Psychotherapeutic and Theoretical Considerations in Acquired Immune Deficiency Syndrome: A Case Study

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PSYCHOTHERAPEUTIC AND THEORETICAL CONSIDERATIONS
IN ACQUIRED IMMUNE DEFICIENCY SYNDROME:
A CASE STUDY

by
Donna Mahoney

A Thesis Submitted to the Faculty of the Graduate School of Loyola University of Chicago in Partial Fulfillment of the Requirements for the Degree of Master of Arts
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Finally, I would like to thank my case study subject, Stan, for granting his permission to use his case materials. This thesis is dedicated to Stan and to all those who suffer from AIDS-spectrum illnesses.
VITA

The author, Donna Mahoney, is the daughter of Thomas J. Mahoney and Eileen (Reidy) Mahoney. She was born on March 13, 1961 in Oak Park, Illinois.

Her elementary education was obtained in the private schools of Chicago, Illinois. Her secondary education was completed in 1980 at Mother Theodore Guerin High School, River Grove, Illinois.

In August, 1980, Ms. Mahoney entered Rosary College and, in September, 1981, transferred to Northeastern Illinois University, receiving the degree of Bachelor of Arts in Psychology in April, 1984. In 1983, while attending Northeastern Illinois University, she was elected Vice-President of Psi Chi. In 1983, she also worked as Assistant to the Activities Therapist at Chicago-Read Mental Health Center.

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CHAPTER I

AIDS AND THE BREAKDOWN OF IMMUNOLOGICAL FUNCTIONING

Introduction

Acquired Immune Deficiency Syndrome, AIDS, a lethal and at present incurable disease, precipitates a profound medical and psychosocial crisis. The complexity of problems confronting people with AIDS and the psychological terror it engenders set the disease apart from virtually every other contemporary health problem. This debilitating disease is complicated by a myriad of psychological and social problems that must be addressed via psychosocial support systems during the course of somatic treatment.

On the broadest level, the disease has created the need for a wide ranging national policy for the funding of research, medical care, and social services. On the community level, the delivery of medical care, social services, and educational-preventative programs tailored to the needs of particular communities are the priority. On the individual level are people most directly affected by the disease--individuals faced with the diagnosis of AIDS, the contagious nature of the disease, its debilitating and disfiguring effects, as well as the symptoms of specific clinical syndromes. Also directly affected are the friends, families, and when the individual is coupled, his partner. While the
individual diagnosed with the illness must reconcile himself\textsuperscript{1} to the multiple losses incurred from a disfiguring terminal illness and eventual death, the friends, families, and perhaps eventually partners must confront the additional psychosocial tasks of anticipating and mourning the loss of their partner, reorganizing, redefining, and carrying on with their lives.

The life stress associated with the occurrence of AIDS should be considered as a special case of stress (Kaplan, 1987). A wide range of responses to AIDS-related stress have been considered, most notably, acute denial of the life-threatening nature of the illness; changes in self-esteem and identity, including the resurgence of homophobic feelings; and feelings of isolation and estrangement from family and the community.

Background

Acquired Immune Deficiency Syndrome is a severe, life-threatening infection which destroys an otherwise healthy person's immune system. The lack of resistance to infection caused by the failure of the immune system leaves the person with AIDS totally unprotected against infections that normally immune people can avoid (Chicago Department of Health, 1986).

By September of 1987, more than 40,000 persons in the United States had been reported to have AIDS. Nearly 60\% of those people had already succumbed to the complicating illnesses that accompany AIDS; with no effective treatment yet available, the prognosis for the
remaining 40% is grim. The number of reported cases is, however, only a small percentage of the number of people believed to be infected with the human immunodeficiency virus (HIV)--the so-called "AIDS virus". Public health officials believe that for every person with AIDS, there are 50 to 100 persons infected with HIV (Illinois Department of Public Health, 1987).

In the United States, gay-bisexual men comprise the highest risk group for contracting AIDS, constitute the majority of cases, and represent the majority of deaths. As of January, 1986, homosexual and bisexual men represented 73% of the total number of AIDS cases nationwide. Other high risk groups include intravenous drug users (17%), hemophiliacs or other persons using anticoagulants (1%), heterosexuals who had sexual contact with persons with AIDS (4%), and recipients of transfusions and other blood products (2%) (U.S. Centers for Disease Control, 1986).

Etiology

Researchers have discovered a virus that can be linked to AIDS, but there is no conclusive evidence that this virus is the sole cause of AIDS. There is even some controversy whether it is the most important factor in the onset of AIDS (Martelli, Pelty, and Messina, 1987). In early 1984, Dr. Robert Gallo at the National Cancer Institute in Bethesda, cultured a virus and referred to it as Human T-Lymphotropic Virus--type III (HTLV-III). In France, where it was also identified, the virus is called lymphadenopathy-associated virus or LAV (IDPH, 1987). HTLV-III/LAV, generally referred to more recently as human immunodeficiency virus (HIV), is considered the primary etiologic
agent of AIDS (Kaplan, et al., 1987).

Putative cofactors related to the onset of AIDS

It has been suggested that cofactors may trigger the rapid progression of HIV infection and the onset of AIDS. Kaplan, Johnson, Bailey, and Simon (1987) offer a substantive model that might be considered an explanation of the onset of AIDS: The onset of AIDS is modeled in terms of the effect of immunodepressive state and its antecedents, notably HIV infection. The social antecedents of HIV infection and (independently) other social factors are more or less direct influences on immunodepressive state. Social antecedents of HIV infection include parenteral drug use, anal receptive intercourse, sexual intercourse with multiple partners, and the psychosocial factors that increase the opportunity to learn and become motivated to engage in these patterns. Independent of these determinants of HIV status, more direct influences on immune depressive status include psychosocial stress, various patterns of substance abuse, nutritional status, other indicators of health status, and the psychosocial precursors of these factors that facilitate the learning, motivation to engage in, or experience of these patterns (p. 152).

The Immunopathogenesis

To fully understand the impact of HIV infection on the human immune system, it is essential to understand the different components of the system and how they function.

The immune system is an intricately orchestrated network of organs, tissues, and cells participating in an effort to defend the body against attack. When functioning well, it is able to identify and
destroy a wide variety of foreign (internal and external) invaders.

From birth, the immune system successfully defends the body against viral, bacterial fungal, parasitic, and other infections. Symptoms often associated with illness (fever, weakness, body aches, swollen glands, inflammation, etc.) are the outward signs that the immune system has been called into action.

Various parts of the body comprise what is referred to as the immune system. Some of the major body parts and systems include bone marrow, the thymus gland, the lymphatic system (vessels and nodes), and the blood stream. The cellular components are leukocytes (white blood cells) which circulate throughout the blood stream (IDPH, 1987).

Two types of lymphocytes (a type of white blood cell formed in the lymphoid tissue throughout the body) are programmed to lie in exclusively wait for specific substances. These are the B-cells and T-cells that form what is known as the "arms" of the immune system. The B-cell arm produces the antibody proteins which identify invaders and begin the processes that lead to their destruction. When the B-cell comes into contact with an antigen—a foreign organism or substance—one of these receptors will fit the antigen's "key". This causes a dramatic change in the B-cell: it attaches itself to the invader and begins to grow. It produces a "memory" cell that is also able to reproduce itself, and these lie in wait for subsequent meetings with the antigen that caused them to come into being (Fettner & Check, 1984).

The thymus gland plays an important role in the development of T-cells. The T-cells go out and ingest the foreign invader by cell-
mediated immunity. The T-cells mature in the thymus and are categorized into three broad types: "helper" T-cells, "suppressor" T-cells, and "killer" T-cells. They function as their names imply. T-helper (T4) cells encourage B-cells to produce antibody. These cells are important to boost and augment the function of the entire immune system. T-suppressor cells (T8) suppress or "shut off" the immune system once the attack is completed. Normally healthy people have twice as many helper T-lymphocytes as suppressor T-lymphocytes. Killer T-cells are lymphocytes capable of destroying antigens. Both B- and T-cells are sent into action in the presence of antigens (Fettner & Check, 1984).

There are various responses involved in the immune defense reaction: Antigens from the external environment (e.g., viruses) must gain access to the body by finding a suitable portal of entry. The first line of protection against antigens is the skin and the mucous membranes of the body's openings.

If these tissues are penetrated, the second level of defenses, the cellular immunity processes, are called to intercept the intruder. Monocytes, or "scavenger cells" a type of phagocytic cell circulating throughout the blood stream, maintain a constant surveillance over the body, paying particular attention to such intruders. Monocytes are able to engulf and destroy antigens upon recognition. Macrophages, another type of phagocytic cell, intercept the antigens and present them to the T-cells. In turn, the T-cells, recognizing the antigen as foreign, stimulate the other immune responses. The "killer" T-cells will have an increased ability to
destroy the antigen on contact; other cells, specifically T4 cells, will be alerted that danger is imminent and will join in on the fight.

The T4 cells begin to multiply, thereby bolstering the activities of the B-cells and causing the humoral immunity process to begin (Humoral immunity activity involves the stimulation of the B-cells to produce antibodies.). Antibodies help to deactivate the antigens and tag them for destruction.

Antibodies attach to the surface of the antigens. Antibody coated antigens are transported through the lymph system where, in the lymph nodes, they are filtered out of the lymphatic fluid and destroyed. This process continues until the attack is over and the antigen is removed from the body (IDPH, 1987).

The breakdown of immune functioning in AIDS

HIV primarily attacks the T4 helper cell. HIV is said to be attracted to T-cells (lymphotropic) because its antigens are designed to fit tightly into the receptor sites on the T-cell surface. As the virus succeeds in progressively destroying T4 cells, the body's ability to defend itself against infections gradually declines (hence the decreased T4/T8 or helper/suppressor ratio). As the number of viruses increase in the body, the number of T-cells diminish. The coordinator cells of the immune system are annihilated. The body is no longer aware it is under attack (Frutchey, Christen, & Rittinger, 1987) (See Diagram A).

AIDS-spectrum illnesses

AIDS is a term that has been inaccurately used to describe the entire range of disorders associated with HIV infection. AIDS is the
Virus (antigen) enters blood stream

Monocytes engulf & ingest antigen

Macrophages present antigen to T cells.

T4 cells multiply and stimulate B cells

Natural T killer cells destroy antigen more easily and effectively

B cells produce antibodies (Abs)

Antibodies coat antigens

T8 cells monitor antigen level & shut down immune response when antigen is removed from body

Ab coated antigens are sent to lymph nodes

Lymph nodes filter & destroy Ab coated antigen

Diagram A: An Immune System Response

Source: IDPH, 1987
final stage of a process which begins months or years earlier. It is characterized by the onset of one or more life-threatening opportunistic infections or cancers which result from the destruction of the disease fighting cells of the immune system. Once HIV infection occurs, it is lifelong and a person can experience a continuum of clinical manifestations, ranging from full health (asymptomatic) to very debilitating and oftentimes fatal diseases.

The HIV antibody test refers to the ELISA (enzyme linked immunosorbent assay) used to detect the presence of exposure to HIV, indicating only that the person has been exposed to HIV and seroconversion. A second test, the Western Blot, is used to confirm reactive (positive) ELISA tests (IDPH, 1987). Persons with HIV infection may be completely asymptomatic or experience persistent generalized lymphadenopathy (PGL)--lymph nodes that are chronically swollen for more than six months in at least two locations, not including the groin (extrainguinal sites) (Frutchey et. al., 1987). Lymphadenopathy patients are prone to numerous minor infections that are not life-threatening. These include fungal infections, herpes simplex and zoster, oral candida, viral hairy leukoplakia, recurrent pharyngitis and intestinal parasites (Abrams, 1986).

