Integration of Client HIV Status in Sexual Dependency Outpatient Treatment:
What is your relationship with HIV?

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The interaction between sexual addiction, compulsive sexual behavior, Hyperphilia, and the risk for HIV infection needs to be better understood. Using the general term of sexual dependency and applying motivational interviewing treatment interventions based upon the six stages of the wheel of change; the author presents an interactive treatment relationship between HIV cofactors at each stage of the six stages for sexual dependency client readiness for change. Therapists, too, have a relationship with HIV. A therapist's understanding of HIV countertransferential experiences at each stage of treatment is emphasized.

Diverse populations who engage in behaviors that result in high risk for HIV infection are widely researched and reported. In the United States the yearly infection rate of newly infected persons with HIV remains fairly constant at 40,000 a year. This infection rate has not dropped below this threshold level despite all prevention and public health efforts. Who comprises these 40,000 new infections every year is what is changing. "Today, according to the CDC (Centers for Disease Control and Prevention) more than half of the 40,000 new cases of HIV infection in the United States each year occur among blacks." (Maugh, 2001)

Emerging populations with escalating infection rates include adolescents, drug users, abusers and addicts, women (especially women partners of men who inject drugs or have been in prison), the mentally ill, the poor and the homeless. New infection rates among gay men, after declining for many years, have recently been increasing among young gay and bisexual men in large urban cities. (Maugh, 2001) "People are continuing to be infected by HIV because prevention programs are not targeted toward them." (Haffner, 1997/1998, p. 3) HIV prevention programs may be hard pressed to meet the wide array of risk factors among various demographic groups based on race, gender, ethnicity and age that play additional roles in each person's relationship with HIV.

Voluminous research on HIV infection within diverse risk groups is available. Maguen and Armistead (2000) find that "In addition to unprotected sex, adolescents reported a number of risk factors, including engaging in sex after alcohol and drug consumption and having anonymous and risky partners."(Maguen & Armistead, p. 172) They also notice that many of the teens engaging in risky behavior did not know their HIV status. Sara Phillips (1995) observes just how important understanding the adolescents' *relationship* with HIV is when she comments, "Approaching sexual risk taking as a subjectively rational behavior rather than as a wholly irrational behavior will most likely improve the impact of sexuality education. In this way, unprotected intercourse is not always a failure to respond to risk but rather a response to some other risk." (Phillips, p.11) She encourages professionals to "tease out these 'other risks' and work them out." (Phillips, p.11) Some studies look more closely at the attitudinal relationship youth develop regarding the HIV virus. By looking at social scripting Mutchler (2000) identifies how gay men form their sexual lives and how these lives are

socially and culturally shaped. Mutchler says "knowing how gay youth use multiple scripts for sex in concrete situations provides insight into how unsafe sex is accomplished, and therefore how it can be mitigated." (Mutchler, p. 50)

Women have been identified as comprising the highest percentage of new AIDS cases in the United States, either through heterosexual intercourse or the sharing of needles during drug use. (Norris, 1994) Substance abuse plays a crucial role in the lives of HIV-affected women. (Friedman, 1997) However, research is needed to assist chemical dependency treatment providers to more readily identify sexually dependent women at risk for HIV infection.

HIV research with other emerging at risk groups supports the need to understand the person's perceived relationship with HIV as an important clinical consideration in treatment. Interviews with men who have sex with men associate unsafe sex with complex issues, such as participants' sexual and affective preferences, the nature of the relationship between partners, ambiguities about what is truly safe, and the influence of dominant cultural values and discourse. (Adam, Sears & Schellenberg, 2000) These complex issues are compounded for people of color. Sik Ying Ho & Kat Tat Tsang (2000) in their interviews with Chinese gay men in Hong Kong and their relationships with Western partners about negotiating anal intercourse observed, "personal, sexual choices are always associated with political struggle or movement" (p. 319). They propose, that for many inter-racial male couples in Hong Kong, the underdeveloped western gay male sexual orientation and enculturation identification and ambivalence towards anal sex in the continuously changing relationship between two persons may symbolize aspects of colonial legacy and its resistance. Matteson's (1997) findings on bi-

sexual and homosexual behavior and HIV risk among Chinese-, Filipino-, and Korean-American men suggest that Asian-American men who expressed acculturation to Asian society and who had sex with men were more likely to comply with safer sex. However, Matteson also finds that, for Latinos, identification with Western Protestantism, or traditional Latin homosexual roles, was related to higher risk behavior. Effective strategies for designing HIV communication programs for African-American men on the basis of complex cultural experiences of gender, race and sexual orientation are identified by Myrick. (1999) According to Myrick, HIV communication designed for populations of African-American men who have sex with men must respond to their cultural context--a context in which African-American men are victims of double discrimination as well as disproportionately high instances of chronic depression and problems with alcohol and substance abuse. In addition, for many African-Americans, having same-sex desire and behavior is not an indication of gay identity. Robinson presents variables to be considered in culturally specific assessment, diagnosis and treatment for sexual addiction among African-American men. (Robinson, 1999) He identifies the need to provide treatment strategies that address the avoidant and numbing strategies common in post-traumatic stress disorder stemming from the historical aspects of slavery, racism and discrimination and the resulting PTSD symptoms.

Williams (1999) identifies the serious concerns for contracting and spreading HIV among homeless alcoholics and drug addicts some of whom may be untreated sex addicts. For mentally ill gay and lesbian clients, Helfand (1993) identifies the need for educating staff regarding issues of homophobia within the mental health system as a key issue. Cuestas-Thompson (1997) proposes that preexisting factors in gay men such as

sexual compulsivity, histories of childhood sexual abuse, substance use disorders, and major depression often predispose the individual to become infected with HIV. He proposes that these same preexisting factors often play a powerful role in how the course of HIV disease impacts the individual. Weiss (1997) identifies the advent of HIV as an explanation for the increasing numbers of gay men seeking relief from sexual addiction. He also identifies the ramifications of unprotected sex among gay men and uses that as a primary intervention tool in sexual addiction treatment. He proposes the need for more thorough scientific research and study regarding the relationship between gay male sex addicts, HIV and safe sexual practice.

Despite excellent demographic research on HIV infection rates within a variety of emerging at risk populations as well as etiological theories that elucidate complex relationship dynamics with HIV among various subgroups, no statistics are available regarding HIV infection rates within the populations of persons being treated for compulsive sexual behavior (Coleman, 1986, 1987, 1990, 1992), sexual addiction (Carnes, 1988, 1989, 1990, Gosling, 2000), and/or hyperphilia. (Money, 1988, 1999) Braun-Harvey (1997) combines these three etiologically differing conceptualizations of problematic sexual behavior under the term sexual dependency, which he describes as a "general non-diagnostic and non-etiological term to describe sexual behaviors that involve problems of sexual control and excessive, intrusive sexual preoccupation leading to psychological distress." (Braun-Harvey, 1997, p. 367) Sexual dependency is used throughout this paper to describe problematic sexual behaviors, while ideas such as compulsive sexual behavior; sexual addiction and hyperphilia will be used only in their specific diagnostic and theoretical definitions.

