Experiential Interventions for Clients with Genital Herpes

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Abstract

Prevalent counselling approaches for individuals with genital herpes have primarily focused on short-term individual and group interventions to reduce stress levels and increase coping strategies for dealing with the disease. This article explores the potential benefits of incorporating concepts and interventions from experiential therapy to help clients deal with the more psychosocial difficulties in learning to live with this disease. Experiential counselling interventions of two-chair dialogue, empty chair, and metaphor are suggested for helping clients work through the emotional sequelae of genital herpes. A case illustration is presented of a young, female, Korean, university student who received 18 sessions of counselling which focused on dealing with the psychosocial aspects of the disease.

Résumé

Les approches de counseling courantes pour les individus souffrant d'herpès génital se sont surtout concentrées sur des interventions individuelles ou de groupe, à court terme. Ces interventions avaient pour but de réduire les niveaux de stress et d'élargir les stratégies d'adaptation pour affronter cette maladie. Cet article explore les bénéfices éventuels pouvant résulter de l'incorporation des concepts et interventions provenant de la thérapie expérientielle afin d'aider les clients à s'ajuster aux difficultés psychosociales d'apprendre à vivre avec cette maladie. Il est suggéré d'employer des interventions de counseling expérientielles consistant en des dialogues avec deux chaises, la chaise vide et des métaphores pour aider les clients à surmonter les séquelles émotionnelles de l'herpès génital. Un cas illustré est présenté concernant une jeune femme coréenne, étudiante d'université ayant reçu 18 séances de counseling se concentrant sur les aspects psychosociaux de cette maladie.

The prevalence of genital herpes has increased greatly over the last two decades (Johnson et al., 1993), increasing the likelihood that counsellors will encounter clients with this disease in their caseloads. In the United States, using a sample size of 13,000 people from national health surveys, researchers (Fleming et al., 1997) found a prevalence rate of 22% for the years 1988-1994. There are interesting gender differences in this prevalence rate with 17.8% of men and 25.6% of women having the antibody to the disease. This difference reflects the fact that women contract the disease more readily from men compared to men contracting it from women and that women more often have older sexual partners which increases the risk of herpes infection (Fleming et al., 1997). It is more difficult to find prevalence rates for Canada. A recent London, Ontario study (Austin, 1998) found a prevalence rate of 16% in a sample of 300 young men from a clinic for sexually transmitted diseases.

Because of its sexual nature and the social stigma attached to it, learning to live with the disease is particularly difficult (Swanson, Dibble, & Trocki, 1995). As with many diseases, however, the emotional

consequences of living with genital herpes are not a common focus of treatment programs. Therapeutic interventions have the potential for helping clients to cope with the emotional sequelae of genital herpes. More specifically, experiential interventions (e.g., two-chair dialogue) are particularly noted for helping clients to work through internal conflicts and facilitate emotional change (Greenberg, Rice, & Elliott, 1993). A case illustration will be presented to describe the use of several experiential interventions to help a client learn to deal with the psychosocial impact of genital herpes.

To begin, counsellors need first to become informed about this sexually transmitted disease (STD). Genital herpes is characterized by outbreaks of ulcerative lesions which are painful when touched. The disease is spread through sexual contact, usually when lesions are present. However, many people are not aware that they have genital herpes because it is possible to contract the disease through invisible viral shedding in the absence of lesions (Swanson, Dibble & Chenitz, 1995). For these people, there is no safe time for sexual relations. The first outbreak (primary genital herpes) is usually the most severe. It is possible to have this initial outbreak and no subsequent recurrences. However, the majority of infected people (80-88%) have recurrent outbreaks (five to eight episodes per year), often with little predictability in timing (Jadack, Keller, & Hyde, 1990; Longo & Koehn, 1993). Some research, though, has linked recurrences to stressful and negative life events (Koehn, Burnette, & Stark, 1993).

While there is no known cure for genital herpes, there are medications which will reduce its symptoms (Koehn et al., 1993). In some individuals, the disease is self-limiting with a mean recovery rate of seven years for 40-50% of infected people (Longo & Koehn, 1993). Of particular concern for women are the longer-term consequences of the disease, such as a greater risk of developing cervical cancer (Jadack et al., 1990) and the possibility of babies contracting neonatal herpes if the mother has active lesions during delivery, spontaneous abortion, and fetal malformations. However, Green and Kocsis (1997) report that the majority of women with herpes will have normal births and minimized chances of infection to the neonate with good clinical intervention (e.g., cesarean section when lesions are active).

