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Rooted in Resilience: Applying Ego Psychology to HIV-Affirmative Social Work Practice

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Research Article

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Abstract

Individuals living with HIV commonly experience intersecting psychological, relational, and societal stressors related to health, stigma, loss, and disclosure. This case study explores the application of ego psychology with a focus on support for grieving and resilience against stigma to HIV-affirmative clinical social work practice with a 26-year-old gay man who experienced acute grief, anticipatory anxiety, insomnia, and difficulty concentrating after receiving an HIV diagnosis and losing his long-term partner to AIDS. Ego functioning, adaptive defenses, affect regulation, relationship patterns, and environmental supports and stressors identified through an eco-map were all included in the formulation, which drew on person-in-environment and intersectional perspectives. Supportive and psychodynamic interventions informed by ego psychology included role-playing, structured problem-solving, psychoeducation, guided grief exploration, reflective listening, and investigation of intellectualization and avoidance. The proposed treatment plan incorporates the Generalized Anxiety Disorder-7, Pittsburgh Sleep Quality Index (PSQI), client self-report, clinician observations and behavioral indicators of relational and community participation to monitor clinical progress. The proposed six-month, ego psychology-informed treatment plan identifies measurable targets for improvement in relational assertiveness, anxiety regulation, sleep, community involvement, and integration of grief related to partner loss and HIV diagnosis, and reduced avoidance related to the diagnosis. Incorporating HIV-related stigma, sexual orientation, relationship vulnerability, and broader person-in-environment characteristics, the case illustrates how ego psychology may be operationalized through quantifiable, client-centered outcomes. Integrating psychodynamic theory with culturally responsive, resilience-informed, and outcome-informed therapy for clients managing chronic illness, bereavement, and identity-related stress is one of the implications for clinical social work.

Introduction

Psychological functioning as well as the relational, cultural, and structural contexts in which illness is experienced must be taken into consideration while providing mental health care for those with chronic illnesses. HIV-positive individuals may experience psychological distress in intersection with grief, fear of disease progression, disclosure concerns, stigma, and disruptions in social and intimate relationships. For LGBTQ+ individuals, these concerns may be especially complex since their experiences with HIV-related and sexual orientation stigma can influence their disclosure, help-seeking social support, and interpersonal functioning. Clinical social work formulations that explicitly address HIV-related stigma and LGBTQ+-related minority stress while integrating psychodynamic theory with person-in-environment and ecological perspectives are still needed, despite the fact that psychodynamic approaches have long addressed affect regulation, defenses, loss, and relational functioning. By demonstrating how ego psychology can guide an HIV-affirmative, culturally responsive, and resilience-focused approach to clinical social work practice, this case-based paper addresses this need.

A framework for understanding how individuals manage internal conflict, affect, relationships, and external pressures is provided by ego psychology, a model created by Heinz Hartmann and later

expanded by the work of Anna Freud and Erik Erikson. Its focus on ego functions, such as reality testing, affect regulation, judgment, and adaptive defenses, is especially pertinent to clients experiencing relational stress, anxiety, grief, and chronic illness. An ego-psychological approach can help individuals who already have strength in self-reflection, accountability, and problem-solving build more adaptive coping mechanisms while maintaining their current functional abilities. Additionally, ego psychology offers a framework for analyzing defenses such as intellectualization and avoidance without approaching them as merely pathological; rather, it considers how these defenses may initially protect psychological functioning but become less adaptive when they obstruct emotional processing.

An affirming awareness of LGBTQ+ identities and the social situations in which clients live is also necessary for the use of ego psychology. The effects of heterosexism, homophobia, stigma, and limited access to culturally responsive mental health must be considered in clinical practice with LGBTQ+ clients. Similarly, rather than depending only on assumptions about HIV progression and mortality from the past, HIV-affirmative practice encourages clinicians to comprehend HIV within the current context of effective treatment and prevention. Integrating these perspectives with ego psychology allows the clinician to consider both intrapsychic processes and the social conditions that contribute to distress.

