, and withdrawing.
- Expectations of others. Enrique expected others not to care about him or to care about him only to take advantage of him. He said that others would reject him if he were to assert himself or his needs.
- Acts of others. Some people would ignore Enrique altogether; others would strike up a friendship with him only, in fact, to take advantage of him, and Enrique would let them. When others would try to understand Enrique's needs, he pushed them away, causing them to become bewildered and irritated.
- Introject (or self-perception). Enrique experienced himself as a defective, helpless human being who could never express his own needs or assert himself and who got taken advantage of by other people.

Krimsy saw Enrique nine times, applying a time-limited psychodynamic approach. Enrique came to every session and seemed to be engaged in the process of psychotherapy. The first two sessions consisted of a recapitula-
tion of the incident in the park, his developmental history, and the arrange-
ment of an agreement for brief psychotherapy. Enrique resented the court
mandate to be in therapy, but he also realized that the process might help him
feel better about himself and understand the park incident. The sessions took
place in English, even though Krimsky was bilingual and had lived in Latin
America. Enrique said Spanish reminded him of his childhood and of being
with his mother; he felt that English was more “neutral,” less threatening, and
would help him control his emotions. In the end, Enrique ended up interspers-
ing English with Spanish during the sessions and eventually spoke only Span-
ish during the last five sessions.

Treatment

Early on in therapy, Enrique expressed his distrust of Krimsky, saying that
the therapist listened only because it was his job and that in “real life” the
therapist would dismiss Enrique as “boring.” Enrique was able to recognize
that he was reacting to Krimsky as he would interact with mother, and Krimsky
pointed out that it was indeed easier to see the therapist as not caring for
him, because this had been his way of experiencing other people in the past.
Enrique agreed and said that it was hard to feel all the time that no one cared
for him.

As therapy progressed, it focused on Enrique’s need to please others in
his relationships, even if he resented the need to please all the time. He and
Krimsky discussed how this need applied in the case of his relationship with
Randy. Enrique also acknowledged that he wanted to please Krimsky, and the
pair explored what would happen if Enrique expressed his needs in relation
with Krimsky. Enrique said that he was scared to look at what he wanted from
therapy and what he needed from his therapist.

Enrique observed that perhaps this had something to do with what hap-
pended in the park with the woman, that perhaps the anger he expressed had
been bottled up inside for a long time. Krimsky pointed out Enrique’s tendency
to conceive of his relationships in only two ways: he either had to please others
or have an outburst. Enrique began to understand the price he paid for this at-
titude: his estrangement from Bob, his lack of relationships and communica-
tion with others, and his legal trouble. Enrique said that he felt terrified that
he would “hurt” them if he were to express anger toward his friends. Enrique
was able to recognize that this fear of “hurting” others made it very difficult
for him to negotiate anything with them or to express his desires, and that per-
haps the situations would unfold differently from what he imagined.
As the sessions went on, Krimsy wondered whether Enrique's insights into his patterns and emotional understandings were forced, articulated merely to please Krimsy just as he had pleased others. Did Enrique, in fact, resent psychotherapy, or had he realized on some level that by participating he was taking care of himself and figuring out his maladaptive patterns? The pair discussed this issue during session number six, and Enrique identified with both perspectives. He was playing the “good patient,” and he also had a sense that he did deserve to feel better.

Later on during that session, Enrique said that he was asserting himself a little bit more with his friend John, for whom he had routinely done many chores and tasks. Enrique felt anxious while confronting his friend, but noticed that he felt better afterwards and that John did not retaliate against him, punish him, or leave him.

Enrique also said that he felt more comfortable with Krimsy, seeing the therapist as more than just a “part of the system.” Enrique then admitted that he was angry with Krimsy for not giving him enough and for not meeting with him more than once a week. He seemed to be confronting his neglectful mother in the transference and finally letting himself know how angry he had been for all these years. As he talked about his neglectful mother, he began to recognize the feeling as similar to how he felt while fighting with the woman in the park; he put a name on it, identifying it as anger. Krimsy asked Enrique whether he felt it was safer to be angry with a stranger than with his mother. Enrique said yes, remembering his mother’s angry outbursts and his childhood fears for his own life.

Shortly after this session, Enrique began to talk about his impending move to Florida. He had decided before psychotherapy began (but after the incident in the park) that he was going to move away from San Francisco to Miami since he had a better support network and life was cheaper there. He felt bad and guilty about having to leave Krimsy and the psychotherapy but also experienced some relief at stopping the process, fearing that if he truly felt better about himself, something terrible might happen. He was not able to articulate what that might be, but Krimsy suspected that further improvement would entail Enrique’s confrontation of his anxieties about asserting himself and a range of consequent fears regarding loss of his mother and her love, castration anxieties, change of lifetime patterns in his relationships, and modification of his object relationships, especially those with his mother.

During session number eight, the pair discussed the move and Krimsy's upcoming two-week vacation, which would take place after session number
nine. Eventually, Enrique admitted that he felt Krimsky was being selfish and that Enrique resented the therapist’s vacation. Enrique surmised that Krimsky was leaving because Enrique had been “bad,” which meant not being “macho” and being gay. Krimsky observed that perhaps Enrique felt afraid to express his anger toward the therapist, so he expressed it toward himself. Enrique said that it was much easier to see Krimsky as abusive and neglectful than as caring, which might mean that he, Enrique, would have to confront the fact that he deserved to be cared for, despite his feelings of “badness.”

Enrique talked about the pain he felt in not being able to tell his mother how much he had loved and needed her when he was young. He said he could never express his irritation toward her because he felt she was already over-loaded with a large family. Krimsky noted this pattern and helped Enrique understand that he was an adult and could have more choices about what to do in his relationships; in fact, he could confront others in ways that might actually deepen these relationships instead of destroying them. Enrique said that he felt comfortable asserting himself even with Krimsky and expressing his anger about Krimsky not being more available to him.

During session number nine, Enrique reported that he was realizing that many of his “friends” had taken advantage of him and that he was beginning to be able to confront them about this. The pair also discussed Krimsky’s upcoming vacation, Enrique expressing feelings of disappointment and a return of his feeling that perhaps Krimsky was just part of the “system.” Enrique did not show up after Krimsky’s two-week vacation and did not return calls. Enrique had left for Miami prematurely and had been afraid to tell Krimsky.

Even though they did not see each other again, Krimsky believed that Enrique benefited from expressing some of his anger and exploring his fears about expressing anger. Enrique learned that he could have needs and that he could ask for things from others while still maintaining a relationship. Perhaps his leaving prematurely was a way to act out his underlying resentment toward the therapist and the feeling that he had to comply with the therapist and the therapy because of the court system and the therapist’s needs. He might also have been unable to tolerate the anger he felt about Krimsky’s vacation and could have decided to retaliate by abandoning the therapist, perhaps because of his fears that Krimsky might be abandoning him.

Enrique did make significant gains in exploring his difficulties, asserting himself, getting in touch with his anger toward his mother, and becoming
aware of the patterns in his interactions with others. Enrique realized that he could let others know about his desires and that others could accept his needs without being angry at him or leaving him. Enrique also realized that he did not have to go along with whatever other people wanted to do; he could establish a dialogue with other people and negotiate his relationships. He could express his anger toward others rather than turn it inward, and actually improve his relationships as a result.

Notes
10. Ibid.


20. Parsons, "Illness and the Role of the Physician."


22. Markowitz, Klerman, Perry, and others, "Interpersonal Psychotherapy for Depressed HIV-Positive Outpatients."


36. De Roche, “Psychodynamic Psychotherapy.”
Chapter Eight

The Role of Psychotherapy in Coping with HIV Disease

John Devine

As with cancer, heart disease, and other chronic and life-threatening conditions, responding to HIV disease is as much an emotional endeavor as it is a physical one. This is true not simply because studies suggest that emotional health may directly affect the body's ability to respond to disease but also because facing a life-threatening disease requires a capacity for coping that goes far beyond the mechanisms we use to deal with everyday life.

Unlike the response to other life-threatening diseases, however, there has been an appreciation of the importance of mental health services for people with HIV disease since the beginning of the epidemic. Although research into specific HIV-related mental health interventions has lagged, providers on the front lines nonetheless can draw on a wealth of experience to help their clients.

The psychosocial issues raised by HIV disease follow the progression of the condition, from learning that one is seropositive through to the dying process. They also encompass the concerns of uninfected family, partners, friends, coworkers, and acquaintances, who watch as this course extends beyond life into bereavement. In response to this range of emotional difficulties, therapists have successfully employed a variety of psychotherapeutic approaches—including individual psychotherapy and group, family, and couples therapy. They have also employed technical variations with respect to the duration and frequency of therapy and have
used diverse frameworks of treatment determined by therapeutic
stance and informed by a specific theoretical orientation.

This chapter defines the range of HIV-related stressors, reviews
the current literature on psychotherapy and HIV disease, and ad-
dresses the most commonly applied treatment modalities, focus-
ing in particular on short-term psychotherapy, an increasingly
common approach. For many therapists, brief psychotherapy is an
outgrowth of pressure from insurance companies or institutional
providers, which limit the number of sessions for each client.
Short-term therapy can, however, be seen as an effective and effi-
cient tool for managing particular emotional difficulties that arise
in the context of HIV disease and may be more congruent with a
client’s plans to address a focused issue in a timely manner. The
theoretical underpinning of time-limited therapy will be reviewed
later in this chapter.

Early in the course of HIV disease, clients face the challenges of
recognizing that they are seropositive and, in response, of accepting
and incorporating this fact into their lives. (About 20 percent of peo-
ple with HIV disease discover they are infected later in the course of
disease when they experience severe symptoms, and therefore need
to adjust immediately to physical disability.) As time passes, clients
confront fears regarding disclosure to employers, friends, family, and
lovers, and, despite new treatments that have reduced rates of dis-
ease progression and death, begin to reassess goals for work and re-
lationships in light of potential disability and a foreshortened life
span. Clients face frustration in terms of the onset and uncertain
progression of physical illness, the difficult process of making treat-
ment decisions, the assumption of the role of “patient,” and the com-
plexity of medical treatment regimens. If antiviral treatment is
effective, clients must come to terms with having a chronic illness,
being dependent for long periods on medications, and redefining
themselves as “able.” If medical treatment does not work or if clients
are unable to access these treatments, clients face existential tasks as
they anticipate and ultimately confront mortality and death. People
with HIV disease are especially at risk for adjustment, anxiety, and
depressive disorders, and for suicide.

Such stressors may affect both emotional and physical health.
Although psychoneuroimmunology remains a field of study in its
infancy, and the literature is complex and often contradictory, research has suggested a relationship between emotional well-being and immune status. For example, using self-report measures, a recent study found a significant association between depression and a more rapid decline of CD4+ cells, suggesting increased disease progression. Another study demonstrated the ability of psychiatric interventions to reduce affective distress, enhance effective coping strategies, and increase survival among cancer patients. These reports, however, conflict with other data from a four-year longitudinal study at Columbia University that employed both self-report and interviewer-derived data; the study did not support a significant association between depression and CD4+ cell count decline or clinical progression to AIDS.

Whether or not there is a direct correlation between mental health and increased longevity, appropriate psychotherapy helps serve the overall goal of mental health care: responding to emotional difficulties, decreasing the symptoms of emotional distress, and improving overall quality of life. Psychotherapeutic interventions can help develop and strengthen coping strategies for people living with HIV disease, improve a person's ability to relate to others, define and correct unhealthy psychological defenses and maladaptive behavior patterns, and replace feelings of isolation, hopelessness, and despondency with a renewed sense of intimacy, purpose, and optimism.

Lessons from the Literature

The professional literature on psychiatric treatment of people with HIV disease has focused primarily on the assessment and management of neuropsychiatric problems, practical interventions for psychosocial stressors, and education and disease prevention. Relatively little has been written on understanding specific psychotherapeutic techniques in the treatment of HIV disease, and given the current changing paradigms regarding treatment and prognosis, what has been written may require revision. A brief overview of some of the literature provides the foundation for the more detailed discussion of specific psychotherapeutic techniques that follows.
The “Phases of Illness” Framework

One way to conceive of the goals of HIV-related psychotherapy is to consider the emotional issues and needs specific to each phase of illness. Gary Lomax and Jeffery Sandler suggest a framework for this examination, basing their formulations on earlier work on the psychosocial challenges at each stage of HIV disease. The advent of successful combination antiviral therapy may change the ways in which individuals proceed through these stages, but for many, the psychological challenges outlined here remain.

The initial phase, HIV diagnosis, is characterized as an emotional crisis, with early reactions ranging from shock, denial, and emotional numbing to marked anxiety and panic. In addition, clients may experience catastrophic expectations, including fears of disfigurement, physical pain, disability, and rejection by loved ones. The therapist’s goal during this phase is to support a client’s appropriate coping reactions while identifying and challenging dysfunctional defenses. Tasks at this phase include providing an empathic, supportive, and reality-based presence, making appropriate referrals to medical and social services, and assessing and monitoring levels of subjective distress, including suicidal ideation. In the context of the success of combination antiviral treatment, the crisis during this initial phase may be diminished. Nevertheless, learning that one is HIV-infected still means catastrophe for most individuals, and the need to adjust to the painful loss of one’s identity as uninfected and healthy is an important one.

Following the initial phase, clients go through a period of gradual acceptance, and they refocus on the need to formulate new meanings about life and goals for living. During this period, which includes what Lomax and Sandler call a “honeymoon phase,” clients gradually come to believe that they are not going to die immediately and, during this asymptomatic phase, that they may “beat this disease.” Therapeutic tasks include exploring and working through fear, anger, guilt, loss, and sadness; supporting “adaptive denial”—the psychological mechanism that allows a client to develop a healthy distance from negative events; and confronting maladaptive denial—a mechanism by which a client refuses to accept his or her illness and, for example, avoids necessary medical care. These tasks have become more complex in light of the suc-
cess of combination antiviral treatment. There are many concrete reasons for clients to be hopeful, related to actual and dramatic improvements in health, as well as many more opportunities for them to deny in dysfunctional ways the risks of untreated or inadequately treated HIV disease.

The third phase is heralded by the development of debilitating illness and is marked by physical deterioration and the letting go of certain aspects of one's life (for example, work), which may exert a great emotional toll. Loss of hope and preoccupation with death and dying become prominent, and therapy may shift to more supportive contact. Improved prognosis has meant for many people not only that the second phase may stretch out for many years but also that many clients are cycling back from the third phase to the second as treatment success reverses previous debilitation. Clients may respond with ambivalence to these developments because of uncertainty regarding the duration of improvements in physical health and an inability to cope with adhering to rigorous treatment regimens.

During the final phase of illness—a phase that progress in treatment has not yet eliminated—the primary clinical goal is to maintain a supportive connection, which may require hospital, home, and hospice visits and telephone contact in addition to routine therapy sessions. Extreme physical decline and the onset of cognitive impairment may limit the degree to which communication can occur; nevertheless, clients can benefit from the continued presence of a supportive contact to help cope with the process of end-stage illness and death and the psychological issues it evokes.

Examining the Therapeutic Alliance

The literature on HIV-related psychodynamic psychotherapy is useful in considering approaches to the issues raised by the stages of HIV progression. It examines the therapeutic relationship and the effects and uses of transference, countertransference, and identification with both seropositive and seronegative clients (see Chapter Sixteen). One commentator highlights the need for a strong therapeutic alliance because HIV infection is often clouded by overwhelming feelings of isolation and alienation. In this context, HIV disease may also be viewed as a narcissistic injury; self-precepts
derived from the sense of oneself as physically intact and healthy and illusory beliefs in apparent invulnerability to disease are shattered by an HIV diagnosis. This is particularly true for those HIV-infected individuals who previously had little contact with serious illness. The client’s overall sense of both physical and psychological self may be threatened, particularly as changes in health status occur, and may strongly influence and reinforce negative self-images of being flawed or deficient. For many gay men, these perceptions reinforce preexisting ones.

Transference and countertransference reactions may also arise in terms of the client’s need to idealize an omnipotent figure—the therapist—in order to manage anxiety related to the loss of control. In addition, clients with HIV disease may unconsciously use other defensive strategies, including projective identification, in order to rid themselves of feelings of helplessness and rage. In this case the therapist may find his or her own feelings of frustration and inadequacy targeted by the client’s projections, leading the therapist to feel a heightened sense of futility. In a commentary on the psychoanalytic treatment of a woman dying of AIDS, Diane Sadowy also identifies powerful transference- and countertransference-based fantasies concerning the omnipotence of the therapist. She goes on to discuss the need, as both the therapist and client face the very real prospect of the client’s death, to disengage and shift from “a rapidly dying external reality and to enter a living vibrant internal reality.” In this context, Sadowy also addresses the need to modify the usual therapeutic parameters—for example, to make changes in the therapeutic “frame” related to session length, telephone contacts, and involvement of significant others in the therapy.

Leon McKusick emphasizes the importance for both seronegative and seropositive therapists of analyzing the nature of their countertransference reactions. Seronegative therapists should be alert to responses of distancing, fears of contagion, survivor guilt, and judgmental attitudes toward their clients’ sexual or drug-related behaviors. Seropositive therapists, on the other hand, must be wary of overidentifying with their clients. In either case, psychodynamic therapists in particular need to examine fully the potential transference issues regarding their serostatus and determine if exploration and possibly self-disclosure of this information would be beneficial or detrimental to the work.
Other models of psychotherapy have been reviewed in the literature, including a study of the efficacy of interpersonal psychotherapy and cognitive-based therapy, the utility of grief and bereavement theoretical paradigms to understand the meaning of loss in the treatment of those affected by HIV disease, and the applicability of self psychology.\textsuperscript{15-17} (See Chapters Seven and Twelve for more information on all of these theoretical stances.)

**The Value of Group, Couples, and Family Psychotherapy**

A number of studies demonstrate the efficacy of group psychotherapy and describe its role in HIV-related care. Fawzy Fawzy examines the effect on mood state of a time-limited educational and support group and found a significant decrease in total mood disturbance scores and an improvement of coping skills.\textsuperscript{18} Similarly, a study of a psychoeducational cognitive-based group therapy intervention measured decreased levels of depression and anxiety and improvement in coping among people with asymptomatic HIV infection.\textsuperscript{19} Jeffrey Kelly found that depressed HIV-infected clients treated in either cognitive-behavioral or social support groups achieved greater reductions in feelings of depression and anger when compared to clients who were not treated, and that group therapy helped these clients shift the focus away from physical symptoms.\textsuperscript{20} It is notable that the social support group—in which members discussed feelings associated with their illness and adopted encouraging and supportive roles toward others in their group—resulted in a greater clinical improvement than did the cognitive-based group. This suggests the importance of formally addressing the interpersonal aspect of therapy.

Researchers have also studied the utility of group psychotherapy to treat specific populations. HIV-infected women in group therapy raise gender-specific issues, including the following: isolation and a greater sense of being unsupported in their illness than are seropositive men, a greater tendency of caregivers to dismiss the severity of their medical complaints, changes in their role within the family as a result of illness, and the potential loss of reproductive choice.\textsuperscript{21} Other researchers focus on the needs of other specific groups, including ethnic minorities, other disenfranchised populations, and dual-diagnosis clients. Finally, other commentators
outline the atmosphere and process of ongoing HIV psychotherapy groups.\textsuperscript{22,23}

Couples and family therapy are crucial adjuncts to individual therapy, because HIV disease is so intimately related to interpersonal relationships and because these relationships can create significant stress among people affected by HIV disease. Pertinent articles regarding these approaches include a pilot study of the efficacy of cognitive-behavioral-based couples therapy\textsuperscript{24} and a discussion of family therapy and HIV disease.\textsuperscript{25} (See also Chapter Seven, “HIV Disease as an Agent of Transformation.”)

Another set of articles addresses the specific legal and ethical dilemmas therapists face in conducting HIV-related psychotherapy, which can arise in the setting of individual, couples, family, or group therapy. Among these challenges are knowing when and how to confront a client’s denial regarding his or her illness and its consequences, and understanding the ethical and legal duties of psychotherapists with regard to their clients’ behaviors, including the duty to disclose.\textsuperscript{26,27,28}

**Selecting a Therapeutic Approach**

A number of factors can influence the mode and nature of the psychotherapy for clients with HIV disease.\textsuperscript{29} Among these are the client’s stage of illness, his or her past experiences in therapy, the presence of significant characterological problems, and the extent of social support available. Other important determinants are the presence of other psychiatric illness, any existing psychopharmacological interventions, and the nature of a therapist’s training and practice. This section and the next review the most commonly used psychotherapeutic approaches—group, family, and individual—highlighting their specific strengths and weaknesses and the problems best suited to each approach.

**Group Psychotherapy**

Joining a support group is often the first step a person will take in responding to HIV-related distress. When it is not the doorway to individual therapy, it is frequently an adjunct. For these reasons, it is appropriate for us to begin a discussion of psychotherapeutic
modes with group therapy. Group therapy for people with HIV disease is particularly effective in providing social support and education, improving coping skills, and decreasing emotional distress. Groups vary considerably with regard to theoretical orientation, composition, duration, setting, and the roles of facilitators and members. In terms of content, however, several issues are common to nearly all groups for clients with HIV disease. These include a focus on physical symptoms (including comparisons among group members), uncertainties regarding disease treatment and progression of illness, stigma and shame associated with risk behaviors, and a central focus on death and dying. Broaching such issues and discussing them with others who share similar experiences can be remarkably healing. Groups can also provide clients a forum in which to explore issues related to medical treatment decisions and to share experiences that can help them navigate this complex area.

We can derive several guidelines regarding group formation and composition from the HIV-related group experience. Groups that are homogenous in terms of sexual orientation, gender, and risk history provide members with the necessary safety and mutual identification to facilitate group cohesion. Homogeneity alone, however, does not ensure cohesion, and the group psychotherapist needs to be particularly attentive to the various stages of group development, including the degree to which group trust and safety has been established, in order to handle anxiety-provoking issues as they arise.

Stage of illness is also an important consideration, because the issues raised by group members will vary depending on where clients are in their illness; too much variation can potentially overwhelm or isolate members. It is difficult, however, to form groups in which all members are at an identical stage in their illness, and it is impossible to maintain such homogeneity over time. There may also be therapeutic advantages to having group members who are at varying stages of illness and who share their experiences of HIV disease, alternately giving and obtaining support from other members.

Conversely, at a time when some people with HIV disease are experiencing sudden improvements in health, the gulf between group members who are able and those who are disabled may complicate this already complex dynamic. It can be a challenging task
for therapists to make room for the group to focus on the needs of both members who are more directly facing disability and death and of those who are focused on living and renewed health. Therapists can achieve the necessary balance between individual and group needs through an open exploration of differences among group members—whether these are related to health status or to other issues—and how both difference and commonality may be influencing the group process.

Members new to the group should agree to a standard contract regarding group attendance, confidentiality, specific group goals, overall group functioning, and time commitment. The introduction of an overly ambivalent member or one who might challenge the contract can destabilize group cohesion and safety and thwart the development of a therapeutic group process. In monitoring contracts, particularly regarding absences from the group, therapists need to do their best to distinguish client resistance from the physical factors that may impinge on the client's ability to attend and participate. Therapists should also examine the effect of absences on the group as a whole, as these may resonate for other members with issues of rejection and abandonment in addition to specific fears regarding failing health.

Whereas outside contact is discouraged in more analytically focused psychotherapy groups, contact among group members outside a support group may be condoned. Contact allows for continuity of support between sessions and may provide practical support—specifically, transportation to and from group sessions. Nonetheless, therapists need to consider potential complications that might result from out-of-group contacts; for example, issues raised in the group by a client could possibly be processed outside the group with another member, denying the group the opportunity to grow through the experience of working through the issue, and interrupting continuity from one session to the next.

As in individual therapy, group members' transference wishes often emerge for an omnipotent therapist to magically cure their physical illness. Concerns relating to trust and acceptance may motivate clients to ask about their therapist's sexual orientation, HIV infection status, and knowledge of HIV disease. Some clients may want to work with therapists who are different from them—for example, who are heterosexual or seronegative—in the belief or fan-
tasy that these people are “healthy” and unaffected by HIV disease. Countertransference reactions, including the therapist’s feeling that only he or she is “healthy” enough to treat group members, may also impede the group’s development and may limit the therapist’s awareness and use of group process. There may instead be a temptation to focus inordinately on the individual, thereby interfering with the engagement of other group members.

HIV group therapists face ongoing therapeutic decisions about balancing discussion between attitudes toward death and dying with life-affirming topics, especially given the impact of new treatments on disease course. A basic rule that is helpful in directing interventions in this regard is to listen for what is not being expressed by the group; for example, is the group avoiding death and dying by focusing only on the positive advances in treatments? If the group seems to be avoiding this subject, the therapist may need to point out the resistance as well as explore the reasons why the group may be finding it difficult to give voice to their concerns.

In striking this balance, it is important for the therapist to keep in mind the stage of group development, including the degree to which trust and cohesion exist among members. Early in group development, the group may experience the rigorous exploration of anxiety-provoking issues as threatening to group integrity. During this phase it might be necessary to support the group’s denial of thoughts and emotions related to death and dying in order to promote an environment in which group members can safely develop trust and acceptance. Once this group culture has been established, and especially if physical decline and death occur among members of the group, it is crucial to promote an active discussion of feelings raised by these events.

**Family Therapy**

As is true for group therapy, family therapy can increase the availability of support for the client and help him or her deal with significant interpersonal relationships. Family therapy seeks to understand the ways in which an individual’s concerns affect and are affected by the family system, and to determine how these problems relate to preexisting conflicts and compromises among family members. It is an effective treatment modality for clients
with HIV disease whose primary supportive relationships with family and with significant others have been weakened as a consequence of the client’s HIV status. For example, clients may be experiencing the stressor of being in a serodiscordant relationship, or a family may be dealing with the issues associated with caring for a client with end-stage disease.

Family therapy has received little attention in the literature on HIV disease and psychotherapy, and it is underused in HIV clinical practice. This may be due in part to the distant relationships that many gay or bisexual men have with their families of origin. It may also relate to anxieties about terminal illness and premature death, as people with HIV disease seek to protect their families (and themselves) from potential shame and stigma. However, by bringing family members together and helping them identify mutual problems and reaffirm their love and concern for each other, therapy can be instrumental in facilitating understanding and support. In addition, therapy can help family members come to terms with illness and death and ease potential bereavement. In working-class and particularly poor families, family therapy focused on problem solving and advocacy can also help ensure the stability of the family system.

The therapist’s role as an educator may be particularly important, because families may be uninformed about HIV disease prognosis, treatment, and transmission. By allaying irrational fears and clarifying rational ones, and by allowing family members to express their emotional responses—including anger, blame, regret, and sadness—the family therapist can help clients and their families reach understanding and acceptance.

Individual Psychotherapy

Individual psychotherapy has been used to treat a wide range of emotional difficulties associated with HIV disease. Although severe mood disorders may require psychopharmacological interventions in addition to therapy, the more common and milder affective disturbances and adjustment reactions are primarily addressed through psychotherapy. As noted earlier, these adjustment reactions are best understood in relation to the phase of a client’s illness. Initial concerns include ambivalence regarding antibody
testing; response to the news of seroconversion; assessment of life
goals in the area of work and relationships; disclosures of illness to
family, friends, and coworkers; and strengthening or development of
social support systems.

As HIV disease progresses and clients develop physical symp-
toms, limitations on the ability to work and to pursue personal in-
terests and clients' increasing dependency on medical and social
supports become prominent issues in therapy. For clients whose
successful treatment has suddenly halted disease progression, is-
ues of working and short-term and long-term goals become cen-
tral; these issues are challenging HIV-related psychotherapy in new
ways. At advanced and terminal stages of disease, clients' decisions
regarding aggressiveness of medical treatments and hospice and
palliative care and their existential concerns regarding death and
dying arise as therapeutic goals. As has always been true—and par-
ticularly so in the context of new antiviral treatments—clients may
move in nonlinear ways through this progression, returning to
health after severe illness, experiencing new symptoms after a pe-
riod of health, confronting a host of serious side effects, and even
believing that they have been "cured."

The decision to embark on either a time-limited or an open-
ended course of therapy is an important initial consideration in
treatment. An open-ended course may be helpful for the client
who has limited social support and wants or needs an ongoing con-
nection for support and who is not primarily limited by time or
money. With the growth of managed care and an increasing de-
mand on public resources, clients are affected more and more by
these limitations. For these clients and for others who feel more
comfortable with therapy that has a perceptible beginning, mid-
dle, and end, brief psychotherapy may be an attractive alternative.

Delineating individual psychotherapy into time-limited and
open-ended approaches may obscure other crucial variations in
psychotherapeutic approach that may have particular relevance for
seropositive clients; for example, although "insight-oriented" psy-
chodynamic psychotherapy is an approach often used with clients
with HIV disease, variations include the use of cognitive-behavioral
therapy, "problem-solving" therapy, and existential therapy.