Sexual Dependency and HIV

In addition to the general lack of acknowledgement of persons with sexual addictions and compulsivity as an emerging population at risk for HIV infection, as well as the absence of HIV infection rate statistics among persons in treatment for sexual addiction and compulsive sexual behavior, a lack of emphasis in the literature exists regarding specific psychotherapeutic treatment approaches for HIV and sexual dependency. The small number of published articles on HIV and sexual dependency focuses primarily on interactive influences between multiple diagnoses with an emphasis on the already sero-converted sexually dependent patient. Sealy (1999) identifies the need for diagnostic vigilance for identifying and treating multiple diagnoses, including HIV infection, throughout the treatment course of sexual addiction. He outlines client history risk factors for HIV infection that lead him to recommend HIV antibody testing for all patients in treatment for sexual addiction. Sealy also discusses how the psychotherapist can support HIV infection treatment by understanding the stages of HIV disease. This is an affirmation of the relational aspects of living with HIV and the changing nature of the client's relationship with HIV disease and the impact on sexual dependency treatment. While Sealy focuses on the recovery and treatment implications with HIV infected sexually addicted patients, Cuesta-Thomson (1997) and Weiss (1997) include discussions of sexually addicted client relationships that are either infected or non-HIV infected. However, both of these articles focus exclusively on gay men in treatment for sexual addiction.

Gaps in the literature exist in reference to sexual dependency assessment and treatment implications for non-high risk HIV infection groups, emerging high risk

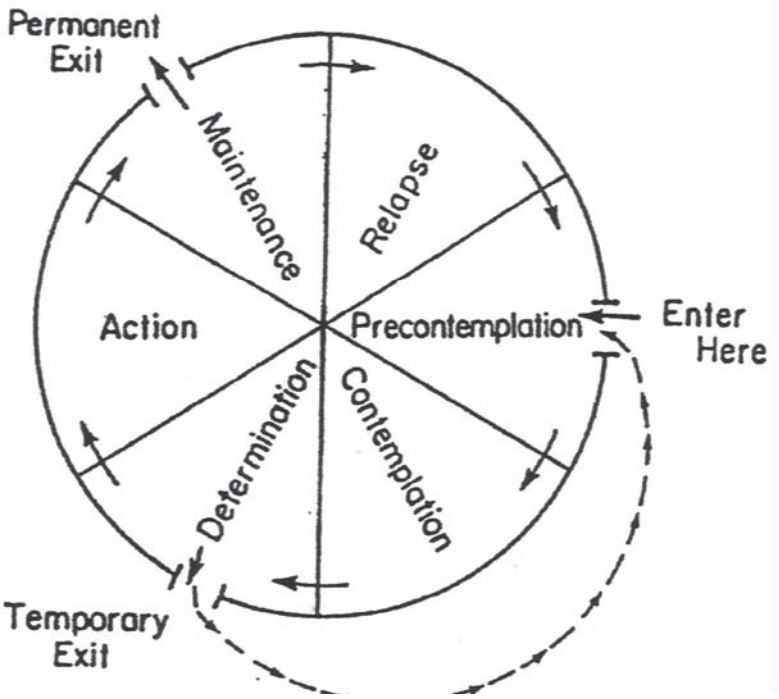
infection groups (other than gay men) in treatment for sexual dependency as well as treatment conceptualizations that address the dynamic and changing relationship with HIV that clients experience as a result of treating dependency. Therefore, a specific focus on the relationship with HIV at all stages of treatment for clients with sexual dependency would be a valuable addition to a vital element of our understanding and treatment of sexual dependency.

Incorporating HIV antibody status into Sexual Dependency Treatment

. Every patient being treated for sexual dependency has a relationship with HIV. To have a relationship with HIV is to acknowledge it exists. HIV is a psychological, behavioral and for some a medical condition that is a companion in the entire choreography of living with untreated or treated sexual dependency. It is the responsibility of every therapist to incorporate his/her client's HIV antibody status in assessment and treatment planning. How a client approaches this relationship with HIV is an ever-present clinical consideration at all stages of treatment for sexual dependency. Varying conceptualizations of stages for client recovery are closely linked to the specific theoretical conceptualizations of compulsive sexual behavior, sexual addiction and hyperphilia. A model of treatment for sexual dependency among substance abusing men that focuses on motivational interviewing strategies originally formulated by Miller and Rollnick (1991) based on the six stages of change researched by Prochaska and DiClemente. (1984) See Figure 1. has been articulated. (Braun-Harvey, 1997)

Figure 1. A Stage Model of the Process of Change

Prochaska and DiClemente



From *Motivational enhancement therapy manual: a clinical research guide for therapists treating individuals with alcohol abuse and dependence.* By Miller, W., Zweben, A., DiClemente, C. & Rychtarik, R. (1995).

"People who are not considering change in their problem behavior are described as **precontemplators**. The **contemplation** stage entails individuals' beginning to consider both that they have a problem and the feasibility and costs of changing that behavior. As individuals progress, they move on to the **determination** stage, where the decision is made to take action and change. Once individuals begin to modify the problem behavior, they enter the **action** stage, which normally continues for 3-6 months. After successfully negotiating the action stage, individuals move to **maintenance** or sustained change. It these efforts fail, a **relapse** occurs, and the individual begins another cycle" (Miller, Zweben, DiClemente & Rychtarik, 1995, p. 4)

Motivational interviewing focuses on moving the client toward the next stage of change and helps the therapist to process the cyclical nature of change with the client. This model will be expanded to include the utilization of the motivational enhancement techniques as a basis for incorporating the client's relationship with HIV throughout the stages of treatment for sexual dependency.

Factors that influence a clients relationship with HIV

At each stage of recovery several co-factors that affect the clients relationship with HIV must be taken into consideration. These factors are gender, sexual orientation, ethnicity/ race, drug use, abuse or dependency, HIV literacy, geography, age, acuity level of dual, triple or quadruple diagnoses, previous or current relationship with persons living with HIV, diagnosed with AIDS or who have died from AIDS complications. The clinical importance of these HIV co-factors varies with the sexually dependent clients motivational stage of change. Each stage of change becomes a different lens for the client and therapist to view how the client's relationship with HIV may be influencing and interacting with treatment for sexual dependency. Reviewing this interactive relationship of HIV co-factors at each stage of change in sexual dependency treatment is the primary focus for the remainder of this article.

Precontemplation: moving towards ambivalence

Precontemplative stage clients are motivated to change by someone else's concern for their behavior. The legal system may want them to change their behavior due to a recent arrest, their spouses may want them to change their sexual behavior due to a recent discovery of a secretive hidden sexual behavior, or their employers may want them to change because of work performance problems. Outpatient therapists concern about

his/her client's possible sexually dependent behavior when the client is coming to therapy for a different stated reason is a common precontemplation stage psychotherapeutic dilemma. The hallmark of precontemplation stage of change is the external motivation to change is based on someone else, not the client's interest or concern about his/her behavior. The vast majority of these potentially sexually dependent clients do not present at a specific program that treats sexual dependency. It is the challenge of the therapist who may have little specialized training in the area of sexual dependency to move the client to the contemplative stage of change. The therapist can use the client's relationship with HIV as a potential tool to accomplish this task.

