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PEER-REVIEWED ARTICLE

Social justice informed psychotherapy and people living with HIV

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ABSTRACT

This article examines the intersectional inequalities experienced by people living with HIV (human immunodeficiency virus) (PLWH) and explores how social justice principles can be integrated into psychotherapy to address these challenges. Drawing on the concept of epistemic justice, the article emphasises the importance of recognising the individuality of each PLWH, acknowledging their unique experiences shaped by factors such as race, gender, sexuality, and socioeconomic status. The article advocates for the use of intersectionality as a tool for conceptualising clients' experiences, critically reflecting and mitigating the relational dynamics. In addition, this article recommends the use of a pluralistic approach when working with HIV-positive clients, encouraging pluralism and diversity in the therapeutic process towards changes. This article introduces a social justice framework tailored to psychotherapy with HIV-positive clients, calling for a broader reconsideration of the implicit biases present within the discipline. It aims to inspire greater effort in navigating the tension between therapists' self-interest and accommodating clients' needs.

KEYWORDS: people living with HIV; social justice; intersectionality; pluralism; epistemic justice; oppression; relational dynamics

PERSONAL POSITION

My interest in HIV-related inequalities was sparked by my experience working with people living with HIV (human immunodeficiency virus) (PLWH) in therapeutic settings. I must acknowledge that though I had direct experience engaging with the community I am writing about, my identity as a trainee counselling psychologist placed me in a position of power, and privilege. In this article, I reflect on how my social position influences power dynamics in

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therapy, and how I have sought to address these dynamics in my work with clients. The recommendations presented in this article serve as a starting point to consider how pervasive systemic forces shape our clients' experiences, and how we, as psychotherapists, can act as agents of social justice by adopting social justice informed practices. I wish to use my position to raise awareness and inspire my colleagues to take further action in challenging the systemic oppressions and intersectional inequalities experienced by PLWH.

INTERSECTIONAL INEQUALITIES EXPERIENCED BY PEOPLE LIVING WITH HIV

Human immunodeficiency virus (HIV) is a virus that can progressively weaken the immune system, and critically diminish its ability to defend the body against infections (Gallo, 2002). HIV-positive diagnoses are heavily stigmatised, with a wealth of evidence demonstrating the link between stigma, treatment adherence, social support, and health outcomes (Katz et al., 2013). Socioeconomic status, social and sexual networks, socio-political context, and how the community perceive HIV all intersect with personal characteristics and shape the experience of PLWH. PLWH commonly experience feelings of helplessness, shame, guilt, isolation, anxiety related to societal perceptions of their condition, and social withdrawal (Lucas et al., 2024; Mayers et al., 2005; Tshabalala & Visser, 2011; Wen et al., 2023). A wealth of evidence has demonstrated that PLWH are oppressed and discriminated against, they are more vulnerable to acts of hostility and discrimination (Katz et al., 2013), physical and sexual abuse (Kubátová et al., 2023; UK Health Security Agency, 2024; Waldron et al., 2021) and stereotyping, labelling, and status loss within a hierarchy of power (Vanable et al., 2006). Ongoing threats to safety contribute to distress and result in mental health issues such as depression, anxiety, substance abuse, and suicidal ideation while hindering the development and expression of an authentic sense of self. These external pressures create intrapsychic and interpersonal conflicts limiting HIV-positive clients' expression of individuality.

Structural inequalities, driven by HIV-related criminalisation, stigma, and discrimination, have created significant barriers for PLWH from marginalised communities to access HIV care and psychological support. Recent research in HIV care revealed how global health policies and narratives reinforce traditional gender and ethnic stereotypes in the delivery of interventions (Dovel et al., 2020; Merriman & Deane, 2023; Mindry, 2024). Merriman and Deane (2023) highlight the gender disparities in international guidelines for HIV support, noting a shortage of social, empowerment, and behavioural change interventions developed for heterosexual men. On the other hand, women accessing support from HIV services reported feeling isolated, criticised, and treated unfairly by staff and other patients (Bogart et al., 2008; Mukamana et al., 2022), due to traditional gender norms in sexual freedom and stereotypes that HIV clinics are 'geared toward gay people' (Bogart et al., 2008, p. 251). Women living with HIV reported significantly higher levels of all forms of stigma—internalised, perceived, anticipated, and structural—associated with HIV while receiving less social support compared to males due to unequal gender norms (Colbert et al., 2010; Mukamana et al., 2022). Relying solely on the traditional definition of evidence-based practice, which suggests individuals' needs can be conceptualised and addressed by following clinical evidence and guidelines for specific groups (Thyer, 2004), fails to address the complex needs of PLWH and has become a barrier to them accessing and engaging with support.

SOCIAL JUSTICE, PSYCHOTHERAPY, AND PLWH

Social justice, as defined by Fouad et al. (2006), pertains to ensuring fair and equitable distribution of opportunities and resources, and addressing inequities where they exist. It involves ensuring equality and fairness for all individuals, irrespective of characteristics or aspects of a person's identity. Resolving social injustices not only mitigates human distress and facilitates lasting changes in those who were oppressed, but also helps prevent these injustices from persisting into future generations. In the context of psychotherapy, social justice informed practice is centred on efforts to transform societal values, structures, policies, and practices to provide marginalised groups greater access to self-determination with an emphasis on the critical role of social justice within interpersonal dynamics (Goodman et al., 2004; Lewis, 2010).

Working with PLWH has been an important yet overlooked area in counselling and psychotherapy literature. Research in counselling and psychotherapy for PLWH has predominately focused on the effectiveness of specific therapeutic approaches in reducing mental health symptoms experienced by PLWH (Petersen et al., 2014; Qin et al., 2022; Tshabalala & Visser, 2011; Xiao et al., 2021; Yigit et al., 2020). Expanding on Sue's (2015) argument, psychological professions often mistakenly assume that theories and approaches developed by dominant groups apply to everyone while overlooking the cultural and political contexts of the techniques and interventions. This is particularly evident among PLWH, where historically marginalised groups—including racial and ethnic minorities, women, and gender identities beyond cisgender men and women—remain underrepresented in HIV care policies and research (Irie et al., 2023; Johnston et al., 2023; Merriman & Deane, 2023).