Open-ended psychodynamic psychotherapy may be ap-
propriate for clients who have a number of issues they want help in
understanding, as well as for those clients who present without clear-cut goals for treatment. Often it can take a period of months before the most salient features of a client’s interpersonal or intrapsychic difficulties emerge. An open-ended or long-term individual therapy may also be more suitable for:

- Clients with more severe character-based disorders, including severe personality disorders, if the goal of the therapy is to induce changes in the client’s defensive strategies and character structure
- Clients in need of ongoing, primarily supportive therapy
- Clients who wish to engage in a treatment that will provide them with a continuing forum for self-exploration
- Clients, particularly people with HIV, for whom the continued presence of the therapist in their lives provides a sense of stability

For clients with HIV disease, the essential principles of treatment are no different from those of other clients. The therapist assumes a nondirective stance and allows for the gradual unfolding of themes related to psychological conflict. The therapist not only listens to how those themes manifest in current and past relationships but also attends to their reenactments within the therapeutic relationship through transference. Eventually the therapist will direct the therapeutic work toward the goal of analyzing the transference, and in doing so will seek to help resolve the specific conflicts that are creating difficulties in the client’s life.

In the HIV-specific setting, the therapist, particularly over the course of long-term therapy, may need to shift from an insight-oriented stance to a more supportive one in the face of changes in health status. At this time of significant change in HIV-related medical treatment, therapists should also be sensitive to changes in therapeutic goals. Clients who have focused in therapy on coming to terms with losses in functional status may now be finding that their goals have, at least temporarily, shifted toward concerns regarding “reentry” and renewed health. These shifts can be unsettling for both the client and the therapist; they both will be affected by the uncertainties and ambiguities that changing treatment paradigms
present. In particular, therapists may find that some clients who have embarked on long-term psychodynamic therapy may want to change to a more short-term, problem-oriented approach that focuses on immediate back-to-work issues and termination of the therapeutic relationship.

**Using Brief Psychotherapy**

The remainder of this chapter defines two forms of brief psychodynamic psychotherapy, identifies applications for these approaches to clients with HIV disease, and illustrates the utility of these models with several case examples. In the process, it clarifies the overall goals of HIV-related psychotherapy. This focus more specifically on brief psychotherapy makes sense in light of a number of factors. Many therapists who work with seropositive clients currently find themselves operating in systems mediated by managed care service limitations or in institutional or program settings faced with shrinking resources and increasing demand. In addition, many clients with HIV disease come to therapy desiring shorter-term approaches. Although it may seem counterintuitive that clients with emotional distress related to a life-threatening illness could be effectively treated in brief therapy, many therapists find that advances in the theory and practice of brief therapy are applicable to clients with HIV disease and can result in enduring improvements in emotional health.

Writing in the earlier part of the twentieth century, Sandor Ferenczi and Otto Rank\(^3\) and Franz Alexander\(^4\) referred to short-term approaches to analytic therapy, recommending that therapists take a more active stance than was usual for the standard psychoanalytic approach in use at the time. They described the advantages of setting finite limits to the number of sessions, emphasizing a more rapid emergence of transference and countertransference issues and a heightened motivation on the part of the client to work actively in the treatment process.

In the 1960s and 1970s, other theorists, working independently, developed brief therapy models that varied considerably in terms of the type of client treated but shared a reliance on certain key features:\(^5\)
The therapist's assumption of an active and optimistic stance.

The relatively rapid assessment of the client's problems with an emphasis on the “here and now,” specifically focusing on current problems in psychosocial functioning rather than on the slower emergence of historical content.

The development of an interpersonal versus an intrapsychic focus, by which the therapist helps the client understand his or her important relationships, thus providing an identifiable foundation on which to base treatment.

Prompt intervention

A heightened focus on and need to address termination issues throughout treatment.

Current “third generation” models of brief dynamic individual therapy include time-limited dynamic psychotherapy, developed by Hans Strupp and Jeffrey Binder, and short-term dynamic therapy, developed by Mardi Horowitz specifically to treat Post-Traumatic Stress Disorder (PTSD). Both approaches have specific applications to clients with HIV disease.

Time-Limited Dynamic Psychotherapy

Time-limited dynamic psychotherapy is an interpersonal model of treatment based on a psychodynamic approach. It allows for the examination of “cyclical maladaptive interactional patterns” within a fifteen- to twenty-session format. Time-limited dynamic psychotherapy posits that although maladaptive ways of relating to others are typically learned in childhood, they are maintained in the present through relations with significant others and can cause symptoms of anxiety and depression.

In treatment, clients will unconsciously press for reenactment of their dysfunctional style with the therapist. The therapist's goal is to respond to the client in unanticipated ways, thereby providing a “corrective” emotional experience and revealing to the client a new emotional and cognitive understanding of the dysfunctional style. As in long-term psychodynamic therapy, the therapist is guided by the “dynamic focus,” a method of organizing and formulating his or her observations. In the case of time-limited therapy, the dynamic focus describes the “pattern of interpersonal roles in
which clients unconsciously cast themselves, the complementary roles in which they cast others, and the maladaptive interaction sequences, self-defeating expectations, and negative self-appraisal that result." The dynamic focus provides a "blueprint for therapy," helping to define the goals of treatment as well as anticipating problems that will occur within the therapeutic relationship. Unlike therapeutic interactions in longer-term models of treatment, the time-limited psychotherapist is more active in communicating interpretations, which are limited in their scope to the specific dynamic focus; he or she diverges more often from the "blank screen" model of therapeutic neutrality typical of classical psychoanalysis and actively acknowledges the time limit, thereby accelerating the pace and urgency of the therapy.

Interpersonal conflict is an ideal focus for time-limited psychotherapy, as the problem is especially suited to the strengths of this approach. Among the conflicts that may arise in the setting of HIV infection are social isolation and the exacerbation of preexisting difficulties (stemming from underlying characterological problems) in making and sustaining interpersonal relationships. A manifestation of this conflict might involve a client with borderline personality disorder who, under the stress of a recent HIV diagnosis, enters a cycle of stormy relationships that leave him feeling angry, rejected, and alone.

Clients without significant preexisting interpersonal difficulties may also experience conflicts as a result of an HIV diagnosis. These can take a variety of forms, including depressive reactions following the loss of autonomy and in anticipation of disability. For instance, a client may be reluctant to develop new interests and relationships out of the fear that he or she may become dependent on others. By examining conflicts concerning dependency, the therapist can help the client relinquish firmly held views about the need for absolute self-sufficiency and dispel irrational and catastrophic beliefs regarding his or her illness. Conversely, therapists might use this approach to help clients with preexisting passivity, which may worsen in the context of HIV, to develop a more active stance toward themselves and their treatment.

Time-limited dynamic psychotherapy is also effective in mediating the emotional reactions and interpersonal disturbances that may result from experiencing HIV infection as a narcissistic injury.
Clients may come to view themselves as flawed, imperfect, and undeserving of health, medical treatment, or meaningful relationships. This self-denigrating view can result from guilt regarding drug-use behavior or internalized homophobia, or may relate to core feelings of worthlessness and shame in clients with narcissistic character disturbances. Time-limited dynamic psychotherapy in this situation can respond to these self-denigrating views and help clients regain a healthy narcissistic investment in themselves and their lives. A case study will clarify how time-limited dynamic therapy operates in practical terms.

Tom: HIV Infection and Feelings of Inferiority

Tom is a thirty-five-year-old single gay man who requests “a few sessions” to help him deal with symptoms of mild depression and anxiety. Tom tested HIV-positive a year ago and initially blamed himself and felt guilt-ridden. During the year, he has remained asymptomatic but has become increasingly isolated from his friends and family. He feels unable to enter into relationships and has stopped dating to avoid “burdening anyone” with his condition.

Tom is a freelance graphic artist and has grown concerned about his ability to embark successfully on new projects. He describes occasional insomnia but denies using drugs or alcohol or having any consistent symptoms of major depression. Tom was raised by emotionally distant parents who readily expressed their disappointment in him. He has had several significant relationships with men in his adult life, which he believes ended because he felt that they lost interest in him.

Tom’s therapist, Helen Carter, works initially to define a dynamic focus that will guide the therapy. She does this by actively listening to the issues Tom raises during the first few sessions and, in contrast to open-ended therapy, relies less on a wealth of historical detail and more on Tom’s description of current problems. Carter notes a maladaptive interpersonal pattern that recurs in Tom’s relationships with his friends and family and sees a similar process occurring in Tom’s approach to initiating relationships. Critical to the workings of this therapeutic model is the identification of ways in which such a maladaptive pattern manifests within the therapeutic relationship.

In this case, the dynamic focus centers on how infection reinforces Tom’s long-standing feelings of inferiority and expectations of rejection. These attitudes surface in transference: Tom feels that he is taking up “valuable time”
and that he doesn’t deserve the fifteen sessions Carter proposes. He appears exquisitely sensitive to the actions on the therapist’s part that might imply disinterest or even rejection. For example, when Carter has to cancel a session, Tom responds in the next session by talking about ending therapy, as Carter “probably has other clients who could use the time with her.”

Carter works to reveal how Tom’s self-denigrating views are affecting current interpersonal interactions, including those in the therapy. She asks Tom about why he feels that she would be better off seeing other clients and offers an interpretive link between this interaction and Tom’s assumptions that his relationships ended due to his own inadequacies. She helps Tom understand his current feelings in light of his past relationships, including those in his family of origin, while providing support and demonstrating genuine interest in him in order to enhance his feelings of self-worth. In this way the therapist actively works to provide Tom with a “new experience,” through which he is able to feel positive regard from the therapist and consequently is able to challenge previously held beliefs that others will reject him. In this case, the termination of therapy will likely induce a similar negative transference, but Carter discusses this with Tom in a way that helps him understand his feelings in light of his personal history.

Short-Term Dynamic Therapy

Following a traumatic event—for example, rape or combat exposure—people experience dramatic shifts in previously held views, or “schemata,” of themselves and the world. They will also undergo changes in states of mind, both undermodulated, expressed as denial and emotional numbing, and overmodulated, expressed as intrusive ruminations. The resulting adjustment difficulties—manifested as painful feelings and dysfunctional behaviors—arise due to a failure to integrate the meaning of the traumatic event into a variety of self-held schemata.

According to Mardi Horowitz, the goal of the twelve-session short-term dynamic therapy model is “to help the patient complete the cycle of ideational and emotional responses to a stress event.” The result is to diminish the “severity and frequency of intrusion-denial phases” and facilitate the “integration of the meaning of the traumatic event into the patient’s view of themselves and their world.” Horowitz underscores the importance of acknowledging
the contributions of a client's personality style to the persistence of the client's maladaptive coping. In contrast to Strupp's time-limited therapy model, Horowitz's short-term therapy focuses more on intrapsychic processes than on interpersonal difficulties. In addition, the model deemphasizes the significance of transference and countertransference patterns and concentrates on understanding the client's characteristic defensive style.

HIV-related applications of this model follow from the conceptualization of HIV disease as a series of potentially devastating stressors. A variety of stressors—the initial response to being seropositive, the development of severe and debilitating medical illness, the letting go of career aspirations, the grief resulting from the deaths of loved ones, the immediacy of one's mortality, and more recently, the challenge of rejoining life after regaining health—may contribute to a series of significant adjustment reactions, which may elicit a clinical stress response syndrome that can resemble PTSD. Feeling overwhelmed and anxious, alternating with periods of feeling emotionally disengaged and in denial, corresponds with the stress-response phases Horowitz describes; these phases interfere with a client's ability to cope and to live a meaningful life.

Therapists using the short-term dynamic approach can help clients modify preexisting internal schemata and modulate dysfunctional patterns arising from HIV-related stressors. This modification in turn allows a functional integration of initial and continuing HIV-related stressors.

**Blanca: Denial and Overwhelming Emotion**

Blanca is a thirty-year-old divorced mother of two, referred for psychotherapy to treat severe anxiety and insomnia, which had developed over the preceding month. She has been seropositive for several years but had had only mild physical symptoms until she was recently diagnosed with AIDS because of a sudden drop in her CD4+ cell count.

Blanca feels "overwhelmed," anxious, and afraid that she will be unable to care for her ten-year-old son and eight-year-old daughter. Prior to her AIDS diagnosis, she had "tried not to think" about her illness and had been inconsistent about her medical care. She has been reluctant to tell her extended family about her HIV disease for fear that they would ostracize her, and in general she has felt isolated.
Blanca’s therapist, Howard McDonald, identifies elements of a stress response syndrome in Blanca’s denial of her illness followed by her feeling overwhelmed and incapacitated by it. He focuses therapy initially on Blanca’s blunted emotional responses and helps her express her most pressing fears in order for her to gain a sense of control over her feeling states. In doing so, McDonald is mindful of Blanca’s underlying cognitive style, which includes a tendency toward jumping to conclusions, impulsivity, and thinking the worst. He works in therapy to counter that style by employing a more reasoned problem-solving approach.

Over the course of twelve sessions, McDonald allows Blanca to voice her greatest fears, which center on her concerns regarding her children’s welfare. He helps Blanca formulate specific plans for identifying those members of her extended family from whom she would feel comfortable asking for assistance if her health deteriorated further. Through this approach, Blanca is able to integrate her illness into her life and, as a result, is able to be more open with her family, who in turn are able to offer her emotional and practical support.

As the epidemic moves into its second decade, there is a continuing need to identify and refine forms of psychotherapeutic intervention so as to better understand and help patients cope with illness. Aside from this evolution in technique, an essential component of the work remains the ability to convey personal qualities of compassion, caring, and positive regard. Despite difficulties, frustrations, and sadness, helping those who are struggling to cope with HIV disease can be among the most gratifying, rewarding, and exhilarating of our endeavors as psychotherapists. Greater clarity about when and for whom to use particular techniques can only improve the lives of clients and deepen the satisfaction of providers.

Notes
Coping, and Affective State on Recurrence and Survival 6 Years Later." *Archives of General Psychiatry*, 1993, 50(9), 681–689.


8. Dilley, “Treatment Interventions.”


42. Strupp and Binder, *Psychotherapy in a New Key*, p. 68.

43. Horowitz, “Short Term Dynamic Therapy.”
Chapter Nine

HIV Disease over the Long Haul
Hope, Uncertainty, Grief, and Survival

Ari Rose

Since the beginning of the epidemic in the early 1980s, the history of HIV treatment has been marked by intermittent flurries of excitement based on rumors, anecdotal stories, clinical trials, and a deeply shared longing for hopeful news to sustain people's spirits. Over time, new treatments have been able to check the progress of the virus, to protect immune-compromised people against various opportunistic infections, and to strengthen the immune system itself. Increasingly, people with HIV are living longer and healthier lives than they would have a decade or even a few years ago.¹

In the course of the epidemic, however, many promising developments ended in disappointment or, at least, fell short of initial expectations. The roller-coaster of HIV treatment, as pioneering HIV therapist Michael Shernoff has called it,² is long, steep, and unpredictable, and riding it remains a daily reality for those who are living with HIV as well as for all those who care for them.

In the mid-1990s, with the advent of protease inhibitors and triple combination therapy, hopes and expectations rose to new heights. Among those who have had access to these powerful drugs, many have responded remarkably well: their viral loads have plummeted to lower than detectable levels, their immune system measurements have rebounded, and they have experienced surges of new vitality and dramatic reductions in opportunistic infections
and moderate to severe symptoms. In 1998, this trend continues for some, although both clinical studies and anecdotal evidence reveal that many individuals are not able to remain at the plateaus they had reached. Many are managing difficult side effects, switching to new combinations, waiting for the newest drug to get approved, and continuing to live with hope and uncertainty. Although the roller-coaster continues, there has been a paradigm shift: the language and assumptions of hope have been firmly incorporated into the vocabulary of the epidemic.

For those who are doing well, living with HIV disease as a chronic manageable condition is not necessarily as simple as “the epidemic is over for me, and I’m getting on with my life.” First, although some have asserted otherwise, the epidemic is not over. As Shernoff has said, “The epidemic is only over for those who have died.” Second, even those who are doing well face a complex set of issues in going about the profound task of reconstructing the future. This challenge is the primary focus of this chapter; it addresses some of the psychosocial issues that accompany this process, primarily issues of hope, uncertainty, meaning, and survival.

Before beginning, however, it is important to express a caveat, already implied. Globally, the vast majority of the twenty-nine million people currently living with HIV disease do not have access to any basic medical care, much less the expensive new medications that, for some, have transformed the epidemic. Many of these people do not have access to simple antibiotics, and some also lack resources for adequate nutrition, clean water, and other basic preconditions for maintaining good health.

In the United States, statistics that show declining death rates and drops in the incidence of opportunistic infections also reveal significant disparities: the new hope and the new treatments fail to benefit many women and people of color, particularly African Americans. Although we acknowledge improved treatment and prospects for survival, we must also be mindful of these differences and remain committed to advocating for access to hope for everyone.

Reclaiming the Future

For the global minority who do have access to care and are doing well with combination therapy, there are many positive and hopeful developments to acknowledge and celebrate. Many of these people
are feeling a renewed energy and strength they have not felt in years. Some are returning to work or school or are seriously contemplating such life changes, making long-term plans they had expected never to make again. Some people are building new relationships with new life partners, while others are mustering the courage to leave relationships that have been unhealthy. Some are experiencing joy and pleasure in their resurgent sexuality. Some are feeling much more motivated to confront their addictions to alcohol, tobacco, and other drugs, as well as other forms of addictive behavior. Others are engaging in or increasing various kinds of physical and recreational activity. Overall, many people are reclaiming a future, representing a profoundly hopeful shift away from the despair and resignation many have understandably felt in the past.

There have always been seropositive people who lived with a tremendous amount of energy and spirit, believing that they would survive for a long time, or at least that they would make the most of whatever time they were going to have. For some of these people, the new surges of hope have not changed their lives dramatically. However, the breadth and intensity of these new hopes have influenced everyone affected by the epidemic, even on its periphery. Our ideas about and images of the epidemic are being reshaped. In the industrialized world, everyone’s expectations have been heightened.

The Spectrum of Experience

Heightened expectations are, of course, experienced differently by different groups of people. For those doing well with the new medications, these expectations can spur them on to make, or at least consider, major life changes. But for those who are having problems due to viral resistance or to troubling side effects, it is difficult to avoid succumbing to panic or despair. Feelings of failure and self-blame are common as people struggle to come to terms with not doing as well as others. It is not new for groups of seropositive people to experience wide disparities of success with treatment, often for no apparent reason. However, now the stakes of success or failure seem higher than ever, so the attendant feelings of inadequacy, shame, or despondency sometimes run deeper.

Especially in communities hardest hit by the epidemic, such as the gay and bisexual men’s community, where many have been
sustained by the camaraderie of shared adversity as well as shared hopes, these disparities in treatment success are difficult to manage. In general, the atmosphere has become more optimistic since the advent of combination therapy, although it has grown more cautiously so. In this context, it has been hard for some who are not doing well to speak up; as someone recently said at a public forum, “I don’t want to spoil the party for everyone else.” Among those who are doing well, some feel self-conscious or guilty about the failed hopes of friends. It remains a challenge for both individuals and communities affected by HIV disease to continue to make room for the whole range of emotions, from exhilaration to despair, that people experience. The solidarity that has sustained so many people through this epidemic is as important as ever, possibly more so. Special attention must be directed to ensuring the inclusion and sustenance of those who are not doing well, who may inadvertently be avoided or even abandoned by care providers and others who feel powerless to restore their health.

Disparities in treatment success are best faced directly. When people are able to speak openly about the awkwardness and pain regarding these differences, it is usually a relief to everyone involved, an opportunity to share the pain that may have become a taboo topic. This kind of openness is, of course, easier to achieve and more likely to be successful in the context of an ongoing support group or a retreat for seropositive people, where participants have the opportunity to develop a sense of caring and community. It is important to note that with current treatments, individuals may move back and forth between “success” and “failure,” rendering categories fluid and requiring participants and facilitators to be inclusive of every experience.

Living with Uncertainty

The relative success of combination therapy has been exhilarating. Although exhilaration is hopeful and exciting, it can also leave people feeling dizzy and disoriented. For everyone affected by HIV disease, the underlying current of uncertainty still runs strong and deep. Questions abound regarding how long new treatments will remain effective, whether particular strains of the virus will become resistant, what short-term or long-term side effects might develop, whether the next wave of treatment alternatives will come along in
time, and whether these new alternatives will be made available to all who need them. Some people fear that they will make major life changes, get sick again, and then feel more vulnerable—physically, emotionally, and financially—than ever.

People living with HIV disease do not necessarily expect answers to these questions, but they need to ask them. They do deserve full acknowledgment and empathy for the feelings behind the questions: fear, skepticism, anger, weariness. Those who provide care to seropositive clients may not always have sufficient time to address this spectrum of emotions. However, providers do carry the responsibility at least to acknowledge the unanswerable questions, to avoid fending them off out of discomfort, and to understand how frightening it might be not to have the answers.

Coming to terms with uncertainty as a basic existential fact of life is an ongoing challenge for all people. To do so while diagnosed with a life-threatening illness is especially challenging. Yet it is crucial for people with HIV disease to address uncertainty if they are to cope with HIV infection over time. Denial may be an effective coping mechanism for a period, but as it wears down, the stressful nature of uncertainty requires a more mature and effective stance toward living in the face of a full range of possibilities.

A seropositive woman I knew for years—I’ll call her Sharon—was extremely hopeful about her prospects for long-term survival. She actively engaged in pursuing various treatment alternatives, was an extremely well informed and demanding consumer of health care services, and spoke publicly about her experiences, giving strength and hope to herself and to others. For several years, Sharon felt angry and sabotaged by any hint that she might not live a long life. Over time, however, she was able to integrate the possibility of death without feeling threatened by it and as a result was able to make guardianship plans for her daughter. Sharon was able to make peace with the uncertainty of her own future without feeling compromised or as though she were giving up. The power of her positive thinking had a major impact on the quality of her life and possibly on her physical health as well, and she was strengthened by being able to embrace her serostatus in a more grounded, less defensive manner.

Through the years, I have seen people like Sharon find relief and comfort in facing uncertainty head-on and learning to live with it. Especially in the early stages of coming to terms with a HIV
diagnosis, it can be too overwhelming to confront the possibility of death. But beyond this initial period, it becomes important for someone who is relatively intact psychologically to confront the whole range of his or her possibilities. As Steven Schwartzberg writes in *A Crisis of Meaning: How Gay Men Are Making Sense of AIDS*, "Coping effectively with HIV . . . involves allowing yourself to experience grievous loss along with bittersweet growth." Whereas Sharon tended toward the hopeful and discounted potential illness and death, some clients on the other end of the spectrum firmly expect only the worst of outcomes. This distortion may help some feel less vulnerable to feelings of disappointment and better prepared for health crises, but they run the risk of not noticing that life is unfolding in the meantime.

**Control and Change**

Uncertainty inevitably brings up the issue of control, one that tends to be surrounded by myth and illusion. Schwartzberg discusses the importance of distinguishing (within environmental, health, and economic constraints) between what can be controlled—for example, current and future life decisions, health care choices, and personal goals—and what cannot be controlled—the past, other people's behavior, and who our parents or siblings are. Further, he discusses the cultural meaning of control, which some pursue unrealistically and others abandon out of a sense of despair or defeat. Clearly, issues of control tend to run deep into a person's psyche. To the degree a person can learn to relate to control realistically and in a relaxed way, he or she can also develop an easier relationship with issues of uncertainty.

Related to the twin issues of uncertainty and control is the difficulty of adjusting to change. There are many people with HIV disease whose basic expectation was that over the years, they would gradually get sicker and die. They had planned the rest of their lives according to this scenario. Not that they were looking forward to these outcomes, but the process of reformulating the scenario in order to prepare for a future of new possibilities was a profound and difficult one.

In the process of assisting people who are facing the whole range of issues related to uncertainty, care providers need to be scrupulously honest about what they do and do not know. For
some this means dealing with their own discomfort about uncertainty, their desire for control, and their feelings of responsibility to “fix” things far beyond their control. When providers take these appropriate steps and do not pretend to have the answers to unanswerable questions, they need to be prepared to deal with their clients’ anger in reaction to uncertainty, trusting that clients will ultimately be more reassured by honesty than by pretense. This is crucial: facing something difficult or disturbing does not mean that a person has to like it. It can be helpful for people to have the opportunity to rail at the cosmic unfairness of living in a world where so much remains unknown and uncontrollable. Ironically, in coming to terms with uncertainty and lack of control, people usually end up feeling more empowered.

Facing the Past, Facing the Future

Re-creating a sense of having a future is an awesome, complex task. Much of it is joyful, but much depends in part on what the future looked like before one’s life was transformed by HIV disease. No adult came to this experience as a blank slate; each already had his or her own history, circumstances, and character. For those fortunate enough to have had a sense of purpose and direction in life, to have felt generally good about themselves, to have had positive and fulfilling relationships with family and friends, to have done meaningful work, and to have felt connected to a community, the opportunity to recreate a future will most likely be experienced as joyful and exciting.

However, for the growing numbers of seropositive people who felt chronically isolated, anxious, or depressed, struggled with major addictions, had limited job skills and opportunities or were doing work they did not like, or were barely able to make ends meet, re-creating the future is likely to be a fearful and problematic process. For an increasing number of people with HIV disease, dealing with these long-standing problems as well as with current governmental policies regarding welfare, health care coverage, and immigration makes it difficult to feel hopeful about the future, no matter how promising new treatments may be. Care providers need to look far beyond the traditionally defined parameters of “HIV issues” in order to assist the full spectrum of clients.
Seropositive people have always needed practical assistance as well as emotional and psychological support. Earlier in the epidemic, practical assistance often focused on tasks related to serious illness and death—for example, arranging for wills and durable powers of attorney to protect the life partners of gay men, or organizing networks of family and friends to provide enough care to enable a person to die at home. These needs still exist, but there are many new tasks related to living for longer periods of time: arranging for long-term housing subsidies; supporting people through long-term substance abuse treatment and recovery; and, increasingly, assisting people in the process of going back to work. This process is both psychological and practical: people need counseling to realistically assess their own skills and work and education history, to protect their own confidentiality and appropriately disclose HIV serostatus, and to face fears of failure. In addition, clients may need help understanding disability benefits, health insurance, and legal protections against workplace discrimination. As clients prepare to take such major steps, it is crucial that they be helped to take them successfully.

Facing the future is further complicated for some by having felt left behind by uninfected peers in the past. For a large number of seropositive people, HIV infection interrupted their lives during a stage of life when they ordinarily would have been building the foundation for a seemingly secure future. When viewing seronegative friends who have settled down to careers, families, financial security, or retirement planning, seropositive people find it difficult not to feel envious, even resentful. It is important to offer clients opportunities to express and face these feelings. It is important, as well, for them to mourn the lost opportunities of the past in order to move forward into a reconstructed future.

The History and Meaning of Survival

Even though the epidemic is not over, successful combination therapy has encouraged growing numbers of seropositive people to contemplate living a normal life span, to confront the prospect of survival and its implications. Some are thinking about posttraumatic stress, even as they acknowledge that we are not yet "post." This epidemic will end at some point, and it is not too early to face
the challenge of envisioning a future beyond AIDS and preparing people to live in it.

In speculating about the nature and future of HIV survival, one source of wisdom is the experience of others who have survived or witnessed ongoing life-threatening trauma. Throughout human history, people have experienced both natural and human-made disasters, and some have managed to survive against great odds. In recent memory, one cannot help but think of the Holocaust—an opportunity not to compare such starkly different phenomena but to learn from the experiences of people who survived.

One lesson from the experiences of these survivors is that “back to the future” is not the same as “back to normal.” Life after a massive trauma is never the same. That is not at all to say that healing is impossible. It is to emphasize, however, the importance of acknowledging the reality and power of trauma as well as the task of rebuilding afterwards.

Another lesson is that it is difficult to reconstruct life when so many people from one’s past have not survived. Mourning such losses is a lifelong process that will be reactivated at all life stages, especially at times of separation or loss. The prospect of aging without one’s peers, for example, is a common issue for many people with HIV disease. Looking at the experience of past survivors, we see that it is possible to build new families and communities and that there can arise a tremendously powerful feeling of triumph in doing so. However, the loss of those with whom we have a shared history is permanent; honoring that history and those who did not survive is crucial.