VanderPlate and Aral (1987) note that many people with genital herpes have difficulty adjusting psychologically to the disease. However, the majority of the research on psychosocial factors has tended to focus on how variables such as stress, coping styles, social support, and locus of control affect herpes recurrence (Hoon et al., 1991; Keller, Jadack, & Mims, 1991; Stronks et al., 1993), rather than examining how the presence of the disease affects the psychosocial functioning of the individual. Yet, the psychological impact of genital herpes on the individual is likely

to be great, especially in the initial stage of the disease. In addition, while infected individuals span the entire adult age spectrum (15-74 years), genital herpes is often the first chronic disease experienced by adults between the ages of 15 and 40 years. For this group of adults, the disease presents a potential disruption of intimacy and psychosocial adaptation during a critical period of psychosexual development (Swanson & Chenitz, 1993).

PSYCHOSOCIAL ASPECTS OF GENITAL HERPES

As with all sexually transmitted diseases, some clients with genital herpes will experience a moral crisis because they interpret contracting the disease as punishment for their perceived sins or as evidence that they are a bad person. The resulting feelings of shame, guilt, and self-blame can be overwhelming for the individual. Subsequently, they can be reluctant to discuss their disease with anyone, thus, reducing their possible social support and increasing their social isolation (Keller et al., 1991; VanderPlate & Aral, 1987). It is also important that counsellors examine their own values and beliefs about clients who have genital herpes. If counsellors have unconsciously internalized the social stigma attached to STDs, they may not be as helpful in facilitating clients to deal with their shame and self-blame about the disease.

A second factor that can contribute to emotional turmoil is the unpredictability of recurrence of symptoms and the lack of a cure for the disease. Both of these conditions can lead to feelings of helplessness, resentment, anxiety, and frustration. Simply learning to live with this uncertainty and lack of control can be a major emotional task for the client (Jadack et al., 1990). As a result, depression has been identified as the most frequent affective response to the disease (Swanson, Dibble, & Chenitz, 1995). In fact, recurrences of outbreaks have been related to depression (Kemeny, Cohen, Zegans, & Conant, 1989).

Another aspect that can affect emotional adjustment with genital herpes and other sexually transmitted diseases is dealing with conflicted feelings about attribution blame. Most clients feel anger toward the person who gave them the disease; however, some clients feel anger at themselves for their perceived carelessness. They will thus blame themselves rather than their sexual partner (VanderPlate & Aral, 1987).

Finally, as with other sexually transmitted diseases, many clients with genital herpes will experience a negative change in their perceptions of themselves as sexual beings. They may feel less attractive and desirable which can lead to feelings of low self-esteem. To avoid the possibility of rejection, they may avoid intimate relationships (Swanson & Chenitz, 1993). If they decide to become sexually active, discussing the disease with a potential partner can be highly threatening and scary (Green & Kocsis, 1997; Jadack et al., 1990; Keller et al., 1991). Once they are

established in a relationship, being forced to observe sexual abstinence during outbreaks of lesions to avoid infecting their partner can be highly frustrating and embarrassing (VanderPlate & Aral, 1987).

THERAPEUTIC TREATMENT APPROACHES

From a review of the psychological treatment literature, Longo and Koehn (1993) report that the majority of studies have investigated short-term individual or group treatment designed to reduce the frequency of outbreaks through relaxation training (e.g., Koehn et al., 1993), hypnosis (e.g., Surman & Crumpacker, 1987), and cognitive restructuring (e.g., McLarnon & Kaloupek, 1988). They conclude from their review that treatments which include specific coping strategies are more effective in reducing outbreaks than supportive therapy by itself.