ARC, AIDS-Related Complex, is the presentation of conditions or symptoms of moderate to severe severity in persons known to be infected with HIV without the presentation of the opportunistic infections or cancers which would qualify for a diagnosis of AIDS. As with AIDS, persons with ARC all demonstrate a significantly measurable and abnormal depletion of T4 cells (IDPH, 1987).
A large number of patients with ARC have persistent generalized lymphadenopathy. Some ARC patients actually have a frank AIDS prodrome. Other people with ARC are those who have a chronic wasting syndrome and die of severe manifestations of ARC, without ever developing an AIDS diagnosis. Some of those diagnosed with ARC probably do have an acute AIDS diagnosis. Patients with ARC, with lymphadenopathy, are in the gray zone. They do not know if they will stay with lymphadenopathy for the rest of their lives or if they will develop AIDS (Abrams, 1986).

AIDS is the final and most visible stage of HIV infection (IDPH, 1987). Persons with AIDS demonstrate a profound and almost total depletion of T4 cells. With the decline in T4 cell population, the immune system also experiences deregulation of other functions.

The major hallmark of AIDS is the onset of one or more opportunistic infections or cancers. The term opportunistic infection refers to "the condition when organisms and tumor cells take advantage of the destruction of the immune system. They seize the opportunity when they can attack the system without any resistance from the host" (IDPH, 1987, p.31).

The following are the most common diseases that can qualify someone for an AIDS diagnosis:

**Pneumocystis Carinii Pneumonia (PCP):** PCP is the most common of the opportunistic infections (OIs) in people with AIDS (PWAs). It is caused by a protozoan, an amoeba-like organism. In PWAs, the PCP protozoan can multiply quickly in the lungs causing pneumonia.

**Kaposi's Sarcoma (KS):** KS is a cancer of the connective tissues that
support blood vessels, although it is usually referred to as a skin cancer because of the visible lesions it produces under the skin. It is characterized by spots that can range in color from pink to purple to brown, depending on skin color. Because KS is a cancer, it is not considered an OI; it is not caused by an infectious agent.

Toxoplasmosis: "Toxo", as it is often called, is a parasite that infects the brain, and sometimes the heart and lungs. Its symptoms include fever, weakness, confusion, seizures, dizziness, and headaches.

Cytomegalovirus (CMV): CMV is a common viral infection that is a member of the herpes family of viruses. Usually it is asymptomatic or causes mild flu-like symptoms. In someone who is immunologically depressed, it can infect almost any organ system and cause serious disease.

Neurologic Complications: The AIDS virus has the ability to directly infect the cells of the brain and the spinal cord, and may produce many of the symptoms of OIs, including motor control problems, memory loss, mood swings, seizures, and confusion. The most common neurologic problem is subacute encephalitis, characterized clinically by poor memory, inability to concentrate, apathy, and psychomotor retardation (Frutchey, Christen, & Rittinger, 1987).

Symptoms typically indicative of AIDS include the following: unexplained persistent fatigue; unexplained fever; shaking chills, or drenching night sweats lasting longer than several weeks; unexplained rapid weight loss; chronic swollen lymph nodes outside groin area; pink, purple, or brown flat or raised blotches or bumps occurring on or under the skin, inside the mouth, nose, eyelids or rectum; persistent white spots or unusual blemishes in the mouth (oral thrush); chronic
unexplained diarrhea; and persistent dry cough, especially if accompanied by shortness of breath (Frutchey et al., 1987).

After the diagnosis of AIDS, the person often suffers many bouts of illnesses, becoming progressively weaker and more disabled with each disease. Over time, most PWAs die from one of the OIs or cancers.

Modes of transmission

Blood, semen, and vaginal/cervical secretions are associated with high HIV transmissibility rates (IDPH, 1987). It is well recognized that HIV is not easily transmitted. The modes of transmission are summarized as follows (IDPH, 1987):

1. Sexual intercourse (vaginal, anal, oral) with an infected partner. Microscopic tears in the surface lining of the rectum, penis, urethra, or vagina allow the virus to enter the blood stream.

2. Direct blood-to-blood contact, for example, by sharing hypodermic needles.

3. During pregnancy, a woman who is infected with HIV can transmit it to her fetus transplacentally or during labor or delivery.

4. Any activity involving direct exposure to blood carries the risk of infection with HIV to health care workers.

Purpose of the Study

The purpose of this research project is to examine psychotherapeutic treatment issues in relation to AIDS-related distress in homosexual males. Specific goals of the project are as follows: a.) to elucidate some of the themes and constellations of emotions that are often aroused by the diagnosis of AIDS, b.) to examine sources of subjective distress and to outline substantive models that present
interrelated adaptive/coping/defensive responses to subjective
distress, and c.) to address the need for specialized interventions and
treatment strategies.

Research protocols will include a compilation of clinical material
from a single clinical case (audiotapes of therapy sessions, progress
notes, and the therapist's personal notes) used to illuminate the
intrapsychic mechanisms of distress. The subject of the case study is
a client from the researcher's practicum site (a community service
center which offers HIV and AIDS-related services to its clientele),
who has tested HIV positive (displaying signs of PGL) and whose partner
has contracted AIDS.

This study will provide much needed data, insight, and
understanding into the experiences of a gay man who, not only suffers
from AIDS-related disorders, but whose partner contracted and will
eventually die of AIDS. On a clinical level, the study represents a
contribution to the clinical literature on AIDS, especially the impact
of AIDS and AIDS-spectrum illnesses on the partner of a PWA, which has
received little systematic attention to date. This research, it is
hoped, will provide anecdotal evidence in support of the
development/implementation of interventions designed to modify the
effects of distress and, as a result, indirectly influence the course
of AIDS.

Building upon a critical evaluation of the clinically relevant
literature dealing with AIDS and AIDS-related disorders, empirical and
theoretical suggestions will be offered which will address three
limitations in the existing literature: 1) the absence of theoretical
models that identify the sources of subjective distress and that specify interrelationships among putative explanatory factors; 2) the lack of systematic attention to the psychosocial issues confronting people with ARC; and 3) the paucity of literature dealing with the distress experienced by the partner's of PWAs and the impact of AIDS-related distress on established relationships.

Organization of the Study

The next chapter presents a review of the literature on the psychosocial dimension of AIDS, exploring some of the unique psychosocial issues that concern persons diagnosed with AIDS, their families, friends, and partners (if coupled). The psychological impact of the diagnosis of AIDS will be examined, in addition to a consideration of some of the themes and constellations of thoughts and emotions that are often aroused by the AIDS diagnosis. The discussion will pivot around three central issues: the loss of self-esteem, the fear of abandonment, and denial of the illness. The literature review will highlight the social processes that influence AIDS-related distress and responses to such stress. Also surveyed will be the research contributions to the literature specifically addressing mourning and bereavement as it pertains to gay individuals.

Psychotherapeutic treatment issues will be addressed in Chapter 3, including an exploration of the client's experience of distress as supported by an illustrative case study. A model for assessment will be presented, using markers from the client's developmental history as indices of his premorbid coping skills. Sources of subjective distress will be identified and examined, along with a consideration of themes
that emerge as his intrapsychic world unfolds. Finally, the role of psychotherapy will be discussed, highlighting two fundamental issues: transferences and countertransferences.

Chapter 4, the final chapter, intends to summarize and evaluate the clinically relevant literature on AIDS and, citing examples from the case study, offer theoretical and empirical suggestions that should be considered in decreasing AIDS-related distress.
CHAPTER II

A REVIEW OF THE LITERATURE: THE PSYCHOSOCIAL DIMENSION OF AIDS

This chapter presents a review of the literature on the psychosocial aspects of AIDS and AIDS-related distress. Affective reactions to the AIDS diagnosis are described, including an evaluation of situational distress models of crisis. Differential psychosocial sequelae in AIDS and ARC are presented, along with a consideration of some of the recent research in the field of psychoimmunology. Finally, special issues of concern to the family and significant others of PWAs and PWARC are addressed, specifically the disclosure of the diagnosis and issues related to mourning in gay relationships.

Literature pertinent to this study is drawn from three sources: clinical and psychosocial literature on AIDS, the existing literature on the grieving process as it relates to gay men, and clinical literature on stress responses and grief.

Much of the literature on AIDS describes the prevalence of antibodies among different risk groups and the clinical presentations and care of AIDS patients by specialists. A small but growing body of literature on AIDS has attracted attention to the psychosocial sequelae experienced by those who suffer from AIDS and AIDS-spectrum illnesses. The representative literature from clinical fields describes affective reactions to the diagnosis of AIDS and the broad range of responses to
AIDS-related stress.

Affective Reactions to the AIDS Diagnosis

Persons with AIDS face a complex set of psychosocial needs and issues as they confront the impact of the terminal nature of the diagnosis on their lives (Helquist, 1987). The diagnosis often precipitates a major psychosocial crisis. Because of the high mortality rate associated with the disease, the diagnosis, in and of itself, is catastrophic. The contagious nature of the disease, its debilitating and disfiguring effects, as well as the symptoms of specific clinical syndromes are other sources of stress (Christ, Wiener, & Moynihan, 1986). The lack of medical knowledge and the absence of curative treatment serve to reinforce a crisis reaction. Emotional reactions of PWAs upon hearing the diagnosis range from affective numbing to affective discharge. Often, the individual experiences shock and denial, and is unable to absorb information beyond learning of the diagnosis. Many respond by feeling overwhelmed, however, and begin to be flooded with every question imaginable, i.e., whether to tell their family, when to tell them, whether to return to work, etc. (Macks & Turner, 1986).

Nichols (1985), in outlining a situational distress model of crisis, observes that during the initial life crisis, life-threatening illnesses may lead to acute denial. If the denial does not lead to a disregard of medical advice, it may be considered an appropriate adaptive response. Spector and Conklin (1987) note that affective reactions to the diagnosis include fear, anxiety, depression, a sense of hopelessness, despair, and a variety of somatic concerns. Other
psychological reactions observed (Morin, Charles, & Maylon, 1984) include the fear of death and dying, guilt, fear of exposure of a gay life style, fear of contagion, loss of self-esteem, fear of loss of physical attractiveness, fears of decreased social support and increased dependency, isolation and stigmatization, loss of occupational and financial status, concerns and confusion over options for medical treatment, and the overriding sense of gloom associated with a degenerative illness.

Velimirovic (1987) has outlined the stages that a person goes through upon learning the AIDS diagnosis or antibody status: shock, denial, crisis, fear, depression, panic, guilt, anger, self-pity, bargaining, search for meaning, fighting, positive action, and finally acceptance. The author neglected to explain whether this stage theory applies to all persons with AIDS, rendering it a very vulnerable theoretical and clinical argument.

In "My Personal Experience With AIDS" (Ferrara, 1984), an account of an individual diagnosed with AIDS, Ferrara poignantly expresses the highly evocative nature of the diagnosis:

The doctor was very compassionate, saying that this was probably the worst news I had ever received in my life, and he was right. All of my mental preparation was insufficient to thwart the tidal wave of emotion that swept over me as I received what, at that time, I regarded as a death sentence (p. 1285).

The AIDS Diagnosis: Stress Responses and the Content of Concerns

The discussion will now turn to a consideration of some of the themes or constellations of ideas and emotions that are often aroused in the PWA by the AIDS diagnosis. Particular attention will be paid to three fundamental issues: the loss of self-esteem, the fear of
abandonment, and the denial of the illness.

Many of the psychological responses and coping mechanisms in dealing with AIDS are similar to those of persons with illnesses such as cancer and heart disease. However, the social and political nature of this disease, as well as its transmissibility, set it apart from other diseases. The fact that AIDS invokes cultural taboos relative to homosexuality, sex, death, and drugs accounts for the stigma attached to the illness. This stigma plays a significant role in the individual's adaptation and response to an AIDS diagnosis (Helquist, 1987).