In order to survive trauma, particularly the effects of massive cumulative grief, survivors defend against becoming psychically overwhelmed by learning how to numb themselves. This “psychic numbing” is one of the five themes enumerated by Robert Lifton as an outgrowth of his work with survivors of massive death experiences; the others are “death imprint,” survivor guilt, “suspicion of counterfeit nurturance”—that is, a mistrust of the depth of understanding or even the motives of those who offer comfort—and the struggle for meaning. Numbing can become habitual, and it can be very difficult for a survivor to feel psychologically prepared to reopen himself or herself to the whole spectrum of human emotions. Survivors may fear that in allowing themselves to experience
any feeling, they may get flooded by horrific images and emotions, and intrusive thoughts are common among those who have survived trauma. Sometimes the most compassionate and intelligent approach to treating trauma is to help a client contain rather than express these emotions, with the hope that over time, the client can build enough psychic strength to dip into the well of horror and grief. Not all wounds heal, and not all should be reopened. People learn to live with scars, and some are able to do so with great wisdom and grace.

Studies of Holocaust survivors teach us that those who resisted and stood up for themselves and for others, even very privately and quietly, often did better afterwards. To a remarkable degree, many people who have lived with HIV disease have done so with the aid of their own great altruism and powerful activism. The experience of helping others and feeling connected to the larger world reduces isolation and expands feelings of mastery and empowerment both in the present and the future. Survivors also teach us that it helps to stay connected to the community of others who have gone through the traumatic experience, although people sometimes feel compelled to dissociate from these connections in order to build new lives.

Finally, survivors teach us about the importance of memory. Whereas some survivors need to contain their emotions about and images of the trauma, many others need to recount their stories to people who will listen with honor and respect. Although the HIV epidemic has been documented in many ways and with much creativity, there are potential oral and video history projects, for example, that could have great value and meaning in the years to come. The community of people affected by HIV has been well served by the NAMES Project Memorial Quilt, but we need additional communal rituals of remembrance, affirmation, and renewal.

As a powerful image of the kind of ritual we require, Schwartzberg movingly describes the Onion Cellar, a fictitious nightclub in Günter Grass’s postwar novel, *The Tin Drum*:

The Onion Cellar is an unusual place. It serves no food or drink; offers no conventional entertainment. Instead, well-heeled patrons sit at crude tables, where they are given cutting boards, paring knives, and onions. They wait obediently until the club owner
instructs them to cut and peel the onions. They start timidly. But then they cut and peel with abandon.

And they begin to cry. Their crying soon turns to wailing, a communal grief mirrored in a skein of individual tears. The patrons turn to their friends and to strangers, weeping and comforting each other. They confess their sins, their hurts, their guilt. They use the onions to gain access to the pain they carry but cannot otherwise express. They come to the Onion Cellar to share this pain publicly, because the experience is less fulfilling if one cuts onion at home and cries alone. Some patrons come only once, others repeatedly, until exhausted of their tears. And somehow, in the process, they feel healed.18

We face a similar situation with the AIDS epidemic right now. We need Onion Cellars. As a community, as shared witnesses and bearers of so much loss, we must find ways to express the pain, the grief, the despair that feels increasingly out of our scope—and to do so safely, emotionally, repeatedly. And we must do so communally, so that others may be there to support and witness, so that we may each serve as comforter and mourner.15

Survivors of any trauma never form a homogenous group; this is certainly true about people living in the shadow of HIV. To say that they are uniformly resilient or heroic would be untrue, although many have shown both characteristics to a remarkable degree. It would also be untrue to romanticize AIDS as a transformative experience, without acknowledging the depth of the losses so many have suffered.

We will continue to suffer losses. Some people will demonstrate dazzling resilience, and some will not. The degree to which we will as individuals and as a society be transformed by this epidemic remains to be seen. The hope, courage, humor, resourcefulness, and determination that have sustained so many to this point will be crucial for the rest of our lives. Therapists will be challenged to persevere over a completely unpredictable and long haul, to summon the full depth and breadth of their skill and their humanity in the process of helping seropositive clients face
the past, live in the present, and reinvent the future. May we all have the strength to continue until the epidemic really is over.

Notes
8. Schwartzberg, Crisis of Meaning.
11. Schwartzberg, Crisis of Meaning.
Chapter Ten

Beyond Stereotypes
Stigma and the Counseling Process

Mindy Thompson Fullilove

In 1996, the New Yorker published a special issue, “Black in America.” The issue included the usual trenchant cartoons, but, for the occasion, each examined an aspect of Black life. A number of cartoons depicted the ways in which stereotypes create alienation between Black and White America.

For example, one cartoon contained the image of a laboratory bench where three White and one Black scientist sit side by side working away. The dialogue bubbles reveal their thoughts. The first White man is thinking, “I wonder how he feels about O.J.?" The second White man is thinking, “I wonder how he feels about Farrakhan?” The next person, a White woman, is thinking, “I wonder how he feels about affirmative action?” The bubble of the fourth person, who is Black, is filled with complex mathematical equations. He is focused on the work—as the others should be.

Another cartoon depicts an upscale New York party, where a White woman says to a Black man, “I’ve seen most of Spike Lee’s movies, so I know what you must be going through.” The offense is amplified by the fact that the reserved, middle-aged, soberly dressed Black man appears to be anything but the typical character of a Spike Lee film. Yet the cloak of sameness is applied willy-nilly.

The author would like to thank Keith Cylar, who offered helpful comments on an earlier version of this chapter.
In a society structured by intergroup enmity, whether between Blacks and Whites, gays and straight people, or between other diverse groups, every interaction runs the risk of replacing genuine engagement with stereotypical interchange. Stereotyping can be harmful in all human interchanges, but its presence in therapy is particularly destructive. Therapy ought to provide individuals with opportunities to explore and reorder the ways in which they experience the self. To provide these opportunities requires the therapist to get to know and react to each individual as an individual. It is impossible to do this if stereotyping comes into play. Stereotypes replace an understanding of the individual with imaginary characteristics of the group to which the individual belongs. Stereotypes concretize images of groups, preventing exploration of a complex reality. Stereotypes applied to individuals in therapy effectively block exploration of self. This chapter looks at the origins of stereotypes and, through three scenarios, explores ways in which stereotypes emerge in HIV-related therapy. It also instructs therapists on how to ensure they do not damage their therapeutic relationships through stereotyping.

How Stereotyping Happens

Few would disagree that stereotypes and stereotypical interactions are harmful in therapy. But this acknowledgment does not mean we have effectively eliminated them, and our failure to do so is a result of a confluence of several forces, as described in the sections that follow.

Believing in Stereotypes

First of all, we all believe in stereotypes and use them in everyday life. A 1994 national survey of people in the United States found that members of all groups endorsed stereotypes about each other. For example, 46 percent of Hispanic Americans and 42 percent of Blacks agreed with the statement that Asians were “unscrupulous, crafty and devious in business.” Asian Americans, in turn, endorsed stereotypes about others: 68 percent endorsed the statement that Hispanics “tend to have bigger families than they are able to support,” and 31 percent agreed that Blacks “want to live on welfare.”
Although the White people polled were somewhat more cautious than others in endorsing stereotypes, a large majority felt that minorities were given the same opportunities as Whites to get a good education, a skilled job, or decent housing.

Stereotyping appears to be a universal human activity, practiced from all sides of every marker of social difference—race, class, region, sexual orientation, gender, religion, and language—providing a kind of social shorthand for otherwise complex intergroup differences. It is, admittedly, easier to think of all Asians as having the same slanted eyes than it is to look carefully at the thousands of variations on eye configuration that exist in the world. Stereotypes are the stuff of our jokes ("How many Poles does it take to change a light bulb?") and our rage ("Fuck you, faggot!") and our dreams ("This big, black buck of a man was panting after me"). Stereotypes change with the times, taking on the nuances of the moment, emphasizing the "outgroups" of the moment, but never disappearing from our social strategies for intergroup relations.

Malcolm Gladwell, a Jamaican who had lived in the United States and in Toronto, was struck by the social construction of "Jamaican" in those two places. In the United States, people from the West Indies were widely believed to be "model Blacks" and were accorded greater respect and opportunities than other Black people. In Toronto, by contrast, West Indians were tagged with all the stereotypes given to African Americans in the United States: they were shiftless, lazy, and prone to living on welfare, and they deal drugs and abandon their children. How could one group of people fit such distinctly different social images? Gladwell wondered, "Didn't Torontonians see what was special and different in West Indian culture? But that was a naive question. The West Indians were the first significant brush with Blackness that White, smug, comfortable Torontonians had ever had. They had no bad Blacks to contrast with the newcomers, no African Americans to serve as a safety valve for the prejudices, no way to perform America's crude racial triage. . . . In America there is someone else to despise. In Canada, there is not. In the new racism, as in the old, somebody always has to be the nigger."

Considering the constancy of stereotyping as a feature of human life, psychoanalysts and others have argued that it represents the workings of a basic psychological process common to all.
people. Some have proposed that the creation of stereotypes occurs as the result of the projection of hated parts of the self on to others. The projection of these shadow parts creates the illusion of a wholly "good" self that can be accepted with equanimity. In effect, stereotyping reduces anxiety for the individual. At its foundation, stereotyping is useful as a way of reinforcing group boundaries and increasing an individual's sense of belonging. Human beings strive for membership in human communities. When healthy avenues of cooperation are blocked by social upheaval or other processes, people may turn to shared hatreds as a source of bonding.

Observation 1: We all construct stereotypes, and then we believe in them. Therefore, we must know which stereotypes we endorse and in what ways they may interfere with helping others. We must also know which stereotypes of our own group we have internalized.

Our Unconscious Judgments

The second force that nurtures stereotyping is an individual's unconscious judgments. We make judgments from inside culture-bound value systems, but we are often blind to this process. Each of us is a product of a particular culture, and we operate within the rules of that culture. Each culture's rules are based on a set of principles that in general are never enunciated but are assumed to be correct. A corollary to these principles is the assumption that the rules of other cultures are wrong.

In order to understand this problem, consider the array of rules various cultures have regarding personal introductions. Should people bow on being introduced? If they bow, how low should they bow? Who should bow to whom? Perhaps people should shake hands rather than bow? If so, how hard is the hand to be held, and in what manner is it shaken? Raised to perform greetings in a certain manner, we will unquestioningly infer bad manners or disrespect on the part of strangers who fail to act as required by our culture. That they may be acting with perfect propriety as defined by a different set of rules is an interpretation unlikely to occur to the average citizen. Because cultural censure
can be quite severe, a stranger’s “social errors” might lead to estrangement or even death.

The growing complexity of our world has made it more likely that we will meet people from disparate parts of the world. The historical diasporas of African and Jewish peoples are matched today by people fleeing war, famine, drought, poverty, and oppression. Women are fleeing genital mutilation; gay men and lesbians search for sexual liberty. The diasporas of our day have created a whirlwind, mixing together people from every isolated hamlet on earth. Susan Sontag observed, “Like the effects of industrial pollution and the new system of global financial markets, the AIDS crisis is evidence of a world in which nothing important is regional, local, limited; in which everything that can circulate does, and every problem is, or is destined to become, worldwide.”

By implication, we must be prepared to meet people of many cultural traditions. We will not always know the meaning of the words, behaviors, and gestures to which we are reacting. We must therefore train ourselves to inquire constantly: Did that act or word or gesture mean what I thought it did?

Observation 2: Because we are blind to the assumptions of our own culture, we must show our work to colleagues from different backgrounds so that they may act as our eyes and ears—that is, as our interpreters.

The Role of Events in Shaping Psychology

Acting as a third force, our models of individual psychology have undervalued the importance of trauma and other stressful events in shaping character and mental distress. A part of what distinguishes people is the event structure of the individual’s life. Minority people, for example, will experience acts of oppression, as well as life conditions, that result from social structures that define and confine them to the margins of society. A gay man growing up in a small town will search in vain for images that affirm his sexuality. In his longing for support and succor, he may eventually accept exile from his birthplace as the price he has to pay to live with some measure of dignity and freedom. John Preston, in an autobiographical essay titled “Medfield, Massachusetts,” described what
it felt like to have to leave home in search of a place for himself: “In some ways I moved into my new life with great joy. There was real excitement in it, certainly there was a great passion... I also experienced rage over what was happening to me. I was being taken from Medfield and everything it stood for. I was the one who should have gotten a law degree and come home to settle into comfortable Charles River Valley politics—perhaps with a seat in the Great and General Court... But I was no longer one of them. I had become too different.”

Events like this shape the life course of a gay man. His efforts to make sense of his experience will define his philosophy and the issues he might bring to therapy. In order for therapy to be meaningful, it must have the tools and the sensibilities to explore the event structure of the individual’s life.

**Observation 3:** If we undervalue events, we might miss the key turnings in a person’s life story. Instead, we must study the great and small happenings in the lives of our clients.

**The Fragmented Society**

The final force that generates and maintains stereotypes arises because society is structured to keep groups apart, giving people few opportunities to get to know each other. It may well be impossible to appreciate the nuances of the life of a house queen or a rap artist unless one has met a few. But it is nearly impossible to accomplish that in U.S. society, structured as it is with visible and invisible boundaries erected around each group.

In 1986, Richard Simon wrote “Across the Great Divide,” an article about the services offered at a mental health clinic in the South Bronx, a poor, underserved area of New York City. The title ostensibly referred to the Harlem River, which separates Manhattan from the Bronx, but really referred to the social chasm between wealthy White family therapists (the writer and his audience) and the poor clinic in the South Bronx. Why was it so important to signal that a social boundary had been crossed? Clearly it had nothing to do with understanding how the clinic served its community, as both clinic and community were located on the “other” side. It is more likely that the title was directed at the stereotypes
of the largely White, middle-class readership of the magazine who would never venture into the South Bronx and thought of it as an awful place. Simon meant to entice them on an exotic journey into "otherness," a little bit like taking a tour with National Geographic.

If the only way a therapist—or any person—gets information about the "other" is through a lens tinted in this fashion, he or she will remain forever in the dark. Rather, therapists must get to know other settings and the people in them if they are to help. An example of this is the effort to understand African American gay men who were "raised" in the church. They are often very religious people for whom the church was a second home. They are also often tortured by the homophobia in the church, which is alienating and confusing. The dual feelings—loving the church but hating being denounced by the clergy—battle within the self of many Black gay men. This conflict undermines self-esteem and interferes with HIV risk reduction and HIV care.

Whether or not there is damage to self-esteem, attacks on gay men and lesbians in the church have meant that many do not know how to apply religious teachings to their own lives. One gay man admitted being baffled by his relationship to the church, which he said spawned in him a "kind of schizophrenic child." He continued, "Part of me says that I need [religion] to keep me in order, because [I] will push every single limit, and there has to be something keeping me in check." On the other hand, he said, he recognized the barriers the church had created for him, and this made it difficult for him to accept it. Understanding the setting of the African American churches is key to understanding the experience of many African American gay men. The same can be said of other people and other settings.

Observation 4: It is hard to get to know people outside of our own group, but we must expand our horizons and our venues.

These four forces not only act independently to keep people ignorant about each other but also act together. For instance, a White man who believes in stereotypes and never meets someone whose family origins are in Asia is unlikely to know how to have a conversation that will reveal a new reality. Each of the forces acts to shape the history and content of the therapeutic relationship.
It is possible for these stereotypical interactions to undermine the therapeutic alliance. But it is also possible that genuine engagement will promote individual recovery.

**Confronting Stereotypes in Therapy**

Treatment occurs in the context of the therapeutic relationship. That relationship, among other functions, serves as a model for exploring past relationships and re-creating present ones. It is the therapist’s task to ensure that this relationship brings into consciousness the stereotypes that both client and therapist may believe in. Assuming that stereotypes are a part of everyone’s thinking, the work in therapy is to identify these stereotypes and make them part of the healing process. The three case examples in this chapter depict therapists and clients working with stereotypes.

Like any other relationship, the therapeutic alliance may incorporate intolerance and insensitivity: it may become a reenactment of other oppressive relationships. How is the therapist to know when the relationship has gone astray? What do relationships look like when they are fraught with negation? Instead of the stuttering progress—from uncovering to working through—that normally characterizes therapy, oppressive therapeutic relationships become stuck in one spot. The therapist’s eager efforts to help the client feel better are undermined by his or her alienating acts—imposing stereotypes, making unwarranted assumptions, radiating fear of the client’s “badness”—that negate the client’s sense of self. Often the client will take on the shadow that is being projected by the therapist. In these cases, the client will become highly symptomatic, exhibiting inconsolable sadness and uncontrollable anxiety.

What does this process of alienation sound like? The following dialogues from fictitious psychotherapy sessions help illustrate the interactions in an oppressive relationship.

*A Loving Man*

Sam is an asymptomatic seropositive gay man who has been making progress in developing a stable intimate relationship. His therapist, Paul, is also a gay man, but one troubled by guilt and doubt about his homosexuality.
Sam: Yeah, Mario’s what I never thought I’d find. Each day I discover new levels of thinking and feeling in the presence of somebody else. It’s probably the first time that I’m not constantly on guard.

Paul: No?

Sam: You know how I’ve always talked about the tension. The tension that something’s going to happen. I guess because, in my life, something always did happen, my mother—I just never knew what would happen with her health. Actually, Mario started coughing the other day and I got really scared. I started to see visions of him lying in the hospital all filled with tubes. But what happened then—and this was the surprising part—I thought, well, I’ll be there to share it with him. And I wanted to just be part of whatever happens in his life. He’s not even HIV-positive, so I was really hugging. Anyway, that was when I decided I wanted him to move in with me.

Paul: (Coughs) Isn’t that a little fast?

Sam: Fast? What do you mean?

Paul: Well, how long have you known him?

Sam: Twenty years.

Paul: You know what I mean.

Sam: Well, it’s still true. I’ve known him since I was ten. We were in Boy Scouts together. I mean, yeah, we’ve only connected as lovers in the past two months. But it doesn’t feel fast because of all that shared history.

Paul: OK, lovers, but live together? I mean, have your boss to dinner with the two of you?

Sam: I’m not out to my boss, so how could I do that?

Although the problems of any therapeutic intervention are many—what to say, when, and how—the issue here is that the therapist takes exception to the client’s plan to live with his lover. Because Sam has been working in therapy to develop a relationship, it seems logical that he move forward to consolidate the affair. The therapist, speaking from his own internalized homophobia, attacks the proposal. Further, he depicts a frightening scenario, which changes the tone of the session from one of confidence to one of fear. He reintroduces dread which, for a moment, the client had escaped.

Such a statement is one of thousands of statements made in the course of therapy. The parties separate, think about what has happened, and meet
again. Let us assume that Paul shares his cases with Jim, a trusted colleague. Paul, who is aware that his own fear might be interfering in his work, plays a tape of his session with Sam. In the following conversation, Paul and Jim review the dialogue.

Jim: (Stopping the tape just as Sam says, “How could I do that?”) What do you think that last intervention was about?

Paul: You know, at the time, I felt that I had to protect him. I was really worried that he would leap into this relationship and ruin everything.

Jim: Has that been his pattern?

Paul: (Thinks about it.) No, not really.

Jim: I was a little surprised listening, because it’s not like you. Especially what you said about his boss. I could hear the fear in his voice; why did you want to frighten him?

Paul: Frighten him?

Jim: (Waits. Paul is clearly struggling.)

Paul: Oh God! Is this my stuff getting into the therapy?

Jim: Hey! Sure sounded like it to me. I mean I thought you’d be jumping for joy that the guy’s made so much progress, and instead you beat him up.

Paul: That’s a little extreme!

Jim: I’m sorry I have to push on this, but listen again.

Jim supports Paul in hearing and acknowledging that, in his statements to Sam, he has reacted to his own disgust at the idea that men could live together. As a child, Paul knew two men who lived together and were the object of many crude jokes in his small town. They were viewed as ridiculous. Paul lived in dread that his own homosexuality might make him equally ridiculous, and this fear was especially linked to the idea of men living together. As Jim and Paul talk about that fantasy and its meaning, Paul is able to see how he reacted in a way that might injure his client. Jim and Paul also work through various scenarios about how to mend the damage. Although Paul cannot undo his earlier statements, he does use the insights gained in his discussion with Jim to provide appropriate support to Sam.

The recognition of the pernicious role of stereotypes has the potential not only to prevent harm but also to promote individual growth and survival strength. The thrust of this example is to suggest that client and therapist must act as monitors, sharing the vig-
ilant watch for homophobia or other kinds of prejudice that might derail the therapy. This is a new kind of equality in the therapeutic relationship, an essential ingredient for cross-cultural work.

A Woman on Her Own

Sandra, a Black woman with AIDS, works with her therapist, Peter, an Asian American gay man. Peter is very comfortable in cross-cultural work and is able to explore differences in a manner that promotes his client's growth.

Sandra: I hated that group. I did not belong in that group with the welfare mother crackheads. Like what was I supposed to do there? Say I'm sorry you're homeless, I just closed a million-dollar real estate deal, and I have AIDS too? It was awful. I was so angry I wanted to rip open every cell in my body and tear out the virus. This virus is taking everything from me!

Peter: What made you most angry?

Sandra: I was looking around the room at all these dope fiends and I was like, I don't think so. This is not me.

Peter: Who are you?

Sandra: What is it with you and this “Who are you” question? I was thinking about you the other day. I said, I know he's gonna ask me this question. I was thinking up smart aleck things to say. But then I thought this is supposed to help me.

Peter: Yeah. It's supposed to help you.

Sandra: Who am I? I'm sad. Can a person be a feeling?

Peter: Why are you sad?

Sandra: It's funny, it's not the AIDS or anything. I mean, it doesn't make sense to me, even. But there was a time when I fit in. I mean if I walked into that room I would have felt close, like I fit, like it was OK—I'm not sure this is clear even to me. It's like I wasn't a self all alone, I was just part of. When I walked in that room I wanted to scream, I'm not this—I'm not poor! I'm not pathetic!—I'm—

I don't know, a real estate mogul. (Snorts in disdain.)

Peter: In my culture, the individual hardly matters compared to the group. To separate, as you have done, is difficult. One loses a lot.

Sandra: (Silent, starts to cry) Isn't that silly? What do a bunch of homeless women have that I need?

Peter: What?

Sandra: Oh just everything. Just love.
Peter: What might a woman do that would let you know she loved you?
Sandra: Comb my hair, cook with me, hold me. Say something like, “Don’t worry, it’ll be all right.”

Sandra, an ambitious and successful career woman, is enraged at the potential loss of class status she expects to experience as a result of her illness. At the same time, attaining that status has meant moving out of her community to function in a man’s world—in reality, a White man’s world. She yearns for the oneness of her youth but is horrified at contact with other women who lack her social and economic achievements. Peter is aware of Sandra’s use of stereotypes to distance herself from others. Peter’s style in therapy is to keep a focus on unraveling her emotions. In order to trace her feelings accurately, he describes a feature of his culture. Although he is asking about differences between their two cultures, the question reveals the special value both place on the life of the group. It helps Sandra recognize that she is yearning for contact with other women.

Peter follows with a question about the ways in which women express concern. This is a key feature of his therapeutic style. He is constantly searching for detail in Sandra’s life. It helps him to understand her; it prevents mistakes that he might make were he to assume commonalities across race, gender, and sexual orientation. This kind of question might appear to be less necessary in an established therapeutic relationship, but, on the contrary, it continues to be of great importance as the relationship matures, reinforcing the connection through the process of discovering the small but real differences between the two parties.

My Therapist, My Friend

This final scenario examines the interaction between Fred, a homeless Puerto Rican man living with HIV disease, and his therapist, Patricia, who is a White lesbian. In this scenario, again, a client expresses stereotypical views, this time directed at the therapist herself.

Patricia: Fred, como esta?
Fred: Muy bien, Patty. But like wait a minute, Patty. Patty, I heard something. I was real upset. I didn’t even want to come talk to you about it. But like you been good to me so I gotta say. Patty, they are saying that your boss is a faggot. What’s up with that?

Patricia: It’s true, Fred. And me, too, Fred. I’m a dyke.
Fred: Patty, why you gotta talk like that? That's not nice. You should watch your mouth. You a nice lady, talking that nasty stuff.

Patricia: Fred, what's so nasty? Don't you call yourself a spic sometimes?

Fred: That's not the same. That's a bad word, but it's not nasty.

Patricia: So what makes dyke a nasty word?

Fred: You know.

Patricia: What? What makes it nasty?

Fred: You know, girls be doing nasty things that they shouldn't be doing.

Patricia: Fred, did you ever do any nasty things?

Fred: I did bad things, but I didn't do no nasty things.

Patricia: What's the difference?

Fred: Like drugs, shooting up, that's bad. I was like an addict and all that. But I like have like with women you know, natural sex. Why you got to say those things to me? You got me all upset and you my friend.

In this scenario, Patricia is confronted with Fred's homophobia. She opens a dialogue that challenges his beliefs about homosexuality as something bad, while at the same time conveying her affection and commitment to him. He is clearly agitated and upset by the news that this person he trusts is “nasty” in a manner that is difficult for him to accept. Yet his acceptance of Patricia could open the way for him to deal with many of the problems that are troubling him. Although he says that he is untroubled by his past needle use, in fact he struggles with shame and guilt about his drug use. Gays are an easy target, allowing Fred to externalize some of his own self-hatred. Patricia must use the strong foundation of her relationship with Fred to get past his prejudices.

Patricia: Fred, remember last week when we had to go to the welfare office?

Fred: So?

Patricia: When we were there, you remember that lady was screaming at that mother? She was saying, “You Indians have too many babies. Why don't you get on birth control?” You said—you remember—you said one thing you were proud of was that you treat people the same. So Fred, how about me? I'm a person.

Fred: You a people. Yeah. And I treat you good. We talk and I got you a card for your birthday. You can't say I don't treat you nice. But you shouldn't do bad things.
Patricia: But Fred, you don’t have to be in my business, do you? I thought we respected that we’re both adults. You do things I think are bad. I do things you think are bad. But we can still be friends; we’re just different.

Fred: I got to like what you do to like you.

Patricia: Well, then maybe you won’t like me anymore now that you know I’m lesbian. I’ll still be here to help you. If you don’t want my help, I’ll get somebody else in the agency to work with you. But Fred, I feel upset that you would throw away all the good times so easily.

Fred: That’s not what I’m doing. I’m not saying I don’t want to work with you. It’s just not what I’m used to.

Patricia: Fred, remember the first time you told me how you robbed old people to get money for drugs? I got to tell you it wasn’t what I was used to either. But I had to get over it because it’s part of what’s been your life. You, your life, I want to help. I’m not here to judge.

Fred: Patty, another thing, we got to talk about. I want to go talk to the doctor about this sore on my hand.

Fred’s abrupt change of subject signals to Patty that she has made her point: he is arguing on weak ground and realizes it’s not a fight worth fighting. Has Fred given up his homophobia? No, he hasn’t. But he has acknowledged that an important person in his life is a lesbian. He also recognizes that Patty has treated him with respect and affection that have been rare in his life. Returning the favor is not much to ask.

In an interesting way, Patricia’s acknowledgment of her homosexuality creates a more level playing field between client and therapist. As a member of a despised group—a group often more reviled than addicts are—Patricia appears vulnerable. Fred has the power to hurt or to protect her. Given the long-standing relationship, he becomes her protector and defender, to himself as well as to others. Her unflinching avowal of her homosexuality impresses him: he never thought she was a wimp, but now he’s even more sure that she’s got the “right stuff.” In his eyes, Patricia becomes “one of the guys.”

In some ways this emphasis on stereotypes must be seen as contradicting the recommendations that cultural sensitivity be attained by learning key facts about the culture of others. The “factoid” ap-
proach emphasizes that Puerto Ricans visit spiritualists and believe in "hot-cold" theories of illness, that Native Americans recognize more than two genders, and that men from New Guinea might run amok. Arthur Kleinman related an anecdote that points out the pitfalls of this quickie anthropology. An eager medical student, having recently completed a course on medicine and culture, asked his patient, a prominent Black banker, if he carried a mojo (traditional folk medicine sack). The banker chuckled at being asked such a preposterous question; the student was chagrined.

Brief descriptions of cultures cannot be applied to individuals. Cultures are created and sustained by the interactions of groups of people in a particular place at a particular time. The beliefs of the group may govern the actions of the individual, but they cannot be assumed to define the individual. Although learning from the individual about his or her cultural background is indispensable, learning about the culture and applying that to the individual is counterproductive.

In an increasingly complex world fraught with racial hatred and other divisions between groups, we must commit ourselves to a plan of work that takes seriously the task of getting to know the individuals in our care. Careful attention to an individual's life story, philosophy, and worldview must be the basis for a therapy that goes beyond stereotypes.

Notes
1. The cartoons mentioned in the text are from "Black in America," a double issue of the New Yorker, Apr. 29 and May 6, 1996, pp. 90, 101.


Part Three

Distress and Disorder
Helping Clients with Psychiatric Conditions

Adjusting to living in the HIV epidemic is a complex process. For many, it is made even more complicated by preexisting psychiatric conditions or by psychiatric disorders that may arise out of the experience of having HIV disease or of facing multiple loss.

Therapists working on the front lines of the epidemic need to be aware of HIV-related psychiatric disorders and be prepared to identify problems as they arise. They need not feel that they should be able to treat all of these conditions; in fact, without special training, counselors should refer these clients to other providers.