To show how ego psychology can be integrated with ecological, culturally responsive, LGBTQ+-affirmative, and HIV-affirmative perspectives in clinical social work, this paper examines a case example of a young man we will call Ron. The case is considered in its original historical context, alongside recommendations for contemporary clinical practice. The therapeutic relationship, the clinician's responses and reasoning, the function of defenses and affect regulation, the impact of stigma and relational stress, and the development of measurable treatment outcomes are all given particular attention. Ron's situation serves as an example of these intersecting concerns. One year after his longtime partner George passed away from AIDS, Ron, a 26-year-old white gay male, is diagnosed with HIV:

The referral was given to Ron at the same time his physician told him that a test for HIV antibodies was positive. Ron was seen by the social worker the day following his diagnosis. Ron is a 26 year old white male, who was carefully and neatly dressed at the time of the interview. He looked extremely fatigued and began the interview by stating that he had had considerable difficulty concentrating in the last 24 hours, had not been able to sleep, and felt "I'm not sure what to say, I'm in shock and I don't even know what to think about all this." When the social worker said "I understand from your physician you had quite a shock yesterday," Ron then said that although he had no active symptoms of AIDS, and felt in good health, he recognized that the diagnosis meant that he might eventually contract the disease. He began to talk about the illness, and spoke very quickly, pausing only occasionally to look at me as though to make sure I was following him.

Ron experiences grief, anxiety, insomnia, fatigue, and difficulty concentrating during his diagnosis. His discomfort is part of a larger history of being rejected by his family, leaving a conservative environment

to pursue an LGBTQ+ identification, facing financial and professional challenges, and having strong connections to the LGBTQ+ community. Ron described the history of his relationship with George:

Ron had come to the city when he was 20 years old. He left his family in West Virginia because he had begun to feel extremely uncomfortable in the very conservative environment in which he had been raised. He was not sure what career he wanted, and he had begun to feel more and more that he wanted to pursue an LBGTQ+ lifestyle. When he came to the city, he said "I felt like for the first time in my life I could be who I really am." He quickly became involved with many activities in the gay community and made several friends. He began working two jobs, initially as a waiter at one of the city's leading restaurants, and with a legal aid clinic during the day. He said he had always thought perhaps he would like to be a legal aid attorney, and his work at the legal aid clinic confirmed his feelings. He began saving money so he could attend law school.

A year later, he met George at a party given by mutual friends. He and George began dating, and Ron said, "although I was seeing other people at the time, within two months I was so impressed with George he was the only person I wanted to see. He felt the same way." They rented an apartment together six months later and lived together. Ron began law school part-time at night. "I had never felt I cared so much about someone who also cared so much about me," Ron said. He looked like he was about to cry, but he continued on. Before they began a sexually intimate relationship, both men had been tested for the AIDS virus with negative results. However, after they had lived together for a year, George contracted a cold and could not shake it off for a month. When he went to the doctor, a blood test indicated he had AIDS.

Ron said, "for two days he wouldn't let me touch him and didn't tell me what was wrong. Later he said he had been trying to decide what to do - he wanted to protect me from how painful he knew it would be for me. He was going to tell me he didn't love me any more and move out. He was afraid of being a burden. But he felt our relationship was the most important experience in his whole life, and he couldn't leave me feeling that he had rejected it. When he told me he had AIDS, I felt I had been cut with a knife, I couldn't bear it." Ron's eyes filled with tears. After a pause, he went on to describe how he had taken care of George as George became progressively more ill. AZT was discovered towards the middle of George's illness. Although it was still highly experimental, they had decided "we wanted to try anything that might keep George alive until they find a cure." Because it was so expensive, Ron began to work another part-time job to pay for George's AZT. Ron went on to describe how George's condition progressively deteriorated. George had several hospitalizations, contracted pneumonia several times, and Kaposi's sarcoma. He had lost 30 pounds, and although Ron said he could see George was trying not to discuss the pain he was experiencing, Ron believed at times it must have been excruciating. He never contracted the dementia that often occurs with AIDS, and Ron commented, "at least we could talk almost until he died." George had died a year ago during another bout with pneumonia.