Epistemic injustice

I argue that the epistemic injustices faced by PLWH have not been adequately acknowledged within our discipline. The term *epistemic injustice* was first coined by the British philosopher Miranda Fricker in 1999, referring to the harm inflicted on individuals in their capacity as an epistemic subject—as knowers, reasoners, and interpreters. Epistemic injustices occur when PLWH's ability to engage in epistemic practices—such as sharing knowledge or making sense of their own experience—is undermined. Fricker (2007) suggests two forms of epistemic injustice: *testimonial injustice* and *hermeneutical injustice*. Testimonial injustice occurs when a person's word is unfairly discounted due to their identity; for PLWH, this can include their HIV status, gender, sexuality, ethnicity, or other marginalised aspects. Historically, HIV has been linked to behaviours like promiscuity, sex work, and drug use—behaviours that have historically discredited individuals in the eyes of society. The prevailing narrative of fear and blame towards those infected with HIV reinforced negative stereotypes, leading to the diminished credibility of PLWH—a clear example of testimonial injustice. Hermeneutical injustice, on the other hand, arises when individuals are unable to make sense of their experiences due to a lack of available interpretive resources. The marginalisation and decentration of PLWH's cultural identities and social positionings in psychotherapy research are examples of hermeneutical injustice. I believe that social justice informed therapy for PLWH can help restore hermeneutical justice by offering the clients a space where they can freely voice and understand their experiences and help them to find the interpretive tools to conceptualise their experience.

Recognising the individuality of each person living with HIV

Another crucial point to emphasise is that each person living with HIV has a distinct life before their diagnosis, shaped by their developmental history, acculturation process, personal losses, or trauma. The experiences of PLWH are inherently intersectional, with each person having unique relationships with their families and communities, shaped by identities such as gender, ethnicity, age, sexuality, and class. The extent to which PLWH experience stigma, oppression, and discrimination varies greatly, depending on family dynamics, cultural values, community attitudes, and the policies and support systems in place in their country at the time. For example, political decisions—whether to advance anti-discrimination and human rights protections or criminalise behaviours associated with HIV—have been shown to play a major role in addressing or exacerbating the health inequalities, discrimination, and injustices faced by PLWH (Kavanagh et al., 2021). These factors influence the specific losses, as well as intrapersonal and interpersonal conflicts PLWH may face post-diagnosis, along with the resources available to support them in navigating their lives moving forward.

In my experience of working with PLWH, *when* the client was diagnosed, linked with the socio-political environment of the time, plays a significant role in shaping the intra- and interpersonal conflicts they experience. The first effective HIV treatment was approved in 1987, and this transformed HIV from a terminal illness to a chronic condition. Before this breakthrough, a HIV diagnosis was often equated with an inevitable death sentence and social isolation—fostering feelings of existential hopelessness, powerlessness, and profound loneliness. Many clients I have worked with that lived through this pre-treatment era and lost loved ones to HIV often share common intrapsychic conflicts: survivor guilt and difficulty moving beyond the ingrained belief that they should not have survived. One narrative that I have frequently encountered is: '*Everyone, including myself, was so certain that I was going to die soon. I came to terms with that, and I lived my days as if they were my last. But I am still* *here. I should be happy that I didn't die—but I can't*'. These clients often lack a space where they can express these feelings, which contradicts the dominant societal narrative that surviving HIV should be a cause for relief and gratitude. They also lacked an available interpretive tool to understand the feelings they were experiencing—the feeling of disappointment, confusion, and how they were stuck in the idea that '*I should be dead*'. These unresolved conflicts have created ongoing challenges in their ability to fully re-engage in life.

In addition to the societal narratives surrounding HIV at the time of diagnosis, local government attitudes towards funding support services for PLWH and the legal environment in which they live play a crucial role in determining their survival and quality of life (Shepherd, 2022). In my client work, I have observed that individuals who were diagnosed with HIV more recently are less likely to experience the same level of hopelessness and helplessness that was common in earlier generations. Knowing that HIV is a manageable condition and having access to support services significantly reduces the psychological barriers to accepting a HIV-positive status. This shift is also reflected in the lower levels of social rejection and discrimination they anticipate or encounter. The global '*Undetectable = Untransmittable*' (U=U) campaign, which raises awareness that PLWH cannot transmit the virus if they maintain an undetectable viral load through adherence to treatment, has contributed to changing perceptions. However, a key factor influencing these varied experiences remains the degree of privilege or marginalisation individuals face within their identities, communities, and broader society. Therefore, I argue that incorporating an intersectional lens is essential for social justice informed practice in working with PLWH.

INTERSECTIONALITY

The term *intersectionality* was first coined by American legal scholar Kimberlé Crenshaw in 1989. Crenshaw (1989) employs the concept to elucidate the overlapping and intertwined systems of discrimination, including racism and sexism, affecting Black women. She critiques the inadequacy of singular or binary frameworks in anti-racist activism, feminist theory, and anti-discrimination laws. The origins of intersectionality, however, can be traced back to the broader multifaceted Black feminist movement in the USA. Notably, the Combahee River Collective Statement is often regarded as an early articulation of intersectionality, underscoring how both the mainstream feminist movement and the Civil Rights Movement of the time failed to adequately address the specific challenges faced by Black women and Black lesbians, resulting from interconnected systems of oppression (Smith, 1983).