As we head into the third decade of HIV disease, HIV-related psychiatric disorders have changed less in substance than in form. For example, HIV-associated dementia is less common today than was once anticipated, and it is more amenable to treatment. Other disorders express themselves in terms of current HIV-related issues—for example, treatment failure and adherence, or an ever-deepening and unresolved bereavement—and the use of psychopharmacological agents has become much more complex in the context of combination antiviral treatments. Other challenges—in particular, working with those with triple diagnoses—are complexes of familiar symptoms or disorders that combine to create new conditions that may or may not be treatable using old interventions.

The fact remains, however, that many of these disorders are familiar, defined as they have always been by the Diagnostic and
Statistical Manual. As with everything related to HIV disease, such familiar characteristics can help providers ground treatment in what they know (and their sense of their own abilities to treat clients), which is a boon as long as such confidence does not obscure the complicating effects of a life-threatening disease. Part Three serves to remind providers of the most common HIV-related psychiatric disorders and highlights important treatment protocols.
Chapter Eleven

Anxiety and Depression
Mood and HIV Disease
Dan H. Karasic
James W. Dilley

Despite promising advances in the medical treatment of HIV, people living with the disease must learn to cope with a variety of stressors and frequently find themselves struggling to manage shifts in mood—some related to HIV disease and some related to underlying affective disorders. Mood states commonly associated with HIV-related coping range from momentary sadness and anxiety or anger to major depressive or full-blown anxiety disorders. In addition, because HIV infects the central nervous system, people with HIV can develop mood disorders associated with primary brain infections; these are classified as organic mood disorders.

Distinguishing mood states directly related to HIV from those that underlie and are exacerbated by it is crucial to treatment, and therapists must be prepared to assess a client’s presentation, determine the cause, and employ a combination of psychotherapy and psychopharmacology to respond. The good news is that major depression, in particular, once believed to be synonymous with HIV disease, is now known to be much less common among seropositive people than previously thought; the less-than-good news is that...
when it does exist it can be devastating and can complicate not only quality of life but also medical care. This chapter reviews known information about the relationship between HIV disease and depression, organic mania, and anxiety disorders, and describes currently accepted treatment approaches.

**Prevalence of Depression and Anxiety**

Early in the course of the AIDS epidemic, several researchers reported significant rates of “depression” among adults with HIV disease. These rates ranged from 1.4 percent to 43 percent for major depression and 13 percent to 54 percent for diagnoses of adjustment disorder with depressed mood. Citing the stress and uncertainty of living with a stigmatizing, life-threatening disease that was previously unknown, these reports were based largely on data collected from hospitalized patients. However, because they reported on clients referred for psychiatric evaluation, some early studies overestimated the prevalence rates of depression in people with HIV disease, leaving the perception that significant depression was an almost inevitable result of living and coping with HIV disease.

More recent studies have shed new light on the subject of depression in people with HIV, and their results have greatly altered this perception. For example, longitudinal studies of nonhospitalized individuals reported much lower rates of clinically significant depression than did earlier samples. Self-report data from a population-based sample of gay and bisexual men in San Francisco found a 20 percent rate of depression among 257 seropositive gay and bisexual men. These findings are similar to a New York study that also found on self-report a 32 percent rate of depression among a more diverse sample of 106 seropositive men and women one year after each received a positive test result. In the New York study, however, elevated depression scores were not associated with whether subjects tested seropositive or seronegative; rather, they were associated with preexisting depression and were higher in female, heterosexual, and injection drug–using subjects.

A study of sixty-one gay men, all of whom were examined at the time of HIV antibody testing, found that the twenty men who tested seropositive showed no more psychological distress one year
later than those who tested seronegative. A study of fifty heterosexual men and women found no difference in anxiety or depression scores between asymptomatic seropositive subjects and seronegative subjects. Finally, another study of fifty-seven seropositive women found low rates of psychiatric disorders.

**Standardized Diagnostic Interviews**

In studies using standardized diagnostic interviews to make the diagnosis of major depression, trained clinical interviewers examined nonclinical samples and found considerably lower rates of major depression. For example, a small San Diego study using the Structured Clinical Interview for Diagnosis (SCID) found that 11 percent of 45 seropositive gay and bisexual men rated a diagnosis of major depression. A study of 442 seropositive men in the military found higher rates of preexisting mood and substance use disorders but also found that 15 percent had current anxiety or depressive symptoms necessitating mental health referral. The study also found that 17 percent of those testing seropositive had serious suicidal ideation and 6 percent qualified for a diagnosis of major depression. Another study of 43 seropositive women found low rates of psychiatric disorder, except sexual dysfunction.

Also using the SCID, a Columbia University study found a 6 percent rate of major depression in a longitudinal study of 124 seropositive gay and bisexual men. Similarly, low rates (also 6 percent) of depression occurred in a sample of 53 “long-term survivors” recruited through the Gay Men’s Health Crisis in New York. These men may not be completely representative of people with HIV disease, but they present an important reference group: they had lived with an AIDS diagnosis for at least three years; they all had had at least one opportunistic infection; most of the men had been told on one or more occasions that he had only a few months to live; most were unable to work; and many had watched friends die from AIDS. Despite these characteristics, nearly all “maintained the conviction that good times lay ahead and that their lives were worthwhile.”

Not surprisingly, higher rates of major depression have been found among injection drug users with HIV disease. Unpublished data from New York found that 23 percent of roughly equal-size
groups of seropositive and seronegative subjects, including both men (147 subjects) and women (76 subjects), had a current depressive disorder. Although the rates of depressive and anxious symptoms were greater than those of the general population, they were no greater than rates for injection drug users in other studies. The authors suggest that HIV status may be less critical in determining mood disorder among injection drug users than the overall degree of psychopathology in this population.

**Stability of Mood Symptoms over Time**

There is disagreement over the stability of mood over time among people with HIV disease. In a recently published study of 112 seropositive men, researchers demonstrated that over the course of nine semiannual evaluations and despite substantial HIV disease progression, there was no significant increase in clinical or symptomatic depression or anxiety. The study also found that psychopathology did not predict death. Similarly, a study of 436 gay and bisexual men found that psychiatric symptoms did not increase over three years of living with HIV disease.

In contrast, among 911 seropositive men in the Multicenter AIDS Cohort Study (MACS) followed as they progressed to AIDS, there was a significant increase in depressive symptoms beginning twelve to eighteen months prior to a subject’s AIDS diagnosis. Clinicians at the San Francisco General Hospital AIDS Clinic have observed that the onset of new HIV-related physical symptoms, especially pain, often relates to the onset of a depressive disorder. An increase in depressive symptoms associated with pain has also been noted by other researchers.

Taken together, these data strongly suggest that the rate of depressive and anxiety disorders among nonclinical samples of gay men with HIV is lower than initially believed. It appears that the rates of depression found in these samples of people with HIV are consistent with studies of other life-threatening illnesses, notably cancer.

Although the psychological and physical challenges of living with HIV and possibly a shortened life span may cause transient symptoms of sadness and anxiety, it is clear that clinical disorders of depression and anxiety in this population are the exception, not
the rule. In light of new antiviral treatments, it is possible that mood disorders caused by failing health may diminish in number. However, as is becoming more clear each day, other challenges to mood emerge as some clients feel better physically yet struggle to cope with the realities of other problems in their lives that had been eclipsed by their failing health. (See Chapter Nine for more on the psychosocial implications of the new treatment paradigm.)

Because the negative consequences of depressive and other mood disorders on quality of life and on social and occupational functioning can be severe, clinicians working with HIV disease must be alert for symptoms and signs of depression and anxiety in their clients. For those clients in whom mood or anxiety disorders are suspected, clinicians should initiate treatment promptly.

**Diagnosis and Treatment of Mood Disorders**

Changes in mood are a natural part of living. People normally feel sadness and elation in response to the range of experiences and thoughts that occur daily. There are times when the expected emotional response may be a prolonged period of depressed mood: for example, when grieving the loss of a loved one.

A depressive disorder occurs when sadness persists, is out of proportion to the degree of stress experienced, or when everyday functioning deteriorates. Mood states with persistent sadness become clinical syndromes when they pass certain thresholds for severity and duration and are categorized by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* as bereavement, major depression, adjustment disorder with depressed mood, and dysthymia. These categories are necessary because each has implications for defining illness, prognosis, and treatment. A brief review of each category offers providers descriptions to inform clinical practice.

**Bereavement**

Bereavement encompasses a common range of reactions to the death of a loved one. Its symptoms are similar to those of major depression; for example, periods of sadness, loss of appetite or weight, and difficulty sleeping may be present. The survivor may also have feelings of guilt about things he or she “might have done,” and
thoughts may focus on wanting to be dead, perhaps to be joined with the deceased. The proportion of the day preoccupied with the deceased and with feelings of sadness tends to decrease with time; however, it is common that these thoughts and feelings will recur at times, months and years later, rekindled by reminders of the loss. Bereavement usually does not result in a depressive disorder. However, if persistently depressed mood lasts more than two months, or if impairment of everyday functioning, suicidal ideation, or preoccupation with feelings of guilt and worthlessness persists, bereavement may be complicated with major depression (see Chapter Twelve for a more in-depth discussion).

Bereavement may be particularly difficult for people living with HIV disease. The grieving process for some seropositive people may be near-continuous at times, as one friend, partner, or family member after another dies. The seropositive person also grieves for the continuing losses in his or her own life. He or she may lose career, goals, home and other possessions, a positive body image, and a sense of autonomy, as well as a community and support system. An initial response to such loss may be numbness, when the alternative emotion is to feel overwhelmed with grief or anxiety. This sense of numbness may persist as losses accumulate faster than a person can assimilate prior losses.

In a study of bereavement in gay men, researchers found that common grieving processes occurred but usually did not result in major depressive episodes, and depressive symptoms were not related to the number of loved ones lost. However, bereaved people living with HIV disease may suffer greater distress than those who are seronegative. In addition to the cumulative load of both interpersonal and individual losses, the death of a loved one brings up the issue of a seropositive bereaved person's own mortality. A death perceived as painful or humiliating may provoke fear that the grieving person's dying process will be similarly difficult. The seropositive caretaker of a partner with HIV disease may also fear that he or she will die alone.

Although symptoms diminish with time and without treatment for most bereaved people, psychotherapy, medication, or both may alleviate discomfort and facilitate a return to normal functioning. For the bereaved person who alternates between repressing grief and feeling overwhelmed by it, the psychotherapist may work on
improving coping skills. Research has long demonstrated that people with HIV disease who are able to take direct action to address life stressors ("active-behavioral coping"), rather than evading confrontation with these issues ("avoidance coping"), suffer less anxiety and depression.28 Therapists can work to strengthen their clients' problem-solving skills and can teach relaxation techniques so that clients feel better able to manage the grief process without feeling overwhelmed and to master feelings of anxiety. For some clients, a focus on past or present interpersonal relationships may be helpful, for example, when there are ambivalent or hateful feelings toward the deceased or when the bereaved person needs help adjusting old relationships or developing new ones. Bereavement groups may be a source of psychosocial support, and group members may model adaptation skills for one another.

Short-term use of medications may also reduce suffering during bereavement. Benzodiazepines such as lorazepam or clonazepam can be used to treat persistent or overwhelming anxiety. Benzodiazepines—such as temazepam—trazodone, or other sedatives such as zolpidem can be used to treat short-term insomnia commonly related to bereavement.

Major Depression

When depressed mood persists and affects functioning and outlook in a pervasive way, a client may be suffering from a major depressive episode. It is critical to quality of life that this clinical syndrome not be missed, because major depressive episodes respond readily to treatment. Symptoms include loss of interest in usually pleasing activities or interests; insomnia; decreased energy; loss of appetite or eating more than usual—resulting in weight loss or gain; crying spells; suicidal ideation; loss of libido; and difficulty concentrating. (See Exhibit 11.1 for a more detailed description.) It is important to note that several symptoms of depression may be due to HIV disease rather than mood:

- Weight loss may be caused by wasting syndrome or other physical illness.
- Loss of appetite may be caused by gastrointestinal disease or nausea from medications.
Exhibit 11.1. Diagnostic Criteria for Depression.

A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (for example, feels sad or empty) or observation made by others (for example, appears tearful). Note: In children and adolescents, can be irritable mood.

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

3. Significant weight loss when not dieting, or weight gain (for example, a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (for example, a drug of abuse, a medication) or a general medical condition (for example, hypothyroidism).

E. The symptoms are not better accounted for by Bereavement; that is, after the loss of a loved one, the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

• Sleep may be affected directly by HIV disease and also by HIV-related medications.
• HIV-related cognitive impairment may cause psychomotor slowing and difficulty thinking or concentrating.
• Fatigue may surface either early or late in the course of HIV disease.
• Recurrent thoughts of death may arise as new physical symptoms amplify fears of mortality.

In diagnosis, focus on the client’s history and on symptoms not likely to be related to HIV disease. Does the client feel sad most of the time? Is he or she uninterested in or unable to enjoy the usual activities that he or she is physically able to do? Has he or she been more focused on negative thoughts? Do any of the symptoms have a discrete time course that is not explained by physical illness? Does the client have a history of major depression? Is there a familial history of depression?

It is possible to confuse the apathy and blunting of affect caused by HIV-related cognitive impairment with depression. However, organic brain disease may cause a bona fide depression. To differentiate between depression and cognitive impairment, look for persistent feelings of sadness and negative thoughts, which indicate depression, or more prominent and persistent cognitive problems such as memory loss or disorientation, which indicate cognitive impairment (see Chapter Fourteen).

Alcohol and stimulant (cocaine or amphetamine) abuse, and sometimes opiate withdrawal, can also mimic symptoms of depression. A period of sobriety is usually necessary to distinguish whether or not the depression is directly substance induced or whether treatment for depression, in addition to substance abuse, is necessary. The client who has not used drugs or alcohol in the previous month but continues to meet symptom criteria for a major depressive episode merits treatment specific for depression (see Chapter Fifteen).

Finally, because it is sometimes impossible to fully differentiate among the depressive symptoms caused by various underlying medical disorders and those caused by depression, providers should give clients the benefit of the doubt. In other words, diagnose depression independently of the medical problem if it appears the client is depressed. Because newer antidepressants with relatively few side
effects are available, antidepressant treatment can be initiated, and the clinical outcome of this treatment can be quickly assessed. If the client does not respond, antidepressant medication can always be stopped. The client will not have been harmed by this intervention and will likely have benefited. The depressed client who is not treated because of uncertainty about whether he or she completely fulfills diagnostic criteria will continue to suffer needlessly.

Adjustment Disorder with Depressed Mood and Dysthymic Disorder

Adjustment disorder with depressed mood is diagnosed when clinically significant depressive symptoms develop within three months of an identifiable stressor, but the symptoms are not sufficient enough to meet criteria for a major depressive episode. Treatment usually centers on psychotherapy rather than medication. Short-term cognitive-behavioral therapy emphasizing improving coping skills, as described later in this chapter, may be particularly useful. Dysthymic disorder refers to chronic depressive symptoms lasting more than two years (often present since childhood or early adulthood) that are not severe enough to meet criteria for a major depressive episode. Antidepressant medication and psychotherapeutic approaches may be useful; however, dysthymic symptoms often respond poorly to treatment.

Treating Major Depression

Psychotherapy and pharmacotherapy are often used together to treat depression. For many clients, these different modes of treatment can work synergistically. Similarly, symptoms that do not respond to one modality may respond to the other. Clients with severe, persistent depression, however, should always be assessed for pharmacologic treatment.

Antidepressant Medications

There is an ever-expanding selection of antidepressant medications, and more are being developed or improved upon. Among those now available are tricyclics, selective serotonin reuptake in-
hibitors (SSRIs), bupropion, trazodone, venlafoxine, nefazodone, and mirtazapine. Clients with asymptomatic HIV disease may be treated with the same dosages as seronegative patients; however, those with more advanced illness should be treated initially with half the usual starting doses, raising dosage only after it is clear the client is tolerating the medication.

SSRIs are the most commonly prescribed antidepressants. They include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), and fluvoxamine (Luvox). SSRIs are very safe drugs and even in overdose situations do not threaten life. They are just as effective for depression as the tricyclic antidepressants, without the latter’s difficult side effects. However, SSRIs can cause nausea, jitteriness, insomnia, and sexual dysfunction. The most common sexual dysfunction is delayed ejaculation, but impotence and loss of sexual desire also occur. These side effects frequently diminish with time or if the dosage is reduced and cease when the drug is stopped. In addition, other medications may be prescribed to treat sexual dysfunction.

For most clients, however, side effects are mild and tolerable when compared to the benefits of improved mood. Because side effects are often most bothersome early in treatment and because significant improvement of depressive symptoms takes two to six weeks of treatment, clinicians need to encourage clients to remain on their medications during this early period. Clinicians should also be ready to switch clients to an antidepressant with a different side-effect profile.

Among the tricyclic antidepressants, it is best to avoid those with greater anticholinergic side effects (causing dry mouth and sometimes constipation) and orthostatic side effects (causing dizziness or faintness when blood pressure falls abruptly after a person rises from lying to sitting or standing), like amitriptyline (Elavil). Desipramine and nortriptiline have fewer of these side effects and are effective for depression as well as for treating the pain associated with peripheral neuropathy. Although most clients tolerate desipramine and nortriptiline well, tricyclic side effects may include anticholinergic and orthostatic side effects, urinary retention, lightheadedness on standing up, increased heart rate, and cognitive impairment, and the drugs may cause the heart to stop on overdose.
For clients in whom insomnia is the most prominent symptom, trazodone (Desyrel) is helpful, but its side effects of morning grogginess and orthostatic hypotension may prevent an effective antidepressant dose from being reached. Bupropion (Wellbutrin) is a stimulating antidepressant, without the sexual dysfunction caused by SSRIs. It is somewhat more likely to lower seizure threshold. The newer slow-release form (Wellbutrin SR) has reduced seizure risk and has been well tolerated by clients at the San Francisco General Hospital AIDS Clinic. It may be helpful for clients who do not respond to the SSRIs, for clients who discontinue SSRIs due to sexual dysfunction, and for those with fatigue accompanying depression. Bupropion may also aid in smoking cessation.

Nefazodone (Serzone) is an SSRI as well as a postsynaptic serotonin blocker and has a low rate of sexual dysfunction side effects. Nefazodone may be helpful with anxiety accompanying depression but sometimes causes excessive sedation or nausea. Mirtazapine (Remeron) is also less likely to cause sexual dysfunction and is helpful for insomnia accompanying depression. Venlafaxine (Effexor) is a serotonin as well as norepinephrine reuptake inhibitor and may be useful for people who do not respond to SSRIs. In people with advanced AIDS and with apathetic withdrawal as the most prominent depressive symptom, the psychostimulant methylphenidate (Ritalin) may improve functioning or mood.

Psychotherapy

Psychotherapeutic treatment for depression may be effective for motivated patients who prefer not to take antidepressants, or it can be used in conjunction with antidepressants. There are a variety of cognitive and behavioral approaches that are appropriate to the full range of depression-related issues. Structured group therapy emphasizing active-behavioral coping skills and teaching relaxation techniques and problem-solving skills has been effective in treating depression in people with HIV disease. Long-standing changes in coping skills have also been achieved through brief psychotherapeutic interventions, other cognitive-behavioral and supportive group psychotherapies, and interpersonal psychotherapy, which focuses on role transitions and interpersonal losses, on acquiring social support, and on improving problem solving.
A wide variety of issues may affect a person’s ability to cope with HIV disease and with depression. Among these are adapting to loss (as discussed previously); disclosing HIV status to family, friends, employers, or intimate partners; facing dependency—including loss of control, reemergence of childhood issues, and rage at caregivers; addressing long-standing self-esteem issues; and examining suicidal feelings. Suicidality may be a symptom of a treatable depression or of a pain syndrome. Most commonly, thoughts of suicide help clients maintain a sense of control, a sense that there is a means to end their suffering if necessary. Usually these feelings remain theoretical, in the distance. Imminent suicidal feelings, especially if a client has made concrete plans, require immediate assessment and intervention.

Relationship issues are often a focus in psychotherapy for mood disorders. Maintaining stable relationships in an environment of bereavement and loss is a challenge, and illness may further disrupt long-standing roles in a relationship. Sexual dysfunction may disrupt patterns of physical intimacy. Finally, career loss and financial difficulties may create stress within a relationship.

**Organic Mania**

An organic manic syndrome has been associated with HIV disease.\(^{36,37}\). Its symptoms include elevated or irritable mood, insomnia, pressured speech, grandiosity, racing thoughts, distractibility, rapid speech, restlessness, and reckless or disinhibited behavior. In clients with no prior history of affective illness, this manic syndrome is often accompanied by HIV-related cognitive impairment and other evidence of a physical basis, such as abnormalities that would show up on a magnetic resonance image of the brain.\(^ {38,39}\) It has been suggested that these manic episodes are caused by the process that leads to HIV-associated dementia.\(^ {40}\)

In other clients, manic episodes are likely exacerbations of preexisting bipolar disorder and are not usually accompanied by dementia. They may also follow the routine administration of high-dose steroids for *Pneumocystis carinii* pneumonia in patients hospitalized for medical reasons. Other cases of manic syndromes are associated with amphetamine and cocaine abuse and with antidepressant medications, and there have been case reports of mania associated with ZDV treatment.\(^ {41}\)
Clinicians should seek to investigate and treat the underlying organic causes of mania. Neuroleptic drugs may bring about the fastest resolution of manic symptoms and are effective in treating the condition’s initial agitation. Newer “atypical” neuroleptics (for example, olanzapine) are particularly useful in controlling psychosis and manic agitation and have a much lower risk of extrapyramidal side effects (stiffness and muscular rigidity) than older neuroleptics. Conventional medium-potency neuroleptics (for example, perphenazine), which are generally well tolerated, may be started at low doses; higher doses of high-potency neuroleptics, such as haloperidol, frequently cause extrapyramidal side effects in people with AIDS.

Neuroleptic drugs, if well tolerated, may be used for long-term treatment but may result in tardive dyskinesia (a nonreversible neuromuscular disorder characterized by lip-smacking or chewing motions and seen in the chronically mentally ill who have taken high doses of neuroleptics over time). Clinicians therefore use mood-stabilizing medications for ongoing management. For example, divalproex sodium is well tolerated and effective, although its side effects include stomach discomfort, sedation, and an increase in liver enzymes. Lithium carbonate is also effective; however, because there appears to be a greater sensitivity to lithium side effects in clients with organic mania, initial blood levels of the drug should be targeted slightly lower than usual. In addition, clinicians should monitor lithium serum levels carefully, because clients with AIDS are particularly susceptible to toxicity secondary to dehydration or renal disease.

Finally, carbamazepine (Tegretol) may also be used to treat mania; however, among clients with preexisting bone marrow suppression, it may reduce the capacity or efficiency of the bone marrow in creating new blood cells. Newer anticonvulsants such as lamotrigine and gabapentin show promise, but there is insufficient evidence yet to recommend these except as second-line treatments.

**Anxiety Disorders**

People with HIV disease may be attempting to cope with social losses, family conflicts, occupational transitions, financial uncertainty, and the uncertainty of the disease process. Under these cir-
circumstances, periods of anxiety are normal. Although there is a wide range in the amount of anxiety a person may experience—some people having by nature an "anxious temperament"—most people are able to respond psychologically and behaviorally to the stress of living with HIV disease and limit the impact of anxiety on the quality of their lives. Only a minority of people—those with anxiety disorders—suffer anxiety of an intensity and duration that causes prolonged impaired functioning. In addition, persons with AIDS with poor coping skills tend to be more anxious.

**Anxiety and Coping**

Active-behavioral coping—taking direct action to address the stressor—is the most effective coping style for reducing anxiety. Active-cognitive coping—forming a mental framework or strategy to respond to the stressor—is of intermediate effectiveness. Avoidance coping—attempting not to address the stressor, for example, by increasing substance use or isolation—is least effective.

The anxious client can learn to cope more effectively with illness-related stressors, often through brief psychotherapeutic interventions. By identifying both overt and covert sources of anxiety and responding to maladaptive defenses, therapists can help clients develop coping tools. Studies in cancer patients have shown that changes in coping style are long lasting and can affect not only anxiety but also the course of illness.44

Structured group therapy has demonstrated efficacy in teaching and encouraging active-behavioral coping techniques.45,46 Among these techniques are problem-solving and communication skills, and relaxation—for example, progressive muscle relaxation, guided imagery, and self-hypnosis. Problem-solving and communication skills training give clients tools to allow them to address stressors more directly. Relaxation techniques foster a sense of internal control over anxiety that helps prevent anticipatory anxiety, which may inhibit clients from actively addressing stressors. The group format allows members to practice newly learned coping skills through role-playing stressful situations, facilitates learning adaptive skills from other group participants, and helps reduce social isolation and thus may encourage more active coping.
Severe Anxiety

Severe, persistent anxiety, affecting day-to-day functioning, may be a symptom of a DSM-IV anxiety disorder. Anxiety disorders include generalized anxiety disorder, panic disorder, agoraphobia, specific and social phobia, obsessive-compulsive disorder, acute stress disorder, substance-induced anxiety disorder, anxiety disorder due to a general medical condition, adjustment disorder with anxious mood, and Post-Traumatic Stress Disorder. Accurate diagnosis is helpful in determining treatment, which varies somewhat between the different disorders.

Panic Disorder

Panic disorder is characterized by the sudden onset of severe anxiety, with a fear of losing control or dying, and somatic symptoms. Although they may be infrequent, these episodes are so traumatic that the person develops a persistent worry or anticipatory anxiety that the attacks will recur. Agoraphobia is the fear of being in places in which escape would be difficult in the event of panic symptoms, such as in a crowd, on a bus, or in a car on a bridge. An agoraphobic person avoids these situations, often by staying home. Panic disorder and agoraphobia respond well to treatment. Cognitive-behavioral therapy has been particularly effective. Antidepressants, including SSRIs and tricyclics, are also effective in preventing or reducing the number of panic attacks. Dosages are similar to those for treatment of depression; if a more stimulating antidepressant such as fluoxetine or desipramine is used, clients should start at a lower than usual dose. Benzodiazepines have the advantage of working more quickly than antidepressants and may be used for immediate relief until the antidepressant takes effect. Long-term benzodiazepine use has the disadvantages of creating dependency and of rebound anxiety with discontinuation.

Generalized Anxiety Disorder

In generalized anxiety disorder, there is excessive worry or anxiety present most days for at least six months. A range of psychotherapies may be effective in response. Relaxation techniques may also be helpful. Pharmacologic treatment includes using buspirone (Buspar); although it takes days to weeks to be effective, it can treat anxiety without affecting cognition or creating dependency.
Adjustment Disorder with Anxious Mood

Adjustment disorder with anxious mood is similar to adjustment disorder with depressed mood described earlier. Treatment includes individual or group psychotherapy; cognitive-behavioral therapies for depression also reduce anxiety symptoms. Training in relaxation techniques can increase a client’s sense of internal control. Buspar or short-term benzodiazepine therapy may also be helpful.

Post-Traumatic Stress Disorder

In Post-Traumatic Stress Disorder (PTSD), the client has symptoms for more than a month after experiencing a severe trauma. The symptoms are of three types:

- Reexperiencing the event—for example, through flashbacks, dreams, or in response to a cue that raises memory of the traumatic event
- Engaging in avoidance and numbing
- Experiencing increased arousal or feeling “edgy”

Treatment includes individual and group psychotherapy, and antidepressants. Acute Stress Disorder is similar to PTSD but lasts less than a month; dissociative symptoms are prominent.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder usually precedes HIV infection, but HIV disease may become a focus for the obsessive thoughts. The SSRIs—at higher doses and for longer periods than when used for depression—deliver effective treatment, preferably in combination with behavioral therapy. Phobias, which are anxiety disorders characterized by fear and avoidance of particular situations, respond well to behavioral therapy.

Substance-Induced Anxiety Disorder and Anxiety Disorder Due to a General Medical Condition

The key to treating substance-induced anxiety disorder and anxiety disorder due to a general medical condition is to identify and treat the underlying cause. Alcohol or benzodiazepine withdrawal and amphetamine and cocaine intoxication are common causes of anxiety. Hypoxia, or decreased oxygen in the blood, as caused
by *Pneumocystis carinii* pneumonia, may present with symptoms of anxiety. Steroids used in the treatment of pneumonia may also exacerbate the anxiety. In addition, other cardiorespiratory disease as well as central neurological conditions may present with anxiety.