Thus, reflecting on the treatment of Ron offers an opportunity to investigate the ways in which grief, chronic illness, sexual-orientation stigma, HIV-related stigma, relational vulnerability, and existing

resilience interact and can be addressed in clinical social work practice.

Theoretical and Clinical Background

Ego Psychology

According to Berzoff et al. (2016), ego psychology places a strong emphasis on the growth and development of ego capacities that allow people to control their emotions, sustain reality testing, manage internal conflict, and adjust to changing circumstances. According to this perspective, defenses are psychological mechanisms that assist individuals to manage their anxiety and protect constructive, adaptive functioning. When defenses obstruct emotional awareness or interfere with judgement and relationships, they can become restricting even though they may be adaptive in some situations. Psychodynamic approaches to psychotherapy also align with attention to affect, avoidance, interpersonal patterns, and prior experiences (Blagys & Hilsenroth, 2002). This theory comprehends Ron's intellectualization and avoidance as ways to deal with overwhelming grief anxiety and identifies opportunities to expand his capacity for emotional processing.

Ego psychology is particularly relevant to Ron's care because his presentation includes both significant vulnerabilities and substantial existing strengths. He maintains employment and pursues his education, demonstrates understanding of his experiences, builds a therapeutic relationship, and engages in problem-solving. These characteristics reflect preserved adaptive functioning that can be encouraged during treatment. Therefore, an ego-supportive strategy can maintain Ron's capacity to function in his relationships, school, and work while emphasizing stabilization, affect regulation, introspection, and gradual exploration of painful material.

LGBTQ+- Affirmative Practice and Homophobia

To do justice to Ron's identity, his difficulties must be formulated ego-psychologically within an LGBTQ+-affirmative framework. Distress may result from stigma, rejection, discrimination, concealment, and the social circumstances surrounding sexual identity rather than sexual orientation as a cause of disease. Ron's experiences with family rejection, leaving a conservative environment to pursue an LGBTQ+ identity, debating whether to disclose his sexual orientation at work, and forming close relationships in the face of HIV all show how interpersonal and structural environments influence psychological functioning.

Mental health providers may lack adequate training in LGBTQ+-affirmative care, underscoring the importance of formal training and supervision (Pachankis et al., 2022). Therefore, to practice effectively, clinicians must learn about LGBTQ+ communities and consider their own assumptions and potential biases. Clients need to be able to discuss identification, intimacy, disclosure, rejection, and stigma in an accepting therapeutic relationship without having their sexual orientation pathologized (Greene, 1997).

This position relates to Ron's identity as a gay man as well as his worries about whether he will be able to have supportive and intimate relationships if he discloses his HIV status.

HIV-Related Stigma and Contemporary HIV Care

The social and medical background of HIV must also be considered when understanding psychological distress connected to HIV. Studies have shown connections between depressive symptoms, stressful life events, trauma, and health outcomes in HIV-positive individuals (Leserman et al., 2007). Fears of disclosure, rejection, loneliness, and worries about relationships and work can all be exacerbated by HIV-related stigma. Intersectional stigma research (Logie et al., 2011) provides further evidence that HIV-related stigma may interact rather than function independently with other social identities and conditions.

Simultaneously, during the time depicted in Ron's initial case, the clinical meaning of an HIV diagnosis has undergone significant change. HIV has evolved from the acute and frequently fatal illness shown in the historical case to a chronic medical condition that many people with consistent access to treatment may successfully manage thanks to modern antiretroviral therapy. The idea that individuals who maintain an undetectable viral load through effective treatment do not sexually transmit HIV is another aspect of modern HIV prevention and therapy. This concept is commonly expressed as undetectable equals untransmittable (U = U). People with HIV who take antiretroviral therapy as prescribed and maintain an undetectable viral load do not transmit HIV to sexual partners, making accurate education about treatment and transmission an important component of HIV-affirmative care (Centers for Disease Control and Prevention [CDC], 2024). At the same time, untreated HIV continues to cause death in many countries in the world, relevant especially now given recent reductions in funding for treatment (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2025). When thinking about how Ron could comprehend his diagnosis if he were receiving therapy today, these developments are therapeutically significant. His fear of AIDS and premature death would remain psychologically meaningful, particularly given George's death, but contemporary medical information could provide a basis for correcting catastrophic assumptions and supporting realistic hope.