Clients with sexual behavioral symptoms may be self-motivated to discuss concerns related to HIV much more readily than those related sexual dependency. A client may present for outpatient treatment at a highly motivated stage of change regarding HIV infection prevention and be at the precontemplative stage of change regarding sexual dependency. It is the job of the therapist who suspects possible sexual dependency (and is now in the role of the external agent who may be concerned about the client's sexual behavior) to keep client sessions focused solely on moving the client to the contemplative stage of change.

Case example: A 43-year-old African-American male in his fourth year of recovery from crystal methamphetamine addiction appears for outpatient chemical dependency therapy because of a recent incident involving anonymous sex with another man that was under the influence of crystal. The client did not use any drugs at the time but he is concerned about future relapse in his drug recovery. The client allowed his anonymous

partner to ejaculate in his mouth. He is concerned about HIV infection but verbalizes no concern or interest in changing his involvement in public sex with men.

Utilizing pre-contemplative sexual dependency intervention strategies the therapist will keep the focus on what motivated the client to come for therapy: HIV infection and drug relapse. The therapist could consider many of the cofactors that affect a client's relationship with HIV as points for discussion. Where has the client received information about HIV? In many communities, agencies providing prevention and education for HIV are perceived as gay men's agencies. This perpetuates the longstanding and incorrect link that HIV is inexorably coupled in most people's mind with homosexuality. How does the client understand his sexual orientation? It is very common among African-American men to see a "gay male" identity as a white male identity. Many black men who have sex with men do not identify as gay, even though their primary erotic orientation is with men. This has been a significant barrier in effective prevention efforts targeted to men of color who have sex with men. Has the client ever been to a resource for HIV information specifically targeted to his racial or ethnic identity?

How often has the client had sexual partners who were under the influence of drugs or alcohol? Many potentially sexually dependent pre-contemplative stage clients who are recovering addicts are deeply committed to their sobriety and open to discussing their sexual behavior when it is focused on staying sober rather than a premature focus on sexual dependency.

Age is another significant factor. Empathizing with the client's lifetime experience with HIV can be an effective stimulus for moving a client toward eliciting

self-motivational statements that are necessary for movement to the contemplative stage of change. This client is 43 years old, which means he most likely had an active sexual life before HIV was identified. The age for this demarcation continues to get older. For instance most people born before 1965 had some sexually active years before the awareness of the existence of HIV. Those born after the late sixties have not known an active sexual life without HIV. People over 35 have had to make an adjustment in their sex lives whereas those under 35 have always had sex in the context of the threat of the virus. Exploring this reality with the client may result in an increase level of awareness on safety and his interest in looking at his sexual world.

Contemplation: living in ambivalence

Movement to the contemplative stage of change is an important shift from the client moving from an intractable position to one of ambivalence. One of the most important contributions of motivational interviewing approaches to help people with addictions is the understanding that ambivalence about change is the first step towards considering change. The ability to live in this ambivalence is an essential skill for both the client and the therapist to accomplish. Here again, HIV can assist the process of moving the client towards looking more closely at sexual dependency symptoms.

Most clients are not ambivalent about becoming infected with HIV. For the most part, they do not want to become infected with the virus, but they may be engaging in sexual behavior that will accomplish this very thing. The cornerstone of contemplative stage change work is to create a situation where the client verbalizes contradictions in his/her behavior s/he is concerned about. It is the therapist's goal to be alert to the

client's articulation of these contradictions and to reinforce the client for identifying these contradictions.

Case example: a 26 year old white single gay identified male presents for therapy because he recently moved to a large urban city to escape the relentless oppression of small town homophobia in a rural farming community. Historically, since the age of 16 his only sexual contacts have been public sex with older men and use of the Internet to masturbate on what is loosely termed "cyber –sex". He is concerned about HIV because he assumes he was safe from HIV infection in his small town, but continues to have public sex allowing anonymous partners to have anal intercourse with him without using condoms. The client is highly anxious about this and is motivated to change the unsafe sexual behavior but does not see a problem with having public sex. In fact it is his preferred sexual venue.

The significant co-factors of sexual orientation, HIV literacy, geography, age and potential dual or triple diagnosis are potential motivations for this client to better understand his relationship with HIV as a means of working towards a clearer assessment of potential sexual dependency. The client clearly states he is concerned about contracting HIV. The therapist may ask "Where did you get the most useful information for yourself about HIV and behavior that would put you at risk for infection?" This keeps the focus on the clients concerns while ascertaining initial information about HIV literacy. Other follow up questions could include; "How long have you been concerned about your sexual behavior putting you at risk for HIV?" "Have you ever spoken with anyone else about this concern?" "Did something happen with your sexual behavior recently that led up to you calling me?" Keeping the focus on the clients HIV concerns

with questions focused on risk co-factors will likely increase feelings of ambivalence about his sexual behavior. By helping the client tolerate his ambivalent feelings about HIV infection, the therapist lays the groundwork for contemplating his sexual behavior as well.

Taking the test to determine HIV infection status (Am I HIV negative or positive?) is a common ambivalent conflict at the contemplation stage of change. Sealy (1999) has identified the need for HIV testing at all stages of treatment for sexual addiction. When sexual dependency is suspected, HIV antibody status and the concomitant ambivalent feelings about taking the test can be a useful tool for maintaining motivation for change. A pre-mature focus on problematic sexual behavior that is not a risk for HIV infection, such as time spent on cyber-sex masturbation, may throw the client back into pre-contemplation thereby increasing the likelihood of terminating therapy. It is a significant change when a client becomes determined to know their HIV status and takes the steps to learn that information.

Another common contemplative stage situation is recovering addicts and alcoholics who are very committed to their sobriety and yet are engaging in sexual behavior that is threatening their sobriety.

Case example: A single divorced 37-year-old heterosexual Mexican-American woman with 6 years of sobriety from crystal methamphetamine addiction and the full time mother of two teenage children is concerned that she may have AIDS. Three months ago she learned she was two months pregnant. The pregnancy ended in a miscarriage two weeks later. She did not see a doctor or tell her sponsor about this. She is frightened that her sexual relationship with her boyfriend, who was released from prison six months ago,

is putting her at risk for HIV. Her boyfriend currently uses injection drugs. She is very concerned about having drug-using thoughts during the last few weeks and is determined to avoid a relapse.

HIV-related questions based on the co-factors of gender, dual diagnosis, (drug addiction and HIV) ethnicity/ race, and age should be utilized to address the client's fear of HIV infection while simultaneously beginning to evaluate for potential sexual dependency. A therapist should assess for sexual dependency as part of an initial treatment plan when a recovering addict/alcoholic with over one year of continuous sobriety is concerned about HIV. The recovering addict may be at the precontemplation stage for possible sexual dependency treatment but may be very determined to remain HIV negative. The client's stage discrepancy in readiness to change her problematic sexual behavior and safer sex practices that will prevent HIV infection is the very tension that motivational enhancement approaches encourage the therapist to focus on in the treatment session. The art of maintaining the client in treatment when the client's stated purpose is not about his/her sexual behavior, but when the therapist believes that sexual dependency symptoms are present, is the essential therapist treatment goal at the contemplative stage of change.