**Drug Interactions**

Protease inhibitors and medications used to treat mood and anxiety disorders may interact. Protease inhibitors, ritonavir (Norvir) in particular, are powerful inhibitors of the various P450 isoenzymes that metabolize antidepressants, benzodiazepines, and neuroleptics. For example, people on tricyclic antidepressants should cut their dosages by one half to two thirds, at least initially, and check blood levels to establish a safe and effective dose. Bupropion is completely contraindicated with ritonavir. SSRIs and nefazodone may also increase protease inhibitor blood levels; however, the clinical significance of this interaction is not known. Although the SSRIs have a very wide therapeutic window, without the danger of overdose of tricyclics, SSRI doses should initially be cut also by one half to two thirds, then increased again as needed for therapeutic response.

The benzodiazepines lorazepam (Ativan), temazepam (Restoril), and oxazepam (Serax) do not interact with ritonavir. Other benzodiazepines such as diazepam (Valium) or clonazepam (Klonopin) do, so clients should switch to lorazepam prior to beginning ritonavir treatment. Those on other benzodiazepines, such as triazolam (Halcion) and flurazepam (Dalmane), should switch to temazepam for treatment of insomnia.

Neuroleptic doses should be decreased prior to starting ritonavir, and clients should be closely monitored. Pimozide (Orap) is contraindicated. Among mood stabilizers, carbamazepine levels are affected by ritonavir, but valproic acid and lithium levels are not. Other protease inhibitors have much smaller effects on psychotropic drug levels. However, triazolam and pimozide may interact with other protease inhibitors and should be avoided.

Transient sadness and anxiety are a normal part of living, and especially of coping with the stresses of living with HIV disease. Mood symptoms that are severe and persistent and affect daily function-
ing are much less common. Because mood disorders can severely affect quality of life and also respond well to treatment, it is critical that these disorders not be overlooked. Clinicians working with people with HIV disease should be aware of characteristic symptoms and make appropriate referrals for treatment when they suspect a psychiatric disorder.

Finally, considering the safety and efficacy of treatments for depression and anxiety disorders, it is advisable to err on the side of treatment. Medications can always be stopped if they are not helpful, but a client with an untreated mood disorder is left to suffer in silence.

Notes


19. Ibid.


43. Halman, Worth, Sanders, and others, “Anticonvulsant Use.”
45. Targ, Karasis, Diefenbach, and others, “Structured Group Therapy.”
47. American Psychiatric Association, DSM-IV.
48. Ibid.
49. Targ, Karasis, Diefenbach, and others, “Structured Group Therapy.”
Chapter Twelve

The Clinical Management of AIDS Bereavement

Peter B. Goldblum
Sarah Erickson

Despite new treatments that prolong the lives of people with HIV disease, deaths continue to occur, and the burden on caregivers remains significant. Like the epidemic of HIV, the epidemic of HIV-related grief is far from over. Even with a 12 percent decline in mortality, twenty-two thousand Americans died of AIDS in the first six months of 1996. It is still too early to determine the long-term effect of medical breakthroughs on mourners, but if anecdotal evidence is accurate, recent accounts suggest that mourners experience dismay at the idea that their loved ones may have just missed the opportunity to extend their lives.

Although AIDS bereavement presents some unique challenges, the human experience of grief is universal. A recent New York study found that people mourning HIV-related losses experience grief symptoms—including numbness, denial, and preoccupation with the deceased—similar to those faced by other bereaved individuals. To the extent that we allow ourselves to develop strong emotional attachments to others, we open ourselves to the experience of loss when these ties are severed.

In addition to the stigma associated with AIDS, homosexuality, and substance abuse, the likelihood of multiple losses due to the epidemic increases the burden for people with HIV disease and those who care for and mourn them. Further, and in contrast to
most life-threatening illnesses, HIV disease has affected disproportionate numbers of young and middle-aged people. The resulting premature death may increase the risk of prolonged or pathological grief reactions in loved ones.9

In the gay and bisexual community, the experience of HIV-related bereavement is not a randomly distributed event.6 Those men who have a history of high-risk sexual behavior are not only more likely to be infected but are also more likely to lose one or more friends to the disease. In fact, men who are HIV-infected are almost twice as likely to have lost a loved one than are uninfected men.7 This places HIV-infected gay and bisexual men in a dilemma: on one hand, the gay community can provide support and assistance in facing the epidemic; on the other, integration into the gay and bisexual community increases one’s risk for multiple losses due to the disease. Likewise, uninfected people who are closely connected to the gay and bisexual community may seek community support to face the challenges of HIV-related bereavement and multiple loss and at the same time risk further grief. Although research evidence is lacking, this dual aspect of community integration is probably similar for other groups with high infection rates, such as injection drug users.

This chapter proposes a coherent clinical model for assessing and treating HIV-related bereavement. The model is based on general bereavement theory and HIV-specific research, including preliminary findings from the Stanford AIDS Caregiving and Bereavement Study.8 Throughout the chapter, the term bereavement refers to the emotional and behavioral reaction to a loss due to the death of a loved one and encompasses both grief and mourning. Grief refers to the subjective emotional experience that follows the psychological recognition of a loss. Normal grief is often difficult to distinguish from a range of psychological disorders, most often depressive disorders. Mourning refers to the process in which individuals strive to adapt to loss and attenuate grief.

Several authors have described the mourning process and ways individuals successfully manage bereavement. In his classic work Attachment and Loss, John Bowlby identified four stages in the typical mourning process: numbing, yearning and searching, disorganization or despair, and reorganization.9 In contrast to describing stages of mourning, J. William Worden identified four tasks that
must be accomplished before mourning is complete. By focusing on tasks, Worden emphasized intentional change on the part of the mourner, rather than the passage of time, as the most important factor in successful resolution of grief. Worden emphasizes intentional change to complete the mourning process, an approach that differs from Bowlby’s and others’ stage theories, which describe the passage of time as leading to a natural resolution of grief. Worden’s four tasks are to accept the reality of the loss, to experience the pain of grief, to adjust to an environment in which the deceased is missing, and to withdraw emotional energy and reinvest it in another relationship.

Within the context of these theories, this chapter outlines a model that separates responses to the loss of a loved one into four bereavement outcomes: uncomplicated mourning, uncomplicated mourning with risk factors, complicated mourning without psychological disorders, and complicated mourning with psychological disorders. Uncomplicated mourning is the adequate management of the bereavement process; the mourner successfully moves through the stages and tasks of mourning consistent with his or her own values and cultural norms. The chapter also identifies ten risk factors of bereavement distress.

**Clinical Assessment of AIDS Bereavement**

Although differential diagnosis of psychological disorders requires a mental health specialist, primary care professionals and community members are frequently called on to identify and respond to problems arising from bereavement. The assessment model described here can also be used to develop a full spectrum of services for people dealing with HIV-related bereavement.

**Risk Factors for AIDS Bereavement Distress**

Certain relationships, behaviors, or personal characteristics place people at risk for *bereavement distress*, a term that encompasses as separate entities both complicated mourning and the psychological disorders that may be associated with bereavement. The risk factors outlined in this section and summarized in Exhibit 12.1 have been compiled from empirical studies on both HIV-specific and general bereavement.

1. Being a caregiver, primary partner, parent
2. Experiencing multiple losses
3. Being HIV-infected
4. Experiencing interpersonal conflict and perceiving a lack of social support
5. Engaging in substance abuse or experiencing substance dependency
6. Experiencing guilt and low self-esteem (including internalized homophobia)
7. Being pessimistic
8. Engaging in avoidance and ineffective coping (including ruminative coping)
9. Experiencing cumulative life stressors
10. Having preexisting psychological disorders

Being a Caregiver, Primary Partner, or Parent
Although AIDS caregiving responsibilities often fall to primary partners, a variety of caregiving arrangements include parents, friends, and community volunteers. Research with gay men suggests that caregivers, both the partners and mothers of HIV-infected people, are at increased risk for psychological distress.11 The Stanford study found that gay male caregivers in all HIV categories—seropositive, seronegative, with AIDS, and untested—had high levels of depressive symptoms, regardless of their own health status.12 Further, their risk for psychological distress was independent of their having many close friends affected by HIV disease (including deaths and diagnoses). These results suggest that the demands of the caregiving role supersede any palliative or deleterious effect of personal health or multiple loss.13

Although there is little empirical data, clinical observation suggests there is added strain on parents who mourn a loss to HIV disease, and it is notable that parental mourning is, in itself, a predictor for complicated bereavement. Parents of both gay men and injection drug users may be estranged from their children due to lifestyle conflicts, and this estrangement may lead to an exacerbation of guilt and remorse after the death of a child. In addition,
parents of young children in the injection drug–using community are likely to be infected themselves. In fact, many have transmitted HIV to their children perinatally, a situation that may represent the most difficult and high-risk bereavement, replete with self-blame and increased or renewed drug use.

**Experiencing Multiple Losses and Being HIV-Infected**

Mourners living in epicenters of the epidemic are likely to have experienced multiple losses due to the disease. A large proportion of them are likely to be HIV-infected, to have lost the core of their support networks, and to worry about who will be there to take care of them. To add to the concrete losses of loved ones and their own physical health, many mourners suffer from a variety of symbolic losses due to the epidemic. For example, many gay men lament the loss of sexual freedom. This accumulation of losses may overwhelm the mourner.

Research related to multiple loss and bereavement remains preliminary. In a study conducted early in the epidemic, John Martin and Laura Dean at Columbia University found that multiple bereavement had a negative impact on survivors, many of whom experienced symptoms of traumatic stress, demoralization, sleep problems, sedative use, and recreational drug use. On a more hopeful note, Martin and Dean found that gay men who survived the first ten years of the epidemic experienced fewer negative psychological symptoms two years after the loss of a loved one than did similar men tracked in their earlier study. However, they also found that those men who were both bereaved and HIV-infected continued to report high levels of psychological distress throughout the epidemic. Another Columbia University research group found that, although bereavement symptoms—notably preoccupation with and searching for the deceased—were related to the number of AIDS deaths reported by subjects, diagnosable psychological disorders were not.

**Experiencing Interpersonal Conflict and Perceiving a Lack of Social Support**

Perhaps the area of greatest agreement between the clinical and research literature on bereavement relates to the importance of perceived social support in mediating psychological health. An
accumulation of research suggests that the perception of social support is more important than any quantitative measure of support.\textsuperscript{17,18} The Stanford study found that among gay caregivers, overall satisfaction with caregivers' support systems was associated with lower depression symptomatology. However, structural aspects, such as the total number of friends or number of gay and nongay friends, were not related to depression.\textsuperscript{19} Another aspect of social support—affirmation by others—has been found to be helpful to mourners.\textsuperscript{20,21} Affirmation includes approval of one's beliefs, feelings, and decisions by important others. This may be particularly important to gay men and lesbians who are new to, or live outside of, supportive gay communities.

Conflict and friction within the social network may have a negative impact on emotional well-being. In fact, the Stanford study found that the amount of friction in a gay male caregiver's networks, the frequency of unpleasant encounters, and social isolation were the most consistently and strongly related support measures related to depression.\textsuperscript{22}

\textit{Experiencing Guilt and Low Self-Esteem}

For some mourners, guilt may arise in response to their own negative evaluation of their caregiver performance; for others, it may be the result of long-standing psychological problems. In addition, many gay and bisexual men experience lower self-esteem related to internalized homophobia.\textsuperscript{23,24} Even those who have lived for years feeling good about their sexuality may be revisited by negative self-images and accompanying anguish after the loss of a loved one.

\textit{Being Pessimistic}

In general, people with an optimistic appraisal style demonstrate better emotional well-being than those who are more pessimistic.\textsuperscript{25,26} The Stanford study found that gay male caregivers who reported greater levels of both general optimism and HIV-related optimism reported less distress.\textsuperscript{27} Although it would appear to make intuitive sense that men who were seronegative or untested would differ from HIV-infected men, all three groups of caregivers expressed similar self-appraisals regarding their ability to cope with the disease.
**Engaging in Avoidance and Ineffective Coping**

Coping refers to the cognitive and behavioral strategies individuals employ to manage specific demands they appraise as taxing or exceeding their resources.\(^8\) Coping has two major functions: to manage or alter the problem that is causing distress (problem solving) and to regulate the emotional response to the problem. Using ineffective methods to cope with bereavement-related problems or emotions may relate to the nature of current stressors or to a more generalized deficit in coping abilities. Many mourners fall back on old patterns of overeating, substance use, or inappropriate sexual behavior in attempts to avoid the pain of grief.

Although much of the research on coping with negative emotions has focused on people who deny or avoid their negative emotions, a large caregiving and bereavement study of nongay mourners conducted by Susan Nolen-Hoeksema demonstrated that people who are overly focused on their emotions are at risk for more severe and lengthy periods of distress.\(^9\) In a pattern described as ruminative coping, people worry excessively but passively about their depression, its symptoms, the implications of their depression, and the consequences that being depressed has on their lives. Although this rumination may appear to be a method to solve problems ("What am I going to do now?") the ruminative person is less likely to engage in active problem-solving behavior.

**Experiencing Cumulative Life Stressors**

The study of nongay mourners also found that the sheer number of stressors one month following the death of a loved one predicted depressive symptoms five months later. These stressors may include financial, occupational, or health problems.\(^9\) For many AIDS-bereaved individuals who are seropositive themselves, their own health status serves as an additional stressor.

**Having Preexisting Psychological Disorders**

People with preexisting psychological disorders may find it more difficult to adequately manage the loss of a loved one.\(^9\) For example, a person who is chronically anxious or depressed may be overwhelmed by the addition of a significant loss in his or her life. Similarly, people with personality disorders—for example, borderline or avoidant—may have difficulty coping with the burdens of bereavement.
Complicated Mourning

Bowlby believed that pathological or complicated mourning is best understood as an exaggeration or distortion of the normal process of mourning. He asserted that pathological mourning and psychiatric illness are more likely to occur in individuals who experienced a significant loss as children and subsequently developed a personality disturbance characterized by a hypersensitivity to loss. Three variants of complicated mourning are widely discussed in the clinical literature: absent mourning, delayed mourning, and chronic mourning.

Absent Mourning

Absent mourning suggests the lack of grief reaction after a significant loss. In some cases, the absence of grief may indicate that an individual was well prepared for the loss, as in response to the death of an aged and gravely ill parent. At other times, however, it is an indication of an impeded mourning process usually stemming from psychological defenses, conscious or unconscious, such as denial or repression. Some people have the self-perception that they are emotionally fragile and are unable to tolerate the pain of grief. Others worry that grief may stimulate overwhelming fears of their own death and dying.

Delayed Mourning

Delayed mourning, like absent mourning, manifests as a lack of grief symptoms. There are some circumstances in which delayed mourning processes may be adaptive. For example, a person who has experienced multiple losses may need to delay mourning less significant losses in order to process those of a greater magnitude. Similarly, a person battling acute exacerbation of his or her own HIV disease may delay mourning the loss of a friend until he or she feels strong enough to handle it.

Chronic Mourning

Chronic mourning involves the undesired persistence of grief reactions, including shock, yearning, searching, disorganization, and despair. Even after the passage of an appropriate length of time (six months is one marker frequently used in the United States),
a person’s subjective experience of the loss continues to be as salient as if the loss had occurred yesterday. In its most severe form, painful memories and thoughts intrude into consciousness and interrupt occupational and social functioning. Although chronic grief often is unremitting, it is not unusual for these mourners to vacillate between periods of absent and acute grief.

Psychological Disorders and AIDS Bereavement

Whether they precede loss or arise from it, psychological disorders complicate the bereavement process. Among the disorders that commonly occur are mood disorders, anxiety disorders, Post-Traumatic Stress Disorder, and substance abuse.

Mood Disorders

A high proportion of gay men who have experienced the loss of a lover meet the criteria for major depression or Post-Traumatic Stress Disorder. A general bereavement study found three results related to loss-induced depression. First, full depressive episodes are common throughout the first year after the death of a spouse. Second, depressive episodes may occur not only in the early months of bereavement but also later in bereavement. Third, four groups appear to be at highest risk for having depressive episodes thirteen months after their loss: younger widows and widowers; those with a past history of depressive episodes; those still grieving at two intervals—two and seven months after the loss; and those who perceive themselves as being in poor physical health. Contrary to clinical lore suggesting that early intense grief is the normal and healthy response to loss, Sidney Zisook and Stephen Shuchter found that intense early grief reactions are associated with later complications, such as chronic mourning, unresolved grief, or depression.

These findings highlight the value of a careful evaluation of depression in mourners. Although this evaluation may be complicated by the overlap of depression and grief symptoms, it is important to offer early psychotherapeutic interventions whenever a client meets criteria for depression. Clinicians should consider antidepressant medication if symptoms are intense, include vegetative signs or ruminative coping, last for more than six months, or
when there is a past personal or family history of major depression (especially if previous depressions were helped by medication). 36

Anxiety Disorders
Although anxiety is an expected and normal response to loss, anxiety disorders may require psychotherapeutic or pharmacological intervention. Anxiety reactions are often overlooked and may be overshadowed by depressive reactions. 37 Studies have found that both panic disorders—with and without agoraphobia—and generalized anxiety disorders may be associated with bereavement, 38 as may the onset or exacerbation of obsessive-compulsive symptoms. Although anxious avoidance of situations that remind mourners of their losses is not unusual, clinicians should consider whether these reactions are evidence of anxiety disorders when these behaviors significantly interfere with social or occupational functioning. 39

Post-Traumatic Stress Disorder (PTSD)
Post-Traumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct experience of an event that involves actual or threatened death or serious injury or other threat to a person’s physical integrity. This may include learning about an unexpected death. To merit a diagnosis, the person’s response must involve intense fear, helplessness, or horror. Furthermore, characteristic symptoms include persistent reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma, and numbing of general responsiveness. Finally, people with PTSD may also suffer from persistent symptoms of increased arousal such as irritability, hypervigilance, and exaggerated startle response. 40 While most AIDS mourners experience some of the symptoms of PTSD, including intrusive thinking and affective numbing, few meet the complete criteria for a diagnosis of PTSD.

Substance Abuse and Dependency
The relationship between substance abuse and HIV-related bereavement is a complex one. Substance abuse can be both a risk factor for bereavement distress and a negative outcome of painful bereavement. A sizable and growing proportion of people with
HIV disease have been infected as a result of unsafe injection drug use, and clinical observation suggests that those mourning the loss of these individuals are at increased risk for psychological distress. Because these mourners are more likely to have a current or past history of substance abuse and may also be HIV-infected, they are more likely to be isolated and stigmatized and to experience financial difficulties.

Research has documented an increased prevalence in alcohol, tobacco, and prescription and nonprescription drug use among mourners—including new users but more often among people already using substances. The heavy use of mind-altering substances may interfere with successful bereavement in several ways. Using drugs and alcohol to anesthetize the pain of grief may block, delay, or prolong the mourning process. In short, substance dependency may be a maladaptive avoidance coping behavior that is used in lieu of more productive problem-solving and emotion-focused strategies.

**AIDS Bereavement Interventions**

In most cases of AIDS bereavement, individuals are able to manage the emotional and physical impact of grief with the support of their friends, family, and community. However, clinicians may be called on to assist individuals at every level of bereavement distress: uncomplicated mourning, uncomplicated mourning with risk factors, complicated mourning without psychological disorders, and complicated mourning with psychological disorders. Bereavement interventions available include preventive and educational approaches; small-group and individual counseling; grief-related psychotherapy; and medical and psychiatric treatment. As outlined in Table 12.1, clinicians should apply bereavement interventions according to the type of mourning a client experiences.

**Preventive and Educational Approaches**

Bereavement education—emphasizing the nature of bereavement, defining effective coping strategies, and encouraging a community-wide norm of support for mourners—can go far to assist mourners in coping with their grief and preventing bereavement-related
<table>
<thead>
<tr>
<th>Level of Distress</th>
<th>Bereavement Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level One:</td>
<td></td>
</tr>
<tr>
<td>Uncomplicated mourning without risk factors</td>
<td>AIDS bereavement education</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Level Two:</td>
<td></td>
</tr>
<tr>
<td>Uncomplicated mourning with risk factors</td>
<td>AIDS bereavement education                   Individual or group counseling</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Level Three:</td>
<td></td>
</tr>
<tr>
<td>Complicated mourning without psychological disorder</td>
<td>AIDS bereavement education   Individual or group counseling Grief-related psychotherapy</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Level Four:</td>
<td></td>
</tr>
<tr>
<td>Complicated mourning with psychological disorder</td>
<td>AIDS bereavement education   Individual or group counseling Grief-related psychotherapy Psychiatric evaluation and treatment</td>
</tr>
</tbody>
</table>
problems. In the early stages of mourning, people often say that they are unprepared for the intensity of their feelings and the level of disruption and are relieved to hear that these experiences are normal.

Bereavement education, which is often provided through spiritual sources, may help mourners place death within an overall religious or philosophical context, thus reducing the sense of alienation. Secular counselors must be sensitive to religious and cultural differences among mourners and should encourage mourners to find ways to cope with mourning consistent with their own religious, cultural, and personal values. A recent doctoral dissertation, completed as part of the Stanford study, found that of those mourners who considered themselves religious or spiritual, the ones who frequently participated in religious or spiritual activities coped better with bereavement than those who did not.42

Community-wide efforts to remove the stigma of HIV disease may decrease the reluctance of some mourners to request support. Programs designed to reduce the isolation of mourners, especially those who live outside the epicenters of the disease, are also important. Community-wide rituals, such as memorial services and candlelight parades, may offset the sense that those who have died have been devalued and forgotten.

Education of health care professionals should encourage sensitivity toward the loved ones of persons with HIV disease. Discussions with partners, family, and close friends early in the course of illness are helpful not only in assessing the quality of a patient's support system but also in validating the important role of loved ones in the patient's life, an act that can facilitate future grieving.

Problem-Oriented Individual and Group Counseling

In general, bereavement counseling seeks to help the survivor accept the reality of loss and express the feelings that accompany this realization. As a survivor is allowed to grieve at his or her own pace, in his or her own way, the emotional bond between the survivor and the deceased gradually changes, allowing the survivor to form new relationships with the living.

Time-limited, problem-oriented individual counseling—focused on tasks of grieving and on mitigating any risk factors—may
be helpful to clients at all levels of bereavement distress. Shuchter and Zisook suggest that rather than viewing the goal of bereavement counseling to be the resolution of psychological attachment to the deceased, which may take several years, counseling should address specific grief-related problems with the understanding that the client can return if additional problems arise in later stages of bereavement. A common feature of AIDS bereavement counseling is addressing the issue of multiple loss or "bereavement overload." Many mourners come to counseling feeling overwhelmed by the number of losses and may need assistance organizing their bereavement to focus on the most important losses. Others may need to separate losses in order to fully grieve each. Counselors should listen for hidden or unacknowledged losses, such as the sense of diminished freedoms or the loss of enjoyable sexual activities. Sometimes the fatigue of grief, in part due to the extended nature of the epidemic, wears individuals down. In such cases, mourners may welcome the suggestion of taking a "bereavement holiday" to focus on other matters for a period of time.

A range of small-group counseling strategies—from one-time lectures or workshops to ongoing counseling groups—can assist mourners. Research on the effectiveness of small groups in preventing bereavement complications has shown that interventions are most successful when they target mourners who demonstrate high levels of distress or specific risk factors. This research stresses the importance of the timing of the intervention: group intervention provided too soon—that is, within the first couple of weeks after loss—may have no positive effects or, as illustrated in one study, may even delay or interfere with the bereavement process. Some programs provide group support for individuals in the later stages of mourning, for example, after the first year subsequent to the loss. These groups may be particularly helpful for people living in HIV epicenters where whole support systems have been decimated.

Bob: Multiple Loss

Bob, a thirty-nine-year-old seronegative gay man, came to counseling six months after the loss of his partner of twelve years, Tom. Bob was disturbed by periods of anguish, grief, and longing, interspersed with times when he felt emotionally numb. Bob had been a devoted caregiver during Tom's two-year...
illness with AIDS. Even so, at times he felt he had not done enough. During the time of Tom’s illness, three close friends of Bob’s died—two from AIDS and one from breast cancer.

Bob despaired. “Everyone’s gone—there’s no one left. I was so busy with Tom that I didn’t have time for Quentin, Charlie, and Sarah. Now it’s too late. I just wish life was the way it used to be.”

Bob was estranged from his family of origin: “They never really accepted my being gay.” During Tom’s illness, Bob had isolated himself from other friends. Now, as he began to pick up the pieces of his life, he felt too embarrassed to reach out to them. Further, many of these friends were HIV-infected, and Bob reluctantly admitted that he did not feel up to the challenge of getting involved with people who might get sick. He felt alone, angry, stuck, and confused.

At his first session with his therapist, Paul Carpenter, L.C.S.W., Bob was surprised to hear himself express that at times he wished he had AIDS. “I can’t stand the idea that I am going to spend the rest of my life taking care of and grieving for my friends.” Carpenter listened empathically; Bob was relieved that Carpenter was not offended by these ideas, which Bob found shocking. Carpenter helped Bob recognize the risk factors that added to the distress of his mourning: isolation, multiple loss, caregiving exhaustion, shame and guilt, and the paradoxical effect of being seronegative. As the two spoke, Bob began to experience a wider range of emotions and to feel validated for his losses. At the end of the initial session, Bob agreed to participate in an eight-week course of bereavement counseling spread over a period of three months, and to attend an AIDS bereavement class to learn about the stages of mourning and about bereavement tasks and overload.

During his sessions with Carpenter, Bob reviewed each of the important losses, including his sense that his life as a gay man had been permanently altered. As he began to focus on each loss individually, he was surprised by some of the deep emotions he had suppressed. As Bob gained awareness of these emotions, he was relieved to find that he once again was able to experience strong feelings of affection for his deceased friends—even though he had not been able to participate in their final days.

Toward the end of the three-month course of counseling, Bob spent his final sessions with Carpenter developing ways to reach out to old friends as well as new ones. Bob joined a bereavement group to help him continue to
work through his conflicted feelings about being seronegative and about his urge to avoid people with HIV disease. As he was ready to leave counseling, Bob noticed that he had a new level of energy and a cautious optimism for the future. He left knowing that there was still much mourning ahead of him yet feeling confident that help was available if he needed it.

Grief-Related Psychotherapy

Mourners who present with preexisting or recent onset of psychological disorders or those for whom the bereavement process is disrupted may require more intensive forms of psychotherapy. Grief-related psychotherapy may follow shortly after a death or may be required to treat delayed or chronic mourning, for which the loss may have occurred many years before.

Mardi Horowitz and his colleagues at the University of California, San Francisco, developed a time-limited (twelve-session) psychodynamic psychotherapy model to assist people experiencing instances of complicated mourning. According to this model, in the aftermath of any stressful life event, certain processes must occur to facilitate assimilation, accommodation, and healthy resumption of living. Individuals must resolve the personal meanings of the stressful event, including its implications for relationships, self-image, and behavior. This process entails the individual’s reappraising the event and revising his or her core models of self, role relationships, and future plans.

The primary goal of this intervention is to reduce the need for psychological defenses against awareness of ideas and images that lead to stress and intolerable emotional states. Therapy accomplishes this goal by helping mourners consciously connect their ideational responses to stressful events and their associated emotional responses. For clients experiencing denial or numbing, the therapeutic task is to encourage reexperiencing grief; for those who experience intrusive-repetitive thoughts or emotions, the task is to promote resolution or in some cases conscious distraction. One technique designed to give clients a sense of mastery is called “dosing,” which entails reexperiencing a bereavement event and its meanings for a specific time, putting it out of mind for a period of time, and once again recalling the event.
Therese Rando describes the benefits of using rituals to enhance psychotherapy with mourners, both those who are in denial of their grief and those overwhelmed by grief. A grief ritual is a formal activity that provides a time and a place to honor an important loss. Mourners may develop their own or opt to use rituals prescribed by their religious or cultural traditions. Through rituals, clients may combat the sense of helplessness accompanying grief and may find a legitimate form to express strong feelings. Clients blocked in their awareness and expression of grief may find that rituals provide a safe context in which to recall memories and the emotions associated with them. For clients having difficulty modulating the intrusion of strong memories or images, rituals may help delimit grief by providing a specific time and place for these painful mental phenomena.

**Ralph: Ritual and Grief-Related Therapy**

Ralph, a forty-seven-year-old Asian gay man, came to therapy four months after the death of Martin, his lover of five years, and three weeks after being discharged from the hospital for his first bout of *Pneumocystis carinii* pneumonia. Ralph exhibited intense grieving and rumination, repeatedly asking, "What am I going to do now? Who is going to take care of me?" Sometimes he sat motionless, numb beyond emotion. At other times, feeling out of control, he experienced extreme anxiety. Ralph spent much of his day crying and longing for his departed partner.