Thus, it is necessary to distinguish between historical and modern situations. Ron's initial case happened early in the HIV epidemic, when the prognosis and available treatments were very different from what they are now. The current analysis considers how a clinician could address Ron's psychological needs in the context of modern HIV treatment while maintaining the original case material. This contrast shows how HIV-affirmative social work practice might address contemporary medical knowledge while maintaining the case's original therapeutic purpose. At the same time, persons diagnosed with potentially terminal illnesses experience catastrophic, traumatized reactions similar to Ron’s (Kiaunyte et al., 2021), and so his care has implications for the care of persons suffering from any illness that is potentially fatal.

Resilience and Person-in-Environment

Ego psychology is further enhanced by a resilience-oriented perspective, which highlights how people overcome hardship by utilizing both their own abilities and the resources of their surroundings. According to Bonanno and Burton (2013), regulatory flexibility is a crucial element of adaptive coping in situations involving loss and continuous stress. Ron's tenacity in pursuing his education and career, his capacity to build connections of support, his readiness to seek treatment, and his ongoing involvement in his community are all examples of resilience. Instead of concentrating only on symptoms or deficiencies, treatment should take these strengths into account (Saleebey, 2013).

The development of psychological functioning within relationships and social systems is also emphasized by an ecological and person-in-environment perspective (Dentato, 2017). While Ron's healthcare providers and the LGBTQ+ communities are significant sources of support, his family relationships are a major source of stress. His intimate relationships involve both emotional connection and worries of loss and burden, while his workplace raises issues about disclosure and possible discrimination. Therefore, an integrated approach examines both ego functioning and external factors that either facilitate or hinder Ron's adaptability.

Case Presentation and Clinical Process

Initial Presentation and Therapeutic Engagement

To protect the client's confidentiality, "Ron" is a pseudonym, and identifying details have been altered or omitted to reduce the risk of identification. Recall that upon initial presentation, Ron experienced several symptoms of trauma: After receiving the diagnosis, he described having trouble focusing, insomnia, and being unsure of what to say or think. Even though he didn't have any active AIDS symptoms and thought he was physically healthy, he realized right away that the diagnosis meant he might become seriously and even fatally ill in the future.

Ron talked quickly about HIV and his worries about the implications of the diagnosis during the first interview. The social worker observed that Ron appeared concerned that she might interrupt or direct his train of thought. Instead of analyzing his nervousness right away or posing up a series of questions, she only gave brief indications that she was following him. This response can be interpreted as an ego supportive intervention: the clinician used supportive listening to help Ron manage his anxiety, creating a stable, non-intrusive therapeutic environment where Ron could keep control over the information he was trying to convey, instead of placing more demands on his already strained ability to organize and regulate his emotional experiences.

As Ron went on, his focus switched from the diagnosis to George, his longtime partner, who had passed away from AIDS a year prior. Ron clarified that due to George's sickness, he had expected his HIV test to come back positive. As he explained the course of George's illness and his own role as caregiver, he

grew extremely emotional and referred to George as the most significant connection of his life. Ron continued to be involved in George's care despite multiple hospital stays, pneumonia, weight loss, and Kaposi's sarcoma. Ron had put in extra hours to assist pay for George's experimental AZT treatment. His admission that keeping George as comfortable as possible had become the purpose of his own life demonstrates both his commitment to his partner and the degree to which providing care had become essential to his identity.

Thus, the clinician's early decision to give Ron's narrative space was therapeutically significant. He was able to remain engaged with painful content while retaining some psychological control through his quick and well-organized explanation of the illness. From an ego-psychological perspective, the clinician could understand this organization as serving a protective function rather than immediately attempting to dismantle it. Ron's inability to openly consider his own potential illness, however, indicated that intellectualization and avoidance were impeding his capacity to comprehend the emotional significance of his diagnosis.