**Self-esteem issues**

The effect of unconscious homophobia on identity development, self-worth, social relationships, and psychotherapy has been described in the literature (Stein & Cohen, 1984); however, in AIDS it has several features that should be appreciated. Gay men and lesbians recognize their sexual identity through a developmental process known as "coming out". According to Stein and Cohen (1984), in coming out, the gay man or lesbian must reclaim disowned or devalued parts of the self (the previously hidden aspects of one's sexuality). Most gay men and lesbians will incorporate society's antigay attitudes into their sense of self-identity. "Homophobia", a term originally used by Weinberg and Williams (1974), refers to the fear or rejection of homosexuality and of persons who are homosexual. This rejection is maintained in the form of internalized homophobia by all members of the society, gay and nongay. An identity crisis occurs when one accepts one's homosexuality and comes out. As Nichols (1986) has written,
"(It) should be understood that AIDS forces one into a new identity crisis, recapitulating the earlier one, and feelings of bewilderment, confusion, and personal and social devaluation may accompany it: patients have referred to this as coming out as a person with AIDS" (p. 212).

The diagnosis of AIDS invariably involves asking questions about the PWA's lifestyle, which often reactivates repressed feelings about sexuality. Frierson and Lippman (1987) saw eleven patients with AIDS in a psychiatric consultation service over a four year period, and found that even patients who were secure in their sexual orientation expressed guilt about some aspect of their past sexual behavior. Many believed that AIDS was a retribution for one's sexual preference, expressing that they were "getting what they deserve". Gay patients may view any illness as punishment for being homosexual, and this is particularly likely with AIDS, which has been so closely linked to homosexuality and, at times, promiscuity.

Altman (1986) points out that sexual adventure was, and may still be, a central tenet of gay life. According to Quadland (1987), sexual adventure may be a behavioral response to learned attitudes, which suggest that a high level of sexual activity with many different partners is a symbol of one's manhood and desirability, and an important part of one's homosexual identity. For homosexual males, sexual identity and the freedom to express one's sexuality as one chooses may become a very important aspect of personal identity. This explanation attempts to explain why physical limitations on sexual activity may affect the PWA's attitudes in relation to his feelings
about himself. Spector and Conklin (1987) suggest that because physical attractiveness is particularly sought and esteemed in the gay subculture, rapid physical deterioration and eventual disfigurement alienate the PWA from the group which has heretofore been a vital source of self-esteem. The interplay between social rejection and the internalized homophobia it may reawaken can produce enormous stress in persons with AIDS.

The fear of abandonment

It has been claimed that the loss of self-esteem and fear of abandonment are greater among PWA's than among those facing other life-threatening illnesses (ie, terminal cancer patients) (Altman, 1986). Many of the patients who participated in the study by Frierson and Lippman (1987) reported feelings of isolation, often comparing themselves to lepers and complaining of the impersonal attitudes of hospital staff members. Many family members and friends also adopted a hands-off attitude, which often resulted in the dissolution of long-standing relationships. Psychosocial stressors, such as the loss of a job and the exposure to social discrimination serve to compound the fear of abandonment.

Spector and Conklin (1987) use Weisman's (1980) model of the psychosocial phases of death in cancer patients to describe some of the isolation and abandonment issues experienced by the PWA. Stage 1, Existential Plight, includes two to three months surrounding and immediately following the diagnosis of a life-threatening illness. Many individuals experience a phase of profound turmoil during this time due to the new awareness of their own mortality. Intense death
anxiety, fear, anger, disbelief, guilt, insomnia, appetite loss, and impulsive behavior may be chaotically intermingled. The existential plight and feelings of isolation are prolonged for PWA's (as opposed to cancer patients) because: 1) AIDS primarily affects homosexuals, a minority group; 2) many PWA's, for various reasons, have not revealed their sexual orientation or illness to their families; and 3) societal stigma against both AIDS and homosexuality is pronounced (Intravenous drug users could also be included in this group.).

 Usually within four to eight weeks after the diagnosis of AIDS, the PWA has entered the Accommodation and Mitigation phase. In this phase, the individual has usually achieved a relatively stable new psychosocial equilibrium in making decisions about continuing vocational activities, medical care concerning the illness, and his general strategy for living with a life-threatening illness. The authors (Spector & Conklin, 1987) observe that their PWAs typically mitigate and accommodate only minimally. The PWA, unlike the cancer patient, is constantly reminded of his mortality by the numerous deaths of his friends and acquaintances in the gay community, which serves to shatter his denial defenses. This makes it difficult to sustain the shock of confronting his own mortality in isolation and reinforces a sense of helplessness. The PWA often experiences death in isolation because of the deaths of friends and the loss of support from the family and significant others. The loss of friends intensifies the fear of abandonment.

The phase of Recurrence and Relapse in cancer patients is connected with the diagnosis of metastasis when the medical goals shift
from cure to palliation. While there is no exact medical phase in AIDS that is similar to this phase in cancer, there does appear to be a clinically similar psychosocial illness phase. Many PWAs go through the first several months of their illnesses with the conscious belief that they will become a long-term survivor or be cured. Then, often precipitated by a hospitalization for an opportunistic infection, they come to the realization that they will die from the illness. This often precipitates an acute psychosocial crisis of major proportions, characterized by intense death anxiety, depression, and often suicidal ideations and threats.

The phase of Deterioration and Decline is the phase when the PWA has entered the terminal stage of the illness. The principles of working with the dying patient (i.e., verbal and nonverbal expressions of caring, encouraging the expression of deep and often contradictory emotions and fears, and then allowing the PWA to withdraw his interest in the outside world as death approaches) seem to be helpful with PWAs as with cancer patients.

The denial of the illness

Denial has been defined by Breznitz (1983) as "a process through which a person attempts to protect himself from some painful or frightening information related to external reality" (p. 257). By contrast to repression and other intrapsychic mechanisms, denial deals with problems emanating from the outside. Denial has generally been viewed as a very primitive defense mechanism (Breznitz, 1983). It has been termed as a pre-stage of the defenses; it occurs in the earliest period of life, the narcissistic stage, in which the child rejects
anything unpleasurable, even before the internal/external distinction is made (Freud, 1936).

The mechanisms of denial are incorporated into one's life style and character structure. Valom (1980) argues that denial is an effort to cope with anxiety associated with the threat to life, and also a function of a deep-rooted belief in one's inviolability. Becker (1973) has also argued that all our strivings and products stem from a single, powerful force—the denial of death.

Denial of the illness is a defense mechanism used by people with AIDS in an attempt to relieve them from the intolerable experience of extreme anxiety. As Menenberg (1987) notes:

He (the PWA) may be ashamed of his disease and its corresponding implications of his lifestyle and may make great efforts to eliminate the fact of his disability. His desire to raise his self-esteem may involve self-acceptance or denial of the illness by minimizing his identification with the devalued group (homosexuals) (p. 20).

Christ et al. (1986) point out that denial can be a useful and necessary defense for patients with a potentially fatal illness because it gives them some degree of control over when and how they will confront their own mortality. For PWAs, however, denial is less likely to provide relief because of all the publicity the disease has received. Additionally, patients are often demoralized by the deaths of other AIDS patients they have known.

Spector and Conklin (1987), in observing group therapy sessions for PWAs, contend that healthier group members exercised much denial in dealing with the medical complications of those in the group whose disease course had progressed further, and avoided discussing issues of terminality. They believed that discussing fatality reinforced a
negative attitude that would not help in fighting the disease, and reassured each other that the disease could possibly be fought with a positive mental attitude. Denial defenses, however, were shattered by the overwhelming reality of watching several group members deteriorate and die.

In the case of AIDS, as is the case in any situation of anticipatory stress, there are cues (with AIDS, physical deterioration and decline) of the imminence of danger. As Breznitz (1983) states "...the objective facts (the multiple deaths of others with AIDS and physical symptoms) ...pierce through the protective veil of illusion, and the person is found totally helpless" (p. 300). The following quote captures a PWA's sense of terror when the denial defenses are shattered:

It was at this point (of physical decline) that I finally realized what was going to happen to me--I was going to die. From the first moment of that realization to this very day, it was not the act of passing from life to death that frightens me but the events that lead up to that point. The body and physical abilities of which I have been so proud and for which I have worked so hard are deteriorating with cancer and weakness (Ferrara, 1984, p. 1286).

Some PWAs, in denying the fatal consequences of the disease, continue to engage in sexual activities precisely because it is their response to anxiety and their means of temporarily reducing anxiety. Velimirovic (1987) reports that in the gay community, an atmosphere of extreme anxiety may increase, rather than decrease, promiscuous sexual activity. However, the author fails to identify possible sources of anxiety and he does not provide empirical data supporting this finding. He also neglects to define "promiscuous".

Quadland (1987) offers an explanation concerning the continuation
of high-risk sexual behavior, other than denial. He purports that continued high-risk sexual behavior in the face of a deadly epidemic, when the individual is well informed regarding risk, may be a problem with sexual control (i.e., subjective perceptions of sexual control). So long as sexual behavior is not troubling to the individual or does not infringe upon the rights of others, it was not defined as problematic. He claims that this behavior may be a learned response in which sexual behavior reinforces the avoidance of anxiety associated with feelings of loneliness, low self-esteem, problems with intimacy, and internalized homophobia. Emmons, Joseph, Kessler, Wortman, Montgomery, and Ostrow (1986) investigated the relationship between psychosocial factors and gay men's attempts to change their sexual behavior in response to the threat of AIDS. The psychosocial factors were chosen based on the Health Beliefs Model--knowledge regarding AIDS, perceived risk of AIDS, perceived efficacy of behavioral change, barriers to behavioral change, and social network characteristics. Five measures of behavioral responses were identified: 1) any change in behavior; 2) trying to limit the number of one's sexual partners; 3) avoidance of anonymous partners; 4) avoidance of receptive anal intercourse; and 5) modification of receptive anal intercourse in ways that may reduce exposure to HIV (i.e., asking one's partner to use a condom). Knowledge about AIDS was consistently and positively correlated with each of the outcome measures. Perceived risk of AIDS and the perceived efficacy of behavioral changes for reducing one's chances of developing AIDS were also related to multiple outcome measures.
Joseph, Montgomery, Emmons, Kirscht, Kessler, Ostrow, Wortman, and O'Brien (1987), in two follow-up studies, explored the relationship between a perceived sense of being at risk for AIDS and a variety of behavioral, social, and psychological consequences. The results demonstrated a range of potentially adverse consequences for those who perceive themselves to be at a greater risk for AIDS, including increased barriers to behavioral change, obsessive-compulsive behavior, social role impairment, and more intrusive worries and concerns about AIDS. These findings do not support those of Emmons, et al. It was suggested that the Health Beliefs Model may be inadequate to explain the outcome behaviors. This inadequacy can be explained given the disastrous idiosyncracies of the AIDS epidemic and the type of behavior changes being recommended. The model was developed to address behaviors with far less dramatic threats and their relationship to behaviors far less central to identity and functioning than sexual behavior. Excessive threat interferes with effective coping under conditions of extreme threat; those at risk may turn to avoidance coping such as excessive alcohol or drug use, thereby increasing their risk (Kaplan, et al., 1987). High risk behavior might also increase if it reflects displaced anger at a group that rejects the subject (Nichols, 1985).