In considering what would be helpful for treatment, Keller et al. (1991) believe that clinicians first need to assess the meaning of the disease for each individual and then help them cope with the consequences of the disease. One study (Swanson & Chenitz, 1993) has examined qualitatively the adaptation process of young adults (18-35 years) with genital herpes. Through retrospective interviews with 70 participants, these researchers found evidence for three general stages of adapting to the disease: (a) Protecting Oneself (dealing with the stigma of being labelled a bad person with an unacceptable disease, a reduction in self-esteem, and loss of trust in others leading to greater isolation of self from others to protect the self); (b) Renewing Oneself (reaching out to others through disclosure while protecting self from possible rejection, balancing life by decreasing stresses and increasing healthy behaviours, and regaining confidence in self as a worthy individual); and (c) Preserving Oneself (adopting a style of controlling information about self which enabled the individual to live with herpes over time by either revealing, accommodating, or avoiding discussing the disease). For participants who had supportive relationships and a stable disease course, the pattern of adaptation to the disease generally followed the above stages. However, participants who experienced a major stress, such as a new partner or a new site of infection, were often forced to return to an earlier stage of the process.

While this study provides valuable information about varying ways that individuals adapt to genital herpes, the information was gathered at one point in time and did not follow the respondents as they progressed through the various stages. When research on previous therapeutic approaches are considered, the studies have focused on short-term interventions to reduce outbreaks rather than on longer-term counselling to help clients deal with the psychosocial difficulties engendered by the disease.

Because so many difficult emotions are associated with genital herpes, therapeutic interventions from experiential therapies (Greenberg, Rice, & Elliott, 1993; Kopp, 1995) could be a helpful adjunct to counselling clients with this disease. The basic assumption of experiential therapy is that unhealthy functioning in clients is due to dysfunctional affective schemata. The goal, then, of therapy is to return the individual to a state of emotional homeostasis, while concomitantly helping clients construct new emotional meanings (schemata) for themselves (Daldrup, Engle, Holiman, & Beutler, 1994; Greenberg et al., 1993). To activate the dysfunctional emotional schema, intensification of emotion is necessary. Once clients are able to feel the intensity of the emotion that is connected to their schematic memories, they are then more able to push themselves past their dysfunctional emotion to a more functional and adaptive emotional response and accompanying restructured schema (Greenberg et al., 1993).

While experiential theory and interventions can be applicable to any client who needs to deal with the emotional sequelae of their issues, it is especially applicable to clients dealing with a chronic disease such as genital herpes. Increasingly, research is finding links between emotion and immune functioning and disease (Daldrup et al., 1994). For example, Hoon et al. (1991) concluded from their study of 153 university students with genital herpes that individuals were susceptible to recurrence of the disease when their immunocompetence was low. Other researchers have linked low immune functioning to psychological stress, repression, and unexpressed anger (Daldrup et al., 1994; Schwartz, 1990). These authors believe that unexpressed emotion can create a state of tension in the body that can have adverse effects on the immune/disease processes. Experiential interventions are ideally suited to aid in the release of dysfunctional emotion by first intensifying the emotion and then resolving it by helping the client to work through the emotion and learn new meanings.

Intensification of emotions is achieved in experiential therapy through the use of specific interventions (e.g., two-chair dialogue, empty chair, metaphor). The two-chair dialogue and empty chair interventions, in particular, are helpful for aiding clients in clarifying conflicting emotions, needs, and wants. Clients often have a strong internal critic which voices the "shoulds" of societal standards. At the same time, clients often have another, usually less strong, part of the self which voices their "wants." The two-chair dialogue gives clients the opportunity to dialogue between these two conflicting parts of the self by actually speaking from each voice while moving physically between two different chairs. The goals of the dialogue are to achieve a greater expression and intensification of experiencing in the feeling self (the wants), a softening of the

harsh critic (the shoulds), and a negotiation between, or integration of, these two parts of the self (Greenberg et al., 1993).

In considering the psychosocial aspects of genital herpes, the two-chair intervention could be quite appropriate for helping clients resolve a number of internal, conflictual splits of the self engendered by the disease: e.g., being a good versus bad person, feeling out of control versus gaining self-control, self-blame versus other blame. While the two-chair intervention can be helpful for heightening and resolving emotions for many clients, there are some clients who will feel too inhibited to move physically between two different chairs. The intervention is also not recommended for clients who have a fragmented self (e.g., some abuse survivors) and thus would not benefit from further splitting of the self (Greenberg et al., 1993).

In contrast, the empty-chair intervention is used for helping clients to deal with unfinished business (an unresolved emotional interaction with the client's environment). These situations often involve clients' unexpressed feelings about unfinished experiences with significant others. With this intervention, the other person or experience is placed figuratively in an empty chair and clients then verbalize their previously unexpressed feelings and unmet needs to the empty chair. The goal of this intervention is to lead toward eventual resolution of the unfinished emotions through self-affirmation. This resolution is achieved by either forgiving or understanding better the significant other without condoning the other's actions (Greenberg et al., 1993).