At the end of the first interview, Ron stated that the time had flown by and expressed astonishment that the session was over. In response, the social worker asked if he would like to return on a regular basis and suggested that it could be beneficial to him to establish a connection in which he could express his feelings over what he had gone through. Ron quickly consented and asked to meet twice a week. His capacity to build a therapeutic alliance served as a crucial basis for further care.

Psychosocial Context and Intersecting Stressors

At the age of 20, Ron relocated to the city from West Virginia because he was growing uneasy with his conservative upbringing and wanted more opportunity to explore his LGBTQ+ identity. After relocating, he worked several jobs, made friends, got involved in the gay community, and pursued his dream of going to law school. Rather than regarding his distress as purely intrapsychic, these experiences highlight the significance of considering his psychological functioning within his social surroundings (Dentato, 2017).

Ron's family relationships were more complicated. Despite his limited memories, Ron remembered his relationship with his father more favorably when his father passed away when he was ten years old. Ron felt alienated from his stepfamily after his mother got married again. These experiences provide context for Ron's later concerns about rejection, belonging, and becoming a burden in intimate relationships.

Thus, both stressors and protective mechanisms would be identified in the eco-map created based on Ron's situation. Family ties were a cause of emotional estrangement and possible rejection. His healthcare providers were important sources of emotional and practical support. His LGBTQ+ community gave him social support and identity validation. While employment offered security, it also raised fears about disclosing his HIV status and sexual orientation. In addition to providing closeness and support, romantic partnerships sparked worries about getting ill, being rejected, and becoming a

burden. These systems show how Ron's psychological functioning was integrated into a setting that included both substantial relationship stress and protective resources.

Grief, HIV, Anxiety, and Defensive Functioning

Ron had a rather abstract approach to his HIV diagnosis during the first few months of therapy. He struggled to think clearly about what he would do if he got sick. It is possible to interpret his propensity to intellectualize the diagnosis as an adaptive response that limited his immediate exposure to intense terror and allowed him to carry on with his daily activities. Therefore, the purpose of treatment was not simply to eliminate defensive responses, but to help Ron develop the emotional capacity to consider his illness more directly:

After two months of treatment, Ron experienced acute anxiety attacks around final exams for the first time in his life. In fact, he found he was so anxious he could hardly write the exam. Upon reflection he recognized that his diagnosis meant to him that his life was so short, and that he felt increased pressure to succeed at everything he did - as though a failure on an exam now reflected upon his entire life. In the course of recognizing the intense anxiety he had been feeling about his diagnosis, which was then displaced onto the exam situation, he began to mourn the loss of his diagnosis, to develop a sense of hope that the medications he was taking could preserve his life, and at the same time to decide that he needed to regard "every minute of every day as a special gift...it’s more than many of my friends have had."

Through therapeutic reflection, he realized that the diagnosis had altered his definition of success and failure. Initially, he perceived fear as being related to the examination itself. He believed that since his life would be brief, he had to excel in everything, as if failing an exam would mean that he had failed in life. The episode illustrates how anxiety initially focused on an immediate academic stressor could also reflect Ron's difficulty tolerating uncertainty about his health and future.

Family Rejection, Homophobia, and Identity

After around six months of treatment Ron was able to think more clearly about the prospect that he would eventually experience AIDS symptoms. He began to think about whether he should set up other sources of support in case he became ill because of his improved tolerance for anxiety associated to the illness. He made the decision to travel to West Virginia with a friend to inform his mother about his sexual orientation and HIV status. His mother's response was rejecting:

his mother reacted with disgust and rejection, as Ron had thought she might. His mother would not speak to him for two days, but eventually said to him, "you've made a choice... we don't like it or agree with it, but we don't want it to get in the way of the time we have left..." Ron commented, "I felt kicked in the stomach by the way she put it. But it’s how she is. I can accept it."

This episode illustrates why an intrapsychic framework is insufficient to explain Ron's distress. There was a real interpersonal and societal foundation to his dread of rejection. Without viewing Ron's sexual orientation as a medical issue, an LGBTQ+ affirmative approach would acknowledge the effects of homophobia and familial rejection (Dentato, 2017).