A thorough psychiatric assessment concluded that Ralph was suffering from major depression. After conferring with Ralph’s primary physician, his therapist, Karen Morley, prescribed an antidepressant medication. She also began building rapport by undertaking a sympathetic review of Ralph’s current medical situation. Through these discussions, Ralph began to understand the relationship between his grief and his own health predicament. Together Ralph and Morley developed a way for Ralph to spend some portion of the day honoring the memory of Martin; during the rest of the day Ralph was to redirect his attention away from painful memories. Each morning Ralph sat for thirty minutes in an area he had designated as a “shrine” and had consecrated with photographs and other items that elicited memories of Martin. Morley encouraged Ralph to speak—in a sense, to carry on a dialogue—with Martin or to write him letters. At the end of the thirty minutes, Ralph...
was to say good-bye to Martin and remind himself that he would return tomorrow.

Ralph was comforted by the ritual, which he saw as consistent with his cultural tradition. The therapy sessions were used to assist Ralph in understanding the personal meanings of his loss and in coping with negative thoughts and affects, and to encourage his reaching out to new people through involvement in community bereavement groups.

After twelve sessions spread over sixteen weeks, Ralph felt more in control of his life, his depressive symptoms were greatly reduced, and he was dating a man he met at a bereavement group. He continued to use his shrine to mourn his beloved partner.

Psychiatric and Medical Intervention

In order to respond to bereavement distress, providers must determine the relationships among mourning, psychological disorder, and physical disease. A thorough assessment, including a careful history of physical and psychiatric symptoms, is crucial to identifying preexisting disorders or vulnerabilities to disorder.

Although it is important to encourage mourners to experience grief, some people may become emotionally overwhelmed and may need assistance to tolerate intense grief. Whenever possible, clinicians should apply nonpharmacological interventions such as general relaxation exercises to reduce stress or behavioral approaches to reduce insomnia. When these approaches are not sufficient, judicious use of tranquilizers and sleeping medication may be indicated.

The use of psychotropic medications in the clinical management of bereavement is an area of great debate. Given the historic misuse of medication to “calm” mourners, there is general suspicion about this approach among bereavement experts. “Although some might argue that the use of psychotropic medications during bereavement is maladaptive in that these substances prevent the bereaved from ‘getting in touch with their true feelings’ and thereby block the resolution of grief, this position has not been validated by empirical data.”

Rando contends that failure to recognize and respect the reality that some mourners require psychotropic medication is as
detrimental as forcing medication without just cause. She suggests that a treatment plan should include a careful medical examination as well as appropriate psychological and pharmacological management. If clinicians suspect suppression of or interference with grief, they should reconsider medication use, keeping in mind that medication should be used as an adjunct to psychological treatment and social support, not as a replacement for them.

This chapter reviews the universal and unique challenges of HIV-related bereavement. Nowhere is the dual nature of bereavement so pronounced as it is for providers who assist people who mourn HIV-related losses. Many providers come from communities hardest hit by the epidemic and are themselves bereaved, mourning the loss of personal relationships and clients. Given the magnitude of the epidemic and the special circumstances surrounding AIDS, the potential for bereavement overload is immense. On the other hand, many providers have found ways to incorporate the profound universal lessons of life and death they have learned through the process into helping their clients and themselves find personal meaning in their lives.

Notes
3. Personal communication with clients and other mental health providers.
6. Martin, J. L., and Dean, L. “Risk Factors for AIDS-Related Bereavement in a Cohort of Homosexual Men in New York City.” In B. Cooper and

7. Ibid.


12. Ibid.


15. Ibid.


17. Erickson, “Social Support.”


22. Erickson, “Social Support.”


24. Ibid.


27. Erickson, “Social Support.”


30. Ibid.


33. Bowlby, "Loss."

34. Martin and Dean, "Bereavement Following the Death from AIDS."


36. Ibid.


44. Rando, *Treatment of Complicated Mourning*.

45. Ostervais, Solomon, and Green, *Bereavement*.


50. Rando, Treatment of Complicated Mourning.
Chapter Thirteen

Personality Disorders and HIV Disease

The Borderline Patient

Michele Killough Nelson
Rochelle I. Klinger

Clients with mental disorders may face significant barriers to obtaining and maintaining care for their HIV disease. Mental disorders can, by themselves, create impediments to accessing HIV-related medical care and antiviral treatment, complicate the doctor-physician relationship, and decrease adherence to complicated drug combinations. Because mental disorders may also reduce impulse control, clients with these disorders may also have difficulty conforming regularly to safer sex and needle-sharing practices.

Among those people with mental disorders who face the greatest challenge both in terms of prevention and care are people with personality disorders. Using the borderline personality disorder as a lens, this chapter offers a view of what it is like to interact with seropositive clients with serious mental disorders. It reviews the epidemiology, etiology, and clinical manifestations of borderline personality disorder and emphasizes the role and process of psychotherapy with borderline clients. It also examines the ways in which the health care team working with these clients can maximize the delivery of appropriate services and minimize the occurrence of problems.
Defining Borderline Personality Disorder

Borderline personality disorder is characterized by volatile emotional states and emotional emptiness, poor impulse control, difficult and often stormy interpersonal relationships, and problems with anger management. These characteristics make borderline clients difficult to treat in psychotherapy. Borderline clients typically require more planning, structure, emotional energy, and time than other clients and may therefore strain therapists and drain a disproportionate amount of resources away from psychologically healthier clients.

Epidemiological studies estimate the prevalence of borderline personality disorder as 0.2 percent to 10 percent in the general population and 15 percent among psychiatric clients.4,5 Approximately 76 percent of borderline clients are female.7,8 A 1993 study found a 33 percent incidence of personality disorder (mostly borderline) among HIV-infected gay men versus 15 percent among seronegative gay male controls.9 The investigators concluded that borderline individuals may be more prone to contract HIV due to impulsive, unsafe behaviors. This finding also suggests that the problem of borderline personality disorder in HIV-infected clients will continue to be significant.

Borderline clients seldom come into psychotherapy on their own unless they are in crisis. Once the crisis has passed, however, they often flee. It is more likely that HIV-infected borderline clients will be pushed into psychotherapy by their health care providers, who feel frustrated and angry with them. Mental health workers who practice in medical settings, therefore, may have longer periods of contact with borderline clients than providers who work in other settings. Borderline clients may also present for treatment in private practice settings if they have adequate financial resources or if they want to avoid seeing a therapist at their medical center.

Given the difficulties inherent in working with these clients, it is important to be familiar with the most common forms of their psychopathology. This familiarity can help therapists better understand the undeveloped personality structure common among these clients and use this knowledge to develop an appropriate and focused treatment plan. Taken as a group, people with borderline personality organization can span the spectrum from relatively
high functioning to low functioning, but a common feature is that their lives are constantly troubled by difficulties in relating to others. Although this difficulty often impedes their ability to form healthy working relationships with therapists, it does not preclude the possibility of significant progress in psychotherapy. But it does necessitate careful evaluation of a client’s level of functioning in order to set appropriate goals and to understand the strengths that can be used as foundations to help the client reach these goals.

Personality disorders are inflexible, maladaptive ways of perceiving or relating to the interpersonal environment that cause functional impairment or subjective distress in an individual. These disorders—including, for example, narcissistic, antisocial, and histrionic personality disorders—are long-standing, characteristic ways of relating to the world, typically emerging in childhood or adolescence and continuing throughout adult life. They are enduring characteristics, not present only at times of distress. This makes a longitudinal history essential to the diagnosis of personality disorders, especially if a person is first seen at a time of great distress such as during HIV-related illnesses. All of these disorders represent exaggerated styles of interacting with others and significantly interfere with a person’s ability to have positive, lasting relationships and to have accurate self-concepts.

The DSM-IV categorizes borderline personality disorder under Cluster B Personality Disorders, which include clients who are often dramatic, erratic, or emotional. The diagnostic criteria include a pervasive and long-standing pattern of instability of mood, identity, and relationships. Identity disturbance leads to feelings of emptiness and boredom; mood instability manifests as rapid swings in demeanor. Impulsive, self-destructive behaviors can also be part of this constellation. (See Exhibit 13.1 for the DSM-IV diagnostic criteria for borderline personality disorder.) Although all personality disorders involve chronic maladaptive behavior patterns, borderline personality disorder is characterized in particular by disturbed interpersonal relationships, poor impulse control, a heightened potential for repeated self-injury, and an increased fear of being alone.

Borderline personality disorder is often coupled with substance abuse or uncertainty about sexual orientation or gender. These may offer additional signs of a client’s feelings of emptiness...
Exhibit 13.1. Diagnostic Criteria for Borderline Personality Disorder.

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Does not include suicidal or self-mutilating behavior covered in Criterion 5.)

2. A pattern of unstable and intense interpersonal relationships characterized by alternation between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging, for example, spending, sex, substance abuse, reckless driving, and binge eating. (Does not include suicidal or self-mutilating behavior covered in Criterion 5.)

5. Recurrent suicidal behaviors, gestures, threats, or self-mutilation behavior

6. Affective instability due to a marked reactivity of mood, for example, intense episodic dysphoria, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days.

7. Chronic feeling of emptiness.

8. Inappropriate, intense anger or difficulty controlling anger, for example, frequent displays of temper, constant anger, recurrent physical fights.

9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

and difficulties with coping. Adjustment disorders and Major Depression are also often seen in clients diagnosed with borderline personality disorder.\textsuperscript{15} This is especially true for HIV-infected borderline clients, who must cope with a threat to life and who may harbor repressed anger toward others and themselves for their current health situation.

Psychodynamic and object relations theorists postulate that the disorder is rooted in the child's unsuccessful struggle to separate and differentiate during the first eighteen months of life. This failure may be the result of constitutional aspects of the child, or of the behavior of a parent or parents or other primary caregivers (for example, custodial grandparents). Many, but not all, borderline clients come from families with a history of extreme neglect or abuse. In addition, within these families there is frequently a historic inability on the part of caregivers to let the child grow up independently.\textsuperscript{16,17}

Another theory, which has gained less acceptance in the literature, suggests that borderline personality disorder is a subtype of the affective disorders, with mood instability manifesting as dysfunctional behavior. In response, theorists who propose this explanation advocate vigorous pharmacological treatment for affective pathology in borderline clients.\textsuperscript{18,19}

**Diagnosing Borderline Personality Disorder**

Unfortunately, few borderline clients present clinically with a neat list of DSM-IV criteria. More frequently, the borderline pathology declares itself in a dramatic and unexpected fashion. Certain features, however, can tip off therapists to the borderline personality disorder.

One clue is that borderline clients often present with stories of other institutions and providers who have "done them wrong." In characteristic fashion, they may idealize a new provider or clinic at first, saying things like, "I know you can help me. . . . You're the only doctor who understands me." Providers should be wary of this kind of idealization, especially if it comes early in the course of the provider-client relationship, and they should be prepared for a later devaluation of their relationship. Initially inflating the value of therapists allows clients to feel more comfortable asking for help
and expecting results. Their sense of emptiness and fear of rejection make them sad and frightened, and attaching to someone else (such as a therapist) is a way to fill this void. The overwhelming needs of borderline clients, however, make it impossible for providers to live up to clients’ expectations. If these issues are not addressed early in the course of therapy, it is likely that clients will feel abandoned when they are inevitably disappointed by their therapists.

When members of a treatment team are split about whether a client is likable, this may be a clue that the client is borderline. Borderline clients who engender strong opposing feelings in members of the team are often using projective identification, a mechanism by which a client projects irreconcilable conflicts onto others, who then act them out for him or her. Thus, one member of the team may defend the client while another berates him, resulting in a struggle within the team.

It is interesting to note that the term borderline was originally used to define clients who seemed to fall between the categories of neurotic and psychotic. This heterogeneous grouping included clients with early schizophrenia or affective disorders, as well as clients who would be defined with borderline personality disorder by current standards. Often these were people who had brief episodes of psychosis under stress, particularly interpersonal stress. However, psychosis did not have to be present for a client to fulfill borderline criteria.20,31,22 The following case example illustrates a common presentation of a person with borderline personality disorder. The case will be revisited in the treatment section of this chapter.

Maurice: Presentation

Maurice is a thirty-four-year-old gay African American man who presented to Anne Graham, a psychologist, for an intake interview. He was referred by the staff at the infectious disease clinic because of problems with missed appointments, demanding behavior, volatile mood, difficulties getting along with the staff, and vague but recurrent suicidal threats.

Maurice arrived early and was surprised when told that Graham could not see him until his appointment time. When she came out for him, he commented on how he had waited in the lobby for a long time, but then began
talking about how good it was to meet her and how many nice things he had heard about her. He told her that his life had been difficult because “everyone’s gone out of their way to do me wrong.” He went on to describe several situations in which others had taken advantage of him.

Maurice was upset about his recent AIDS diagnosis and, consistent with his perceptions of the past, felt that everyone was abandoning him. He said that no one came to visit him in the hospital when he was ill, and he complained that he felt constantly misunderstood by his friends and most of his family, who had rejected him when he disclosed his homosexuality. The only positive relationships he described were with his grandmother, who had died, and a new lover, who was “wonderful” and whom he had been dating for two weeks. Maurice also told Graham that he had had many lovers in the past and described a series of intense relationships cut short as each boyfriend disappointed him. Maurice said it was no wonder that he had been driven to drink and use drugs—everything from speed to heroin.

Maurice acknowledged difficulties getting along with the staff at the infectious disease clinic. He felt they saw him as “just another number.” He boasted that skipping appointments was a good way to let them know that he did not care about them either. Maurice said he sometimes felt suicidal, primarily because of loneliness and frustration over his declining health. He said he told the staff at the clinic about this but did not believe they cared enough to do anything about it.

Maurice thought psychotherapy might help him deal with all these feelings. His goal was to confront people who had wronged him. He said that he might be interested in having a session with his parents so that he could tell them how much they had hurt him and to see if they could work things out. Maurice was also concerned that he might become depressed during the course of his illness and hoped that therapy might stop this from happening. Finally, he wanted to talk about dying, which sometimes “terrified” him, particularly when he was trying to go to sleep at night.

Clinical Features and Challenges in Treatment

Most psychotherapists feel challenged and frustrated when working with clients diagnosed with borderline personality disorder. These clients are difficult and time-consuming to manage, and the literature is unclear about whether anything other than limited
improvement can be expected even with the best treatment. Clients with both borderline personality disorder and HIV disease often experience a magnification of borderline symptoms because they have difficulty coping with the added emotional, financial, and interpersonal stressors that a serious medical illness imposes. There are four key clinical issues for therapists treating borderline clients with HIV disease:

- Helping the client secure whatever resources—medical, financial, or social—that will help minimize stressors.
- Improving interpersonal skills to facilitate the development of healthy relationships.
- Teaching the client ways to reduce self-injurious behaviors and increase positive, adaptive ones.
- Addressing the client’s feelings in a way that promotes open discussion and exploration of issues.

Interpersonal relationships are difficult for all borderline clients to maintain. Volatile mood, tendencies toward splitting (pitting one provider against another), poor impulse control, and a demanding nature preclude healthy, lasting relationships and instead result in alienation from others. HIV-infected borderline clients experience new and increasing needs, including the need for regular medical care and for external financial support because of their decreased ability to work. They are, however, often unable to work effectively within the social services system to get their needs met because they alienate even the most patient professionals.

HIV-infected borderline clients have more trouble maintaining positive relationships than other borderline clients because of HIV-related stigma and rejection. Their problems with impulse control and desire for immediate gratification may cause others to fear that these clients will act irresponsibly and spread the virus. This injects skepticism and anxiety into the clinical relationship, sabotaging trust. In addition, health concerns and legitimate needs for attention are often camouflaged by the chaos of the client’s life and his or her anger about having become infected.

This profile is especially trying for mental health professionals because these clients have difficulty processing and resolving issues. It can seem as if the same themes—for example, “I am the victim”—
repeatedly play out in therapy, leaving therapists with the sense that there has been no real progress. As clients get more frustrated with their declining health or with the perceived lack of cooperation and support from others, it is likely that they will create chaos and conflict in an attempt to avoid dealing with these painful issues. Such chaos may take the form of calling repeatedly, missing appointments, or behaving in a seductive fashion toward the therapist. Exploring these actions with clients will be helpful, but it may also be beneficial to make appropriate accommodations to the physical realities of declining health, for example, hospital or home visits. 

HIV-infected borderline clients are often more sensitive to abandonment issues than other people with borderline personality disorder; in order to get their needs met, they may try to play physicians, nurses, and therapists against one another, alternately de-valuing and idealizing these practitioners. This “splitting” may be the only way that borderline clients can deal with their inability to see the middle ground between the extremes of good and bad in themselves and others. It is important to note that there need not be a treatment team for splitting to occur. Clients may introduce other people from their lives—a lover or parent—and use them against the therapist. For example, a client may complain that his lover gives him insufficient attention in hopes of having the therapist respond by increasing the number or length of sessions.

Although society has become more understanding and less condemning of people with HIV disease, there remains an expectation that clients will behave responsibly to protect their own health and that of others. This is difficult for HIV-infected borderline clients, because they do not like to be told what to do. Borderline clients tend to live in the moment and have difficulty planning ahead. They often express resentment that HIV-specific resources are linked to expectations about their behavior. These clients see authority figures and resource allocators as biased against them and, at best, have ambivalent relationships with such people. These same issues are usually played out during therapy sessions, and the attachments between these clients and their therapists are fraught with ambivalence, resentment, and strong dependency needs.

Feelings of emptiness and boredom are typical for all borderline clients. As borderline clients begin to grapple with HIV disease,
however, many experience these feelings in a new way, often recognizing that their lives have not been what they had hoped. Some clients describe themselves as “hollow” or “empty” and express great sadness about this realization. They also realize that their lives will be shorter than they expected and that they may not have the chance to make changes they would have liked to make. For some clients, dealing with these existential issues can precipitate a major depression or a desire to escape from what they perceive as the futility of their lives. It is important to monitor these feelings because such borderline clients can easily become suicidal; and because they have difficulty controlling their impulses, they are more likely to act on these inclinations.

Other clients may respond to their illness by experiencing an existential shift that promotes positive change and growth. It is also important to note, however, that even when clients desire to make positive changes, they frequently do not have the coping skills to implement these changes.

Finally, in considering treatment issues, psychopharmacology offers some options that should not be completely forgotten. As noted previously, the affective instability and chronic dysthymia so common in these clients can lead to the development of major depressive disorders. In such instances, treatment with antidepressants is often helpful. Similarly, complaints of severe anxiety and difficulties with insomnia can sometimes be helped by neuroleptic drugs.

Psychotherapy and the Therapeutic Relationship

There is limited research on the effectiveness of psychotherapy with borderline clients. Controlled outcome studies are rare, and at present no single approach is generally accepted to be more or less effective than other approaches. Otto Kernberg, who has written extensively about his experiences with traditional and nontraditional psychoanalytic psychotherapy with borderline clients, suggests that focusing on transference and the clinical manifestations of defense mechanisms is most useful.26 27 28 Aaron Beck, a cognitive-behavioral psychotherapist, focuses more on developing a working relationship with the client, decreasing dichotomous and distorted thinking, gaining control over emotions and impulses that often
lead the client to participate in self-destructive behaviors, and strengthening the client's self-concept. Neither author, however, presents significant empirical data to support his position.

Considering how frustrating and difficult it can be to work with borderline clients with HIV disease, it is helpful to remember that it is unlikely that therapy will alter a client's basic personality structure. Instead, the therapy process generally seeks to strengthen adaptive behaviors and coping mechanisms to improve quality of life. The therapist accomplishes this by providing constant feedback to help clients identify and generalize acceptable behaviors. During this process, the therapist also labels maladaptive behaviors and coping mechanisms and encourages clients to avoid them. It is also beneficial for the therapist to help clients learn to anticipate the consequences of their behaviors. For example, if a client asks for money from her mother to pay the rent and does not act appropriately appreciative—that is, she does not say thank you or try to make arrangements to pay it back—then it is unlikely her mother will want to lend her money again. Introducing clients to basic social skills and simple social situations can help them understand similar and more complex situations.

It is important to remember that although most clients desire to live more positive, productive lives, this desire is insufficient to effect true change. Good intentions without good coping skills usually lead to feelings of frustration and disappointment, which often result in a resumption of previous maladaptive behaviors. Basic social and coping skills are a necessary foundation for achieving long-term change.

The therapeutic relationship is perhaps the most significant tool in the treatment of clients with personality disorders. Although HIV-infected borderline clients commonly have numerous difficulties with interpersonal relationships, they usually do not understand their roles in these interactions. Therapists can use the safety of the therapeutic alliance to help clients explore their feelings about relationships.

Therapists need to give clients constant and carefully phrased feedback and to remain open to feedback from clients. Being mindful that clients will relate to therapists in the same way they relate to others can enable therapists to respond appropriately when clients express ambivalent, conflicted, and angry feelings.
toward them. This knowledge can also help therapists provide immediate feedback to clients when they begin to inject chaos into the therapeutic relationship; this feedback allows clients to examine the emotional origins of their behaviors, which in turn helps clients understand the angry, rejecting responses of others and allows them to alter the situation and move forward. It is most easily undertaken by commenting on the therapeutic process rather than by directly addressing the content of what clients are saying or doing. For example, if the client misses two appointments and shows up late to the third, it is best not to engage in an argument but instead to ask what was happening that the client was avoiding psychotherapy.

Interpersonal group psychotherapy has also been useful in treating some HIV-infected borderline clients. These groups focus on helping clients learn how to interact with others in appropriate ways by providing feedback about interpersonal style and encouraging participants to modify these styles within the group. Despite the pain this process may elicit, clients usually find that this immediate feedback helps them understand the effects of their behaviors on others. Providing both positive and negative constructive feedback can minimize the emotional resistance. Borderline clients may find these groups difficult, because they must "share" the therapist with others and do not receive the therapist's undivided attention. It is important for therapists to prepare individual clients ahead of time about what is expected from them and what they can expect from the group.

Some clients will benefit from both group and individual psychotherapy, either concurrently or sequentially. In these situations, it is best to have two therapists involved so that clients do not feel that their individual therapists owe them special favors within the group and so they understand that the confidentiality of their private sessions is being preserved. In such a situation, clients should be informed that the individual and group therapists will regularly communicate, both to provide a unified treatment approach and to limit opportunities for splitting.

Finally, it is important to recognize that most therapists, no matter how patient, become frustrated working with borderline clients. Recognizing and exploring negative countertransference allows therapists to use their reactions to better understand clients' effects on others and to gain additional information for treatment
planning. It is also necessary for therapists to process these feelings in formal or informal supervision, consultation, or personal psychotherapy, and to discuss them with the other team members. Failing to do so may lead to frustration with the client and the therapeutic process.

Maurice: Treatment

During their first session, when Maurice told Graham about his terror of dying, his hope of reconciling with his parents despite his anger toward them, and his desire to confront those who had wronged him, Graham encouraged Maurice to discuss these feelings. She listened supportively, asked questions to clarify his statements as necessary, and learned more about his previous relationships, his substance use, and his family. The last fifteen minutes of the session were spent planning treatment goals, including considering ways to improve Maurice’s medical compliance, discussing how to get his needs met by others in more appropriate ways, and talking about improving his relationship with his family.

Maurice agreed to compile a list of his concerns and questions about his medical condition for the next session. Maurice signed a release so that Graham could talk to his health care providers. Graham made it clear that she wanted to coordinate with the treatment team and share information as appropriate. Maurice asked if they could set up a meeting with his team in the near future. Graham encouraged him to wait until he had discussed his list of concerns with her first.

Graham and Maurice also discussed options to improve his social support, and Graham agreed to get information about local support groups for him and bring it to the next session. The two agreed to meet weekly and focus on helping him both process his feelings and better manage some of his practical concerns.

Graham recognized that working with Maurice would require a slow and careful approach. She knew her task would be to try to sustain his good feeling toward her; at the same time, she acknowledged to herself that she would inevitably disappoint him whenever she did not comply with his wishes or “failed” to intervene with his medical team to get him what he wanted. Graham hoped, however, that by anticipating problems, by explaining to Maurice what she could and could not be relied on to do, and by being explicit and consistent in her approach, she would be able to help him manage his feelings.
Responding to Chaos

In approaching borderline clients with HIV disease, therapists should consider paying special attention to two central issues. First, it is important to stay calm and aloof from the chaos borderline clients create. To minimize the effects of the chaos clients will inject into the therapeutic relationship, therapists must set firm and consistent limits with clients and carefully outline the client's and therapist's responsibilities. This is often done by using contingency contracts. Therapists may use these contracts to outline specific client requirements, including that the client be on time, call at least twenty-four hours in advance to cancel or change an appointment time, or complete homework assignments. The contract should clearly spell out the consequences of compliance or non-compliance. For example, clients may have to pay for missed sessions, or psychotherapy may be terminated if an individual misses three or more sessions.

Second, if clients bring chaos into the therapeutic relationship, they may succeed in baiting the therapist into conflict, thereby gaining inappropriate control. Often, the end result of such conflict is that negative countertransference obliterates an objective view of the situation. Arguing with clients, even borderline clients at their most contentious, is inadvisable because it shifts the focus of therapy from the client's well-being to the dynamics of a power struggle.

Borderline clients will also often try to create conflict to get out of situations that are unfavorable to them. For example, a client may reframe a therapist's comment about inappropriate behavior as a personal criticism—"You don't like me"—thereby shifting the focus away from the behavior. Although borderline clients are not particularly adept at managing conflict or chaos, they understand that others are not either. This maladaptive coping mechanism allows them to maintain control over situations by shifting the attention where they want it. As described earlier, it is helpful to focus on the process rather than on the content of the conflict.

At other times, especially in group psychotherapy, clients will try to shift the focus onto themselves if they believe they are not the center of attention. Rather than directly asking for assistance, they may dominate conversations, behave inappropriately, or test
limits to ensure that their needs are met. Again, pointing this out in a matter-of-fact, nonjudgmental way while it is happening will provide useful feedback and allow clients to ask for attention in more appropriate ways. Engaging in an argument will only escalate the situation and result in the client's becoming the center of attention.

Further, counselors working with borderline clients with HIV disease must contend not only with a serious psychiatric disorder but also with a serious medical illness. It is important for therapists to be familiar with the symptoms and course of both conditions. In particular, it is often necessary to distinguish between real medical problems and ones clients fabricate or report for secondary gain, for example, as attempts to get attention or to shift attention from such problematic behaviors as drinking or using drugs.

**Team Management of Borderline Clients with HIV Disease**

The medical, psychological, and social complexities of HIV disease usually necessitate the involvement of multiple providers and disciplines. This is particularly true at teaching hospitals where many people with HIV disease receive care. The team approach is a strength in the care of this population, but it can also be a liability in managing HIV-infected borderline clients who employ splitting and projective identification. In these settings, it may be most useful for therapists to serve as consultants to the treatment team rather than as counselors to clients.

The most important goal in providing care in institutions is to establish clear communication among treatment team members. The first step is to assemble the team for a network meeting, or case conference, about the client. It is critical that all the primary providers are there, including the primary physician, nurse, and social worker. With especially difficult clients, assigning a primary contact person to the client will minimize opportunities for splitting. The network meeting also serves to defuse tension and gives the team an opportunity to vent frustrations.

It is often necessary for mental health professionals to educate the treatment team about the features of borderline personality disorder and to help develop a treatment plan specifying treatment
goals and client and staff responsibilities. In general, these plans structure as many aspects of team-client interactions as possible. For example, client responsibilities may include coming to appointments on time, taking medications regularly and as prescribed, monitoring and reporting physical changes, communicating complaints to appropriate parties, and asking for help directly when it is needed. If clients call repeatedly and inappropriately, the team should establish and enforce telephone limits. If clients begin trying to split staff, staff should directly acknowledge this behavior and encourage clients to speak directly with team members about their concerns. Staff responsibilities may include responding to clients’ requests for help as soon as possible and seeing clients on time.

Team management of borderline clients must seek to balance the authentic medical, psychological, and practical needs of clients while setting reasonable limits for staff. As client needs change, the treatment plan should be appropriately modified. By providing clients with copies of their treatment plans, staff ensure that client needs are addressed; clarify responsibilities and commitments; and minimize opportunities for clients to act out to gain attention, split staff, or receive material gains. The following case example illustrates the value of appropriate team management.

Janine

Janine is a twenty-six-year-old White woman who found out she was HIV-infected two years ago when her six-month-old son Ronald became ill with AIDS. She and her boyfriend, Roger, also seropositive, have a long history of injection cocaine and crack abuse and were probably infected by sharing needles. They continue to use crack intermittently. In addition to Ronald, Janine has a seven-year-old daughter, Mary, who is uninfected. Ronald has been seriously ill with recurrent pneumonia and failure to thrive. Janine and Roger have been in relatively good health.

Janine was concerned about Ronald’s health, and hospital staff initially viewed her interest as supportive. However, her behavior quickly became demanding and erratic. She alternately idealized then devalued different providers on the treatment team. She called several times a day to demand time, attention, money, and supplies, such as diapers and bus tickets, from administrative as well as clinical staff.
When her physician set limits on her interactions, she went outside the clinic to complain to hospital administrators and to other community institutions. Naturally, when she approached community groups claiming that her sick child was not receiving adequate care, they responded by confronting clinic staff.