With genital herpes, the empty-chair intervention could be quite useful in helping clients talk to the person who gave them the disease in order to resolve some of the anger they likely feel toward that person. It could also be used to help a client practice revealing their disease to a new sexual partner. As with the two-chair intervention, there will be some clients who are unwilling to experiment with such a different form of therapy. However, Greenberg et al. (1993) emphasize that before any of these interventions are introduced, the counsellor must establish a therapeutic relationship that is characterized by genuineness, empathic attunement, an accepting bond, and a working collaboration.

Another experiential intervention is the use of metaphors. Kopp (1995) describes metaphors as carrying meaning from one domain to another. He argues that what makes metaphors such a powerful intervention in therapeutic work is that they combine two forms of cognition (imaginal and logical) into a third form of metaphoric cognition. In this process, clients paint word pictures which integrate nonlinear/imaginal communication with linear/verbal communication. The goal of the intervention is to help clients experience the metaphor fully before working at ways to transform it in directions that will be helpful to clients.

For example, if a client speaks about her "black hole of depression," she is first helped to describe the image fully and then describe her feelings of being in that black hole. Next, she is encouraged to transform the metaphor by changing it in any way that she wants (e.g., she might consider ways of getting out of that black hole). Finally, the counsellor invites the client to relate the metaphor to her life situation, in this case by considering what in her own life might provide a ladder to help her get out of the black hole (Kopp, 1995). Adler (1993) notes that working with metaphors in this way can be experienced by clients as being less threatening than working directly with more difficult feelings.

Metaphor work has been used to process emotions with a wide variety of client issues, e.g., bulimia (Cummings, in press), resistant inmates (Romig & Gruenke, 1991), and university clients with more general concerns (Martin, Cummings, & Hallberg, 1992; Ulak & Cummings, 1997). Using metaphors and imagery to work with emotions that accompany genital herpes has the potential for helping clients to represent their internal conflicts and problematic emotions in a symbolic form that can be less threatening than working with the more physical interventions of two-chair and empty-chair. Counsellors can assess clients in early sessions for their natural use of metaphoric language as a guide for determining whether a client might respond well to working with a visual image to represent their shame, anger, helplessness, guilt, or self-blame about their disease. There will, of course, be some clients that are more concrete thinkers, more externally focused, and less introspective who may not respond well to using a metaphoric approach.

The following case illustration is offered as an example of using experiential interventions in conjunction with other counselling strategies with a young female client who sought counselling to deal with her genital herpes. This client is not presented as a typical female client with herpes, but rather as one possible example of a client who is struggling with the disease.

THE CLIENT

The client was a 22-year old, Korean Canadian, art major at a large Canadian University. Sohee (pseudonym) was the middle of three children from a very traditional, high-achieving, Korean family. She had contracted genital herpes 1—years earlier from her boyfriend at that time (a two-year relationship). The relationship did not end as a result of her contracting herpes, mainly because she believed no one else would want her. She had ended the relationship, however, right before beginning the counselling sessions. Her presenting request was for help in dealing with her great anger and grief over her illness and figuring out how she could live with the disease and be in another intimate relation-

ship. She had experienced several recurrences of herpes, but was not on medication to manage symptoms. Even though she had lived with the disease for 1—years, she found herself crying for days just prior to seeking counselling. She had kept her herpes a secret from everyone until she told her counsellor about it in the first session. She manifested many of the typical psychosocial beliefs and feelings of clients with genital herpes such as believing that she was being punished by God for being a bad person (promiscuous), blaming herself for being stupid enough to contract the disease, feeling both rage and helplessness, and believing that she would be alone for the rest of her life because no man would want a sexual relationship with her. While the case illustration below focuses specifically on using experiential interventions in relation to working with genital herpes issues, the work with this client was much broader covering a complexity of issues including low self-esteem, poor choice in men (either men who made her feel inadequate or men she could feel superior to), anger at parents who divorced when she was a teenager, unresolved feelings about previous sexual experiences (unwanted sex from age 15, a recent pregnancy and abortion), indecision about graduate work or employment for the following year, and relating with both women and men in her life. The counsellor was the author, a registered psychologist and counsellor educator with 15 years of clinical experience whose counselling orientation included a blend of experiential, psychodynamic, and feminist approaches.