For Ron, the pain of rejection based on his sexual orientation and HIV status was aggravated because of longstanding feelings in his family:

He talked more about his parents, especially how critical and rejecting they were. He felt he had had a more positive relationship with his father, although he also conveyed that since his father had died when he was 10, his memories were indistinct. When his mother had married his stepfather, they had had two more children, and Ron remembered he had always subsequently felt "like an outsider in the family."

From an ego-psychological standpoint, therapy could assist Ron's ability to understand that his feelings of loss about George's death were also exacerbated by the loss of his father when he was a child. Further, his feelings of being an "outsider" due to his LGBTQ+ orientation had had a prequel in his feelings about his step-family. Therapeutic reflection helped Ron set reasonable boundaries and look for helpful relationships elsewhere while also examining how these events contributed to expectations of rejection and abandonment.

Employment, Disclosure, and HIV-Related Stigma

Questions about employment and disclosure became increasingly important as Ron approached the end of law school. He was worried that his homosexuality might be discovered through psychological testing during a job interview. Ron stated that this was not his main concern when the social worker explained that such testing would not reveal his sexual orientation. He was worried that disclosure might have an impact on his employment and access to health insurance, but he also did not want to stay in the closet at work.

Ron's situation went beyond just deciding whether or not to disclose his sexual orientation. Research on men living with HIV/AIDS has also identified financial, psychiatric, medical, and cognitive factors associated with employment status (Rabkin et al., 2004). In addition, he had to think about his employment, insurance, privacy, and the possible repercussions of disclosure. Instead of challenging Ron toward or away from disclosure, a modern HIV-affirmative clinician would similarly encourage informed decision-making while providing accurate information regarding HIV transmission, treatment, confidentiality, and any legal protections.

Intimacy, Loss, and Fear of Becoming a Burden

Another aspect of Ron's experience was triggered by his subsequent relationship with Bruce. At first, Ron said that losing a loved one and going through the pain of George's death again was his worst fear.

However, as his therapy progressed, he became aware of another concern: he was afraid that becoming ill would cause emotional harm to a future partner and that he would become a burden:

He felt guilty about possibility "inflicting emotional wounds" on a partner if he became ill. He feared he would be a burden if he became ill, and that his partner's grief would be too painful to bear. At the same time, Ron wanted to be remembered; he felt if he had an intimate relationship and became ill, "then I will be alive in someone's memory."

George's earlier concern that he may become a burden to Ron was repeated in Ron's anxiety. As a result, Ron was not only preparing for his own illness, but also for the potential to replicate the relational pain that he had gone through while taking care of George. Ron, on the other hand, wanted to be remembered and thought that being in a close relationship would help him stay alive in someone's mind if he fell ill.

Eventually, Ron told Bruce that he was HIV positive. Ron suffered greatly because of Bruce's initial tearful response and eventual breakup. Ron experienced profound hopelessness during this period, describing a wish to "leave forever," while reportedly stating that he would not act on this feeling. This statement underscores the importance of distinguishing the client's documented account from any additional safety assessment or clinical recommendations. After that, Bruce got in touch with Ron and said he wanted to get back together. They resumed their intimate relationship after Ron responded positively.

Later Treatment Progress and Resilience

Ron showed improved self-care and inner well-being over time. He continued to engage in social relationships, exercised frequently, and made progress at work. He had not experienced any AIDS symptoms for two years following his diagnosis. He reported that he normally tried not to worry about his future, despite the fact that he still felt unclear about it. These alterations show how environmental support and psychological adaptability interact. Instead of eradicating grief or doubt, Ron improved his ability to cope with uncertainty. Resilience and adaptive functioning are demonstrated by his ability to continue working, maintaining relationships, exercising, working with healthcare providers, and participating in the community.