This concept has been applied in a variety of contexts as an analytic tool for examining how overlapping systems of power shape social dynamics within diverse societies and influence individuals' lived experiences (Hill Collins & Bilge, 2020). Intersectionality recognises the interconnection and mutual influence of the seven core intersectional identities: race inclusive of ethnicity and culture, gender, class, sexual orientation, disability, age, and religion, along with other intersecting identities (Moodley & Lubin, 2008). In psychotherapy, intersectionality offers a framework for us to reflect on the interplay between power, marginalisation, and privilege within society, how intersecting identities shape our client's experience, and how these dynamics may influence the therapeutic relationship. Moreover, it bridges *scholarship* with *activism*, encouraging practitioners to transform research findings into actions that promote social change (Cole, 2009; Grzanka, 2020). Despite its potential, the application of intersectionality within psychology has faced critiques for being superficial and often limited to simply understanding clients' experiences (Grzanka, 2020). For example, Hook and colleagues define intersectionality in psychotherapy as to 'work collaboratively with clients to understand the unique intersection of clients' various aspects of identities' (Hook et al., 2013, p. 354). Such a definition undermines the use of intersectionality, minimises the role of the practitioner's identity in the relational dynamic, and fails to address intersectionality's core aim of exposing structural inequalities and driving systemic change.

We need to consider how multiple identities intersect with being HIV positive and compounding the injustices faced by PLWH. Research has consistently shown that HIV-related inequalities are exacerbated by intersectional inequalities, such as structural racism, gender disparities, class inequalities, and sexual orientation, each adding an additional layer of vulnerability to oppression and discrimination (Watkins-Hayes, 2014). PLWH identity as members of one or more marginalised communities, for example, people of colour or the LGBTQ+ (lesbian, gay, bisexual, transgender, queer, and other identities) community, and often encounter stigma linked not only to their HIV status but also to their cultural identities. Studies have shown that PLWH from marginalised groups report significantly higher levels of stigma and discrimination (Beer et al., 2022). For instance, a homosexual man of colour living with HIV may face not only HIV-related stigma but also racial and sexual orientation-based discrimination, with experiences distinct from those of a heterosexual woman of colour living with HIV (McConnell et al., 2018; Nydegger et al., 2021).

Another intersectional identity that needs to be considered when working with PLWH is social class. With the physical health and social challenges associated with HIV, PLWH are significantly more likely to live in poverty. While global statistics on social class among PLWH are limited, data from the UK, where I practice, highlight this issue. A national survey conducted in 2022 found that one in two PLWH struggle to afford basic needs (UK Health Security Agency, 2024). Income inequalities are particularly pronounced among PLWH from multiple marginalised communities, with over 70% of those from ethnic minority backgrounds struggling to meet basic needs, compared to less than 40% of their white British counterparts. The ongoing challenges of living in poverty compound with the other intersectional inequalities experienced by PLWH can translate into a sense of extreme powerlessness, shame, inferiority, self-doubt, and social isolation (Goodman et al., 2009). The class differences between us can become blind spots for us to recognise the unique challenges faced by our clients. Thus, psychotherapists must adopt an intersectional approach that considers individual, community, and societal factors influencing the experiences of PLWH and the relational dynamic, to provide socially just and ethically sound psychotherapy.

Critically reflecting on and mitigating relational power dynamics

Operating from an intersectional lens involves practitioners reflecting on their own identities, and how their social group memberships may impact their work. As psychotherapists, we must recognise that our identities play a crucial role in shaping the power dynamics within the therapeutic relationship. The importance of our continuous self-reflection on issues of oppression, power, and privilege in our own lives is widely emphasised in professional literature and guidelines (Goodman et al., 2004; Pope & Vasquez, 2016; Shaw, 2010; Winter & Charura, 2023). Extensive evidence suggests that practitioners who are aware of how their social positioning shapes their values and experiences are less likely to make faulty assumptions, unintentionally perpetuate harmful power dynamics, reinforce negative stereotypes, or inadvertently replicate past injustices experienced by marginalised individuals (Leary, 2000; Sue, 2015; Sue et al., 2007). Addressing power differentials may be especially salient when working with PLWH because we can be gatekeepers to resources; for example, welfare providers may require documentation from us as evidence that the situation the clients are in is detrimental to their wellbeing which further complicates the power dynamics.

Regardless of our theoretical orientations, it is crucial that we remain open to engaging in dialogue with clients about identities, collaboratively exploring and addressing the values, assumptions, and biases that shape both parties' perspectives throughout the therapeutic relationship. Within the counselling literature, there have been growing calls for counsellors to assume responsibility in helping clients navigate their culture-specific values, attitudes, beliefs, and experiences in the therapeutic process because the practitioners hold a significant power advantage within the relationship (Day-Vines et al., 2007, 2021; Lee et al., 2022). I believe this assumption should also extend to psychotherapy, especially when working with PLWH, given the hermeneutical injustices this group faces. However, we need to be cautious about how we implement this in the therapeutic process. Navigating differences in culture, identity, and power requires delicacy, particularly as we strive to understand how intersectional identities shape relational dynamics. Clients may not always be ready or willing to engage in developing critical consciousness—pushing too hard could do more harm than good, inadvertently imposing our own cultural values on them, deepening their sense of disenfranchisement, and reinforcing the epistemic injustices they face (Hailes et al., 2021).

When working with people living with HIV (PLWH), I strive to address power dynamics by critically reflecting on the differences and similarities in our intersectional identities, while remaining open to acknowledging them when appropriate. Using myself as an example, I am a middle-class, heterosexual, cisgender, Chinese female trainee counselling psychologist.

Certain aspects of my identity place me in marginalised groups—being female and an ethnic minority—while other aspects, such as my middle-class and cisgender status, afford me privileges that contribute to the structural inequalities faced by other groups. These intersecting identities shape my worldview, influence my perspective on social justice, and inevitably affect the power dynamics within my therapeutic relationships with clients. In my client work with HIV-positive clients, I often try to remove myself from the 'expert' status associated with the title of 'Trainee Counselling Psychologist' by openly acknowledging my limitations in fully understanding their subjective experiences. When exploring our shared and differing intersectional identities in the process, I tend to focus on more visible factors like gender, ethnicity, and age. I believe that differences in class, disability, and in this context, HIV status, should be approached with additional care. While acknowledging my privileges can promote cultural sensitivity and potentially improve the therapeutic relationship, it may also inadvertently reinforce a client's sense of otherness and replicate the feelings of past alienation.