Future research should consider an expanded set of predictor variables (cofactors or intervening processes which might mediate the risk of developing AIDS) in order to determine whether it is possible to explain more of the variability in behavioral risk reduction.
Gradually, public attention has increasingly focused on people who are at risk of AIDS and who have conditions apparently related to immune disorder, but whose conditions are not yet included within the CDC's (Center For Disease Control) definition of AIDS itself. Physicians and researchers have yet to agree on a universal definition or name for these conditions, and much uncertainty exists for patients, caregivers, and service providers (Helquist, 1987). For researchers, the lack of a clear and stable definition of ARC makes it difficult to choose comparable cohorts, confounds interpretations of results, and adds to the difficulty of comparing results among studies (Mandel, 1986).

An emerging theme in the literature (Helquist, 1987; Kinnier, 1986; Mandel, 1986; Morin & Batchelor, 1984) emphasizes that the psychosocial needs of people with ARC (PWARCs) have been unrecognized and underestimated. Whereas most clinicians are well educated about the signs of AIDS, the earlier signs of ARC are less well known and more diffuse. The uncertainties that arise from this confusion often exacerbate patients' negative reactions. As Mandel (1986) reports, "The uncertainty faced by PWARCs makes it clear (that PWARCs are) even more distressed than those with AIDS" (p. 83). It has been suggested (Kinnier, 1986; Mandel 1986) that both the range and intensity of PWARCs' affective reactions to the diagnosis reveal that they are reacting as if they have been diagnosed with a life-threatening illness. Because the uncertainty evokes similar fears in others, it has been reported (Mandel, 1986) that friends will often collude in
denial and contribute to an "everything will be fine" scenario, rather than empathize with the person who has the symptoms. Other psychosocial stressors identified for those "living in the gray zone" include employment concerns, i.e., they may feel guilty in taking needed time away from work to recuperate from intermittent illnesses, and financial worries since PWARCs do not qualify for Social Security benefits (Mandel, 1986; Morin & Batchelor, 1984).

There is disagreement on how to best meet the psychosocial needs of this group. Some researchers and clinicians (Coates, et al., 1984; Holland & Tross, 1985) believe that stress plays an important role in both susceptibility and progression of AIDS, based on findings in psychoimmunity that demonstrate a quantifiable relationship between emotional distress and immunologic ablation. Those suggesting such a relationship would argue for active interventions (biofeedback, relaxation training, and hypnosis) to reduce stress for people with evidence of immune suppression.

To summarize, much of the psychosocial literature on AIDS describes affective reactions to the AIDS diagnosis and discusses specific stress responses in relation to the onset and course of AIDS. Three central issues were highlighted: self-esteem issues, the fear of abandonment, and the denial of the fatal consequences of the illness. Clinical reports and Weisman's model of the psychosocial phases of death were presented in an attempt to elucidate the content of concerns. Several empirical and theoretical gaps exist in the literature. Firstly, as was mentioned, Velimirovic's (1987) stage theory fails to explain whether all PWAs progress through the stages
outlined. Consequently, the theory contributes little, if anything, to our understanding of the impact of the diagnosis of AIDS. Another shortcoming is that scant information exists concerning the treatment of those who test HIV antibody positive (or who are diagnosed with AIDS or AIDS-spectrum illnesses) who continue to engage in high risk behaviors. The research relevant to behavioral reduction is limited in scope in that it fails to consider cofactors or intervening processes that might mediate the risk of developing AIDS. Lastly, the clinical literature on the psychosocial aspects of ARC is meager and, of the sporadic articles that do exist, is anecdotal in form.

Stress Response Models and Psychoimmunologic Considerations

Various models of psychological responses to an AIDS diagnosis have been outlined, such as situational distress models of crisis (Nichols, 1985) and adaptive responses by stage and task (Macks & Turner, 1986).

Situational distress models

The diagnosis of AIDS is catastrophic (Morin & Batchelor, 1984; Morin, Charles, & Malyon, 1984) and the emotional reactions of patients can be understood in terms of situational distress. Situational distress is said to occur when a stressful event produces reactions that are experienced by almost everyone in the situation and which are similar from one individual to another (Nichols; 1986). These reactions occur in three phases: a crisis, a transitional state, and a deficiency state. In AIDS, however, the reactions have been described in four stages: the initial crisis, early adjustment (the transitional state), the stage of acceptance (the deficiency state), and the
preparation for death (Nichols, 1985).

**Initial Crisis:** The initial crisis, described earlier, is characterized by emotional numbness (denial) alternating with periods of intense anxiety. Horowitz (1973), in outlining responses to severe life threats, describes this phase as follows: "States of intrusion (intense anxiety) and of denial (periods of nonchalance, with cognitive and affective denial) do not occur in any prescribed pattern, but do appear to oscillate in ways particular to each person" (p. 30). Many AIDS patients report intrusive thoughts of suffering and death (Helquist, 1987). These initial reactions probably serve an adaptive function in helping the individual fend off threatening affects, while moving toward cognitive and affective integration of the event.

Supporting denial was found to be adaptive (Hackett & Weisman, 1969; Hackett & Casem, 1970; Weisman & Hackett, 1966) in that patients facing terminal illnesses who were successful "deniers" not only lowered their anxiety and raised their hopes, but also survived significantly longer.

**Transitional State:** The transitional state begins when alternating waves of anger, guilt, self-pity, and anxiety supersede denial. Emotional lability is seen throughout the course of the illness. PWAs speak of the "roller coaster" of AIDS, referring to continual changes in emotional and physical functioning (Nichols, 1986). It is a time of distress, confusion, and disruptiveness. PWAs may suffer from the loss of friends, jobs, income, and residences. Social rejections are deeply felt, compounding the sense of loss. Changes in self-esteem, identity, and values, estrangement from family and community, and considerations of suicide may occur (Nichols, 1985).
The Deficiency State: Formation of a new, stable identity occurs upon reaching the stage of acceptance. Patients learn to accept the limitations that AIDS imposes on them, but also realize that they can still manage their lives by reacting to the disease with more reason than emotion (Nichols, 1985).

Preparation For Death: The fear of becoming totally dependent on others usually supercedes the fear of death (Nichols, 1985). Practical considerations and matters of "unfinished business" (such as asking for or granting a forgiveness, seeing or speaking to certain persons once again, or finishing a creative project) are usually attended to at this time.

Mack and Turner (1986) have described the different stages of psychological responses to an AIDS diagnosis, in terms of specific tasks and issues (including the therapist's tasks). The beginning stage, in which the person is diagnosed with AIDS, is a period of crisis. Emotional responses vary from affective numbing to affective discharge. The therapist's task is to help contain the fear and anxiety, reassuring the client that there will be time to make decisions regarding who to disclose the diagnosis to, finances, etc.

After the initial crisis resolves, AIDS patients enter a middle phase in which two distinguishing tasks emerge. The first is that of getting on with life—that is, learning to live in the face of a life-threatening illness instead of waiting to die. The clients' ability to continue to deny his illness is lessened. The second task is that of confronting immediate and anticipated losses, ranging from loss of mobility, independence, and self-esteem to anticipated death. The
therapist's task is to encourage emotional expression, increase coping skills as much as possible, assist in managing fluctuating moods and physical states, and to provide opportunities for maintaining a sense of control and mastery. Therapy can help by encouraging clients to realize that they can retain the power to manage certain aspects of their lives. Clients are urged to assume an active role in helping to take care of other patients or by participating more aggressively in their own treatment.

When the client is close to death, the focus of issues and tasks shift. Both the AIDS patient and loved ones can experience great fear of pain, abandonment, and death. Interventions must be designed to work with the entire support system by honoring the patient's wishes and facilitating the dying process for all involved. "Death with dignity", a policy in which medical intervention other than pain control is withheld, may be unavailable in some hospitals. The therapist should investigate the policies of the institution and help to arrange a transfer to a hospice or a home, if necessary. The problems that may be encountered between the patient's two families, biological and community, should be addressed by the therapist. Visiting privileges, next of kin issues, and the arrangements after death are some of the difficulties that often arise.

In general, the literature on stress responses to the AIDS diagnosis provides a number of insights into the psychological and social processes that influence AIDS-related distress and responses to such stress, which is expected to influence the course of AIDS. A significant limitation of the literature is that all known or suspected
predictors of risk for HIV infection and/or immune deficiency states have not been considered simultaneously within an overarching theoretical framework; nor has there been sufficient consideration of the factors that influence the experience of AIDS-related stress or the modes of response to such stress. Stress response theories (i.e., Nichols' Situational Distress Model) need to be broadened to capture the full range of potentially significant explanatory factors.

**Psychoimmunologic considerations: bridging the gap?**

The emotional reactions and coping responses of PWAs and PWARC are obviously important for the quality of their lives. They may also be essential for another very important reason: Emotional experiences may affect the actual immunologic processes that determine health outcomes. Psychoimmunology is "the study of psychological, behavioral, and environmental stress factors modulating immunity and immunologically resisted diseases or diseases related to immunologic abreaction" (Coates, et al., 1984, p. 1310). Recent research in the field of psychoimmunology (Ader, 1981; Coe & Levine, 1986) has demonstrated the effects of psychological and emotional factors on various aspects of immune function. The strong emphasis that biomedical and epidemiologic researchers have placed on the transmission of AIDS reflects a lack of attention to the fact that exposure to a pathogenic agent is a necessary but rarely sufficient condition to induce the expression of disease symptomatology (Martin & Vance, 1984). Coates et al. (1984) underscore the importance of focusing on the interface between environmental, psychosocial, and behavioral factors in proposing that all research on AIDS include a
A comprehensive model may provide a useful starting point for investigating the role of both transmission and vulnerability factors in AIDS. Such a model postulates that exposure to an AIDS agent (HIV) will lead to clinically significant symptomatology only under conditions of host vulnerability, defined as an individual's specific and nonspecific immunologic competence. The authors (Martin & Vance, 1984) point out that an interactive approach allows for a variety of different models (e.g., additive versus interactive, linear versus nonlinear, categorical versus continuous) to be empirically tested and contrasted in order to evaluate the relative contribution of transmission factors as against vulnerability factors to the risk of AIDS and to examine the conditional relationships that may exist among them. This area is enticing in that the hope of personal empowerment is offered in the absence of effective biomedical treatments for AIDS. To date, no research evidence exists that such factors are contributing cofactors in AIDS disease progression. Further research should address the complexity of the natural history and etiology of the disease, using models that are capable of evaluating the relative contribution of agent, host, and contextual characteristics leading from health to illness.

Affective Reactions of the Family and Significant Others

The psychosocial aspects of the AIDS crisis affect not only those with AIDS, but also the people in their lives. Lovers, friends, and family are likely to experience significant distress and may need psychosocial services. Because AIDS is a mysterious and stigmatizing
illness, the psychological issues for significant others may become more complicated than those with other life-threatening illnesses. Public knowledge of their association with PWAs stigmatizes them and subjects them to the powerful threat of social rejection in a frightened and homophobic society. As a result, lovers, friends, and families must either accept these consequences or avoid turning for support to neighbors, coworkers, or others from whom they might ordinarily receive encouragement or solace at a time of crisis.

Disclosure of the diagnosis and related issues

Families and significant others whose loved one contracted AIDS through sexual contact may face a complex set of problems. Similar problems may be encountered by families whose loved one contracted AIDS through needle sharing drug use. The loved ones of PWAs--family, partners, spouses, and friends--may feel that their lives resemble a roller coaster ride. One day may hold hopeful reports of a potential treatment while the next sees the person with HIV infection confront a new bout of illness. Loved ones often have many questions related to AIDS transmission, risk reduction, casual contagion, and AIDS infections. Fears related to contagion are often reported (Martelli et al., 1987). The families of a gay or bisexual man with AIDS may not have known of the individual's sexual orientation. For those, the diagnosis of AIDS brings with it the disclosure of a life-threatening illness as well as the disclosure of sexual orientation (Morin & Batchelor, 1984). Families who do not accept the homosexuality of a person going through such a difficult period are likely to experience considerable difficulty. Members may harbor intense feelings of fear,
anger, and sadness. The fear of AIDS often triggers homophobic responses in more than one family member. There will likely be a period of adjustment while the partner and family members develop a pattern of caregiving. Conflicts between wanting to be supportive but feeling repelled by the behavior are common (Helquist, 1987).