Angry at Janine and concerned about Ronald, the team called in a psychiatrist, Susan Paterno, M.D., to consult about the case. Paterno organized a network meeting in which team members voiced frustrations and concerns. The team then assigned Janine and Ronald a primary nurse, physician, and social worker to manage the case. They arranged a schedule of visits to the clinic and informed Janine that she should contact her social worker no more than once a day, except in the case of medical emergency. They also developed a diaper distribution schedule to address Janine’s concerns about this issue. The team distributed the plan to Janine and to all staff, including the frontline clerical staff and hospital administration.

At first, Janine tested how serious the staff were about enforcing the contract. For example, she approached the front desk clerk, Ellen, to ask for diapers when she knew she was not scheduled to get them for several days. Ellen, who was aware of the contract, politely excused herself and spoke with Janine’s social worker, John, to ensure that the schedule had not been changed. Ellen and John then spoke to Janine to remind her about the contract, make sure there was no medical emergency, and reiterate the terms of the contract. When the staff repeatedly affirmed the contract, Janine settled in and followed it most of the time. Her satisfaction, Ronald’s care, and the staff’s frustration level were much improved.

Paterno held follow-up network meetings at regular intervals to support staff and help them enforce the plan. At one point, staff members became lax about the rules, and Janine returned to some of her old behaviors, but the team was able to resume the plan with good results. It is important to note that administrative staff—who dealt with Janine more than clinical staff—were critical players in the implementation of the plan.

Working with HIV-infected borderline clients is a difficult and challenging task even for the most experienced clinicians. This population provides unique challenges because of the complexities of
their medical and psychiatric disorders. Providers must recognize and process the interpersonal and practical problems, the stigma of the disease, and the feelings of emptiness borderline clients face. Reasonable but firm boundaries and limits are crucial to avoid the chaos that borderline clients inject into therapeutic relationships.

Individual and group psychotherapy are generally helpful for borderline clients, and including mental health professionals in treatment teams can manage these clients in institutional settings. With borderline clients more than others, therapeutic goals must take into account physical limitations, clients’ ability to work in therapy, and their desire for change.

Notes
7. Widiger and Weisman, “Epidemiology of Borderline Personality Disorder.”
9. Perkins, Davidson, Leserman, and others, “Personality Disorders in Patients Infected with HIV.”
21. Groves, “Patients with Borderline Personality Disorder.”
23. Eversole, “Psychotherapy and Counseling.”
24. Groves, “Patients with Borderline Personality Disorder.”
29. Beck and Freeman, *Cognitive Therapy of Personality Disorders*.
30. Eversole, “Psychotherapy and Counseling.”
32. Groves, “Patients with Borderline Personality Disorder.”
Chapter Fourteen

The Diagnosis and Management of HIV-Related Organic Mental Disorders

Wilfred G. Van Gorp
James W. Dilley
Steve L. Buckingham

People with HIV disease can suffer from cognitive changes resulting from a variety of underlying conditions. In fact, clinicians have known for some time that the brain is more likely than not to be affected at some point in the course of the disease: autopsy studies have found that at least 90 percent of people who die with AIDS have some degree of central nervous system abnormality.1

HIV displays a predilection for certain portions of the brain, most notably those structures located below the level of the cortex. These areas, termed subcortical structures, are involved in mood, the regulation of affect, psychomotor speed, and fine-motor precision—and this helps explain the depressive symptoms and psychomotor speed and fine-motor slowing in illnesses that disrupt the subcortex.2,3 Opportunistic infections can also directly affect the brain and cause physical or mental disability among some people with HIV disease. The most common of these infections include toxoplasmosis, cryptococcal meningitis, progressive multifocal leukoencephalopathy (PML), and lymphoma. In addition, delirium (which is associated with an underlying medical abnormality or toxicity) or toxic states brought on by substance
abuse, can also cause cognitive changes among people with HIV infection.

Not everyone with central nervous system (CNS) abnormalities experiences cognitive impairment, and among those who do, the degree of impairment is variable. Minor cognitive impairment typically includes mild memory loss or slowing during complex or timed tasks. Full-scale dementia comprises more severe problems with memory and other cognitive abilities that interfere with the ability to care for oneself or to fulfill work or social obligations. In addition, although emotional difficulties do occur among individuals who experience traumatic life situations, such as facing a potentially fatal illness, changes in mood and affect can themselves reflect central nervous system disease.

In general, cognitive dysfunction related to HIV infection can be diagnosed as “HIV-associated cognitive-motor complex.” Within this complex, clients with moderate to severe cognitive impairments are diagnosed with “HIV-associated dementia”; individuals with subtle to mild cognitive impairment are diagnosed with “HIV-associated minor cognitive-motor disorder impairment.”

Some of the causes of cognitive impairment can be successfully treated, whereas others can only be managed. But in order to respond appropriately to the range of cognitive symptoms, mental health professionals who work with HIV-infected clients must be knowledgeable about the disorders that cause cognitive impairment and must feel comfortable managing them using both medications and psychotherapy. This chapter, following the case of Lisa, plots the course of HIV disease and its cognitive effects on a single client, offering insights into the assessment and treatment of HIV-related organic mental disorders.

**Screening for Cognitive Impairment in HIV Disease**

Because of the known association between HIV infection and cognitive impairment, the most important task for the mental health provider is to be alert to the potential signs and symptoms of impairment. These symptoms function as an “early warning system,” and heeding them ensures that clients have the best chance of successful treatment. Among the symptoms that the provider should
notice and monitor over time are slowing in thinking or psycho-
motor speed and decreased spontaneity. Among the symptoms that
can indicate acute illness are the onset of prolonged or severe
headaches, seizures, and progressive muscle weakness evidenced as
difficulty walking or abrupt changes in handwriting or other fine-
motor skills. Should any of these symptoms develop or worsen, the
provider should suspect neurological involvement and immediately
refer their client to his or her physician for further evaluation.

In general, “slowed thinking” is a common complaint among
many people with HIV disease, especially among those at later
stages of the illness. For example, a person may initially report con-
centration problems, forgetfulness, and difficulty balancing a
checkbook. Depression or agitation, rather than an HIV-related
central nervous system disorder, may be the cause for these com-
plaints. More than one study of asymptomatic and symptomatic
seropositive individuals has found that a subject’s self-report of cog-
nitive failures did not relate to the actual degree of his or her ob-
jective neuropsychological functioning; instead, it related to mood
state. Those who were more depressed tended to complain of
more cognitive failures than those who were less depressed, re-
gardless of the objective level of their neuropsychological abilities.

Likewise, symptoms associated with substance abuse may over-
lap with those associated with HIV-related neurologic disease. For
instance, a client with a long-standing history of alcoholism may
have clinically significant memory impairment, having difficulty es-
pecially recalling information he or she has recently learned. Sub-
stance-abusing clients may also have short-term memory loss (not
being able to retain information over a period of five minutes or
more) and difficulty completing multiple-step tasks. If a client is
also infected with HIV, it is often difficult to tease apart these po-
tential causes of cognitive impairment, particularly in those with
more advanced stages of immunosuppression.

Brief tests of mental status, such as the Mini–Mental State Exam,
have not been shown to be sensitive screening devices for cognitive
impairment in individuals with HIV infection. Standard psychol-
ogical and neuropsychological tests administered and interpreted
by a neuropsychologist are the most sensitive measures to detect
subtle, HIV-related cognitive dysfunction. Comprehensive neu-
ropsychological examinations may be necessary to uncover even
more subtle, subclinical impairment and to assist in making a differential diagnosis among depression, chronic substance abuse, a history of learning disability, and HIV-related cognitive impairment.

Additional tools exist to enable clinicians to screen larger numbers of seropositive clients efficiently. Psychomotor slowing—a general slowness in thinking coupled with slowness in physical movement—and memory impairment are hallmark characteristics of mild to moderate levels of HIV-related cognitive impairment. Therefore, measures that assess these functions should most effectively detect the existence of HIV-related cognitive impairment. However, it is important to note that because psychomotor slowing occurs as a result of many conditions, detecting it gives little information about the actual cause of impairment. Among brief cognitive tests, the first two described here are particularly sensitive to psychomotor slowing and memory impairment:

- Trail Making Test A and B. Trail Making Test A consists of an array of the numerals 1 to 25 distributed on a page. Clients connect one number to the next, in order, as quickly as possible. Trail Making Test B includes both numerals and letters, and the client must sequentially alternate from a numeral to a letter, back and forth, as rapidly as possible (for example, 1-A, 2-B, 3-C).  

- Symbol Digit Substitution Test. In this test, the client is shown a series of numerals paired with symbols. Applying this "key," the client must write down as rapidly as possible the symbols associated with an array of numbers that are presented in a generally random order, within ninety seconds.

- Other memory assessment tests. Memory assessment using a list-learning test such as the Rey Auditory Verbal Learning Test or the California Verbal Learning Test can also be useful. These tests consist of learning and then recalling a list of words presented over several trials, usually followed by a short- and longer-term delayed recall.

Testing using all of these measures must be conducted by individuals who are trained in the administration and interpretation of psychological tests and who understand psychological testing, normative databases, and brain-behavior relationships. Lisa's case
offers an overview of screening and diagnosis of cognitive impairment including the application of this array of tests. (Note: Because Lisa represents a "teaching" vehicle to illustrate various aspects of HIV and its common effects on the brain, the case may appear somewhat contrived at times.)

Lisa: The Progression of Organic Mental Disorder

Lisa, a thirty-seven-year-old married woman, learned she was HIV-infected two years ago when she donated blood at her company-sponsored blood drive. To her dismay, her husband John also took the test and discovered that he too, although asymptomatic, was HIV-infected. After questioning, John acknowledged that he had occasionally engaged in sexual activities with men and had only recently discovered that one of his sexual partners had AIDS.

When she learned she was infected, Lisa’s viral load was 60,000 copies per milliliter and her CD4+ cell count was 180. (Although some disagreement exists about when antiretroviral therapy should begin, viral loads of greater than 5,000-10,000 are considered "high," and treatment is recommended. Also note that because Lisa’s CD4+ count was below 200, she also qualified for a diagnosis of AIDS.) The fact that her immune system was already significantly compromised suggested that she had become infected several years ago. Her physician, Phillip Garcia, M.D., recommended combination therapy, and she began treatment with zidovudine (ZDV, AZT); lamivudine (3TC), a drug similar in action to ZDV; and ritonavir (a protease inhibitor). Because her CD4+ cell count was below 200, Garcia also started her on Bactrim (an antibiotic) to prevent the development of Pneumocystis carinii pneumonia (PCP). During her initial appointment, Lisa also admitted to excessive alcohol use during her college years (three or four mixed drinks a day several times per week), but she said she had had no prior psychological or psychiatric treatment. She did describe a history of mental illness in her family, including an aunt with a bipolar disorder and a grandfather with Alzheimer’s disease.

Lisa was upset when she learned she was infected with HIV and that John had been sleeping with men for years without her knowledge. Because of her distress, she began seeing a psychotherapist weekly. She expressed sadness, which was not severe and seemed to focus on her concerns about HIV infection and her anger about her husband’s bisexuality. At Lisa’s request, John joined Lisa and her therapist for several sessions to enable Lisa to confront John more easily about her sense of betrayal. Because her mood symptoms were not severe and she was able to continue working and to take care of herself and her fam-
ily, Lisa was diagnosed with adjustment disorder with depressed mood and not with major depression. Lisa saw her psychotherapist for six months until she reported a significant improvement in her mood and believed that she had adjusted to her illness.

Lisa also saw Garcia regularly during this time. Unfortunately, because of a past history of chronic hepatitis, Lisa was unable to tolerate ritonavir or any of the protease inhibitors. Her viral load consequently remained high.

*Depression and Delirium*

Lisa remained psychologically stable for three months after terminating with her therapist. At that time, she gradually became depressed, lost ten pounds, and exhibited classic “neurovegetative” signs of depression: increased sleep—especially during the day—diminished appetite, decreased interest in sex, and failure to enjoy the activities she had found enjoyable.

In response, Lisa resumed outpatient therapy, this time with sessions twice a week. Because of the severity of her symptoms, her therapist referred her for psychiatric consultation. Her psychiatrist, Susan Lee, M.D., discovered that in addition to feelings of depression, Lisa was experiencing fatigue, night sweats, and nausea, which contributed to her weight loss. However, she also found that Lisa admitted to thinking about suicide—“Yeah, I think about it; it would solve a lot of problems and I wouldn’t have to go through all this”—although she denied that she would ever do anything to harm herself. Susan also reported significant feelings of guilt and worthlessness. In response, Lee made a diagnosis of major depression. She prescribed the antidepressant sertraline (Zoloft) at the usual dose. (Had Lisa been able to tolerate a protease inhibitor, the dose would have been decreased because protease inhibitors strongly compete with the body’s mechanism for metabolizing these antidepressants and cause the blood level to be effectively higher than in someone not taking a protease inhibitor. See Chapter Eleven for a more detailed discussion of this issue.) In addition, Lisa continued with ongoing psychotherapy.

Three weeks after resuming therapy, or about ten months after she was first diagnosed with HIV disease, Lisa’s husband telephoned her psychotherapist to report that Lisa had awakened that morning feeling ill and confused. She was unable to say where she was and was easily distracted. She told her husband there were “lots of other people in the room, coming and going,” even though no one else was present. John telephoned an ambulance, which took Lisa to her local emergency room.
At the hospital, the emergency room physician noted that Lisa's condition was stable and then phoned her psychiatrist and asked her to evaluate Lisa. Lee found that Lisa was confused and distracted and was experiencing both visual and auditory hallucinations and that her speech was tangential and rambling. Mental status testing demonstrated that Lisa had a severe attention deficit and impaired "digit span": she could immediately repeat only three digits forward and no digits in reverse (far below the normal seven digits forward—plus or minus two digits—and five in reverse). Lisa demonstrated other cognitive deficits as well, including difficulty with arithmetic calculations, memory, writing (agraphia), naming objects (anomia), and some word substitutions (paraphasia).

Lee gave Lisa a provisional diagnosis of delirium—an "acute confusional state" (as defined in the next section). In this case, subsequent laboratory and x-ray studies revealed an elevated white blood cell count, fever, and a previously undiagnosed pneumonia. Lisa was admitted to the hospital and treated with antibiotics, and her mental state gradually improved over the next seventy-two hours as her pneumonia subsided. At the time she was discharged, Lisa's mental status had returned to normal, and Lisa had resumed antidepressant treatment and weekly outpatient psychotherapy.

Delirium is probably the most common cause of abrupt change in the mental state of people with HIV disease, occurring especially among acutely physically ill hospitalized clients. An abrupt onset, a striking deficit in attention, and the presence of hallucinations are characteristic of delirium. Because many of the ongoing medical conditions people with HIV disease face can lead to delirium and because delirium is associated with high rates of death, altered mental status requires immediate medical attention.

Delirium can be acute or chronic and may be caused by a number of medical abnormalities, such as toxicity related to medication; or metabolic disturbance, for example, an electrolyte imbalance related to dehydration, high fever, or undiagnosed infection. Other HIV-related causes might include toxoplasmosis (a parasitic brain infection), cryptococcal meningitis (a fungal infection of the covering of the brain), and neoplasm (a brain tumor), all of which in themselves can produce cognitive abnormalities.

Because delirium seriously affects attention, neuropsychological and mental status tests of attention and concentration will un-
cover the greatest impairment. In particular, delirium will degrade digit span and mental control. Because of their variable attention, individuals with delirium may experience a pattern of "spotty" neuropsychological deficits in other cognitive domains as attention waxes and wanes during the assessment. They may also suffer from agraphia and aphasia (a language abnormality affecting speaking and comprehension), rambling and tangential speech, and neuropsychiatric complications such as visual or auditory hallucinations and delusions.

Delirium is different from HIV-related minor cognitive-motor disorder or HIV-associated dementia in several ways. Delirium typically presents with an abrupt onset of confusion, dramatic attention difficulties, and a language impairment characterized by rambling, incoherent speech and writing. In contrast, HIV-associated dementia and HIV-associated minor cognitive-motor disorder usually appear more slowly over time and leave basic attention intact, affecting only the more complex attributes of divided and sustained attention.

After an acute delirious state resolves, neuropsychological testing can be useful in assessing whether and to what extent underlying cognitive impairment may be present. This follow-up analysis is important, because it is not uncommon for a delirium to be superimposed on an underlying dementing condition. In fact, because people with brain damage are at higher risk of developing delirium, it is likely that one of the reasons that delirium is common among people with HIV disease is that they frequently have underlying cognitive impairment caused by neurological damage.

Physiologic and biologic measures are also important tools necessary to diagnose the causes of delirium and to distinguish delirium from HIV-associated dementia. Neuroimaging (computerized tomography scans and magnetic resonance imaging scans) and an analysis of the cerebrospinal fluid are needed in order to rule out other neurologic infections. Blood analyses, including complete blood count (CBC) and vitamin B₁₂ and folate levels; thyroid function tests; and a general blood chemistry panel, which tests electrolyte levels as well as kidney and liver function, are also important. Finally, an electroencephalogram (EEG) can aid in differential diagnosis by indicating an overall decrease in the brain's electrical activity—a classic sign of a dementing illness.
The Subtle Effects of HIV in the Brain

Six months after her episode of delirium (now sixteen months after her initial diagnosis of HIV), Lisa's depression had gradually lifted. Because her mood had improved significantly and because Lisa did not like the idea of taking medications, she insisted on stopping her antidepressant. Lee, her psychiatrist, discontinued her Zoloft, while Lisa continued weekly psychotherapy.

Three months later, Lisa's husband telephoned her psychotherapist to inquire whether Lisa had reported being in several minor automobile accidents over the previous two months. Lisa's psychotherapist reminded John that she was not at liberty to discuss the content of Lisa's therapy sessions. John acknowledged this position, saying that he only wanted her to know that these incidents had occurred and that, in general, Lisa did not seem to be herself: she had become emotionally "flat" and had difficulty maintaining her train of thought. John said that the reason he was calling now was that Lisa had telephoned him from a nearby shopping mall that morning and told him that she had lost her car.

Listening to John, Lisa's psychotherapist realized that she had noticed that Lisa had become increasingly withdrawn and had shown more pronounced psychomotor slowing over the past several months. Her therapist also remembered that Lisa had reported several memory lapses, which the therapist had ascribed to a mild clinical depression, and that during therapy, Lisa had appeared uninterested and emotionally flat. Further, she recalled that Lisa had seemed clumsy and weak when they last met. Her therapist referred Lisa to a neurologist, Kevin Sills, for evaluation of the memory lapses and clumsiness.

Sills examined Lisa and noted that although she exhibited all of these signs plus a slight increase in her reflexes (hyperreflexia), the examination detected no specific neurologic abnormalities. Sills ordered an MRI and a lumbar puncture, both of which were found to be normal. Lisa's responses to a general mental status screening exam were correct, but she was slow in her reactions and often appeared unsure of her answers. During the interview, Sills was struck by the discrepancy between Lisa's flat, slowed presentation and the lack of depressive or pessimistic content in her speech. In fact, despite her presentation, Lisa denied any pessimism and indicated that she expected to "maybe get better and fight off this thing until a cure is found."

Sills referred Lisa to a neuropsychologist for assistance in distinguishing between HIV-associated minor cognitive-motor disorder, HIV-associated demen-
The neuropsychologist administered a comprehensive battery of neuropsychological tests, which detected lower than expected scores measuring psychomotor speed, set shifting (the ability to mentally shift from one task to another), and memory. (See Exhibit 14.1.)

Memory testing (the California Verbal Learning Test) revealed that Lisa’s recall (the ability to remember recently learned new information) was more impaired than recognition (the ability to choose the correct answer from a list of answers). Because of this constellation of symptoms, Lisa’s activities of daily

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intelligence</strong></td>
</tr>
<tr>
<td>Wechsler Adult Intelligence Scale—Revised</td>
</tr>
<tr>
<td><strong>Attention</strong></td>
</tr>
<tr>
<td>WMS-R Attention/Concentration Index</td>
</tr>
<tr>
<td>Digit Span</td>
</tr>
<tr>
<td>Auditory Consonant Trigrams</td>
</tr>
<tr>
<td>CalCAP (computerized reaction time performance task)</td>
</tr>
<tr>
<td><strong>Language</strong></td>
</tr>
<tr>
<td>Boston Naming Test</td>
</tr>
<tr>
<td>Controlled Oral Word List Generation Test</td>
</tr>
<tr>
<td>Boston Diagnostic Aphasia Examination</td>
</tr>
<tr>
<td><strong>Memory</strong></td>
</tr>
<tr>
<td>Wechsler Memory Scale—Revised</td>
</tr>
<tr>
<td>California Verbal Learning Test</td>
</tr>
<tr>
<td>Recall of Rey Osterrieth Complex Figure</td>
</tr>
<tr>
<td><strong>Visual/Spatial</strong></td>
</tr>
<tr>
<td>Recall of Rey Osterrieth</td>
</tr>
<tr>
<td>WAIS-R Subtests: Block Design and Object Assembly</td>
</tr>
<tr>
<td><strong>Executive Functioning</strong></td>
</tr>
<tr>
<td>Wisconsin Card Sorting Test</td>
</tr>
<tr>
<td>Stroop Color Interference Test</td>
</tr>
<tr>
<td><strong>Mood/Affect</strong></td>
</tr>
<tr>
<td>Minnesota Multiphasic Personality Inventory-2 (MMPI-2)</td>
</tr>
<tr>
<td>Beck Depression Inventory</td>
</tr>
</tbody>
</table>
living—for example, balancing her checkbook and recalling a shopping list—were compromised. In contrast, Lisa’s language and most visual-spatial functions were relatively intact. Lisa also scored within the normal range on the Beck Depression Inventory, with items that reflected her concerns about her physical appearance and weight loss resulting in a slightly elevated overall score. In the absence of significant findings of depression or other neurologic cause for her cognitive difficulties, and in light of the impact of these neurocognitive deficits on Lisa’s ability to manage her activities of daily living, the neuropsychologist concluded that Lisa had HIV-associated dementia. The neuropsychologist suggested that Lisa come back in four to six months to confirm the diagnosis based on retesting and to monitor Lisa’s course.

Diagnosing HIV-Associated Dementia

HIV-associated dementia most closely resembles a subcortical dementia, which is distinguished from a cortical dementia such as Alzheimer’s disease by several key neuropsychological features. Among the hallmark characteristics of a subcortical dementia are psychomotor slowing, memory disturbance, and difficulty with complex cognitive tasks that require shifting between two tasks or concepts. Unlike Alzheimer’s disease, HIV-associated dementia is usually characterized by forgetfulness rather than a frank inability to learn new information.

For example, a person with an HIV-associated dementia may have difficulty recalling a list of words or medication instructions but will often be able to recognize the correct information from multiple choices—indicating that the individual has learned the material but has difficulty retrieving it. Lisa would frequently “forget” agreements she had made with her husband, John, even after he made a concerted effort to repeat them when they were made. When Lisa failed to “remember” the agreement later, John would remind her, and she would be able to recall the discussion.

As noted earlier, because the range of impairment is broader than that encompassed by a diagnosis of HIV-associated dementia, HIV-associated minor cognitive-motor disorder describes more “mild” cases in which activities of daily living are not as seriously affected. The essential difference between these two conditions is that in HIV-associated dementia, the client’s symptoms are sufficiently severe to interfere significantly with social or occupational
functioning. Lisa met this threshold and satisfied the four criteria for a diagnosis of HIV-associated dementia: she had a positive HIV antibody test result; she experienced disarming cognitive, motor, or behavioral symptoms that interfere with occupational or social functioning; her symptoms were confirmed by another person; and a medical work-up ruled out any other condition that might account for the impairment.

Of course, it is important to note that dementia itself may make the person with HIV disease an unreliable historian. For example, some clients will overinterpret their disabilities because of anxiety or depression; others may so in order to qualify for medical disability payments or other social services. To relieve the clinician of having to rely solely on the subjective statements of the client, HIV-associated dementia must be diagnosed only if cognitive problems and their effects on a client’s life can be confirmed by an “objective” means or a reliable informant. It is often a client’s partner—in Lisa’s case, John—who, because he or she has the benefit of witnessing a client’s behavior often and under a variety of circumstances, first identifies cognitive problems. For example, John reported Lisa’s impaired motor skills, memory loss, and general withdrawal and lack of social involvement.

Although the frequency of neurological abnormalities in people with AIDS is high, the expression of these abnormalities as symptoms of cognitive impairment is much lower; that is, most brain abnormalities do not lead to cognitive impairment. Two studies found an annual incidence of HIV-associated dementia to be approximately 7 percent in people with AIDS. In addition, a study finding that HIV-associated dementia occurs more frequently in the very young and the very old suggests that these populations may be at increased risk for this condition; however, did not find increased frequency in the elderly. Although the literature is complex and sometimes contradictory, most researchers and clinicians agree that it is relatively uncommon for asymptomatic people with HIV disease to experience HIV-associated dementia. A comprehensive review of thirty-six cross-sectional and nine longitudinal studies stated, “If one accepts the heightened power of larger studies, then it must be concluded that there is insufficient evidence to support the argument for an increased prevalence of neuropsychological deficit in asymptomatic
individuals." Thus, although asymptomatic people with HIV disease can experience HIV-associated dementia, it is sufficiently uncommon that clinicians should thoroughly rule out all other potential causes for symptoms of cognitive impairment.

Although there is no cure for HIV-associated dementia or for HIV-associated minor cognitive-motor disorder, studies have found ways to curtail their development and manage them. Among these approaches are the use of medications and environmental engineering, which are described in more detail at the end of this chapter. Furthermore, in light of HIV antiviral therapies, including combinations with protease inhibitors and new drugs, the incidence of HIV-associated cognitive decline may further decrease.

Differentiating HIV-Associated Dementia from Depression

Clinical depression, which can also produce symptoms of cognitive impairment, has been found in 6 to 15 percent of people with HIV disease at some stage of their illness. These rates are consistent with findings that clients with a number of neurological disorders have elevated rates of depression even when compared to other medically ill clients. For instance, Parkinson’s disease, Huntington’s disease, and progressive supranuclear palsy—all of which can produce a subcortical dementia in some people—can lead to higher levels of depression when compared to other medically ill clients with comparable functional disabilities, such as severe rheumatoid arthritis. These findings lead to the conclusion that mood disorders in people with subcortical disease, including HIV infection of the brain, may represent central nervous system changes rather than solely psychological reactions to illness or disability.

The symptoms of clinical depression may mimic those of HIV-associated dementia, and vice versa. Psychomotor slowing, fatigue, irritability, difficulty concentrating, weight loss, and insomnial may occur in either case. Whenever there is evidence of a subjective mood disturbance, marked by sad affect, crying, hopelessness, guilt, and self-loathing, clinicians should first treat the probable depression and then reevaluate clients for residual cognitive deficits that may represent a coexistent dementia.

Although this course of treating depression first is wise, there are several clinical features that may nonetheless help to differen-
tiate clinical depression from HIV-associated dementia. First, clinicians should differentiate between a depressed and apathetic affect. Clients who are depressed may indeed be characterized as lethargic and indifferent, but they also communicate a sense of sadness or emotional pain. Apathetic clients usually do not emotionally reach out or communicate emotional distress. Clinicians or informal caregivers asked to evaluate a client should pay attention to the feeling they get when with the client. Being with depressed clients usually makes a person feel sadness or distress. Being with apathetic, dementing clients, in contrast, often leaves one feeling emotionally flat. This distinction may be a difficult one for informal caregivers who are emotionally attached to clients. Watching one’s child or partner begin to change and become distant—whether because of sadness or apathy—is never easy and clouds the caregiver’s judgment.

Second, consider a client’s psychiatric history. People with a history of depression are much more likely to have a recurrence of major depression than those who do not, and this remains true even in the face of a life-threatening illness. In addition, clients with a family history of depression are at greater risk of being clinically depressed. Also, clients with dementia tend not to be motivated toward suicide—recall that they are more apathetic and less distraught than people who are depressed. Thus, clinicians should also consider the presence of suicidal thinking as a sign of depression.

Third, observe a client’s functioning over time to verify clinical conclusions. If the cognitive impairment continues to predominate and progress, the diagnosis of HIV-associated dementia becomes more likely.

Fourth, keep in mind that dementia and depression can coexist. If the usual signs and symptoms of depression are evident, clinicians should refer clients to an HIV-knowledgeable psychiatrist for evaluation; these clients may benefit from a trial of antidepressant medications. Some researchers have also used psychostimulants for depressed people with HIV disease, and preliminary data suggest cognitive and affective improvement in people with early HIV-related cognitive impairment, without the addiction or drug seeking that may accompany psychostimulant use.

Finally, some medications—including steroids or anticancer drugs—may have depressive effects. Clinicians should consider
their role when seeking to diagnose the cause of a depressive disorder.