From my experience, HIV-positive clients often find their identity reduced to their HIV status by those who know about it. Highlighting our difference in HIV status, for instance, could unintentionally reinforce barriers, limiting the client's ability to define their identity beyond the label of being HIV positive. Interpersonal power dynamics become even more complex when I share aspects of my identity with my clients, such as gender and ethnicity. I make a conscious effort to consider how our shared identity might obscure important differences in our life experiences. If not carefully addressed, my understanding of how HIV is perceived and the gender stereotypes prevalent in Asian cultures can manifest as unconscious bias in how I conceptualise and understand my client's experience. This may lead me to unconsciously impose the negative stereotypes and injustices faced by others onto my client, potentially undermining their autonomy and weakening the therapeutic alliance. I try to maintain my critical awareness by discussing my application of intersectionality in client work during clinical supervision. Supervision provides a valuable space for me to reflect on the therapeutic relationship from a different perspective and develop strategies to address relational dynamics more effectively.

PLURALISM AND MONOCULTURAL BIAS

I argue that social justice informed psychotherapy for PLWH necessitates adopting the philosophical stance of *pluralism*, which posits that any substantial question may have multiple varied, yet sometimes conflicting, answers (Rescher, 1993). Building on this concept, Cooper and McLeod (2007) developed the pluralistic approach to therapy, a framework that emphasises shared decision making between client and therapist. The pluralistic approach to therapy is grounded in three core principles. First, *pluralism across orientations* encourages therapists to remain open to diverse ways to conceptualise clients' experiences of distress and approaches to addressing their needs. Second, *pluralism across clients* highlights the importance of recognising client diversity and tailoring therapy to individual needs rather than offering a one-size-fits-all model. Third, *pluralism across perspectives* underscores the significance of client participation in selecting therapy tasks and methods and deciding therapeutic goals. The pluralistic approach aims to create a structure that accommodates various pathways to change, rather than prescribing a singular, fixed method for therapeutic progress (Cooper & McLeod, 2007). By applying the pluralistic approach, we can better honour the individuality of each HIV-positive client, a point I emphasised earlier. Moreover, it serves as a crucial tool for practising from an intersectional lens and for restoring epistemic justice to HIV-positive clients.

My support for the pluralistic approach stems from my critical examination of the *monocultural* bias—the procedural norms embedded in our profession, which can become a source of cultural insensitivity and undermine therapeutic alliance (Gone, 2009). We need to recognise and reflect on the limitations of psychotherapies and the orientations we practice from. While our role as psychotherapists positions us to advocate for the value of therapy, we must remain vigilant against potential biases that may lead us to assume therapy is always the optimal or universal solution. Recognising these biases allows us to approach our work with greater humility and cultural sensitivity. We need to reflect on how the therapeutic orientations we adopt shape our understanding of the sources of our clients' distress and influence the structure and goals we set for therapy.

Beyond traditional therapy

Activism and advocacy are constitutive components of the social justice work of therapists endeavouring to address intersectional inequalities rooted in oppression and power (Grzanka, 2020; Mallinckrodt et al., 2014). As defined by Toporek and Liu (2001), advocacy in psychotherapy represents actions that the practitioner takes, within and beyond the psychotherapy context, to eliminate the external and systematic barriers impairing clients' wellbeing. Advocacy may result in improvements in socio-political and economic inequalities through influencing how public decisions are made. Winter (2019) highlights that to truly embody social justice principles in our practice, we must incorporate a socio-political lens into our formulation, tailor our approach according to the needs of our client, and consider the border resources available to our clients—therapy may not always be the most appropriate or effective course of action. Specifically, this is important when working with PLWH, where loss of social networks, status, financial security, and resources to meet basic needs are common. It is not uncommon that my HIV-positive clients express concerns about their ability to commit to therapy due to financial constraints, such as being unable to afford travel expenses. Remote therapy often is not a viable option for them due to a lack of privacy in their living situations. Frequent and unpredictable hospital appointments further complicate their ability to engage in therapy. To address these barriers, I reached out to the organisation

I volunteer with to inquire about potential reimbursement for travel expenses. I also advocate for flexibility in boundaries related to practices, such as focus of the therapy and cancellation policies to better support our clients' needs.

We need to consider other forms of psychological support that might be available to our HIV-positive clients to accommodate their individual needs. In my client work, I often refer to the *Standards for Psychological Support for Adults living with HIV*, published by the British HIV Association (BHIVA, 2011). BHIVA (2011) outlines a stepped-care model of psychological support for PLWH, which includes a range of services: information, advice, peer support, self-management courses, screening for cognitive difficulties and comorbid conditions alongside HIV, as well as counselling, psychological therapies, and specialist mental health interventions. We need to consider the limit of the therapy that we can provide, and actively collaborate with our clients to determine the most appropriate course of action. The interpersonal conflicts and lack of social support experienced by PLWH can often be addressed by developing new support networks and engaging with communities that share similar experiences. Extensive literature demonstrates the unique value of peer support in helping HIV-positive individuals navigate the health system. Peer support not only offers interpretive tools for understanding complex health information but also provides strategies for managing their condition (Berg et al., 2021; Boucher et al., 2020; Feldman et al., 2023; Monroe et al., 2017). By considering these resources in therapy, the process can potentially help address the intrapsychic conflicts that hinder clients from seeking additional support, such as fear of association with the HIV community and difficulty in accepting their HIV-positive status.