The client had volunteered to be part of a research project on important events in counselling. As part of this research project, the dyad completed 14 sessions between January and the end of April. After a four-month summer break, the dyad resumed counselling in September as part of another research project on important events. They completed 28 more sessions between September and April for a total of 42 sessions. However, only the first 18 sessions dealt directly with her genital herpes and some of these sessions will be highlighted below.

Both client and counsellor completed the Important Event Questionnaire (Cummings, Martin, Hallberg, & Slemon, 1992) at the end of each session with the following five questions: (a) What was the most important thing that happened in this session? (b) Why was it important and how was it helpful or not helpful? (c) What thoughts and feelings do you recall experiencing/having during this time in the session? (d) What did you find yourself thinking about or doing during the time in between sessions that related in any way to the last session? (e) Are you experiencing any change in yourself? If so, what? The counsellor also wrote a 1-2 page summary of the content of each session. These writings from the client and counsellor provided the basis for the following case description.

CASE ILLUSTRATION

The first four sessions focused on Sohee's feelings about her herpes and other negative sexual experiences in her past. Because she did not remember receiving any sex education, she passively allowed boys to do what they wanted sexually with her beginning at age 15. Contracting herpes felt like one more bad sexual experience over which she had no control. These experiences left her feeling that the herpes was a punishment from God for being a bad person. She, thus, blamed herself for contracting the herpes. She wrote, "I felt really disgusted about telling my counsellor about things I let happen to me. I didn't want her to think I was a slut." The counsellor in these early sessions emphasized relationship building, making connections among experiences, refuting her negative self-talk, and providing accurate information about herpes (both through reading material and referral to a doctor).

What was most noticeable about Sohee's processing style in these early sessions was how deeply entrenched her dysfunctional beliefs about her disease were. Early attempts at cognitive restructuring and refuting of beliefs were met with great resistance by the client. For this reason, the counsellor began to consider ways to engage the client on a more emotional level by watching for internal conflicts or splits in the client that might benefit from a two-chair dialogue. In the fifth session, Sohee reported being interested in a man, but being afraid to encourage him because of fear of rejection when she told him about her herpes. The counsellor decided that a two-chair dialogue might help clarify this conflict. Together, client and counsellor described and labelled the two sides as, "I want" to take a risk with a relationship and "I'm scared" of being rejected and should be responsible by not infecting someone else. The client then began talking from each side as she moved between the two chairs. During the dialogue, softening occurred to the stronger, "I'm scared" side when she said that maybe she could be selfish and try a relationship. Her post-session writings revealed this softening, both in her negative view of her badness and in her intended action: "I felt so relieved after splitting myself up with the conversation with the two parts of me. I felt that perhaps I could at least get to know this person I'm sort of interested in. I'm not such a bad person, just a diseased person. But at least I'm a good diseased person and not a bad diseased person."

However, this more positive view of self did not last. In sessions 6-8, she returned to a more depressed state when she revealed a previous pregnancy and abortion that had occurred at the beginning of her relationship with the man who had given her herpes. She interpreted both experiences as further evidence, combined with her herpes, that she was stupid, bad, and self-destructive with her body. Once again, she could not see that she would ever be able to be in a relationship. During these sessions, the counsellor helped Sohee find patterns in her interactions

with men (becoming quickly involved sexually, then remaining passively in the relationship because of believing that no one else would want her), encouraged her to assess the impact of her Korean culture on her beliefs, and emphasized the positive coping skills that she had used given her circumstances. By session 9, Sohee was feeling better about herself and was beginning to consider forgiving herself: "I guess I'm feeling a lot cleaner and I feel that I'm a pretty OK person. I just have weaknesses like everyone else I suppose."

Even though she was expressing more positive feelings about herself in session 10, she still could not see herself in a relationship. When the counsellor commented that, "You can't imagine anyone accepting your herpes because *you* don't accept it," Sohee responded that she did not know how to accept her herpes. At this point, the counsellor suggested that the client put her herpes in an empty chair and talk to it, saying whatever she needed to tell it. As Sohee began this monologue, she mainly expressed her great anger at the herpes for ruining her life. However, she was able to tell the herpes that there was a very small positive thing from getting it: it made her stop abusing her body and look for a man who "counted" rather than just taking any guy. In the midst of her negativity and self-criticism, she appeared to make a small step toward accepting her herpes. At the end of the session, she wrote: "I am feeling less and less worried about my herpes and can go days without thinking about it. Whereas before, I couldn't go hours without thinking about it."