Even at the time Ron was being treated, some persons who were HIV+ never contracted AIDS, and some exposed to HIV never became HIV+. This information would be important to share with Ron, to help him hold in his mind the complexity of his fears of illness and death and his current healthy functioning and reasonable hope for a good and long life. When Ron terminated his treatment and departed with Bruce, it appeared his hope that he might be one of the fortunate persons to be HIV + and spared AIDS could be coming true. This underscores the importance of preserving clients' hope even in the face of potentially catastrophic illness (Kaiunyte et al., 2020). If Ron were undergoing treatment today, in addition to psychological care, the clinician would provide Ron with contemporary HIV education. Now, considering current antiretroviral treatment, viral suppression, and contemporary HIV prevention, Ron could distinguish his grief and fear in the comforting light of the medical realities of living with HIV today.

Similarly, it is important for any client experiencing a potentially fatal illness to concentrate on and treasure any moment of wellness and joy.

Treatment Plan and Evaluation

As seen in the above case study, Ron’s treatment plan consisted of individual therapy for six months using ego psychology-informed psychodynamic and supportive approaches to address the self-determined goals of managing grief related to partner loss, reducing anxiety associated with HIV diagnosis, and improving relational functioning and coping capacity. The first goals of the suggested six-month treatment plan were to improve emotional control and integrate grief related to Ron's HIV diagnosis and George's death. Reflective listening, guided grief exploration, affect identification, and investigation of intellectualization and avoidance were all components of ego psychology-informed supportive therapy. Contemporary HIV psychoeducation would acknowledge the emotional importance of George's death while addressing Ron’s concerns about the course of his own HIV status.

A second goal was to enhance social support and relationship functioning. Ron overcame his worries of rejection, disclosure, and becoming a burden to others by practicing communication, working collaboratively to solve problems, and investigating relational patterns. His autonomy in making disclosure decisions were supported by LGBTQ+-affirmative practices, which would assist him in finding supportive social networks. Family relationships and employment issues, access to healthcare, and community resources were all addressed from a person-in-environment perspective. Client-reported relational confidence, engagement in selected support activities, and advancement toward communication and disclosure goals were all used to measure progress. Although not used in Ron’s case, for the purpose of evaluating progress, in addition to client reports and clinician observations, measures such as repeated evaluations of anxiety and sleep using the (GAD-7; Spitzer et al., 2006) and the Pittsburgh Sleep Quality Index (PSQI; Buysse et al., 1989) could all be used to track progress.

Discussion and Integration of Theory

Ron's case serves as an example of how ego psychology, person-in-environment theory, and LGBTQ + and HIV affirmative practices complement one another. Intellectualization and avoidance may reduce emotional processing while temporarily protecting functioning, as explained by ego psychology. The ecological perspective places these reactions in the context of Ron's family relationships, employment concerns, medical experiences, and social support. HIV-affirmative and LGBTQ+-affirmative approaches also acknowledge that stigma, rejection, and concealment are responses to structural and interpersonal circumstances rather than merely intrapsychic struggles. By incorporating these viewpoints, clinicians can help Ron regulate his emotions while strengthening his reality-testing about the environment with which he has to cope.

The case also emphasizes how crucial it is to evaluate suggested interventions without overstating their effects and to base clinical formulations on the client's personal experiences of the value of the

treatment as well as the clinician’s observations (Drisko, 2010). This approach requires cultural humility, supervision, and contemplation of potential countertransference.

Conclusion and Implications for Practice

Ron's case serves an example of how ego psychology can be combined with person-in-environment, LGBTQ+, and HIV-affirmative perspectives to address stigma, grief, anxiety associated with illness, and related vulnerability. The main conclusion for clinical social workers is that to enhance adaptive functioning, social variables that shape clients' experiences as well as psychological processes must be considered. Emotional support, accurate health information, collaborative treatment planning, and attention to significant sources of resilience and connection should all be included in modern, affirming care. The case provides a framework for combining theory, culturally sensitive practice, and outcome monitoring in clinical work with individuals living with HIV and similarly potentially serious illnesses today.

Declarations

Ethics Approval:

The manuscript presents a composite clinical case developed from multiple clinical cases. Case details were modified to protect confidentiality and anonymity. As the manuscript presents a de-identified composite case rather than an individual participant's clinical history, research ethics approval was not required.