Relevant to my previous point, many PLWH face significant challenges in meeting basic needs, such as debt, housing, and access to welfare support. These issues, which traditional therapy may not address, are crucial in determining their wellbeing and contribute to their distress. As a volunteer counsellor at a local HIV charity, I collaborate closely with other professionals in the organisation to provide holistic support for my clients. A social justice informed approach requires us to routinely inquire about clients' basic needs as part of the clinical assessment process and actively assist them in obtaining necessary resources (Appio et al., 2013). We should also consider providing flexibility in the focus and boundaries of therapy to meet the individual needs of our clients. When working with clients who are in the process of accessing welfare support and are finding the process challenging, I offer them the choice to either continue pursuing their original therapeutic goals or shift the focus of the hour to collaboratively develop strategies for effective interactions with social service agencies. By validating and addressing clients' experiences of institutional barriers, we can empower them to advocate for themselves and others (Carr et al., 2023). Additionally, exploring available options, support systems, and community strengths can enhance clients' self-worth, confidence, and critical consciousness, encouraging them to challenge oppressive institutional practices and work towards social change. Sharing tasks and responsibilities with other resources can alleviate the professional and personal burden on us endeavouring to address the social injustices faced by our HIV-positive clients.

Acknowledging the potential benefits of medicine

Another *monocultural* bias that I observed within our profession is a bias towards disregarding the power of the medical model in understanding distress. With the contemporary shift of a social justice perspective emphasising *power with* rather than *power over*, practitioners and scholars have been actively critiquing and rejecting the medicalisation of distress (Carr et al., 2023; Sanders, 2006). As a trainee counselling psychologist, I firmly believe in the philosophy underpinning the discipline, that we need to operate from a holistic lens and view individuals as unique, relational beings with autonomy (Strawbridge & Woolfe, 2010). However, I also believe that, while we challenge the traditional medical model of distress centred solely on the individuals (Tribe & Bell, 2018), we should not disregard the potential role of biology on distress, and the benefit of psychopharmacology for our clients.

This perspective is particularly crucial when working with PLWH. HIV infection can lead to cognitive impairments and neurological changes that affect people's experience of distress and emotional regulation, with research consistently demonstrating the link between depressive symptoms and cognitive impairments among PLWH (Rabkin et al., 2000; Rubin & Maki, 2019; Starace et al., 2002). I noticed in my experience of working with HIV-positive clients, that for some of them, their intrapersonal conflicts have a neuropsychological basis—feelings of confusion, powerlessness, and helplessness persist due to severe cognitive impairments and a chronic sense of fatigue. In my experience, it is common for the role of cognitive impairments to be overlooked by both clients and professionals. Clients may internalise these cognitive difficulties, perceiving them as indicators of inferiority or inadequate intelligence. '*I thought I was just getting old, or I am just not as good or as smart as others*.' They may refrain from disclosing these difficulties to the professionals involved in their care due to the internalisation of their challenges. Additionally, when PLWH experience cognitive impairments, their responses during assessments and therapeutic interactions may be limited and brief. This can often be misinterpreted as clients being guarded or unwilling to engage. Even though as psychotherapists we do not have the expertise to directly address the impact of cognitive impairments on our clients, acknowledging the role of biological factors in their distress can help alleviate feelings of self-blame and shame and may be essential for them to engage in the process.

This is particularly important for PLWH from multiple marginalised groups who often face numerous barriers to accessing HIV care. By exploring and understanding the biological basis of their challenges in therapy, we can empower clients to advocate for themselves to access the appropriate treatments from the healthcare system, fostering new power relations between them and medical professionals. In addition, the physical health challenges stemming from a weakened immune system may require psychiatric medication for resolution. While psychotherapy may facilitate their self-acceptance of having been infected with HIV and the limitations it imposes, PLWH may need psychopharmacology to manage specific physical symptoms, for example, clouding of consciousness, in order to engage in psychotherapy, to immerse in the process, and to address the intra- and interpersonal conflicts they are experiencing.

CONCLUSION

Social justice informed practice for working therapeutically with PLWH requires us to adopt an intersectional lens. This involves critical reflection on the power and privileges inherent in intersecting identities, and how these shape the clients' experience of distress, contributing to both intra- and interpersonal conflicts as well as relational dynamics. We also need to interrogate the limitations of the theoretical orientations and structural paradigms from which we operate, including the biases shaped by own our positionalities. I argue that the integration of social justice informed practice is imperative to delivering psychotherapy that upholds the ethical standards of our discipline. How can PLWH, or anyone for that matter, receive the ethical and socially just psychotherapy they deserve if we do not reflect on our biases and set aside our beliefs about what is right or wrong in different views on therapeutic issues?

Social justice informed practice often relies on the voluntary efforts of practitioners, who must navigate the tension between self-interest and the accommodation of clients' needs. This additional burden, often unrecognised within the scope of regular workloads, can lead to burnout, hopelessness, and even anger (Helms, 2003). Without a robust professional support system, therapists working on the frontlines of social justice risk being oppressed by the very mission they seek to fulfil. In light of these challenges, this article introduced a social justice framework specifically designed for psychotherapy with HIV-positive clients. This article calls for a broader reconsideration of the implicit biases present within the discipline and aims to inspire actionable change among practitioners, to share responsibilities with other professionals and organisations in the ecosystem of support services. Collaborative engagement with external resources is crucial, not only in providing holistic support but also in helping us uphold our commitment to social justice, all while maintaining our own wellbeing.