The client's determination to maintain sobriety is the motivational strength to utilize. With committed recovering addicts such as this female client, the therapist can continually focus on the determination to stay sober and the contradictory behavior that the client knows will lead to relapse as the focus for initial intervention. A premature focus on out of control sexual behavior does not meet the client at the stated motivational focus and will likely lead to termination of treatment. The therapist will meet the client

at her stage of readiness for change by affirming the client's own judgment about her perceived risk for relapse. Examples of this are: "Your right to be worried about relapsing", "Your sobriety seems very important to you", "You seem very certain that you want to stay sober, that's so important to keep in mind at a time like this."

Women, especially women of color, living with concerns about possible HIV infection have fewer resources than men for safe and informed places to discuss these fears. Many times the therapists' office is the only place they may be willing to disclose behavioral concerns. Gossip among Twelve Step program members and fears about a sponsor's rigid judgmental dogma in response to disclosure are common reasons for clients choosing a therapist as a starting place. The determination to stay sober is also the focus of questions regarding HIV. "How do you think your fear about not knowing if you have HIV is effecting your sobriety?" "What motivated you to come to therapy to talk about this first rather than discuss this with your sponsor?" Have you been concerned about your HIV status at any other time in your sobriety?" "Have you been this honest with anyone else about these concerns?" The therapist will listen to the answers to these questions and wait to focus on sexual behavior concerns after the client begins to verbalize her own awareness of the conflicting goal of HIV prevention and her current sexual behavior. She might comment on her inability to ask her partner to use a condom because it might bring up a focus on her sexual history and behavior. She might begin to discuss her shame and secrecy about her past sexual behavior and continued preoccupation with always being in a sexual relationship. She might begin to see that the main reason she continues to stay with her boyfriend is because of her preoccupation with always being in a sexual love relationship even though her current partner may threaten

her sobriety and the safety of her children. Inviting the client to explore these fears about her sexual behavior in the context of staying sober will support her motivation for treatment. The therapist's continued focus on the client's stage of readiness for change results in a stronger foundation to explore the highly charged ambivalent feelings about self-destructive sexual behavior.

Successfully navigating the normal resistances presented by ambivalent clients is an essential therapist skill at the contemplative stage. Clients may argue, interrupt, deny or ignore as a way of coping with their ambivalence. A skilled therapist can utilize reflection, emphasis on personal choice and control, reframing, or the client's strong belief in the principles of the Twelve Step programs to help the client stay focused on his/her ambivalence and the feelings associated with this conflict-ridden state.

Because so few therapists specialize in treating sexual dependencies and even fewer contemplation stage clients contact specialists in treating such dependency, the vast majority of pre-contemplation and contemplation stage of change work with potentially sexually dependent clients concerned about their relationship with HIV is conducted in a vast array of medical, mental health and public health settings. However, some contemplation stage clients will contact specialists in sexual dependency. Hospital based sexual addiction treatment centers, residential long-term care programs and outpatient groups and individual psychotherapy practice settings make initial contact with contemplation stage of change sexual dependency clients. These sexual dependency contemplators are struggling with the ambivalent conflict of considering change and not considering change.

Clients who identify as HIV positive may be motivated to seek treatment for sexual dependency for a variety of reasons. They may be concerned about becoming re-infected with more virulent strains of the virus, or feeling conflicted, guilty or shameful about having unprotected sex without disclosing their HIV status with their sex partners. For others, the sexually dependent behavior may be a mood-altering, trance inducing situation that acts as an "HIV free zone" that is a release from the worries and complications of combining living with HIV and having sexual relationships. Perhaps the compulsive sexual behavior is an obsessive-compulsive anxiety reduction mechanism that is part of an untreated anxiety or panic disorder. Some HIV positive men present for treatment for sexual dependency due to a secret paraphilia that has been a source of shame and confusion for most of their sexual lives and only through the constant attention to sex via living with HIV are they finally willing to contemplate the complications of living with an unusual or troublesome turn-on.

Once again, utilizing the pre-existing relationship with HIV is a valuable tool in addressing ambivalence towards changing sexual behavior. If this is the first time the client is discussing possible sexual dependency the therapist should focus on the assessment phase of treatment as the only "change" to consider. Just like the decision to test for HIV infection, the initial focus of sexual dependency treatment is to find out if you have the condition. The most common mistake therapists make when working with a client at the contemplation stage is prematurely focusing on the client achieving a behavioral change in their sexual behavior. It is important to remind the client that agreeing to engage in an assessment for sexual dependency is an action!

Case example: A single 28-year-old gay white male living in a large urban city that he has lived in his entire life presents for a sexual dependency assessment in an outpatient office. He enjoys engaging in frequent, compulsive, anonymous public sex in bathrooms and parks. He is worried the police might arrest him. He has been HIV positive for eight years; his t-cells have been dropping for a year and his viral load level continues to increase. He does not want to "get sick" but is ambivalent about beginning protease medication treatment for HIV because "I will have to take them for the rest of my life." The consequences of his sexual behavior are that his life is very unscheduled with much of his time spent in the pursuit of anonymous sex. He does not want to continue spending this much time in search of sexual activity but really likes having anonymous public sex. The regimentation required for taking the medication will not allow him to continue with his time consuming sexual behavior and he does not want to take the medications unless he can be compliant with the pill-taking regime.

The primary client motivation is to resolve his conflict between treating his HIV and his sexual dependency and not treating either of them. This dual diagnosis contemplation stage of change requires a parallel track of motivational interventions that focus on eliciting self-motivational statements from the client that move him towards a more determined plan of action in treating HIV and sexual dependency. Helping the client see the fusion of these two concerns is a valuable place to focus. Each time the client retreats into the illusionary world that he can take his medications without changing his sexually dependent behavior requires questions or reflective listening that point out the contradictions in this statement. "You told me you are so busy with seeking out sex and staying up all night cruising the park that you could never stay on schedule

with your medications, are you saying to me that that has changed?" "You sound angry and upset that yet another part of your life is being controlled by HIV, that you can't just have sex the way you want to and stay healthy anymore" "It seems like we are dealing with two conflicts at the same time, your fears about taking the HIV medications and your ambivalence about changing your sexual behavior." Keeping the therapy sessions focused on this conflict while proceeding with an assessment for sexual dependency without beginning treatment for sexual dependency is a useful way to address the ambivalence yet invokes determined action. Reminders such as "All we are doing here is helping you determine if you have a sexual dependency, you are not making any commitment to change your sexual behavior." "After the assessment is concluded then we will talk about treatment recommendations and then you can decide if you want treatment or not." This approach is very similar to addressing the motivational ambivalence surrounding beginning aggressive HIV medication treatment. Physicians will articulate specific t-cell levels and viral load counts that are thresholds for recommending beginning anti-viral therapy. The patient is given the parameters well in advance of reaching these threshold levels and is given the choice of what to do once these threshold levels are reached. Reminding the client that ultimately it is his choice how to proceed and that as a therapist you are interested in him making the most informed and carefully considered decision possible can paradoxically result in increased motivation to move towards the determination stage of change.