Consent to Participate:

Not applicable

Consent to Publish:

Not applicable

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Author Contribution

M.P. conceptualized the manuscript and developed the theoretical and clinical analysis. M.P. wrote and revised the manuscript and approved the final version for submission.

References

1. Berzoff, J., Flanagan, M., L., & Hertz, P. (2016). *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (4th ed.). Rowan & Littlefield.
2. Blagys, M. D., & Hilsenroth, M. J. (2002). Distinctive activities of cognitive-behavioral therapy: A review of the comparative psychotherapy process literature. *Clinical Psychology Review*, *22*(5), 671–706. https://doi.org/10.1016/s0272-7358(01)00117-9
3. Bonanno, G. A., & Burton, C. L. (2013). Regulatory flexibility: An individual differences perspective on coping and emotion regulation. *Perspectives on Psychological Science*, *8*(6), 591–612. https://doi.org/10.1177/1745691613504116
4. Buysse, D. J., Reynolds, C. F. 3rd, Monk, T. H., Berman, S. R., & Kupfer, D. J. (1989). The Pittsburgh Sleep Quality Index: A new instrument for psychiatric practice and research. *Psychiatry Research*, *28*(2), 193–213. https://doi.org/10.1016/0165-1781(89)90047-4
5. Centers for Disease Control and Prevention (2024, April 12). Treating HIV. https://www.cdc.gov/hiv/treatment/index.html
6. Dentato, M. P. (2017). *Social work practice with the LGBTQ Community: The intersection of history, health, mental health, and policy factors, 4th edition*. Oxford: Oxford University Press.
7. Drisko, J. W. (2010). How clinical social workers evaluate practice. *Smith College Studies in Social Work*, *71*, 419–439.
8. Greene, B. (1997). *Ethnic and cultural diversity among lesbians and gay men*. Sage Publications. Kiaunyte, A., Ruskus, J., Telmentiene, R., & McCrea, K. T. (2021). Even in Fateful Situations a Vital Optimism Remains: Social Work Accompaniment with Persons with Cancer. *The qualitative report*. 10.46743/2160-3715/2021.4459
9. Joint United Nations Programme on HIV/AIDS (2025). *AIDS, crisis and the power to transform: UNAIDS global AIDS update 2025*. https://www.amfar.org/wp-content/uploads/2025/07/UNAIDS-report-Clean.pdf
10. Leserman, J., Pence, B. W., Whetten, K., Mugavero, M. J., Thielman, N. M., Swartz, M. S., & Stangl, D. (2007). Relation of lifetime trauma and depressive symptoms to mortality in HIV. *The American Journal of Psychiatry*, *164*(11), 1707–1713. https://doi.org/10.1176/appi.ajp.2007.06111775
11. Logie, C. H., James, L., Tharao, W., & Loutfy, M. R. (2011). HIV, gender, race, sexual orientation, and sex work: A qualitative study of intersectional stigma experienced by HIV-positive women in Ontario, Canada. *PLoS Medicine*, *8*(11), e1001124. https://doi.org/10.1371/journal.pmed.1001124
12. Pachankis, J. E., Soulliard, Z. A., van Seager, I., Layland, E. K., Clark, K. A., Levine, D. S., & Jackson, S. D. (2022). Training in LGBTQ-affirmative cognitive behavioral therapy: A randomized controlled trial

across LGBTQ community centers. *Journal of consulting and clinical psychology*, *90*(7), 582–599. https://doi.org/10.1037/ccp0000745

13. Rabkin, J. G., McElhiney, M., Ferrando, S. J., Van Gorp, W., & Lin, S. H. (2004). Predictors of employment of men with HIV/AIDS: A longitudinal study. *Psychosomatic Medicine*, *66*(1), 72–78. https://doi.org/10.1097/01.psy.0000108083.43147.6d
14. Saleebey, D. (2013). *The strengths perspective in social work practice: 6th edition*. Needham Heights, MA: Allyn & Bacon.
15. Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, *166*(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092