REFERENCES

Appio, L., Chambers, D., & Mao, S. (2013). Listening to the voices of the poor and disrupting the silence about class issues in psychotherapy. *Journal of Clinical Psychology*, *69*(2), 152–161. https://doi.org/10.1002/jclp.21954

Beer, L., Tie, Y., McCree, D. H., Demeke, H. B., Marcus, R., Padilla, M., Khalil, G., & Shouse, R. L. (2022). HIV stigma among a national probability sample of adults with diagnosed HIV—United States, 2018–2019. *AIDS and Behavior*, *26*(S1), 39–50. https://doi.org/10.1007/s10461-021-03414-6

Berg, R. C., Page, S., & Øgård-Repål, A. (2021). The effectiveness of peer-support for people living with HIV: A systematic review and meta-analysis. *PLOS ONE*, *16*(6), e0252623. https://doi.org/10.1371/journal.pone.0252623

Bogart, L. M., Cowgill, B. O., Kennedy, D., Ryan, G., Murphy, D. A., Elijah, J., & Schuster, M. A. (2008). HIV-related stigma among people with HIV and their families: A qualitative analysis. *AIDS and Behavior*, *12*(2), 244–254. https://doi.org/10.1007/s10461-007-9231-x

Boucher, L. M., Liddy, C., Mihan, A., & Kendall, C. (2020). Peer-led self-management interventions and adherence to antiretroviral therapy among people living with HIV: A systematic review. *AIDS and Behavior*, *24*(4), 998–1022. https://doi.org/10.1007/s10461-019-02690-7

British HIV Association. (2011). *Standards for psychological support for adults living with HIV*. https://www.bhiva.org/StandardsForPsychologicalSupport

Carr, E. R., Davenport, K. M., Murakami-Brundage, J. L., Robertson, S., Miller, R., & Snyder, J. (2023). From the medical model to the recovery model: Psychologists engaging in advocacy and social justice action agendas in public mental health. *American Journal of Orthopsychiatry*, *93*(2), 120–130. https://doi.org/10.1037/ort0000656

Colbert, A. M., Kim, K. H., Sereika, S. M., & Erlen, J. A. (2010). An examination of the relationships among gender, health status, social support, and HIV-related stigma. *Journal of the Association of Nurses in AIDS Care*, *21*(4), 302–313. https://doi.org/10.1016/j.jana.2009.11.004

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist*, *64*(3), 170–180. https://doi.org/10.1037/a0014564

Cooper, M., & McLeod, J. (2007). A pluralistic framework for counselling and psychotherapy: Implications for research. *Counselling and Psychotherapy Research*, *7*(3), 135–143. https://doi.org/10.1080/14733140701566282

Crenshaw, K. W. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1989*(1), article 8. https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8/

Day-Vines, N. L., Cluxton-Keller, F., Agorsor, C., & Gubara, S. (2021). Strategies for broaching the subjects of race, ethnicity, and culture. *Journal of Counseling & Development*, *99*(3), 348–357. https://doi.org/10.1002/jcad.12380

Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M. J. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development*, *85*(4), 401–409. https://doi.org/10.1002/j.1556-6678.2007.tb00608.x

Dovel, K., Dworkin, S. L., Cornell, M., Coates, T. J., & Yeatman, S. (2020). Gendered health institutions: Examining the organization of health services and men's use of HIV testing in Malawi. *Journal of the International AIDS Society*, *23*(S2), e25517. https://doi.org/10.1002/jia2.25517

Feldman, M. B., Tran, T. T., Boucher, L. M., Abdelqader, F., Raker, A. R., & Hile, S. J. (2023). A process and impact evaluation of a peer-led HIV self-management program. *Evaluation and Program Planning*, *96*, 102175. https://doi.org/10.1016/j.evalprogplan.2022.102175

Fouad, N. A., Gerstein, L. H., & Toporek, R. L. (2006). Social justice and counseling psychology in context. In R. L. Toporek, L. H. Gerstein, N. A. Fouad, G. Roysircar, & T. Israel (Eds.), *Handbook for social justice in counseling psychology: Leadership, vision, and action* (pp. 1–16). Sage Publications. https://doi.org/10.4135/9781412976220.n1

Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198237907.001.0001

Gallo, R. C. (2002). The early years of HIV/AIDS. *Science*, *298*(5599), 1728–1730. https://doi.org/10.1126/science.1078050

Gone, J. P. (2009). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. *Journal of Consulting and Clinical Psychology*, *77*(4), 751–762. https://doi.org/10.1037/a0015390

Goodman, L. A., Liang, B., Helms, J. E., Latta, R. E., Sparks, E., & Weintraub, S. R. (2004). Training counseling psychologists as social justice agents: Feminist and multicultural principles in action. *The Counseling Psychologist*, *32*(6), 793–836. https://doi.org/10.1177/0011000004268802

Goodman, L. A., Smyth, K. F., Borges, A. M., & Singer, R. (2009). When crises collide: How intimate partner violence and poverty intersect to shape women's mental health and coping? *Trauma, Violence, & Abuse*, *10*(4), 306–329. https://doi.org/10.1177/1524838009339754

Grzanka, P. R. (2020). From buzzword to critical psychology: An invitation to take intersectionality seriously. *Women & Therapy*, *43*(3–4), 244–261. https://doi.org/10.1080/02703149.2020.1729473

Hailes, H. P., Ceccolini, C. J., Gutowski, E., & Liang, B. (2021). Ethical guidelines for social justice in psychology. *Professional Psychology: Research and Practice*, *52*(1), 1–11. https://doi.org/10.1037/pro0000291

Helms, J. E. (2003). A pragmatic view of social justice. *The Counseling Psychologist*, *31*(3), 305–313. https://doi.org/10.1177/0011000003031003006

Hill Collins, P., & Bilge, S. (2020). *Intersectionality* (2nd edition). Polity Press.