In session 11, Sohee reported that she wanted to tell her sister and brother about her herpes (a big step for her) while she still had the counsellor's support before the sessions ended in one month. However, by the next session, she was back to her negative self stating that she could not accept her herpes by the time the counselling finished. The counsellor felt that a new experiential approach might help the client to break out of her negativity. Because Sohee had used metaphoric language from the beginning of the counselling, the counsellor asked for an image that would represent her inability to accept her herpes. She chose an image of an insurmountable wall and explored her hopelessness about ever getting over it. After the session, she wrote: "I still seem to be resisting going past the 'wall' that stops me from accepting my herpes. It seems like the wall that is stopping me from changing is just too permanent." After working with this image (e.g., describing how she felt as the wall, considering whether there were any ways over or around the wall), she was finally able to admit that she was not willing to accept her herpes because then she would have to work at forming a relationship which still felt too hard for her to do. It was easier to use the herpes as an excuse to remain alone. She remained in this negative, hopeless state for the last three

sessions (12-14) of the semester, ending counselling with both client and counsellor feeling that the work was unfinished.

After a four-month summer break when Sohee was away from the university, counselling resumed in September. In the first session (#15), she reported that she had told four people about her herpes (including her brother and sister) during the summer break and had felt accepted by them. She had also had a sexual encounter. Both of these experiences were major breakthroughs given the great difficulty she had had the previous spring in revealing her secret and allowing herself to be sexual again. It appeared that she had used the four-month break from counselling to integrate some of the learnings from sessions. However, she had not found the courage to inform her sexual partner about her herpes, leaving her feeling negative about herself: "I'd been feeling so guilty and awful about my deceitfulness with him that I was just waiting for my counsellor to get upset with me. But she just sat back and didn't say anything bad. I'm still waiting for her to chew me out or at least mention that what I did was dishonest and that I put someone else's health at a risk."

In the next session (#16), Sohee described a nightmare that she had during the week. In the dream, a monster sprang out of her that was slimy and had the head of a baby. The monster was awful and was heading toward her boyfriend when she woke up. The counsellor began by asking, "What comes to mind with this dream?" Sohee immediately said that she knew the monster was her herpes and that she felt scared for both herself and her boyfriend. In working with the dream, the counsellor asked Sohee, "Is there any way that you can look the herpes monster in the eye and hold your ground instead of letting it terrify you?" She replied, "Well, if I was so clean and a truthful, really good-hearted and healthy-minded person, then I'd be so clean that even if the monster tried to touch me, it would shrivel up because I would be too clean to touch." The counsellor then asked her what needed to happen for her to feel like that good-hearted person. Sohee replied that she needed to tell her boyfriend about the herpes. The rest of the session was then spent in discussing specific strategies for telling him about her herpes.

Sohee continued working on building her courage to tell her boyfriend about her herpes in session 17. When she was considering the risks of telling her boyfriend, she was reminded of the time when she went sky diving and was paralyzed in the plane because she thought that she was going to die. However, she finally just jumped. Counsellor and client then worked with this image of taking the plunge to reveal her herpes.

Before the next session (#18), Sohee had told her boyfriend about her herpes. When exploring her feelings around this event, she reported two metaphors: feeling like she had jumped from the plane with her parachute not yet open, and feeling like a large, open wound on which he

could pour lemon juice. Much of the session was then spent helping her find her own parachute inside of herself as she waited to see if he would still want to have sex with her after knowing about her disease. Sohee wrote: "We talked about how to prepare for the worst and to prepare a parachute of my own to hold me up instead of relying on my boyfriend to provide one for me."

Although the counselling with Sohee continued for 24 more sessions, session 18 was the last one in which herpes was a major topic. The most likely reasons for this change in focus was that the relationship with her boyfriend stabilized after her disclosure and she had no more outbreaks of the herpes. The following sessions focused on learning to be herself in that relationship, as well as dealing with her ambivalence about pursuing an advanced degree and career in art. Two-chair dialogue and metaphors continued to be used with the client on these issues.