Determination: Planning to change

Becoming ready for change and having a plan toward action is the cornerstone of the determination stage of change. Recognizing when a sexually dependent client is

ready for change is an important and sometimes difficult clinical skill. Indications of a sexually dependent client moving into the determination stage of change include: complete cooperation with the assessment process, genuine interest in the assessment information and the personal relevance it may have for him/herself, punctuality and consistency with keeping appointments, maintaining focus on the assessment process without therapist imposed limits, and a general reduction of feelings of urgency, anguish and impatience with the assessment process. The most important clue is when the client begins to verbalize previously unarticulated self-observations regarding his/her sexual behavior or thoughts.

Many HIV positive persons have not cognitively linked the interrelationship of living with HIV and their ongoing out of control sexual behavior. It is not uncommon to have a sexually dependent person who has been living with HIV for many years not disclose HIV status to family, friends, co-workers or sexual partners. Each of these circumstances may have very different motives for this non-disclosure of HIV status. He/she may want to avoid discrimination in the workplace, or anticipated shunning reactions from friends or family. Abandonment fears from newly formed dating or love relationships may also motivate his/her non-disclosure. Linking these perceived client fears with the felt shame from his/her sexual behavior and how this interaction fuels his/her sexually dependent behavior is an important link for clients to make.

Sexual orientation disclosure and positive sexual orientation identity development may also be a significant co-factor in living with HIV and sexual dependency. In North America, HIV is inexorably linked with male homosexuality. This means that to discuss HIV will automatically lead to thoughts and feelings about homosexuality in both the

speaker and the listener. Persons with HIV relentlessly live this experience. Add race, ethnicity and religion to this experience and the multitude of interacting influences that contribute to patterns of sexually dependent behavior can be overwhelmingly difficult to sort out. A client in an assessment for sexual dependency will benefit from a therapist's acknowledgement of these tensions. The therapist should encourage the client to discuss his experience of the fears and judgments of family, workplace and friends regarding homosexuality as a result of living with HIV.

The anxiety about safer sex combined with homophobia may be an unseen force that propels a sexually dependent client into dissociative coping mechanisms. Walt Odets (1995) explores the complex level of denial surrounding gay men's unrecognized anxious feelings regarding protected sex. "Few men have complete confidence in safer sex, especially if unconscious, often irrational fears are included in the consideration. The very fact of protected sex is at least an unconscious reminder of the *potential* lethality of the act, and although unconscious and irrational fears might be dissipated by acknowledgment and clarification, the politics of protected sex rarely permit that." (p. 25) Listening for client comments that may hint at ambivalent feelings about safer sex, or a sense of futility in maintaining safer sex practices over time may be an important moment in the assessment process to begin exploring a connection between destructive sexual behavior and HIV anxieties.

It is just as important for clients who are HIV negative or who do not know their HIV status, to explore the relationship between HIV and their sexually destructive behavior. Clinical considerations in assessment include: client presentation of his/her HIV status in initial interview (Is it brought up by client? When did the client bring it

up? What did the client say?) Does the client know his/her HIV status? When was his/her most recent HIV antibody test? Is fear about possible HIV infection a significant motivating factor in seeking treatment for sexual dependency? What feelings or self-awareness does the client initially express regarding the relationship between HIV and sexual behavioral concerns?

The sexual dependency client who does not know his/her HIV status has either never been tested or has been tested and subsequently engaged in risky behavior. Some clients who have never been tested or who deny the risk of his/her behavior since last being tested will often say s/he is HIV negative or think of him/herself as HIV negative. Other clients will assume s/he is HIV positive and see no benefit in having this confirmed by a test until symptoms of an HIV-related opportunistic infection emerge. The avoidance and resultant anxiety from not having an HIV test may be a significant factor in continued sexually dependent behavior. The assumption of being HIV positive without an HIV test can result in serious depression that fuels the mood altering compulsions of sexual dependency. Inability to resolve this avoidance of HIV testing may correlate with poor sexual dependency treatment outcomes. It is important to constantly assess which issue garners the highest level of determination for client change and to highlight that determination to assist the client in resolving his/her ambivalence about the co-existing dual disorder. In the situation with a client whose HIV status is unknown, his/her determination to change his/her troubling sexual behavior can be a significant motivational tool to eventually take the HIV test.

A client who is very anxious that s/he is HIV positive but has not had a recent HIV test presents a different determination stage strategy for the sexual dependency

specialist. Is the client's concern with being HIV positive a recent development? How often has the client considered being tested and then changed his/her mind? Does s/he think being tested now will help in his/her treatment for sexual dependency? Has he been tested before and worried that the result might be positive? The task of the therapist is to again look for the connections with HIV concerns and the avoidant, dissociative, trance inducing, mood altering sexually dependent behavior patterns.

For some sexually dependent clients, a negative test result with a pattern of compulsive unsafe sex, can lead them to discount the risks of their behavior. Some clients go so far as to conclude that they must be one of those men who have the genetic mutation that make them immune to HIV infection. Facing sexual dependency and having a new HIV test will require the client to confront this level of denial.

Part of the determination stage involves contemplating the kinds of changes the action stage will entail. Movement from the determination stage to the action stage can be clearly articulated and agreed upon between the client and the therapist. Clarifying tasks to be accomplished before treatment begins is an important part of moving from determination to action. Therapists need to set limits on clients who are too eager to begin drastic behavior change without a carefully considered plan. Clients in the determination stage need to be reminded they are in a process of determining *where* to start and have not yet started. Therapists should remind clients that the treatment plan is a joint effort planned in a clearly articulated procedure. This allows a space for clients to ask questions and to clarify motivations for therapist recommendations. Therapists should provide an actual assessment review with initial early action stage treatment recommendations. Clients moving towards action will have completed previously agreed

upon series of tasks such as reading assigned books or chapters, preparing a written sexual health plan, attending self-help meetings, having a medication assessment with a psychiatrist, completing a sexual history and other assessment tools.

The last step in the determination stage is an agreement to begin treatment. The assessment should include a plan for resolving specific conflicts regarding the client's relationship with HIV. These recommendations may outline when the client will decide to be tested for the first time or when next to be tested for HIV. For the HIV positive client it may mean talking with his/her physician about when to consider beginning anti-retroviral therapy. The client's sexually out of control behavior may need to be stabilized for a period of time in order to optimize prescription pill taking schedules. For other HIV positive clients it may mean outlining a plan for disclosing HIV status to family, friends or specific workplace colleagues as well as the reasons not to do so if these are considered reasonable concerns. It may also include recovery related goals for when to disclose HIV status with sexual partners. For many gay men and recovering drug addicts it may be an extensive soul searching process of deciding whether to limit potential dating partners to HIV positive partners only, or to renegotiate sexual boundaries for safer sex with their current partner or spouse. It is important that HIV be an integral component of the treatment plan for every client completing an assessment and beginning to enter into the action stage.

Action stage: Finally here, can I stay here?

The action stage is the stage of change that treatment psychotherapists and addiction counselors are usually most comfortable addressing. It is also the stage when a client's relationship with HIV acts upon the recovery process for sexual dependency in

specific and influential ways. Taking action in treating sexual dependency means entering a process that will be filled with both success and relapse. The wheel of change, that is the foundation for motivational enhancement, understands that taking action towards change will result in a pattern of successful change and relapse behaviors. Therapists working with sexually dependent clients at the action stage of change must understand the additional interactive influences posed by HIV on this pattern of change and relapse.