Many families must face a double adjustment in coping with a son (or brother) who is gay and has AIDS. This may create immense conflict and trauma for parents and siblings. The level of denial in such families was probably fairly high already if the sexual identity of the son (or brother) was undisclosed before the AIDS diagnosis. Parents and siblings must confront the psychological pain caused by the loss of this defense (Helquist, 1987).

The friends of PWAs face a series of particularly distressing issues (Morin & Batchelor, 1984). Gay friends may be especially vulnerable because they can readily identify with their friend. Other reactions include an awkwardness in discussing the illness and problems in working through fears of contagion. For many, the diagnosis of a friend leads to a confrontation with existential issues (death, meaninglessness, etc.) and difficult appraisals of their own lifestyles.

The lovers of PWAs have special problems and needs. Issues of achieving a balance between dependence and independence occur for two men in a relationship when one of them, or both of them, have AIDS (Helquist, 1987). Morin and Batchelor (1984) suggest that lovers of PWAs have more reasons for developing emotional problems than concerns over their own health. Lovers are almost certain to face
discrimination, fear, and legal impediments as they help their lover through the last months or years of his life. Frequently, family members get involved in a conflict situation with the PWA's lover because they perceive the lover as having more control in vital treatment decisions. The family may not have accepted the lover as a legitimate partner (Christ et al., 1986). These psychological demands serve to compound existing grief and health worries, and suggest the need for mental health and support services.

The preceding review of the impact of the diagnosis on significant others highlights the paucity of literature addressing the distress experienced by the partners of PWAs and the impact of AIDS-related distress on established relationships. Scant information exists about the number of PWAs who are partnered and the incidence of AIDS among partners. The research presented indicates a great deal of distress and the need for a high degree of adaptation on the part of partners. This is undoubtedly a clinical area in need of theoretical and empirical attention.

Mourning in the context of gay relationships

The clinical literature on the grief and mourning process as it pertains to gay men is meager. As Shelby (1987) points out in his thoughtful review of the literature, the inattention to gay grief in the literature represents a lack of support of same sex relationships and a disregard of a gay person when a death occurs. Widespread belief that gay relationships are short-lived and based only on sex makes it difficult for most people to conceptualize the affectional bond that can exist between two men (Klein & Fletcher, 1987). Siegel and Hoefer
(1981) define grief as "an intense emotion that floods life when a person's inner security system is shattered by an acute loss, usually the death of someone important in his/her life" (p. 517). Their article, "Bereavement Counseling For Gay Individuals", intends to sensitize therapists to the particular concerns and issues of the gay bereaved. The authors present the stages in the grieving process (outlined by Parkes, 1972) and the stigma attached to individuals who have lost spouses. Also discussed were the potential problems posed by "the lack of societal mechanisms, sanctions, and resources to aid in the bereavement process of gay individuals" (p. 523). The main argument of the article is that social ostracism and the resulting need of many gay individuals to conceal their sexual identity and the role that the relationship played in their life may serve to intensify the isolation and depression experienced by surviving partners of relationships. Additionally, the lack of social sanction and support may further deprive surviving partners of essential roles and rituals designed to comfort and acknowledge the depth of the loss.

Many theorists and clinicians have provided exemplary discussions of the grief process and effective means of treatment. Perhaps the most well known is the theory postulated by Elizabeth Kubler-Ross (1969), who described five stages in the grieving process--denial, bargaining, anger, depression, and acceptance. Others (Shearer & McKusick, 1986) have questioned the concreteness of these stages, suggesting that the five concepts be viewed as psychological attributes of a bereavement process or an adjustment to a life-threatening illness or to death.
Parkes (1972) interviewed twenty-two widows at various intervals following the death of their husbands. Based on the information generated from those interviews, he conceptualized the process of mourning as consisting of five experiential phases: alarm, searching, mitigation, anger and guilt, and gaining a new identity. One methodological limitation of this formulation, however, relates to the small sample size in that twenty-two participants is hardly representative of the entire population of widows.

Grief experienced by significant others of PWAs

Issues of loss and bereavement need to be addressed most carefully for PWAs and for their lovers and families. Since most gay men with AIDS are fairly young, their lovers and friends are not as equipped to deal with the issues of death as older people may be (Morin & Batchelor, 1984).

Spouses discover that there is a stigma attached to being a survivor. Former friends are often embarrassed in their presence and may shun them. The surviving gay lovers bear a double stigma and, as was mentioned, are often denied the comfort of the rituals of mourning. They may not be consulted about the funeral and other arrangements and may be treated by the biological family as if they were distant friends (Stein, 1986).

Helquist (1987) during clinical work with six surviving male lovers of men who died of AIDS, identified common characteristics that may be of help to a clinician approaching treatment of bereavement in gay men. First, these men were experiencing bereavement in a community which is becoming expert in the stages of bereavement, including
Each man seen for counseling complained that his friends were getting tired of hearing him talk about his lover. All of them described pressure from their associates to conduct their grief in appropriate fashions. As Klein and Fletcher (1987) observe, "No descriptive title identifies the mourner, who may not have 'come out' and may be unable to express feelings in the workplace" (p. 22).

After the death, lovers frequently become more aware of their own susceptibility to AIDS; a fear of contagion may be suspended in order to remain close to their dying friends. Moreover, lovers are acutely aware of the physical manifestations of AIDS and are often quite fearful of contracting it or transmitting it to anybody else (Helquist, 1987). Gay lovers often have to fight the family for the primacy of their bond and the independence of their relationship (Shearer & McKusick, 1986). In this population, research on the link between bereavement and suppression of immune response is particularly relevant. It is known that immune response is compromised in bereavement (Stein, 1986), which may increase the vulnerability to AIDS of grieving members of risk groups.

Christ et al. (1986) note that the task of mourning is often complicated for the families of PWAs. The family may have been estranged from the PWA for a long time before the illness or death. In some instances, the PWA requested that the parents not be informed of the diagnosis until he is very ill or, in a few cases, had died. When this occurred, family members expressed feeling of guilt, isolation, neglect, abandonment, and isolation. This can result in excessive self-recrimination on the part of family members. Also, because of the
stigma associated with the illness, families may not get the kind of emotional support in their period of mourning that is usually available to the bereaved.

Summary

Much of the psychosocial literature on AIDS addresses the emotional impact of the AIDS diagnosis and provides elaborate descriptions of the psychosocial processes that influence AIDS-related distress and responses to such stress. Three general limitations in the literature emerge as significant: 1) the absence of theoretical models that identify the sources of subjective distress and that specify interrelationships among potential explanatory factors of AIDS disease progression; 2) the lack of empirical attention to the distress associated with ARC; and 3) the scarcity of literature that addresses the psychosocial issues confronting the partners of PWAs and PWARCs. A broadened perspective, including psychological, behavioral, and environmental stress factors, was suggested to improve understanding of risk factors, disease incidence, and disease progression. Overall, the bulk of the research is anecdotal and not empirical. Findings are based on clinical observations, citing little or no empirical data to support the results. Studies are needed that employ reliable, valid, and psychometrically sophisticated measures of complex human behaviors with adequate resolution of problems concerning recall, specificity, and appropriate study design.
CHAPTER III

CASE STUDY

Introduction

Psychotherapeutic treatment issues will be addressed in this chapter, using clinical material from a single case to exemplify sources of distress associated with AIDS-related disorders. A model outlining assessment procedures will be presented, along with a detailed account of the client's psychosocial history. A description of the treatment will follow, centering around transference and countertransference issues. Sources of subjective distress will be identified, in addition to a consideration of the client's characterological defenses. Finally, termination issues will be explored and an evaluation of the treatment will be provided.

The subject of the case study is a young man named Stan, who has tested HIV antibody positive and whose partner has been diagnosed with AIDS. Informed consent to use his clinical material was obtained and his confidentiality was ensured by using a pseudonym in place of his real name. The following case presents an example of the partner's initial adjustment to the diagnosis of AIDS, and also illustrates the impact of the progression of the disease on their lives.

Stan is a 34-year-old man, approximately 5'10" tall, weighing approximately 150 pounds. He reported seeking counseling because his
partner, Rick, was diagnosed with AIDS on December 21, 1987. The diagnosis precipitated feelings of resentment toward his partner, due to Stan's belief that he must assume total responsibility for his partner's care. The diagnosis also lead to several disruptions in their relationship, including frequent arguments with his partner about the type of medical care his partner is receiving, worries that his partner is demanding all of his time, and concerns that their relationship is consumed by AIDS.

**Diagnosis and Assessment**

Stan was seen at intake on February 15, 1988. From therapy, he stated that he wished to improve his relationship with his partner (i.e., to communicate more openly about Rick's medical care) and to plan to allot time for activities outside of his primary relationship. Although he was unwilling at intake to provide details about his health status, in therapy he revealed that he had tested HIV antibody positive (date unknown). Physical symptoms of Persistent Generalized Lymphadenopathy (PGL), a persistent swelling of the lymph nodes resulting from HIV infection, were reported, along with insomnia of moderate severity. According to Stan's physician, his physical symptoms seem to indicate signs of ARC. A diagnosis of Adjustment Disorder with Depressed Mood was assigned (American Psychiatric Association, 1987).

Nichols (1986) offers several recommendations in gathering information about a client's past history, noting that particular attention should be paid to the client's ability to cope with stress. He suggests that one should assess their ways of perceiving (selective
attention, hypervigilance), ways of thinking (rumination, use of intellectualizations, denial), and their usual style of responding to stress (habitual avoidance, alcohol or other drug use, acting out or anger, feeling defeated or overwhelmed, or striving for mastery). The therapist should also note the adaptive or maladaptive nature of the coping mechanisms for the client.

Psychosocial history

Stan and his siblings (one older brother and three younger sisters) were born in Wood River, Illinois and raised in a small town in South Central Illinois. He and his siblings were raised by both of his parents. Stan's eldest brother died when Stan was an infant, and his parents gave Stan his brother's name. For Stan, being named after his brother lead to a diminished sense of self importance in that "they (his parents) didn't even bother to think of an original name". As Stan was growing up, he frequently disagreed with his parents. His father managed a little league baseball team, and both Stan and his brother were players. Stan detested baseball and, consequently, believed that his father and brother were against him for being "different". In session, little mention was made about his relationship with his mother. He did, however, disclose that she was unresponsive when he revealed his homosexual identity to her. Because of her unresponsiveness, Stan believed that she disregarded his thoughts and feelings.

With his siblings, Stan expressed feeling alienated and ignored. Being the "middle child", he was neither the star athlete nor one of the babies. Stan recounted that during his grade school years he was
criticized by his teachers for performing poorly in Mathematics, yet he
demonstrated much talent in art and painting. Despite his attempts to
cultivate relationships with the other children at school, he felt
alienated from them because they were of a higher socioeconomic status
(Stan's father was unemployed.). He established two significant
relationships during his grade school years: one with a friend from
kindergarten, Michael, which he still maintains to this day, and one
with a friend from first grade, a slightly retarded boy. He revealed
that he usually associated with children who were also ostracized
because he was reassured that they would always accept him.