**HIV-Associated Psychosis and Mania**

Two months after her diagnosis of HIV-associated dementia, Lisa became convinced that three strangers had moved into her house and would occasionally talk to her. John reported noticing her talking to "another person," even though no one else was in the room. When questioned, Lisa reported that she was talking to her new houseguests.

Psychosis can range from a single delusion ("someone is poisoning my food") or a group of related delusional ideas, to active auditory and visual hallucinations. Although HIV-related psychosis may be caused by a variety of conditions, it is usually connected to HIV-associated dementia; and although there have been some reports of psychosis occurring among the first symptoms of HIV-associated dementia, it is usually manifest as acute delirium in the late-middle or end stages of HIV-associated dementia. Among the causes of psychosis in people with HIV disease are the following:

- An organic delusional disorder or organic hallucinosis
- Delirium, possibly caused by medication toxicity, drug withdrawal, or a metabolic disturbance
- A coexisting schizophrenia or a schizophrenia-like disorder
- Major depression with psychotic features

If psychosis accompanies a pessimistic, morbid outlook, this may suggest depression with psychotic features. A family history of psychosis may more strongly suggest a coexisting schizophrenic disorder. Finally, clinicians should review a client's medications and, if this is the first episode of psychosis, prescribe a general medical workup for the client to rule out medical causes of psychosis, including medication toxicity, metabolic imbalances, and central nervous system infections.

Symptoms of mania—including pressured speech, spending sprees, and sleeplessness—have been reported in clients with various neurologic disorders, including HIV disease, especially fol-
owing injury to certain areas of the brain. Mania may also occur in response to various pharmacologic agents—legal and illegal—and clinicians should be vigilant to the possibility of mania in response to withdrawal from these drugs. Finally, central nervous system disorders—including PML, toxoplasmosis, and tumor—can all produce mania, especially if they affect the frontal lobes or the frontal and subcortical connections.

Clients with cognitive impairment who also demonstrate psychotic or manic behavior can benefit greatly from psychopharmacological approaches in conjunction with supportive psychotherapy. Antipsychotic medications in low doses or with prophylaxis against side effects are particularly helpful for several reasons. First, they decrease psychotic symptoms in those with organic mental disorders, including HIV-associated dementia, and cognitively impaired clients can tolerate dosages comparable to those used in the general population. Second, these agents can be used to control agitation. Finally, antipsychotics in modest dosages can be useful in clients with severe character disorders. The choice of antipsychotic agent should be dictated by the side-effect profile. Mid-range potency agents such as perphenazine (Trilafon) and thiothixene (Navane) rather than the high-potency haloperidol (Haldol) may be the first drugs of choice. Haloperidol has been associated with severe side effects in some people with AIDS. Initial dosing may begin with 2 milligrams of Trilafon twice a day or 2–5 milligrams of Navane per day, with 0.5–1 milligram of benztropine (Cogentin) twice a day as prophylaxis against the development of extrapyramidal reactions (stiffness and muscular rigidity). Upper levels of dosing are dependent on a client’s tolerance, the severity of symptoms, and the emergence of side effects.

**Treatment for HIV-Related Organic Brain Disorders**

Cognitive and motor slowing makes it difficult for impaired clients to function in situations that require quick decisions and action. For example, working in a busy office where the individual must act quickly may frustrate the mildly impaired client and may promote a sense of failure. Further, unfamiliar environments may lead to increasing confusion.
Practical Recommendations

For clients like Lisa and others with HIV-related cognitive impairment, several practical recommendations can assist in the struggle to adapt to cognitive changes and the resulting limitations. Many clients complain that it is the simplest of these limitations that create the most frustration. To respond to these difficulties, caretakers should consider the following approaches:

- Place a large calendar near the bedside or prominently in the living space to remain oriented to month, date, and year.
- Use notes, reminders, lists, and appointment books to cue recognition. Maintain a telephone log and a medication log.
- Use a tape recorder to dictate thoughts and questions.
- To respond to motor and gait disturbances, alter living arrangements as much as possible to avoid stairs.
- Limit the number of different caretakers and distractions.
- Avoid crowds or having more than one visitor at a time.
- Allow more time for conversations.
- Keep instructions as simple as possible and give one instruction at a time. Break large tasks into smaller ones, and keep a log for complex projects.
- Keep to a routine; for example, go to bed and get up at roughly the same time each day.
- If able to drive, plan routes in advance, allow plenty of time, and take a friend along. Don’t drive in heavy traffic.

As is true for people with other subcortical disturbances, clients with HIV-associated dementia may lack the necessary initiative to begin an activity even if they are motivated to undertake it. Family members or loved ones may provide the crucial impetus for starting a desired activity.

Friends, family members, and partners may be understandably frustrated by the physical and mental debilitation of their loved one. Many have little or no understanding of neurological functioning or of the diseases that affect cognition. Upon hearing the term dementia, many people imagine the most severe clinical characteristics, such as complete memory loss and a vegetative state. Helping clients and their loved ones to better understand neu-
ropsychological functioning and the kind of changes associated with subcortical disease can reduce fears and worries about cognitive impairment.

Friends, family members, and partners may also feel a "need to blame" and may act on this impulse by attributing a client's forgetfulness to willful stubbornness or manipulation. Education of a client's caregivers is the best antidote to this type of misattribution. Families and caretakers must realize that cognitive impairment reflects actual brain damage rather than volitional behavior.

Psychotherapy may be an appropriate treatment approach for a client in the early stages of HIV-related cognitive impairment, when the therapist can help the client and his or her partners, family, and friends understand cognitive impairment and behavioral modifications that can manage it. For example, Lisa and John both found that Lisa's work with her therapist was helpful, especially as John began to take over more of the responsibility for running the household and having to manage their lives as well as Lisa's failing cognitive capacity.

Through this process of learning, therapy can assist clients in sorting out the activities they can continue and those they cannot, and in setting limits for activities that may create potential problems. Such planning may make the difference between success and failure in adapting to and coping with cognitive changes and may prevent further assaults on the self-esteem of clients already beset by limitations, frustrations, and feelings of failure on many fronts. Finally, therapy can offer clients emotional support to handle these assaults and the opportunity to express their frustrations about declining capacities.

Pharmacological Treatment

Pharmacological treatment of HIV-associated dementia is somewhat controversial and is focused on treatment either of the underlying HIV infection or of the symptoms associated with it. For example, research has shown that ZDV in high doses is sometimes helpful in improving cognition and that joint administration of ZDV and a protease inhibitor may also improve a client's functioning. In fact, had Lisa been able to tolerate a protease inhibitor, the development of HIV-associated dementia may have been
avoided altogether. Although protease inhibitors generally don’t cross the blood-brain barrier in therapeutic amounts, the combination of a protease inhibitor plus ZDV or another similar drug seems to be effective in inhibiting progression of HIV-associated dementia and may even reverse it, presumably by reducing the viral load. Another pharmacological approach is to treat the slowing nervous system with stimulants, although this strategy has been shown to have only short-term positive effects.

It is crucial for mental health providers caring for people with HIV disease to be aware of the effects of HIV infection on the organic aspects of mental health and cognitive capacity. Because of the complexity of the issues confronting clients and their providers, a team approach to handling HIV-related organic disorders facilitates the best care. The team should include the client, his or her physician, family members and caregivers, the client’s psychotherapist, a neuropsychologist, and a psychiatrist. By ensuring a wide range of expertise, providers ensure coordinated care and accurate diagnosis and treatment. Cognitive impairment can be treated or at least managed, making a significant difference in the lives of people with HIV disease, but treating it demands vigilance: early detection, accurate diagnosis, sound clinical intervention, education, and flexibility.

Notes


16. Lezak, Neuropsychological Assessment.

17. Spreen and Strauss, Compendium.


35. Hriso, Kuhn, Masdeu, and others, “Extrapyramidal Symptoms.”


39. Ibid.

Chapter Fifteen

Addressing Substance Abuse in Clients with Psychiatric Disorders and HIV Disease

Joan E. Zweben

Substance use often functions as the "wild card" in AIDS care, influencing the diagnosis of HIV-related and psychiatric disorders as well as the efficacy of medical and therapeutic interventions. Any amount of substance use, even short of meeting criteria for addiction, can have an impact on HIV disease and psychiatric conditions. The combination of these three elements—substance abuse, psychiatric disorder, and HIV disease—presents mental health practitioners with the most complex clinical situation: working with "triply diagnosed" clients.

Although each component of the triad contributes its own complexities to the mix, it is alcohol and drug use that has the least predictable effect. Unfortunately, this is also the element clinicians are often the least equipped to handle.

From a mental health perspective, it is therefore important to understand the historical relationship between psychotherapy and substance abuse treatment. When traditional psychotherapeutic approaches were found ineffective to treat addiction, a number of

This chapter reflects ideas presented in The Alcohol and Drug Wildcard: Substance Use and Psychiatric Problems in People with HIV, by Joan E. Zweben, with Patt Denning (San Francisco: UCSF AIDS Health Project, 1998).
alternatives developed outside the mainstream of mental health care. Although these new approaches proved to be productive, the process resulted in the artificial separation of psychotherapy and substance abuse treatment. For a time, this separation obliged individuals to seek help for their alcohol problems from one system, their drug problems from another, and their mental health problems from a third. Although many of the barriers to integrated care have been removed, they have left a legacy: mental health and medical providers outside the alcohol and drug treatment system are often ill equipped to handle clients with multiple diagnoses. At the same time, the stigma attached to addicted clients has perpetuated their isolation and discouraged the development of integrated treatment.

This chapter first examines the relationships among the members of the treatment team who might treat a substance user with HIV disease and mental illness and then looks at how these relationships might facilitate effective assessment, diagnosis, and treatment of these intertwined disorders.

**Basic Training and Addiction Treatment**

Basic training for mental health providers typically has not required competence in addressing alcohol and drug use. Thus, the most seasoned therapists have been the least knowledgeable and skilled substance abuse providers. In most states, training and continuing education requirements have begun to address this situation, but until material on alcohol and drug use is integrated into the core curriculum of psychiatrists, psychologists, and social workers, professional training will not produce providers who are fully competent to handle these problems.

As epidemiological studies and clinical realities have moved alcohol and drug use into the foreground, medical and mental health practitioners have shifted from ignoring addiction to excluding substance abusers from care or requiring them to seek addiction treatment before receiving medical or psychiatric services. However, the addiction treatment system was, and remains, inadequately equipped to handle the influx of triply diagnosed clients that the system has experienced during the past several years. In addition, the treatment system is, by and large, designed for clients who understand
from the outset that they need to do something about their alcohol and drug use. Those who do not yet embrace this goal but who are interested in other kinds of medical, psychological, or psychosocial help continue to fall between the cracks.

Finally, at times and in places where substance users have been able to access other forms of care, providers have been confused about how to prioritize treatment tasks. This has been one of the most confounding aspects of triple diagnosis. For example, if a co-existing psychiatric disorder has a strong influence on a client’s alcohol or drug use patterns, should that disorder be addressed first? Will addressing it be enough to eliminate the client’s problems? Can a psychiatric disorder be effectively treated if a client continues to drink or use drugs? Can a client achieve abstinence or even make progress toward abstinence if his or her psychiatric disorder is not confronted? How important is it to deal with psychodynamic factors in order to influence alcohol or drug use? These are the types of questions, addressed later in this chapter, that providers must face in seeking to treat HIV disease and mental health disorders in the context of substance use.

Addictive disorders are characterized by behaviors that are compulsive and under intermittent or unpredictable control, and persist in spite of adverse consequences. Although triple diagnosis refers to people who meet these criteria as well as the criteria of a psychiatric disorder and HIV infection, clinicians should remember that alcohol and drug use can be a problem long before the person is considered to have an addictive disorder. People with severe mental illness, in particular, can be exquisitely sensitive to the substances they use; the effects of moderate use on less severe psychiatric disorders, immune function, and HIV progression are less clear.

Clinicians who are not addiction specialists lack the detailed knowledge of drug effects that might enable them to identify adverse consequences quickly, particularly if symptoms are relatively subtle. For example, alexithymia—the inability to identify or experience feelings—is present among people with a history of childhood trauma, but it is also common among marijuana smokers. The result is that once therapists arrive at a plausible psychodynamic explanation for a symptom or condition, they often do not consider other possible factors. In this way, the effects of substance use are underestimated.
The interplay of the three conditions that constitute triple diag-
nosis produces a separate entity, all the more challenging
because the many interactions among the components are poorly
understood. One condition, by itself, may not be severe; but when
combined with symptoms of the other two, it may create a critical
situation. For example, a person with HIV-associated cognitive im-
pairment may be only slightly impaired in his or her daily life; but
if substance use or a psychiatric disorder limits his or her ability to
cope, this minor condition could have increasingly harmful effects.

Provider Subcultures and Systems Issues
At least three specialty systems—medical, mental health, and sub-
stance abuse treatment—are involved in the care of triply diag-
nosed clients. Each system has its own goals, its own language, and
its own set of assumptions—assumptions that may remain unstated
until conflict arises over how to address the needs of a particular
client. Until recently, these disciplines have worked in relative iso-
lation punctuated by misunderstanding. But collaboration, no mat-
ter how difficult, is essential in order to respond adequately to all
aspects of the three disorders. It is a skill as complex as clinical in-
tervention itself but, except among social workers, has received lit-
tle emphasis in professional training. The result of this isolation
has been confusion about what constitutes appropriate care for
triply diagnosed clients. It is possible, however, to create a frame-
work for clinical decision making that can guide collaboration and
inform care, without artificially synthesizing theoretical approaches
that are fundamentally different.

For example, medical staff in clinics and private practice are
usually comfortable assuming a leadership role, making decisions,
and taking action promptly. Under ever-increasing time pressure,
however, they may be less inclined to initiate communications and
share information and more likely to assign tasks to other members
of the team. They may label a former addict as "drug-seeking"—
because he or she is using more pain medication than was pre-
scribed—without taking into account the increased tolerance
created by the drug addiction. They may refuse adequate pain
medication to a person known to abuse drugs; on the other hand,
they may medicate anxious patients as a way of decreasing office
or telephone time spent reassuring them.
Meanwhile, mental health providers often endorse a more holistic model and may be impatient with a physician's focus on a particular disease rather than on the general welfare of the client. When working collaboratively with medical staff, mental health providers can be invaluable because they typically spend more time with the client and can help address many of the issues—such as housing or insurance problems—that interfere with the client's adherence to medical treatment. The case management background of most social workers facilitates their ability to identify and address practical needs.

Finally, addiction treatment practitioners tend to be more comfortable making decisions and taking action than the average psychotherapist, in part because addiction treatment is usually highly structured, a feature that is objectionable to some psychotherapists. In addition, addiction specialists understand that someone who is drinking and using often has impaired judgment and may not be capable of making appropriate decisions. Both medical and mental health staff can become frustrated with the rigidity characteristic of some—but not all—aspects of the addiction treatment system. In the absence of effective communication, tensions among practitioners from these different disciplines can escalate quickly.

Addiction treatment is commonly characterized by structure, multiple behavioral expectations, and discrete treatment components. Psychotherapy, on the other hand, usually incorporates minimal structure, other than the schedule of regular sessions that are its primary component. Many therapists are uncomfortable with eliciting behavioral commitments. Most outpatient addiction treatment is abstinence oriented. Although total abstinence may be difficult to achieve, the goal itself does not usually vary, because abstinence is viewed as the foundation required before meaningful progress can be made on other issues. Psychotherapy, on the other hand, has a wider range of goals and less consistent priorities. Some psychotherapists may not even understand or endorse the need for abstinence as opposed to other forms of controlled use. For example, they may share the view that drinking is "normal" and hence controlled drinking a reasonable goal, even in clients who have repeatedly demonstrated they cannot moderate their use. With the increasing acceptance of harm-reduction approaches, it is important to determine whether therapist endorsement of harm-
reduction goals is based on a knowledgeable assessment of the client or on na"ıveté or discomfort with the goal of abstinence.

Whereas addiction treatment makes alcohol and drug use the primary focus, psychodynamic psychotherapy explores underlying psychological processes as a means of bringing about change. If ill timed, this focus on process can undermine sobriety by elevating anxiety before abstinence is firmly established. But in other circumstances, exploring dynamics can remove important obstacles to progress toward abstinence. Unlike addiction treatment, which often includes breath and urine testing when costs permit, psychotherapy rarely makes use of such testing, which many therapists consider invasive and abhorrent. Therapists and counselors in addiction treatment are active and directive; psychotherapists in private practice have a variety of styles, some of which are more compatible with addiction treatment than others. All of these differences pose challenges to practitioners working with HIV-infected patients with mental health disorders who also drink or use drugs.

Frustrations may also arise when addiction treatment providers have difficulty convincing mental health workers that a client’s symptoms are typical of certain types of alcohol and drug use patterns rather than being related to “only” an emotional problem. On the other hand, mental health practitioners may object to what they see as a blanket labeling of a client as a drug addict when they believe the use is clearly initiated by emotional problems. Mental health workers may see a refusal to treat someone who is actively using as abandonment, whereas some addiction treatment practitioners see continuing to provide services as colluding in perpetuating the addiction. It is noteworthy that only physicians are bound by an oath to work with all patients, whether or not they are abusing drugs. Physicians thus have little understanding or patience for this conflict between mental health and substance abuse practitioners.

Cross-Training

Despite the aforementioned problems, there is reason to be optimistic about developing treatment protocols that marshal the varied expertise of several different professional "cultures." This is particularly true when all providers can agree that services should be driven by the needs of clients.
The first step to ensuring client-driven services is making a commitment to comprehensive “cross-training.” For example, successful cross-training in settings dealing with substance use and mental illness has consisted of training addiction specialists in some aspects of psychological assessment and in altering their tendency to use a confrontational approach when working with emotionally fragile clients. In turn, mental health workers learn about the nature of addiction, the stages of its progression, and the essential elements of successful recovery. Such cross-training is facilitated by regular case conferences and individual supervision.

To build a successful, cross-trained team, it is also important for all the members to clarify and agree on shared approaches to assessment, treatment planning based on client needs and available services, consultation, and protocols that allow flexibility to alter treatment plans or change providers. Among the tasks that should be addressed are:

- Defining team leadership and how collaboration will be managed
- Agreeing on the parameters of a comprehensive assessment
- Prioritizing disorders and establishing a process for changing priorities
- Communicating among team members while respecting patient confidentiality
- Clarifying the shape of the client-provider interaction and the depth of the emotional relationship with the client
- Dealing with client crises and other issues related to the accessibility of each provider
- Understanding philosophical differences and filling gaps in knowledge across disciplines
- Discussing different perspectives on medication and psychoactive drugs
- Clarifying the complex insurance issues of multiply diagnosed clients

Any member of the team can take the initiative to define who will play what roles in these tasks and how the team agrees to function. The necessity of “passing the baton” as symptoms change or as HIV disease progresses should not be an occasion for professional turf wars. Mutual respect and an understanding of differences allow
Assessment and Diagnosis: Differentiating Substance Abuse from Other Disorders

The initial evaluation of any client should define his or her status in the context of safety, stabilization, and maintenance. Once safety and short-term stabilization have been achieved and any immediate crisis has passed, the clinician’s first task is to assess the client’s problems. Although problems in each area—substance use, psychiatric status, and medical condition—must be addressed, providers must prioritize treatment and define appropriate expectations for clients. A chronic amphetamine user, for instance, is unlikely to keep appointments for HIV-related care or to adhere to medication regimens. Unless a medical emergency requires hospitalization, he or she will probably be best served by first arranging for substance abuse treatment, which offers the best chance of improving the efficacy of all other interventions. This is true now more than ever, when successful treatment for HIV disease requires strict adherence to antiviral regimens. Alternately, a deeply depressed client may be unable to participate in the activities that promote sobriety, and a person with HIV-associated dementia may find himself or herself unable to maintain a previously well established sobriety. Because these conditions are highly fluid, clinicians must remain alert for improvement or deterioration on all three dimensions.

Another important consideration in assessment is that at the time of initial presentation there is usually no reliable way to distinguish between symptoms of alcohol and drug use and symptoms of psychiatric disorders. For example, the hallucinations described by a schizophrenic individual may be indistinguishable from those evoked by amphetamine intoxication, and depression seen among clients after a “speed run” can appear identical to the depression of someone who has never used amphetamines. A client’s acknowledgment of alcohol or drug use, or a positive Breathalyzer test or toxicology screen, can support a clinician’s hypothesis that symptoms will abate with abstinence, but these do not definitively settle the issue. The most practical approach to distinguishing
between addictive and other disorders is to establish an alcohol- and drug-free window—verified by breath testing or urinalysis—for a circumscribed period and to observe the client’s symptoms during this time. Knowing about the effects of the client’s substances of choice and the temporal relationship between his or her substance use and the appearance of psychiatric symptoms can further clarify the situation.

Differential Diagnosis

To establish a diagnosis in a client presenting for care, clinicians must consider the relative contributions of medical conditions, psychiatric disorders, and substance abuse. For example, clinicians need to understand how long after abstinence one can expect the effects of substance use to disappear and how long it will take for the body to restore equilibrium after a substance is eliminated from the system. For example, after two or three days, a psychotic condition resulting from stimulant intoxication will usually begin to clear. However, among some long-term chronic methamphetamine users, psychotic symptoms may persist for months or years. Attention and concentration in regular marijuana users may take three to six months to improve noticeably. To further complicate the process, each person’s system adapts to abstinence at a different rate.

Interviewing a client about his or her history of drug and alcohol use can refine the differential diagnostic assessment. This history should include the following factors (for each drug): age at and circumstances of first use, date of last use, and typical patterns of use, including amounts, source of money to buy drugs, attitude of significant others toward use, and previous attempts to treat addiction. During this process, it is important to remember that mood has a strong influence on memory and thus can bias a client’s reporting. For example, clients crashing from stimulant use will usually give a history consistent with depression; later, when their mood has improved, a different perspective will emerge. In addition, cognitive processes, including memory, can be affected by both substance use and HIV-related cognitive impairment, and information from others—family members, friends, and coworkers—can be a crucial supplement to a client’s history. It is also criti-
ical to ask questions regarding the client’s psychological function, especially covering depression and anxiety, and the stage of the client’s HIV disease and current HIV treatments.

Once it is clear that a psychological disorder coexists with addiction, it is useful—though often difficult—to determine which disorder is primary and which is secondary. The primary disorder is the one that occurred first, and the interviewer must work to establish the temporal relationship among clinical symptoms and other factors. For example, the clinician might ask, “Can you tell me the first time you ever experienced significant depression? Were you also drinking at the time?” These distinctions are important, because although addictive disorders and psychiatric disorders must be addressed as independent, coexisting conditions, prognosis and treatment strategies follow the course of the primary disorder. For example, a person with a primary addictive disorder has a better long-term prognosis than a person with primary schizophrenia. Similarly, a person with a primary panic disorder who began drinking in order to reduce symptoms may well be happy to give up alcohol once the panic disorder is treated. Having said this, treatment must eventually address both primary and secondary disorders.

In undertaking assessment, consider the following questions:

- Do episodes of substance use occur after an upsurge of psychiatric symptoms?
- Do psychiatric symptoms tend to occur only after episodes of substance use?
- Does substance use continue in the absence of psychiatric symptoms?
- Do the symptoms of mental illness return when psychopharmacological treatment for these symptoms is discontinued?
- Does the client’s history suggest the development of a particular mental health disorder that was delayed or obscured by substance use?

### Diagnostic Cautions

Keep in mind several diagnostic cautions—in particular, the role of misdiagnosis in predicting treatment success and motivating providers. Making personality disorder diagnoses in the context of
substance use is particularly difficult. For example, of those voluntarily entering treatment, only a small number of clients will meet criteria for antisocial personality disorder, despite the fact that many have anger management problems or engage in criminal behaviors such as drug dealing, prostitution, or stealing. Because the diagnosis of antisocial personality disorder has strong negative associations, it can lead to artificially low expectations for treatment success. Notably, when clinicians make rigorous efforts to establish the independence of antisocial behaviors from substance abuse–related behaviors, the rates of antisocial personality disorder among alcohol and drug users drop markedly.\textsuperscript{4}

Newly abstinent clients may temporarily appear narcissistic or grandiose. Although these characteristics may serve positive motivational functions in treatment and recovery, they may also lead to misdiagnosis. Overlooking Post-Traumatic Stress Disorder can also lead to confusion. People with a history of severe trauma may appear unable to experience or express feelings. People who are unable to cope with their HIV diagnosis or who are suffering the effects of watching dozens of loved ones die appear similarly impaired. These factors can result in misdiagnoses that may discourage care providers from investing time and effort in a client.

Alternately, clinicians may overestimate the positive effects of substance use for clients with especially difficult lives. For example, high levels of substance use are well documented among people with severe mental illness. Taken as a whole, this group uses alcohol and drugs for the same reasons other populations do: to relieve discomfort, to socialize, and to celebrate. However, a look at the negative consequences of substance use in this population highlights the importance of alcohol or drug treatment.

At least two studies have found that substance abuse can temporarily reduce symptoms in subgroups of schizophrenic patients, who report feeling less dysphoric, less anxious, and more energetic while intoxicated.\textsuperscript{5,6,7} In the short run, drugs that are abused do appear to modulate the effects of psychological distress and can mediate the side effects of prescribed medications. These improvements often fuel resistance among substance users to change their behavior. Continued or excessive use, however, almost always increases psychiatric symptoms, particularly among psychotic or cognitively impaired clients. People with chronic mental illness
who regularly use alcohol and drugs show greater hostility, suicidality, and speech disorganization; have poorer medication compliance; and are less able to attend to regular daily activities such as eating regular meals, managing finances, and maintaining stable housing. Even when a client offers a plausible explanation for self-medication, it is important to remember that drug use usually undermines long-term treatment progress.

**Addiction Treatment: Setting Appropriate Goals**

Most of the addiction treatment system in the United States focuses primarily on achieving abstinence. This position is derived from the disease model tenet that a person who has crossed the line to uncontrolled use cannot return to controlled use. This does not mean that a therapist should terminate a client who fails to achieve abstinence, rather that the therapist should validate every step of a client’s progress toward abstinence—even if this includes controlled use—at the same time emphasizing to the client that abstinence offers the greatest benefits. The therapist seeks to avoid being controlling or punitive about drug use, without endorsing a goal of controlled use.

Furthermore, treatment stresses the goal of abstinence from all intoxicants, not just an individual’s primary drug of choice. There are three major reasons for this recommendation. First, it addresses the tendency of an addict to substitute one drug for another. It is common for people who have successfully stopped using heroin or cocaine, for example, to turn instead to alcohol. Because problems with substitution may not occur immediately but can develop over a long period of time, the frequency of negative outcomes is often underestimated. For instance, a heroin user may remain free of heroin for ten years before appearing in an alcoholism inpatient unit for treatment, having been admitted for medical complications of drinking.

Second, many people relapse to their substance of choice following use of another substance. Most cocaine users readily acknowledge that if they have a glass or two of wine and someone offers them cocaine, the chance that they will refuse is small. What is less often appreciated is the frequency with which a glass of wine or a joint of marijuana taken today can influence relapse to the
primary drug of choice six weeks from now. Researchers postulate that there is a common craving center in the brain that stimulates the desire for the primary drug of abuse when any other intoxicant is used.

Third, the process of relapse also encompasses the state of mind—the longing to get high—that precedes the actual behavior. Hence, rationalizing the use of another intoxicant is a precursor to actual relapse behavior. "I just achieved something very significant; I deserve to celebrate," or "I'm stressed out with this bad news; I need to console myself," are examples of common justifications. Similar processes can undermine HIV risk-reduction behaviors. Rationalizing and longing for forbidden sexual practices may precede unsafe sexual behavior in a pattern quite similar to a drug relapse episode.

Although the ultimate goal is abstinence, addiction treatment providers have increasingly accepted relapse potential as a common characteristic of addictive disorders. At the same time, they have recognized that many people reduce or eliminate alcohol and drug use without seeking specialized treatment. Those who seek such treatment represent a subgroup of substance abusers who, for a variety of reasons, face greater obstacles to abstinence.

**Abstinence Versus Harm Reduction**

For clients who cannot or will not achieve abstinence goals, other interventions may provide benefits. These alternatives are often grouped together under the rubric of "harm reduction." Harm-reduction education and intervention may be appropriate when clients will not accept abstinence goals even after they explore their resistance; when drug use is minimal or moderate, and significant adverse consequences are difficult to establish; or when cognitive impairment or other physical or mental deterioration makes abstinence goals unrealistic.

Harm reduction works through a process of identifying practices and beliefs that endanger individuals and communities and developing strategies that reduce these risks. Strategies encompass a wide range of programs and approaches, including HIV-related outreach and education; needle exchange; moderation or controlled use; and "wet" or "damp" housing—that is, housing for