SUMMARY AND CONCLUSIONS

This client presented many of the typical psychosocial concerns of people coping with genital herpes. She believed that contracting the disease was punishment from God for being a bad person because of her previous sexual experiences. She blamed herself for the disease and felt powerless against it. Lastly, she was convinced that she could never have another sexual relationship and her only choice was to remain alone for the rest of her life.

How can experiential interventions be used with a client dealing with these issues due to having genital herpes or other sexually transmitted diseases? In this particular case illustration, the client possessed a very strong, negative internal critic that certainly predated the contracting of genital herpes. When the counsellor tried to counter this critic with more cognitive interventions in earlier sessions, the client's critical voice (and resistance) appeared to strengthen.

One advantage of using experiential interventions, such as two-chair dialogue, is that they bring into conscious awareness a client's previously covert internal dialogues (Greenberg et al., 1993). Instead of counsellors providing alternative viewpoints (e.g., refuting irrational beliefs), clients hear an active expression of their own opposing sides in creative contact with each other as they work toward a more integrative solution, usually involving some form of accepting their own needs and wants. This phenomenon occurred with Sohee when she experienced both the two-chair dialogue and the empty chair intervention. Through both interventions, she strengthened somewhat the side of herself that wanted to risk having another relationship.

Another advantage of experiential interventions is that they have the potential for engaging the whole person, especially in connecting the affective/imaginal self with the cognitive self. Sometimes it seems easier

for clients to work through problematic emotions by using an intervention such as metaphor which works simultaneously at several levels. Sohee worked with metaphors in four sessions: the insurmountable wall of her resistance, her monster herpes, taking the plunge to disclose her herpes, and her unopened parachute. In session 11, she appeared to gain greater clarity about the meaning of her resistance by working with the wall metaphor. In later sessions (16-18), working with metaphors appeared to help her find direction and courage for taking action in her life.

Finally, using experiential interventions does not guarantee a smooth progression through the change process. For Sohee, there appeared to be steps forward followed by steps backwards. While experiential interventions can be helpful in exploring both client progress and resistance, time is also needed for clients to integrate any learnings from these interventions. As an example, Sohee appeared to use the four-month break from counselling to integrate moving beyond the wall of resistance by disclosing her herpes to people in her life and beginning a new relationship.

This type of therapeutic change for clients dealing with the psychosocial impact of sexually transmitted diseases will most likely require longer-term counselling than the typical six-week group sessions that are offered by public health agencies. However, experiential interventions can still be a helpful adjunct for these shorter-term programs as well. For example, Kopp (1995) discusses using metaphoric methods in brief psychotherapy that is centred on a focal problem or conflict (e.g., telling a sexual partner about a sexual disease). He recommends that counsellors be more directive and have more structured sessions than in longer-term counselling in order to move more quickly through the metaphoric process.

While Sohee was not presented as a typical female client dealing with genital herpes, one still needs to address the specifics of her case that may make her responses unique. First, her past experiences of sexual reactivity, abortion, termination with the boyfriend who gave her herpes, and her traditional Korean upbringing may have shaped her attribution of responsibility for, and exacerbated her guilt about, contracting genital herpes. In addition, her feeling of low self-esteem prior to contracting the disease most likely contributed to an increased sense of unworthiness which deserved punishment in her eyes. Clinicians will certainly have clients with herpes who are at the other end of the continuum on some of these issues from Sohee, such as directing their anger about the disease outward instead of inward, who do not have a problematic sexual history and contracted the disease within a loving relationship, and have sufficient self-esteem not to lose their sense of worth. However, even these clients will have sufficient negative feelings about contracting such an

invasive disease that they can benefit from experiential interventions.

On the other hand, the client in the case illustration was a cognitively complex, self-aware, university student who generated images naturally. In contrast, some clients are more concrete thinkers who do not visualize easily and thus, may have difficulty with these interventions. Also, while Sohee as a Korean responded well to these interventions, they may not be a good fit for some clients from various ethnic groups who may value control of emotional expression, e.g., some Asian groups (Leong, 1992).

Experiential interventions have not been commonly used with clients who are dealing with the emotional aspects of adjusting to living with genital herpes. However, they may be quite helpful with some clients in facilitating an integrative change process from a self-blame view of self to a more accepting view of self, from a stance of hopelessness to a stance of increased self-confidence, and from an orientation of aloneness to risking being in an intimate relationship.

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