Stan's adolescence was depicted as a period when he formed a
number of new relationships. While in high school he became involved
in a number of social and academic clubs (art editor for the school
newspaper, member of the Spanish club), with the hope of gaining
approval from the students he perceived were in a higher social class
than he. Fearing a negative evaluation, however, he continued his
involvements with people he considered to be the "underdog people".
Also, his attempts at becoming more socially active failed to assuage
his sense of isolation and alienation. Described as the worst years of
his life, Stan frequently experienced bouts of depression and periods
of withdrawal. He felt ostracized by his peers because, in his view,
he was physically unattractive and didn't have the material possessions
(a car, clothes, etc.) that the others had. His only source of solace,
he recalled, was his relationship with a woman, 15 years his senior,
who he met through the church that he attended. She was his mentor and
confidante in that he felt free to express his feelings of isolation
and estrangement to her, without fearing rejection or ridicule. He disclosed that he frequently entertained thoughts of engaging in sexual activities with her, yet his fantasies were never actualized due to his fear that sex would interfere with their emotional bond. One could conjecture that Stan experienced difficulty in integrating sexuality and emotional intimacy. The origins of this difficulty could be explored in the treatment.

When asked about his psychosexual development, one of Stan's earliest recollections involved being called a "fag" and taunted on the playground while in kindergarten. He explained that his long hair and effeminate appearance during that time may have provoked the other children to tease him. During puberty, his brother showed him how to masturbate and, according to Stan, it was the only good thing that they ever shared. Stan and his friend Michael, from kindergarten, would also masturbate while viewing issues of Playgirl magazine, but Stan would never reach orgasm. During his high school years, he sensed that feelings of sexual attraction were beginning to emerge toward other males on his basketball team. In fact, his first sexual encounter was with one of the boys from the team. He revealed that they engaged in sexual activities other than intercourse (mutual masturbation, oral sex) due to Stan's conflicted feelings of excitement and guilt. His parents, he recounted, were strict Roman Catholics who conditioned him to believe that sexual intercourse was "solely a reproductive function". He was restricted from dating women during his high school years because his parents insisted that he devote his time to academic pursuits. Unbeknownst to his parents, he dated a girl in a nearby town.
but, because of invading feelings of guilt regarding sex, they maintained a platonic relationship. During his junior year in high school, his erotic feelings toward men began to strengthen and, subsequently, he decided to disclose his homoerotic feelings to his friend, Michael. Michael, however, dismissed Stan's homoerotic urges as "just a phase", leading Stan to mistrust his own sexual urges. His first sexual experience with a woman took place on his 21st birthday, followed by several sexual relationships with women. Upon graduation from high school, he attended Southern Illinois University, where he maintained a three year relationship with a woman. Describing their relationship as "tumultuous", he expressed feeling sexually frustrated and dissatisfied while he lived with her. He recalled that the permissive sexual atmosphere of the 1970's, resulting mostly from the Gay Liberation Movement, encouraged him to "come out" and act upon his homoerotic strivings. He had two fleeting sexual encounters with men, leading to the breakup of his relationship with his girlfriend. After the breakup, he moved in with three lesbians and one homosexual male, and had a brief affair with the male. Due to his excellent academic record in undergraduate school (and also due to his desire to excel in an area that his brother was weak in), he decided to attend graduate school to pursue a Master's degree in Art. While in graduate school his repressed sexual urges emerged, and he consequently engaged in numerous anonymous sexual encounters. He felt as though he "couldn't get enough sex" after being sexually frustrated with women for so long.

Shortly after earning his graduate degree, Stan met his current partner, Rick, and they have been living together for almost seven
years. It is not known whether the couple remained monogamous during this period. He reported a five year history at his current place of employment, a flower shop. At the time of intake he was a participant of a support group for significant others of PWAs. Outside of his primary relationship, he maintained little social contact with others.

Based on the information obtained during the intake interview, his past history appeared to reveal that issues related to feeling inferior (i.e., he was given his dead brother's name, he compared himself unfavorably to his brother and to his peers) and, subsequently, feeling alienated and disregarded were thematically significant. Because of his experience of difference, his ego development required a reckoning with invisibility and stigma. Some resistive behaviors were evidenced in relation to parental demands about dating, suggesting that these issues may require further exploration in treatment. The material about his adolescent development seemed to indicate a developmental lag in social and sexual functioning, which is not unusual for individuals who later identify themselves as gay or lesbian. Coleman (1982) notes that individuals with same-sex preferences are usually not afforded an adolescence during their teen years, resulting in the loss of chronological adolescence. Because most people in our society are encouraged to follow a heterosexual adolescence, he adds, homosexual individuals oftentimes fail to enter their true adolescence until their chronological adolescence has long past. For Stan, his compulsive sexual behavior may have functioned, in part, as a means of attempting to "catch up" developmentally, especially in terms of his sexual development. Issues related to losses (i.e., the loss of a
heterosexual identity, the loss of significant objects) were identified as areas to be elaborated in the therapy.

On the basis of the assessment model suggested by Nichols (1986), it appears that Stan responds to stressful life events by avoidance coping (withdrawal from social contacts), acting out (acting out his sexual impulses during graduate school), and striving for mastery (in attempting to excel academically). Signs of ego resilience that were noted during the interview included his ability to sustain relationships (i.e., his long-term relationship with his friend, Michael; his enduring relationship with his current partner, Rick), his five year employment history (indices of stability); his apparently high level of intellectual insight into his problems (based on his responses to the questions); and his willingness to seek social support.

A Description of the Treatment

This section will explain some thematic concerns which may appear during the course of psychodynamic psychotherapy with AIDS-affected individuals. Material from Stan's case report will be used to illuminate some of the sources of AIDS-related distress and the effects of the diagnosis and course of AIDS on his relationship with his partner. Issues involving transferences, countertransferences, and unconscious processes will also be discussed.

The treatment was conducted at a community service center which provides HIV and AIDS-related services to its clientele. The psychotherapy services at the agency are time-limited (ten weeks in duration), and clients are made aware of this fact at the time of
intake. The premise underlying the short-term dynamic approach to treatment is that clients are likely to respond to AIDS as they have to stressful situations in the past. A developmental perspective is used to assess the client’s ego strength and ability to relate to the therapist. A circumscribed problem area is then identified as the focal area of the treatment. Clients are referred to an outside agency or private practitioner if it is determined that their problems cannot be adequately addressed in ten sessions. The author was assigned to serve as the therapist. The therapeutic objectives centered around three areas: 1) Stan’s concerns about providing care to his partner, while facing his own possible illness, 2) his worries about the implications of his positive HIV status, and 3) issues about the effects of disease progression on his relationship with his partner.

An insight-oriented approach to treatment was determined as the treatment of choice to identify the sources of his resentment toward his partner and to explore his feelings of guilt in attending to his own needs. Supportive interventions focusing on enhancing Stan’s coping skills were also employed. Within a dynamic framework, the treatment can be organized according to transference and countertransference distortions, the client’s character defenses, unconscious mental processes, and resistances to the treatment (Chessick, 1983).

Transferences and Countertransferences

AIDS may have a dramatic impact on transference and countertransference issues. Fundamentally, transference is "a form of resistance in which the patient defends himself against remembering
and discussing his infantile conflicts by reliving them" (Chessick, 1983, p. 145). Issues related to intimacy, trust, and dependency are brought to the forefront with AIDS, and the relationships of the clients to their therapists may be stormy as a result. During treatment with Stan, he frequently reported feelings of frustration in attempting to meet his partner's emotional and medical needs, and anger that his needs were disregarded by his partner. However, when the focus of the discussion would shift from his partner's needs to Stan's needs, Stan would diminish the importance of his concerns with references such as "I know that this is trivial but..." A similar dynamic appeared to be operative in the therapeutic relationship. His wish to nurture the therapist was reflected in his associations as he offered mineral water to her. The therapist functioned as "the child"; the client as "the parent". The following dialogue from a therapy session illustrates this point.

Stan: Would you like some mineral water?

Therapist: Well, Stan. I think it's important that we talk about this.

Stan (somewhat defensively): Well, it's just a gesture of hospitality--trying to be comfortable. It's like, "Let's socialize." It's easier to talk. I thought you would feel the same way.

Therapist: It seems to me like you were hoping that I would feel more comfortable.

Stan: Yea, it must be hard for you to do this, working with AIDS. I thought you would be less nervous if we had a drink together.
Stan seems to have conflicted feelings about relying on the therapist for support. The manifest content suggests that he wants his dependency needs to be acknowledged; however, on a latent level, he communicates a resistance in addressing his dependency needs and he strives to compulsively meet the needs of others. Nichols (1986) notes that the therapist may be seen as the client's only ally and, if so, the AIDS-affected individual may feel trapped into courting the therapist's favor but angry at the loss of his independence. In the case of Stan, one could speculate that he is defending against a fear of losing his independence by being compulsively self-reliant and harshly unaccepting of his own limits. Breznitz (1983) posits that a common defensive response to a serious life event is to adopt an illusion of self-sufficiency in order to maintain an illusion of attachment. It could be inferred that Stan engages in compulsive caretaking behavior in an attempt to attenuate the anxiety associated with the anticipated loss of his partner.

Countertransference issues emerge in any therapeutic experience, but they are particularly significant with AIDS-affected individuals because of society's reactions to AIDS and homosexuality. Countertransference seems to appear "when the therapist is made anxious by the patient, when he fears feelings and ideas which therapeutic investigation may arouse in him, and when his desire to avoid anxiety and its dynamic roots force him into assuming defensive attitudes" (Chessick, 1983, p. 155). Helquist (1987) identifies the following major countertransference issues for professionals working with AIDS-affected individuals: 1) the fear of the unknown, 2) the fear of death
and dying, 3) denial of helplessness, 4) the fear of homosexuality, 5) over-identification, and 6) anger. Stein (1988) points out that the therapist working with gay men needs to possess a willingness to encounter the special problems associated with a group that is oppressed within society, and to be open to self-examination regarding one's own reactions to homosexuality and gay persons.

In conducting treatment with Stan, the therapist confronted her own homophobia and her fears of death and dying. As a nongay therapist, she had to develop an appreciation of the dynamics of a gay relationship. Confronting death elicited power and control concerns for the therapist, as well as her own issues related to loss. Clinical supervision helped the therapist to acknowledge feelings of helplessness and the tendency to collude with the client. The countertransference reactions, in supervision, were also used to provide information about the client. For example, with Stan the therapist frequently felt that she wanted to nurture him. Assuming that the therapist was not suffering from a countertransference character disturbance, it is likely that the client evoked similar responses in others, including his partner. In analyzing the therapist's countertransferences, it could be argued that the client is guarding himself from the anxiety inherent in individuating from his partner (and, perhaps on a latent level, from the therapist) by seeking nurturance from the therapist. Taken a step further, his care taking behavior may serve to conceal his need to be taken care of.

The client's transference reactions (his attempts to nurture the therapist) may represent a defense against conflicts involving intimacy
and dependency. His care taking behaviors seem to be associated with a psychological merger that reflects a lack of differentiation and a fear of attachment to the therapist. Moreover, the clinical material served to reverberate the therapist's own conflicts revolving around intimacy and dependency issues. Upon examination, she discovered that her internalized homophobia functioned much like an Achilles' heel onto which concerns about her own dependency needs were displaced. The countertransference analysis helped the therapist to avoid the temptation of truncating the client's exploration in order to bind her own anxiety. Stan's character structure, and implications for treatment, are considered in the next section.