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353–366. https://doi.org/10.1037/a0032595

Irie, W. C., Chitneni, P., Glynn, T. R., Allen, W., Chai, P. R., Engelman, A. N., Hurtado, R., Li, J. Z., Li, P., Lockman, S., Marcus, J. L., Ogunshola, F. J., Rönn, M. M., Haberer, J., Ghebremichael, M., & Ciaranello, A. (2023). Pathways and intersections: Multifaceted approaches to engage individuals from underrepresented and marginalized communities in HIV research and career development. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *94*(2S), S116–S121. https://doi.org/10.1097/QAI.0000000000003265

Johnston, C. D., O’Brien, R., & Côté, H. C. F. (2023). Inclusion of women in HIV research and clinical trials. *AIDS*, *37*(6), 995–997. https://doi.org/10.1097/QAD.0000000000003514

Katz, I. T., Ryu, A. E., Onuegbu, A. G., Psaros, C., Weiser, S. D., Bangsberg, D. R., & Tsai, A. C. (2013). Impact of HIV-related stigma on treatment adherence: Systematic review and meta-synthesis. *Journal of the International AIDS Society*, *16*(3 Suppl 2), 18640. https://doi.org/10.7448/IAS.16.3.18640

Kavanagh, M. M., Agbla, S. C., Joy, M., Aneja, K., Pillinger, M., Case, A., Erondu, N. A., Erkkola, T., & Graeden, E. (2021). Law, criminalisation and HIV in the world: Have countries that criminalise achieved more or less successful pandemic response? *BMJ Global Health*, *6*(8), e006315. https://doi.org/10.1136/bmjgh-2021-006315

Kubátová, A., Fialová, A., Stupka, J., Malý, M., Hamplová, L., & Sedláčková, S. (2023). Stigmatization and discrimination of people living with HIV in the Czech Republic: A pilot study. *Central European Journal of Public Health*, *31*(3), 210–216. https://doi.org/10.21101/cejph.a7782

Leary, K. (2000). Racial enactments in dynamic treatment. *Psychoanalytic Dialogues*, *10*(4), 639–653. https://doi.org/10.1080/10481881009348573

Lee, E., Greenblatt, A., Hu, R., Johnstone, M., & Kourgiantakis, T. (2022). Developing a model of broaching and bridging in cross-cultural psychotherapy: Toward fostering epistemic and social justice. *American Journal of Orthopsychiatry*, *92*(3), 322–333. https://doi.org/10.1037/ort0000611

Lewis, B. L. (2010). Social justice in practicum training: Competencies and developmental implications. *Training and Education in Professional Psychology*, *4*(3), 145–152. https://doi.org/10.1037/a0017383

Lucas, N. A., Bates, G. W., & Buzwell, S. (2024). I am more than HIV: A qualitative exploration of factors that can strengthen resilience among HIV-positive gay men in Australia. *Sexuality Research and Social Policy*, *21*(1), 372–387. https://doi.org/10.1007/s13178-023-00829-9

Mallinckrodt, B., Miles, J. R., & Levy, J. J. (2014). The scientist-practitioner-advocate model: Addressing contemporary training needs for social justice advocacy. *Training and Education in Professional Psychology*, *8*(4), 303–311. https://doi.org/10.1037/tep0000045

Mayers, A. M., Naples, N. A., & Nilsen, R. D. (2005). Existential issues and coping: A qualitative study of low-income women with HIV. *Psychology & Health*, *20*(1), 93–113. https://doi.org/10.1080/08870440410001722949

McConnell, E. A., Janulis, P., Phillips, G., Truong, R., & Birkett, M. (2018). Multiple minority stress and LGBT community resilience among sexual minority men. *Psychology of Sexual Orientation and Gender Diversity*, *5*(1), 1–12. https://doi.org/10.1037/sgd0000265

Merriman, C., & Deane, K. (2023). Evaluating HIV policy: A gender analysis of the representation of women and men in UN AIDS HIV-prevention guidelines. *African Journal of AIDS Research*, *22*(1), 9–17. https://doi.org/10.2989/16085906.2022.2154232

Mindry, D. (2024). Engendering care revisited: Decolonizing global health and dismantling gender stereotypes in HIV care in Africa. In C. Kemedjio & C. Lynch (Eds.), *Who gives to whom? Reframing Africa in the humanitarian imaginary* (pp. 119–135). Springer Nature Switzerland. https://doi.org/10.1007/978-3-031-46553-6_6

Monroe, A., Nakigozi, G., Ddaaki, W., Bazaale, J. M., Gray, R. H., Wawer, M. J., Reynolds, S. J., Kennedy, C. E., & Chang, L. W. (2017). Qualitative insights into implementation, processes, and outcomes of a randomized trial on peer support and HIV care engagement in Rakai, Uganda. *BMC Infectious Diseases*, *17*(1), 54. https://doi.org/10.1186/s12879-016-2156-0

Moodley, R., & Lubin, D. B. (2008). Developing your career to working with multicultural and diversity clients. In S. Palmer & R. Bor (Eds.), *The practitioner's handbook: A guide for counsellors, psychotherapists and counselling psychologists* (pp. 156–175). SAGE Publications. https://doi.org/10.4135/9781446215234.n11

Mukamana, D., Gishoma, D., Holt, L., Kayiranga, D., Na, J. J., White, R., Nyblade, L., Knettel, B. A., Agasaro, C., & Relf, M. V. (2022). Dehumanizing language, motherhood in the context of HIV, and overcoming HIV stigma—the voices of Rwandan women with HIV: A focus group study. *International Journal of Nursing Studies*, *135*, 104339. https://doi.org/10.1016/j.ijnurstu.2022.104339

Nydegger, L. A., Dickson-Gomez, J., & Ko, T. K. (2021). Structural and syndemic barriers to PrEP adoption among Black women at high risk for HIV: A qualitative exploration. *Culture, Health & Sexuality*, *23*(5), 659–673. https://doi.org/10.1080/13691058.2020.1720297

Petersen, I., Hanass Hancock, J., Bhana, A., & Govender, K. (2014). A group-based counselling intervention for depression comorbid with HIV/AIDS using a task shifting approach in South Africa: A randomized controlled pilot study. *Journal of Affective Disorders*, *158*, 78–84. https://doi.org/10.1016/j.jad.2014.02.013

Pope, K. S., & Vasquez, M. J. T. (2016). *Ethics in psychotherapy and counseling: A practical guide* (5th edition). Wiley.