The action stage will almost always include involvement in a group setting as part of treatment. It may be a Twelve-Step based self-help group, an outpatient psychotherapy group or a psycho educational experience. Regardless of the specific combination of group settings, the action stage involves a significant amount of self-disclosure. Again the client's relationship with HIV is an important influence. For HIV positive persons disclosure is a constant pressure and influence in interpersonal relations and interactions. Do I disclose my HIV status? Why am I disclosing my HIV status? What is the purpose in disclosing my status? Do I under or over disclose my status? These questions are now intertwined with newly incorporated treatment goals for sexual dependent behavior. Action stage sexual dependency treatment goals that incorporate HIV status include being rigorously honest about ones sexual life with whomever such honesty is necessary to maintain sexual dependency recovery. This may include planning for boundaries of when to disclose ones HIV status in possible sexual situations with new partners or disclosing HIV status to current or new members of an outpatient therapy group. It is interesting to observe when new group members choose to share HIV status with the group. Some may wait for a current group member to his/her HIV positive

status. Other new members may choose to share their status immediately and seek out other HIV positive or negative group members with whom to identify.

The client's unconscious and unresolved feelings about living with HIV will surface when the sexually dependent symptoms begin to subside. The very act of increasing abstinence as a sexual behavioral goal will remove a powerful defense from deeper feelings that have been inaccessible due to dependent behaviors. These feelings will be reflective of the emotional adjustment in relating to HIV. A client who is worried about risk for HIV infection and newly recovering from sexually dependent behaviors may begin having anxious feelings and disturbing memories of specific sexual situations that could have resulted in HIV infection. A healthy survivor who has been HIV positive for many years may only now, in early sexual abstinence, begin to experience the delayed shock, anxiety or depression that is more common in the newly diagnosed HIV positive individuals. Untreated sexual dependency will interfere with meaningful development of reasonable HIV coping behaviors at every stage of HIV disease. "The psychotherapist can support HIV infection treatment by understanding the stages of HIV disease and possible interventions." (Sealy, 1999, p. 205) Sealy recognizes that the stages of HIV disease interact with the patients own highly personal issues requiring a high clinical skill level that can challenge even the most experienced therapist. For some HIV positive clients this may mean facing decisions and choices made long ago that played a role in their HIV infection. A recovering addict may grieve the loss of HIV negative status as yet another consequence of his/her self destructive and addictive drug use. These intense feeling of sadness and regret may be a risk factor in maintaining sexual sobriety. Predicting this interactive influence can decrease the demoralization and confusion for

action stage clients by helping clarify why they feel like relapsing despite their strong motivation and determination to follow their sexual health plan. Action stage clients who are HIV positive benefit from repeated therapist invitations to consider how his/her feelings and emotions of living with HIV, today, are being avoided or displaced by retreating into sexual fantasy or compulsive behavior.

Clients who have never had an HIV test may discover that the denial mechanisms utilized to avoid being tested are in direct conflict with the newly embraced values of sexual recovery. The action stage client faces a conflict between honest self-knowledge regarding his/her sexual dependency treatment and a desire to avoid such HIV status knowledge. The tension of being the only group member who has not been HIV tested may be a significant tension that all group members will need to process. Longer-term group members may be a valuable asset in pointing out the improbability of maintaining sexual dependency treatment goals without knowing HIV status.

Case example: A 41 year old Jewish single bi-sexual male from a large east coast city with a 20 year history of hiring both male and female prostitutes voluntarily presents for treatment. He has spent over eight thousand dollars on hiring sex workers in the past year. He is tired of the financial cost for this behavior. He went to a public health office to be tested for HIV eight years ago after an experience where a condom broke during anal intercourse with a female sex worker. He did not go back for the test result. The assessment reveals a paraphilic component to his sexual behavior. He must be wearing women's underwear to achieve a satisfying or reliable orgasm. Almost all of his masturbatory behavior since early adulthood has exclusively included this fetish. His bi-sexual orientation, his paraphilia and his paying for sex have all been sexual secrets he

has never disclosed to the men and women with whom he has been in coupled love relationships. He was married for 6 years in his twenties. He felt intense fear about the risk of infecting his wife with HIV when the virus first began to be recognized in the early 1980's. His compulsion for hiring prostitutes and fear of infecting his wife with HIV was a significant factor in his choice to end the marriage. He has never disclosed this to his ex-wife even though they remain good friends. Although highly motivated to take action to end his hiring of sex workers and to develop more honest and intimate love relationships as a bi-sexual, he continues to be ambivalent about testing for HIV.

This situation requires the therapist to simultaneously move between action stage interventions with his sexual behavior and contemplation stage interactions when discussing his HIV status. The therapist may encourage him to include in his sexual health plan disclosure to any sexual partner that he does not know his HIV status because he has never been tested. Disclosing he has never been tested for HIV to his sexual partners allows him to practice honesty, an important action stage skill. This moment may also generate denied feelings of guilt, embarrassment or fear connected with his decision to remain untested. This feeling will conflict with his more conscious feelings of contentment with choosing to not be tested. The conflict between these two feeling states increases the likelihood of increasing feeling of ambivalence about not being HIV tested, the very ambivalence that is the center of entering a contemplation stage of change.

Therapist inability to flex his/her interventions between these two differing stages of change will block the ability of the client to develop tolerance of conflict while at the same time experiencing satisfaction in taking healthy action. The therapist may

encourage the client to include disclosing that he has never been tested for HIV as a boundary before considering any sexual interaction, even if it is a relapse sexual situation with a sex worker. The client may utilize group therapy to be honest about the relapse and get support for having followed the boundary of HIV discussion in a sexual situation. This mixture of relapse and progress is the hallmark of early stages of sexual dependency treatment.

For the HIV negative sexually dependent client, the action stage presents another set of interactive influences that affect the treatment and recovery process. Some HIV negative sexually dependent clients regularly engaged in unprotected sex all through the years of out of control behavior. Others maintained safer sex boundaries before entering treatment even though the rest of their sexual life was mostly self-destructive. The psychological benefits that come with successfully meeting initial sexual dependency treatment goals may result in an emotionally safe container for clients to explore past choices with sex and HIV. Clients may try to understand why s/he maintained such clear boundaries about safer sex, yet was so out of control with his/her other sexual behavior? Clients may begin to identity with a strong, capable part of themselves that was with them even in the worst of times with their dependency. Exploration of how they kept this boundary may be a clue into deeply help beliefs that conform to cultural values about survival and the value of life. Walt Odets (1995) discusses the importance of examining the psychological motivations to engage in unprotected sex, "because these motivations-conscious or unconscious-conflict with cultural values about survival" (p. 205). He writes about the psychopathology of engaging in unprotected sex as being more about the "individual's deviation from cultural and social expectations than about an intrinsic

property of a mental state." (pp.204 – 205) Newly recovering sexually dependent clients can examine their motivations for engaging in unprotected sex as part of deviating from cultural and social expectations. Some sexually dependent clients may need to find less self-destructive means to express the non-conforming deviant part of him/herself.