Examining the client's characterological defenses: The embeddedness-emergence dialectic

Individuals uniquely respond to psychological threat based on their developmental history and their habitual style of coping with stress (avoidance coping, adaptive coping modes, etc.). The characterological defensive structures exist for the purpose of internal camouflage; the nature of the core dynamic conflict is concealed by repression, denial, and other dysphoria-reducing maneuvers. Yalom (1980) postulates that the modes of coping with the awareness of death are denial-based, and the two major bulwarks of the denial system are the archaic beliefs that one is either personally inviolable (and, therefore, striving toward individuation) and/or protected eternally by an ultimate rescuer (and, therefore, striving toward fusion). The two modes are diametrically opposed, though by no means mutually exclusive. Extreme adherence to either mode, he adds,
results in a characterological rigidity that is obviously maladaptive.

Stan's character structure can be understood around the motif of individuation. His clinical picture depicts an individual who has struggled against any form of control (i.e., he defied his father's wish for him to like baseball; he resisted parental demands about dating) and, due to his restricted social network, developed skills at self-sufficiency. He responded to periods of crisis by withdrawing, expressing the belief that no one was capable of meeting his needs.

In therapy, he often complained of feeling helpless and out of control. Also expressed were feelings of guilt that he may have inadvertently infected his partner. During one session, he exclaimed that he had no tolerance for sick people because sickness was out of his control. Frequent references were made about "taking separate vacations" (away from his lover) and "needing time alone". As the therapy progressed, he revealed feeling "burdened by the therapy" and "imposed upon by Rick's (his partner's) demands for medical and emotional attention". His flat affect in describing his partner's emaciated appearance suggested that he was attempting to deemphasize the anxiety-provoking nature of his partner's decline. Further exploration revealed that his concerns about his partner's deterioration were a function of his worries about his own physical condition and anticipated immobility. When the therapist interpreted Stan's attempts to court her favor (by bringing her mineral water and the newspaper), the derivative messages of the interaction were revealed, as follows:

Therapist: I notice Stan that you're giving me things-- mineral
water and the newspaper. I'm wondering if that's how you feel with Rick, that you're giving and not getting anything in return.

Stan: Oh, I see the connection. Since I feel hostile toward Rick, because I'm constantly doing and giving, that you might interpret my giving water as--well, you thought I might start feeling hostile toward you.

In this example, Stan was using the defensive strategy of reaction formation. This mode of defense is the development of convictions or character traits that are exactly the opposite of the unacceptable trends in the unconscious mind (Chessick, 1983). Thus, one possible interpretation is that Stan's self-reliance is the antithesis of his trend toward dependence, which is unconsciously unacceptable. Stan's sense of self-sufficiency was hypertrophied. What was truly dreadful to him was to be dependent and static; these conditions ignited terror because they represented death equivalents. For Stan the anticipated loss of his partner and his own HIV status challenged his belief of personal inviolability. Schneider (1984) substantiates this point by noting that the loss of a significant attachment is often viewed as a threat to all significant attachments, including the individual's own life. Stan's response to the threat was to deny his vulnerability by maximizing his perceived personal strengths. As Breznitz (1983) succinctly states, "By exaggerating one's image of strength, the illusion can be created of greater control over the events" (p. 208).

The therapeutic alliance

It has been stated (Yalom, 1980; Chessick, 1983) that it is the therapeutic relationship that is curative in catalyzing therapeutic
change. What is not always known, however, are the details of how psychotherapy heals or fails. Nonetheless, this fact does not mean that it is impossible to understand some of the specific factors involved in therapeutic healing or therapeutic failure. Chessick (1983) contends that, for the therapy to be effective, the therapist must guide the client in the realization of his active participation in creating life experiences by examining difficulties in the therapeutic relationship. Through this process the client recognizes that disruptions in the therapeutic relationship are similar to difficulties in relationships in the client's life outside of treatment.

Regarding the treatment of Stan, his presenting dilemma was that his partner's AIDS diagnosis precipitated feelings of resentment toward his partner, leading to several disruptions in their relationship. While in the treatment, Stan became increasingly aware of the fact that similar dynamics were operative in his relationship with the therapist. By examining disruptions in the therapeutic relationship with the therapist, Stan became capable of communicating unconscious material (his repudiated feelings of hostility toward his partner and, on a secondary level, toward the therapist) to the therapist. As a result, the therapist became increasingly capable of understanding the unconscious material from Stan and interpreted it back to him. These relational dynamics are reflected in the following:

Stan: I don't always feel comfortable talking about these things—you know, Rick's condition and everything. Well, I thought you would be less nervous too if we had a drink together (referring to the mineral water).
Therapist: It seems like you perceive me as nervous and you're hoping that I'll feel more comfortable in here. You've been talking about how you feel in your relationship with Rick. Well, you and I have a relationship too. I'm wondering if this is how you feel with Rick--like you want to comfort him.

Stan: Yea, I do the same with him. I made him coffee today. Maybe it's the same thing--trying to make people feel comfortable. It may relate to my hostile feelings toward him--doing things for him and having to bear the burden (sounding angry). I resent having to do everything, but I turn around and do it anyway.

Therapist: Stan, you're starting to sound angry about having to "bear the burden", as you say.

Stan: I am! I'm sick of hearing his complaints about his shingles and everything. I want to be alone!

Stan, in this example, seems to have an enlarged view of the extent and nature of his problems and of his active role (through the mechanism of his care taking behaviors) in bringing about problems in his relationship with Rick. In exploring his emotional difficulties in his relationship with the therapist, he discovered the centrality of his conflict about his dependency needs.

Another relational problem in the treatment of Stan involved his all-or-none thinking, seeing the therapist as an enemy ("Therapy is a burden; I want to be alone.") and as a rescuer (manifested by his attempts to merge with her in bringing her "gifts"). The resulting relational shifts were confusing to the therapist and, if they weren't addressed in clinical supervision, could have potentially disrupted the
course of treatment.

Termination and disposition

Levinson (1977) refers that the termination phase of the treatment as "the final recapitulation of the beginning phase of therapy" (p. 480). Chessick (1983) adds that the termination (the final stage in the treatment) must provide the client with an opportunity to experience grief and mourning reactions in whatever intensity the client will experience it.

As the termination stage of the treatment approached in the treatment of Stan, he cancelled two appointments explaining that, on one occasion he had to take Rick to the hospital, and, on the other, he suffered from the flu. During the sessions his associations contained themes of separation (taking separate vacations from his partner and the possibility that his partner might move to Iowa) and anger toward his partner, which could be inferred as veiled references to the termination of treatment. It appears as though threats of separation (from his partner and the therapist) aroused feelings of anger in Stan. Because the termination was institutionally determined, he viewed the ending of treatment as a rejection, exacerbating feelings of anger. In diagnostically assessing Stan's dynamics, the therapist concluded that the cancelled appointments represented Stan's resistance to the termination. For Stan, the ending of the therapy reverberated conflicts and fears related to the anticipated loss of his partner and the loss of past objects. His affect was flat as he recounted the death of a friend from the past, perhaps indicating attempts to keep internal upheaval under control by maintaining protective bulwarks
against intense affects.

For the therapist, the process of termination reawakened her own feelings of separation and loss. The institutionally imposed termination date engendered feelings of anxiety and anger in the therapist, who colluded with the client in the wish to ensure the maintenance of the therapeutic relationship rather than confront the forthcoming separation. In clinical supervision, the therapist was encouraged to understand the nature of this aspect of the treatment and identify her own reactions to the termination. Her countertransferences were used to help the client to understand his characteristic ways of dealing with ending relationships. The therapist guided him in directly confronting the separation process and allowed him to give expression to his strangulated affect, which helped Stan to identify his feelings of anger toward Rick and the therapist. Upon termination, Stan decided to seek couples therapy at an agency suggested by his partner.

Evaluation of the Treatment

Stan's treatment accomplished the following objectives: 1) He identified his compulsive care-taking behavior (manifested by his attempts to nurture his partner and the therapist) as a defensive coping strategy in dealing with the anticipated loss of his partner and possible loss of his own health status, 2) Previously unrecognized feelings of intense anger and hostility toward his partner were acknowledged, allowing him to begin to grieve these anticipated losses, and 3) He realized the importance of depending on others for support by becoming aware of and understanding his attachment to the therapist.
An examination of his transference reactions revealed that Stan responded to the anxiety associated with individuating from his partner (and the therapist) by attempting to merge with his partner (and the therapist). The core dynamic was that his nurturing behaviors functioned as an intense effort to ward-off painful affects associated with threats of separation. Stan developed an appreciation of the complexity of his problems in realizing that his partner's physical deterioration forced him to confront the unpalatable truth of the finiteness of his own existence. His partner's physical condition is likely to worsen and his own health status may deteriorate, necessitating a reliance on emotional support systems (Although Stan stated that his family was a source of support it is questionable, considering his extreme presentation of self-sufficiency, that he relied on them very often.). Further exploration in treatment should address the following areas: 1) the nature of his relationships with his parents and siblings, particularly with his mother, to determine if similar themes of separation are elaborated, 2) grieving and death and dying rituals in his biological family, 3) specific reactions of his support system and family, biological and community, to his partner's AIDS diagnosis and his positive HIV status, and 4) his engagement in behaviors that might increase his risk of further exposure to HIV (In therapy, he stated that he practices safe sex behaviors and that he doesn't abuse alcohol and other drugs. Further assessment may identify other potentially risky behaviors.).
Summary

This case study illustrated several issues and clinical themes that can be addressed in treatment of AIDS-affected individuals. Several themes relate to issues addressed in psychotherapy in general (trust, intimacy, and dependency), while others are particular to PWAs (because of the stigma associated with homosexuality and death). The case of Stan represents an example of an individual who, not only suffers from HIV infections, but whose partner was diagnosed with and will eventually die from AIDS. He is in a uniquely precarious situation in that his partner will die from a mysterious disease that has raised a great deal of national anxiety (rational and irrational) and he faces an uncertain future regarding his own health. Since he is young (34 years old), he is not as prepared to confront issues of death as older people might be. His social network is restricted, resulting in feelings of isolation and estrangement. Upon entering treatment, his central concerns revolved around conflicts with intimacy and dependency in his relationship with his partner. In the treatment the dynamics of the therapeutic relationship were explored, and it was concluded that similar difficulties existed in his relationship with the therapist. Stan's clinical picture indicated that his reactions to his AIDS-related fears represented a resurgence of conflicts regarding dependency and loss issues. His "coming out" process and his struggles to achieve a health gay identity were portrayed in his developmental history, apparently revealing that social rejection issues were reactivated by the AIDS crisis. For these reasons, psychotherapy with AIDS-affected individuals should address the psychosocial development
of gay males and the subjective meaning that each gay individual assigns to the AIDS crisis and his sexual identity. Identifying some of the sources of distress may help clinicians to gain an understanding of the attitudes that underlie the sexual behaviors of homosexual men, as they attempt to influence these behaviors. Additional psychotherapeutic recommendations are offered in the chapter that follows.
CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Acquired Immune Deficiency Syndrome is quickly becoming a major epidemic and a "psychological emergency" (Kinnier, 1986) in our society. Beyond the obvious medical dilemma, AIDS presents a psychosocial challenge. This research project examined psychotherapeutic treatment issues in relation to AIDS-related distress in homosexual males. Particular attention was paid to the wide range of responses to distress, most notably, denial of the terminal nature of the illness, changes in self-esteem and the resurgence of internalized homophobia, and the fear of abandonment and isolation from the family and community.

A critical review of the clinical and psychosocial literature on AIDS revealed an accumulating body of knowledge relevant to understanding affective reactions to the AIDS diagnosis and psychological issues during the course of the illness. A situational distress model (Nichols, 1985) was presented, along with a stage theory (Macks & Turner, 1986) outlining adaptive responses to the AIDS diagnosis.