Qin, K., Zeng, J., Liu, L., & Cai, Y. (2022). Effects of cognitive behavioral therapy on improving depressive symptoms and increasing adherence to antiretroviral medication in people with HIV. *Frontiers in Psychiatry*, *13*, 990994. https://doi.org/10.3389/fpsyt.2022.990994

Rabkin, J. G., Ferrando, S. J., Van Gorp, W., Rieppi, R., McElhiney, M., & Sewell, M. (2000). Relationships among apathy, depression, and cognitive impairment in HIV/AIDS. *The Journal of Neuropsychiatry and Clinical Neurosciences*, *12*(4), 451–457. https://doi.org/10.1176/jnp.12.4.451

Rescher, N. (2005). *Pluralism: Against the demand for consensus* (reprint). Clarendon Press.

Rubin, L. H., & Maki, P. M. (2019). HIV, depression, and cognitive impairment in the era of effective antiretroviral therapy. *Current HIV/AIDS Reports*, *16*(1), 82–95. https://doi.org/10.1007/s11904-019-00421-0

Sanders, P. (2006). Why person-centred therapists must reject the medicalisation of distress. *Self & Society*, *34*(3), 32–39. https://doi.org/10.1080/03060497.2006.11083918

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology*, *7*(3), 233–243. https://doi.org/10.1080/14780880802699092

Shepherd, J. (2022). 'We can't be perfect all the time': Life with HIV before antiretrovirals: A narrative analysis of early published stories by women with HIV in the United Kingdom. *Women's Health*, *18*, 174550572210787. https://doi.org/10.1177/17455057221078726

Smith, B. (Ed.). (1983). *Home girls: A black feminist anthology*. Kitchen Table, Women of Color Press.

Starace, F., Bartoli, L., Aloisi, M. S., Antinori, A., Narciso, P., Ippolito, G., Ravasio, L., Moioli, M. C., Vangi, D., Gennero, L., Coronado, O. V., Giacometti, A., Nappa, S., Perulli, M. L., Montesarchio, V., La Gala, A., Ricci, F., Cristiano, L., De Marco, M., … D'Arminio Monforte, A. (2002). Cognitive and affective disorders associated to HIV infection in the HAART era: Findings from the NeuroICONA study: Cognitive impairment and depression in HIV/AIDS. The NeuroICONA study. *Acta Psychiatrica Scandinavica*, *106*(1), 20–26. https://doi.org/10.1034/j.1600-0447.2002.02289.x

Strawbridge, S., & Woolfe, R. (2010). *Handbook of counselling psychology*. SAGE Publications.

Sue, D. W. (2015). Therapeutic harm and cultural oppression. *The Counseling Psychologist*, *43*(3), 359–369. https://doi.org/10.1177/0011000014565713

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*(4), 271–286. https://doi.org/10.1037/0003-066X.62.4.271

Thyer, B. A. (2004). What is evidence-based practice? *Brief Treatment and Crisis Intervention*, *4*(2), 167–176. https://doi.org/10.1093/brief-treatment/mhh013

Toporek, R. L., & Liu, W. M. (2001). Advocacy in counseling: Addressing race, class, and gender oppression. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *The intersection of race, class, and gender in multicultural counseling* (pp. 385–414). SAGE Publications. https://doi.org/10.4135/9781452231846.n16

Tribe, R., & Bell, D. (2018). Social justice, diversity and leadership. *The European Journal of Counselling Psychology*, *6*(1), 111–125. https://doi.org/10.5964/ejcop.v6i1.145

Tshabalala, J., & Visser, M. (2011). Developing a cognitive behavioural therapy model to assist women to deal with HIV and stigma. *South African Journal of Psychology*, *41*(1), 17–28. https://doi.org/10.1177/008124631104100103

UK Health Security Agency. (2024). *Positive voices 2022: Survey report*. https://www.gov.uk/government/publications/hiv-positive-voices-survey/positive-voices-2022-survey-report

Vanable, P. A., Carey, M. P., Blair, D. C., & Littlewood, R. A. (2006). Impact of HIV-related stigma on health behaviors and psychological adjustment among HIV-positive men and women. *AIDS and Behavior*, *10*(5), 473–482. https://doi.org/10.1007/s10461-006-9099-1

Waldron, E. M., Burnett-Zeigler, I., Wee, V., Ng, Y. W., Koenig, L. J., Pederson, A. B., Tomaszewski, E., & Miller, E. S. (2021). Mental health in women living with HIV: The unique and unmet needs. *Journal of the International Association of Providers of AIDS Care (JIAPAC)*, *20*, 232595822098566. https://doi.org/10.1177/2325958220985665

Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *Annual Review of Sociology*, *40*(1), 431–457. https://doi.org/10.1146/annurev-soc-071312-145621

Wen, H., Zhu, Z., Hu, T., Li, C., Jiang, T., Li, L., Zhang, L., Fu, Y., Han, S., Wu, B., & Hu, Y. (2023). Unraveling the central and bridge psychological symptoms of people living with HIV: A network analysis. *Frontiers in Public Health*, *10*, 1024436. https://doi.org/10.3389/fpubh.2022.1024436

Winter, L. A. (2019). Social justice and remembering ‘the personal is political’ in counselling and psychotherapy: So, what can therapists do? *Counselling and Psychotherapy Research*, *19*(3), 179–181. https://doi.org/10.1002/capr.12215

Winter, L. A., & Charura, D. (Eds.). (2023). *The handbook of social justice in psychological therapies: Power, politics, change*. Sage.

Xiao, Y., Shao, Y., Na, Z., Zhao, W., Wang, R., Fang, S., Tan, X., Shan, L., Yu, G., & Wang, J. (2021). A systematic review and meta-analysis of telephone-based therapy targeting depressive symptoms among low-income people living with HIV. *AIDS and Behavior*, *25*(2), 414–426. https://doi.org/10.1007/s10461-020-02999-8

Yigit, I., Modi, R. A., Weiser, S. D., Johnson, M. O., Mugavero, M. J., Turan, J. M., & Turan, B. (2020). Effects of an intervention on internalized HIV-related stigma for individuals newly entering HIV care. *AIDS*, *34*(1), S73–S82. https://doi.org/10.1097/QAD.0000000000002566

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