A sexually compulsive behavioral history that includes repetitive unprotected sex that could have resulted in exposure to HIV is a complex issue for the action stage client. Motivation for maintaining abstinence may be very closely tied to the desire to remain HIV negative. However, staying HIV negative now involves choices not previously made with regularity, mainly engaging in protected safer sex in all sexual situations. A client may decide to set new personal boundaries for safer sex. Part of formulating these boundaries may motivate the client to attend an HIV education program designed to help persons make informed choices about safer sex. Clients may be unsure about risks associated with oral sex, safer sex with HIV positive partners, or just may benefit from sitting with other HIV negative persons who are interested in remaining negative. This subgroup is also faced with deeper psychological feelings and concerns that may begin to surface in early abstinence. Odets once again provides a roadmap for some of these problematic reasons people engage in unprotected sex. Odets (1995) suggests that powerfully felt feelings about survival and death are connected with choices for engaging in unprotected sex. "AIDS is such an available and psychologically meaningful way for a gay man to not survive, it is surprising how difficult it has been for us to acknowledge that some men engage in unprotected sex for precisely that purpose" (Odets, 1995, p. 206) For the recovering sexually dependent gay man, a death of a friend or lover by AIDS may have been seen as an important and meaningful expression of identity and

allegiance and he must now evaluate if this possibly unconscious tribal affiliation remains a potent force in his sexual life. Group therapy can be a very important treatment arena for such explorations. Twelve-step groups, individual therapy, and/or a trusted sponsor is much less likely to arouse these deeply held conflicts. The interactions that come from a consistent, regular, reliable, trusted small group psychotherapy is the very environment that will stimulate feelings and interactions connected with dynamics connected with allegiance and identity.

Client age may also be a significant issue at this stage of treatment. Is the client of the age group that has always known HIV as a sexually active person, that age group now in their mid 30's or is his/her compulsive sexual history a mixture of pre and post AIDS? Did some of his/her self-destructive patterns emerge long before concern for HIV? Odets (1995) believes that another explanation for engaging in unprotected sex is connected with feelings that one will not survive. "A sense of inevitability that so many gay men feel about their futures and HIV. Many men with consistent negative test histories and safer sex behavior to match do not believe they will survive. Patients often say they *know* they are uninfected but feel *like* or *believe* they are positive-or will, somehow, inevitably become so" (p. 208). Sexual dependency recovery may include a deep decision to discard the irrational feeling of complete hopelessness with respect to becoming HIV infected. Recovering clients may begin to see themselves as no longer deserving HIV as a reasonable consequence for sexually dependent behavior. For clients who have not known a sexual life without HIV, the sense of inevitability may be more connected with the irrational sense of impossibility that one can have a full and exciting sex life without eventually becoming infected with HIV. For the recovering sexual

dependent, this means not only finding a meaningful sexual life in sobriety but also exploring the meaningfulness of a sexual life that includes avoiding HIV infection. Self-esteem conflicts may emerge when thoughts about “Do I deserve to stay HIV negative?” are combined with the same questions regarding deserving a sexually healthy life.

The dissociative, trance like state so common with sexual dependent behavior is another significant factor in relationship to action stage recovery. Many sexually dependent clients have little experience with sex without retreating into a fugue state of de-realization and denial.

Case Example: A 63-year-old white gay man has been living with his partner of over 30 years with a history of computer sexual compulsion comes to group and reports going on line late at night to chat in a sex related chat room. He made arrangements to go to another man’s house for sex. When he got there he realized even though he was in violation of his sex plan regarding anonymous sex with partners on the Internet, he still wanted to maintain his boundary about discussing safe sex and HIV status before having sex. When he began this conversation with the man in preparation for sex, he began to think about “the group” and how he would have to come to group and talk about “going off my plan”. He was not in a complete fugue state, and as a result of discussing HIV before sex chose to leave without having sex.

This is yet another time where the therapist as well as members of a therapy group may be called upon to make distinctions between various stages of motivation for change. Reinforcing the honesty in group, the respect for his boundary to remain HIV negative and discuss HIV in sexual situations will need to be balanced with an exploration of what relapse factors contributed to him being on-line looking for sex. This may be an

important opportunity for the client to explore his history of maintaining a fugue state in anonymous sexual encounters in part by his denial of HIV concerns.

Maintenance and Relapse: The necessary component of choosing to take action

The skills required to maintain any changes in the action stage may be different from the skills required to make change initially. The case examples from the action stage demonstrate how intertwined and inseparable relapse and maintenance of behavior change are in the stages of recovery. Once a clear decision for action has been made the client is in a constant state of choice to either maintain the behavior change or relapse and have to experience the ambivalence of returning to the action stage all over again to attempt to maintain this change once again. For sexual dependency recovery and HIV risks this pattern is fraught with potential risks. What if a relapse involves unsafe sex and risk for HIV infection? How does my recovery plan deal with the implication of relapse and the ensuing confusion about my HIV status? I am HIV positive and had a relapse. I did not engage in safe sex and I know the identity of my partner. Do I return to this partner to tell him about my status? How do these decisions affect my ability to maintain my sexual health plan? In ongoing sexual dependency treatment, the important factor in a relapse is the response by the client and the therapist to the relapse. Relapses require the client to contemplate what led up to relapse and become determined to work to return to a maintenance level of functioning. This is a process that will be repeated often as recovery progresses. The risk for HIV infection as part of the relapse will be an important variable to explore each time a relapse with another sexual partner is disclosed. Group therapy clients may be more hesitant to disclose having unprotected sex than to disclose other aspects of going off their plan. Fear about group judgments will reflect

their own internal feelings of self-criticism, aggression and terror at having to yet again face their relationship with HIV. It is this relentless presence of HIV along with their ongoing treatment of sexual dependency that is so helpful for group therapy clients to share with each other. Group treatment is a valuable source for clients to be reminded that each of us struggles at times with his/her relationship with HIV. At times everyone may attempt to flee the anxieties, worries and frustration with living in a sexual world where HIV is present in our places of sexual pleasure and joy. In a group setting, a client reporting a relapse where risk of HIV infection may have occurred, is an important opportunity for all group members to review, share and reprocess their own evolving and changing relationship with the virus.

The Therapists Relationship with HIV and Countertransferential Considerations

Countertransference can be a valuable source of information for therapists doing individual and group psychotherapy. Countertransference as it relates to clients who may be in treatment for sexual dependency has been written about in the context of group psychotherapy with substance abusers (Vannicelli, 2001). Henry (1996) outlined personal qualities that are necessary for success as a group therapist working with adolescents and HIV-related risk taking. Bernstein (2000) proposes a cultural literacy model for straight therapists working with lesbian and gays in family therapy. Perry and Barry (1998) discuss the personal characteristics of treatment staff working with gay male sex addicts and their impact on the initial course of treatment. Kooden (1994) explores specific therapist reactions and feelings that he calls countertransference disclosure which he defines as irrational, inappropriate disclosure about the therapist's specific reactions to the client that have nothing to do with the client (p. 43).

Information about countertransferential issues that emerge for therapists in their work with recovering sexually dependent clients and their relationship with HIV does not exist. The remainder of this article will attempt to address this complex interaction between the feelings that the patient creates in the therapist that relate to the therapist's own relationship with HIV (termed subjective countertransference see: Winnicott, 1949) as well as the feelings that the patient "puts into" or induces in the therapist (termed objective countertransference see: Winnicott, 1949). These countertransferential moments are important relevant information about central themes and issues regarding the client's relationship with HIV.