The case study of Stan intended to identify some of the sources of subjective distress associated with: 1) HIV infection, early symptoms, and the perception of the adverse consequences for the individual and
his relationship with his partner; 2) the adaptive/coping/defensive patterns that are evoked by subjective distress (denial, entry into the social support network); and 3) the unique antecedents of these mutually influential variables (indicated by the client's developmental history). The case material also highlighted the impact of AIDS and AIDS-spectrum illnesses on the partner of a PWA, an area which represents an empirical/knowledge gap in the literature to date.

Kaplan et. al. (1987) outline a substantive model that attempts to explain the presumed effects of subjective distress on the course of the disease: The course of AIDS is described as a function of modes of response (coping/adaptive/defensive responses) to AIDS-related distress. These responses influence the course of AIDS via their effects on immune deficiency status and HIV infection. Responses to subjective distress affect the course of the disease by influencing HIV infection. Changes in behavioral risk factors, for example, may regulate the frequency of multiple exposures to HIV, and entry into the medical care network may prompt treatments that target HIV. Responses to subjective distress may also modify the distress and behavioral patterns that compromise the competence of immune responses.

In conclusion, much of the existing literature that addresses stress responses considers too narrow a range of explanatory factors. If changes in behavior that increase the risk of AIDS are relevant to understanding the course of AIDS, it is essential to examine how transmissibility factors and host vulnerability factors influence health outcomes. A broadened perspective, including psychological, social, and environmental factors was suggested (Coates et al., 1984;
Psychotherapeutic Recommendations

These observations support the assumption that PWA's, unlike cancer patients and other terminally ill individuals, cannot rely on a built-in societal support system. The lack of such a system and the unique issues that this population must confront creates the need for specialized interventions. Based on these observations, and on psychotherapeutic recommendations suggested by Nichols (1986), the following recommendations to therapists working with PWAs are offered:

1) Psychotherapy training programs should provide sufficient training and supervision concerning sexuality in general and homosexuality in particular in helping therapists to appreciate specific developmental and social issues associated with being gay. Also, special training may be needed before therapists are able to maintain appropriate contact and offer compassionate care to terminally ill patients; 2) Therapists should explore countertransference reactions, homophobia, fear of death, loss issues, etc. in clinical supervision/consultation to neutralize their unconscious homophobia and develop the ability to be at ease with persons who may be dying; 3) Because AIDS-affected individuals are likely to be involved in a life-style that increases their risk of exposure to HIV, PWAs need immediate educational and emotional support in risk reduction which calls for crisis intervention and therapy that actively advocates behavior change (i.e., interventions to reduce stress and to eroticize safe sex); 4) Therapists who intend to work in this area have to have an adequate
knowledge base of what is known about the illness and keep abreast of scientific developments in basic research and medical treatment; 5) Therapists should understand the epidemiology of AIDS and be convinced that it is not transmitted easily. They must know that they are not endangered by their interactions with PWAs. Otherwise the therapy will be compromised by inappropriate fear and personal concern; 6) Due to the high burnout rate in working with terminally ill individuals, it is suggested that some type of support group, formal or informal, be arranged for the therapists. Such a group should provide an atmosphere for the ventilation of feelings and offer emotional support in the form of caring/constructive feedback; 7) PWAs or members of a risk group should have a mental status exam at the time of intake. The assessment of PWAs may be complicated in AIDS by organic Central Nervous System (CNS) pathology and may mimic either a retarded depression or psychosis. In evaluating abnormalities in CNS functioning, the possible side effects of prescribed drugs should be considered; 8) Therapists can provide family members with a brief discussion of homosexuality including the positive aspects of the gay community and relationships, helping them to identify their false beliefs and encouraging ventilation of anger, guilt, and disillusionment; 9) Therapists should consider whether or not to disclose their sexual orientation to clients. Nichols (1986) recommends that it is almost imperative for gay and lesbian therapists to "come out" to clients in severe distress; the disclosure, he notes, may furnish the support needed to get them safely through the AIDS crisis. In insight-oriented treatment, the meaning of the disclosure to the client will have to be
examined; 10) The therapist should ascertain whether the PWA has "come out" to his family and assess the status of the PWA's support network; 11) In bereavement counseling, therapists should develop an understanding that the emotional reactions to AIDS and to homosexuality may both interfere with the grieving process. A history of how one mourned in the past and what helped in that bereavement may indicate the type of assistance needed; and, overall, 12) Interventions should be developed and evaluated for their potential in helping therapists improve their ability to meet the psychosocial and medical needs of their clients.

The suggestions offered are extensive and may seem prohibitive to persons considering providing their services to persons troubled by AIDS. This complex and devastating disease may force therapists to assume unaccustomed roles with clients, colleagues, and agencies of health care. Major steps have to be taken to foster collaboration between psychologists and nonpsychiatric physicians. Strong and humane leadership is necessary to bring about a cooperative response. Therapists are in a unique position with AIDS in that they can participate in social change by forcing society to confront some of its taboo subjects, including death and sexuality. Therapists are critical to the leadership needed to manage the AIDS catastrophe.

**Recommendations for Future Research**

Future research on the psychosocial aspects of AIDS will need to address the following research questions: 1) What psychosocial factors contribute to the etiology and pathogenesis of this disease? Kaplan et al. (1987) suggest a methodological approach guided by a theory that
specifies the nature of the relationships among a broad range of mutually influential explanatory factors (contextual, psychological, and social); 2) What cofactors and intervening processes mediate the risk of developing AIDS?; 3) What is the number of PWAs who are partnered and what is the incidence of AIDS and AIDS-spectrum illnesses among partners?; 4) What problems result for surviving partners of PWAs due to the lack of social and legal sanctions to aid in the bereavement process for gay individuals?; and 5) Is immune response compromised by bereavement and, if so, is it possible to intervene with these factors and other related factors (stress, alcohol, etc.), restore immune function, and resolve disease?

The research agenda on the clinical implications of AIDS should include the following questions: 1) What can therapists and caregivers do to promote health-enhancing behaviors and discourage behaviors that are deleterious to health?; 2) What types of interventions are needed to ameliorate the problems of those who test HIV positive (or who are diagnosed with AIDS or AIDS-spectrum illnesses) who continue to engage in high risk behaviors? Two ancillary questions related to this are a) What attitudes underlie the sexual behaviors of homosexual men? and b) What is the relationship between changes in attitudes and reduction in high risk sexual practices?; and 3) What can therapists and other caregivers do to assist in the grieving process? Although anecdotal data exists that addresses some of these questions, controlled randomized experiments in these areas may be important for AIDS research and, more generally, may have significant implications for behavioral medicine and psychoimmunology.
Therapists working with this catastrophic illness may be able to assist individuals to achieve personal growth because the AIDS crisis may allow them to explore, more honestly than before, the meaning of their existence. For some, the diagnosis of AIDS may lead to a reconciliation with estranged family members. Other gay men may use their AIDS diagnosis as an opportunity to "come out" to others, thus advancing an awareness of homosexuality in our society. Wirth (1986) wrote that "AIDS first crushes us, then invites and impels us to reintegrate, to make ourselves whole in a new way." (p. 138).

The consideration of these therapeutic and theoretical/empirical recommendations hopes to increase understanding of the psychosocial processes underlying AIDS-related distress and adaptive/coping/defensive responses. Such increased understanding, it is hoped, will improve the probability that more informed policy decisions will be made and that more clinical interventions will be implemented with the goal of forestalling the onset of AIDS or assuaging the unwelcomed consequences of this dread disease.
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Glossary of Terms

Acute: illnesses which are usually of brief duration but severe.

Antibody: produced by the B cells, found in tissue fluids and blood serum; produced in response to the stimulus of a specific antigen and capable of combining with that antigen to neutralize or destroy it.

Antigen: any substance that is recognized as foreign by the immune system.

ARC: an acronym for AIDS-Related Complex. A variety of chronic symptoms that occur in some persons who are HIV infected, but whose conditions do not meet the CDC’s surveillance definition of AIDS. The severity of symptoms and illnesses associated with ARC ranges from mild to very severe.

B-cell: a type of lymphocyte that produces antibodies to create immunity against certain diseases in response to stimulation by an antigen.

Chronic: conditions which persist over long periods of time.

ELISA: an acronym for Enzyme Linked Immuno-sorbent Assay, a test used to detect antibodies in blood samples.

Etiologic Agent: a biological, physical or chemical entity capable of causing disease.

Helper Cells (T4 Cells): T lymphocytes which enhance antibody production and cell mediated immunity.

HIV: Human Immunodeficiency Virus: In 1986, an international committee on the taxonomy of viruses chose HIV as the accepted name for the recognized etiologic agent of AIDS. HIV then replaced HTLV-III/LAV/ARV.

HIV Antibody Test: refers to the ELISA used to detect the presence of antibodies to HIV, indicating only that an individual has been exposed to HIV. A second test, the Western Blot, is used to confirm reactive (positive) ELISA tests.

Host Susceptibility: the factors unique to the individual which may predispose him to infection or illnesses by an infectious agent.

Humoral Immunity: the human defense mechanism that involves the production by B cells of antibodies which circulate throughout the blood-stream.
Incubation: the period of time from entry of a germ into the body to the appearance of disease symptomatology.

Kaposi's Sarcoma: a tumor or cancer of the blood vessel walls which appear as purple lesions on the skin. In persons younger than 60 years of age, this sarcoma is most commonly associated with HIV infection.

Killer Cells: a lymphocyte capable of destroying antigens.

Leukocyte: any white blood cell.

Lymphocyte: a type of white blood cell (including T and B cells) formed in the lymphoid tissue throughout the body.

Macrophage: a leukocyte capable of phagocytosis, a member of the cell mediated immune response. Macrophages present antigens to the T4 cells for destruction and for the stimulation of humoral immune response.

Mode of Response: the bridge by which an infectious agent is delivered to a new host (either direct or indirect).

Monocyte: a leukocyte capable of phagocytosis.

Onset: the beginning or initial symptoms of disease.

Opportunistic Infection: diseases that take advantage of the body's lowered resistance to infection caused by the destruction of the immune system by the AIDS virus. These infections capitalized on the weakened immune system using the opportunity to cause infection and illness. Currently, the most common of the diseases associated with AIDS is PCP.

Persistent Generalized Lymphadenopathy (PGL): persistent swelling of the lymph nodes resulting from HIV infection.

Phagocytes: different types of cells classified together because of their shared characteristic ability to engulf and ingest antigens.

Phagocytosis: the destruction of antigens through the process of engulfment and ingestion.

Pneumocystis Carinii Pneumonia (PCP): currently, the most common opportunistic infection associated with AIDS. PCP is caused by the parasite Pneumocystis carinii.

Portals of Entry: points at which etiologic agents gain access to the blood stream.

Scavenger Cells: see phagocytes.

Seroconversion: the presence of specific antibodies in the blood. In the case of HIV infection, this indicates that an individual has been
exposed to the AIDS virus.

Seroprevalence: the overall occurrence of HIV antibodies with a specific population at any point in time.

Shingles: this condition is caused by herpes varicella zoster virus. Shingles are small, blister-like clusters, surrounded by reddened, swollen and itchy skin usually found along nerve routes. While many persons with AIDS and persons with ARC present with shingles, shingles frequently occur in immunocompetent persons.

Suppressor Cells: a subgroup of lymphocytes also called T8 cells which monitor the immune system functions and "turn off" the immune response when the antigen has been destroyed.

Syndrome: a set of symptoms which occur together.

T Cells: a type of lymphocyte which protects against viruses, parasites, and fungi; T cells regulate the various cellular and humoral components of the immune system.

Toxoplasmosis: a protozoan infection which can cause pneumonia infection in the brain, inflammation of the kidneys and skin rashes.
APPROVAL SHEET

The thesis submitted by Donna Mahoney has been read and approved by the following committee:

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirement for the degree of Master of Arts.

Date: 12/7/88

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