Sexual Dependency, HIV and Therapist Subjective Countertransference

Significant factors that may stimulate therapist subjective countertransference while addressing psychotherapeutic HIV themes for clients in treatment with sexual dependency are most often the same factors that clients will present in treatment. Has the therapist been tested? What are his or her safer sex boundaries and guidelines? Does the therapist understand what dynamics may be at work when he or she slips in his or her own safer sex behavioral expectations? Regardless of how close or distant a personal relationship the therapist may have with HIV, working with sexual dependency will bring the therapist into continuous and psychologically intimate contact with HIV. Vannicelli (2001) writes "It is thus essential for the therapist to maintain a continuously self-reflective stance, examining his or her own feelings and attitudes in response to the patient"(p. 46–47). The number one priority is for the sexual dependency treatment provider to have an ongoing relationship with a mentoring supervisor who can act as a reasonable container to identify and clarify subjective countertransferential moments that

arise in working with clients. It is also a skilled supervisor's job to discriminate between the supervisory content and the material that would be better addressed in the therapist's personal therapy. Having both a supervisor and personal therapist allows the sexual dependency treatment provider to keep a clearer boundary with his/her own subjective countertransference. This clarity allows for the more clinically useful objective countertransference from the client to be identified and in turn allow the therapist to better help the client.

For example, a therapist notices he is having an irritated and frustrated reaction to a group member sharing his experience of unprotected anal sex with a female sex worker he hired the day before. Despite the clients concerns, fears, and his desire to change his behavior, the therapist discloses his disappointment with the client's progress in treatment. He goes on to say that he is uncertain the current treatment plan is working for the client. The therapist realizes what he was doing only after the client breaks down in tears and says, "If you don't think there is hope than who do I get to count on when I am feeling so hopeless like I am today?" This is when the therapist realizes the client needed him to hold his hopelessness for him while the client practices being honest about his relapse and begins the process of returning to a determined course of action for change. He begins to notice his emotional disclosure of hopelessness and discouragement is not a reflection of the other group members. He realizes he had blurted out this response before any of the other group member's reacted to the clients story. He knows all about being an adequate holding container as part of group therapy, so why today was he unable to perform this function?

In supervision the therapist identifies that the last five new clients he has assessed for sexual dependency treatment were HIV positive and all were engaging in frequent unsafe sexual behavior. He noticed that unusually for him he began to avoid asking about HIV status in the initial client interviews. He begins to realize a certain dread washed over him each time a new client appears for treatment, and identifies this dread as having to deal with HIV status. He begins to think his groups are going to be "taken over by HIV and become AIDS groups." Exploring this fear further he realizes he is experiencing his own survivor guilt as an HIV negative person. He has had thoughts of disclosing his HIV status to group members, but knows this would only serve to address this guilt. There is no indication that the group is interested in his HIV status. The therapist concludes the supervision by realizing he has underestimated the ongoing intensity and professional difficulty that working with both sexually dependent clients and a large population of HIV positive persons requires of him. He realizes that his own denial of his job difficultly resulted in an empathic failure. The failure to empathize was in direct response to a client who may be frustrated by how difficult is his recovery process from sexual dependent behavior.

Sexual Dependency, HIV, and Therapist Objective Countertransference

Although the distinction between subjective and objective countertransference is not always precise and clear, the therapist's curiosity and ability to know him/her self as well as self-observe his/her reactions to a particular client's issue or concern is essential to discriminating between these two countertransferential moments. When a therapist is able to understand the induced feelings that result through objective countertransference, it can help with understanding the patient's inner life and how the client relates to others.

Observing objective countertransference in group psychotherapy interactions can also allow the therapist to experience these client feelings and relationship patterns in the context of a variety of relationships. A particularly important form of objective countertransference is when the client induces the therapist to experience many of the unacceptable feelings that the client experiences about himself. This is commonly referred to as projective identification. Sexually dependent clients have many aspects of themselves that can be painful to accept. Combining these sexually dependent parts of themselves as well as their feelings and experiences with HIV, which is almost universally an unwanted relationship, can result in powerful experiences of projective identification. Vannicelli (2001) has outlined a variety of leader dilemmas and countertransference considerations in group psychotherapy with substance abusers. Sexual dependency group treatment poses similar therapist predicaments. The therapist may be stymied by countertransference feelings when a client continues to relapse and is not disclosing his/her behavior. The client who is not reporting relapses in his/her sexual health plan may believe that reporting a relapse may impede his/her ability to continue engaging in abstinent sexual behavior. The client may also not be reporting a relapse to protect his/her relationship with the therapist and the group. In other words, relapse may be a threat to the attachment with the therapist and the group. If the therapist feels helpless, lost, unsure about whether the treatment is really helping s/he might use this internal sense to connect with the client and see if s/he is having similar feelings. For example asking, how are you feeling coming here and acknowledging to the group that you have not been following the contract you made with the group to report all relapses? What does it feel like to be taking this step towards honesty today?

Incorporating concerns regarding HIV may be important to explore, especially if the therapist feels a strong desire to not bring this part of the relapse to the client's attention. This desire on the part of the therapist could be a disowned part of the experience that the client does not want to acknowledge as relevant. The therapist's reticence to inquire about sexual safety with regards to HIV in the context of the relapse behavior may be a useful empathic bridge to connect with the client and the group. A comment such as, "This is a big step for you to get honest about your sex plan, but I notice no one in the group is asking about how you handled safe sex during these slips, I find myself wondering if I am the only person in the group thinking about this." Allowing for silence will be a good gauge for the group therapist to sense both the client's and the rest of the groups' current willingness to go further in discussing HIV themes that may be present today in the group.

This has been an initial attempt to comment on countertransferential concerns when treating sexual dependency and HIV. This is an area that is rich with the complexity of navigating the multitude of emotions, reactions and forces at work when a therapist works with his or her own feeling experience in psychotherapeutic work with sexually dependent clients.

Conclusion

Clinical utilization of the six stages of change represented by the wheel of change in sexual dependency treatment provides a valuable lens for both client and therapist to understand the relational aspects and repetitive practice inherent in identifying and changing problematic sexual behavior. Research directed towards better understanding of effective motivational interviewing approaches for outpatient treatment for sexual

dependency is recommended to expand current knowledge of effective alternative treatment approaches. The current literature on sexual addiction outpatient treatment approaches draws heavily from alcoholism and drug addiction treatment traditions with significant integration of Twelve Step program principles and spiritual development. Additional research on which sexually dependent client populations are more likely to maintain successful treatment outcomes with various treatment approaches would also be an important contribution to improving treatment outcomes.

Despite stabilizing HIV infection rates across the United States, it remains unknown what proportion of newly HIV infected persons may be overly represented among persons in treatment for sexual dependency. Despite lack of research on prevalence rates for HIV infection among persons with sexual dependency, it is incumbent upon the professional community that treats sexual dependency to take a leadership role in including sexual dependency assessment and referral in prevention, intervention, testing and treatment for persons infected with HIV. It is hoped that this article will stimulate interest in treatment providers to challenge themselves and their clients to more actively explore and address the intertwining influences of HIV and sexual dependency.

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