

## **Shame, Gay Men, and HIV Disease** **by Stephanie Sabar, MSW, LCSW**

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Shame is a powerful emotion. It can strip us of our pride, our sense of entitlement to feelings and needs, and our belief in our own autonomy, control, and competence. It can lead to social isolation and spiritual despair. Among HIV-infected gay men, stigmatized for both their sexuality and their illness, shame expresses itself poignantly. “How could I have become infected? I thought I was practicing safe sex.” “I finally got up the courage to tell him I’m infected. He said he’d call—that was three weeks ago.” “I can’t go to the beach with this damn tube sticking out of my chest.” “If I have to think positively one more minute I am going to scream.” “Here I am, a grown man, with my mother changing my diapers.”

Each of these comments explicitly reflects an aspect of the experience of shame for people living with HIV disease. But shame is often hidden—the root of the word means “to cover,” “to hide.” Mental health professionals working with people with HIV disease need to be able to recognize and treat this powerful emotion, most importantly because it can sabotage the openness crucial to the therapeutic process.

### **What Is Shame?**

Shame is a judgment against the self, a feeling that one is bad, defective, incompetent, inadequate, weak, unworthy, unlovable, stupid, or disgusting. Normal shame is a painful, but passing, experience. Shame becomes pathological when it is internalized, when one identifies oneself, in essence, as permanently and totally flawed as a human being.<sup>1</sup>

Shame is a “family of emotions” ranging from feeling awkward, self-conscious, apologetic, and embarrassed to feeling ridiculous, degraded, humiliated, naked and unexpectedly exposed.<sup>2</sup> The use of any of these words may signify shame as a therapeutic issue. Body language can also clearly reveal shame through blushing, covering the face, shrinking, avoiding eye contact, drooping the shoulders, hanging the head, expressing confusion and an inability to think clearly, and stammering.

It is important to distinguish shame from guilt. Guilt arises from an act against a moral code of values. For this transgression, a person can express remorse, make amends, or ask forgiveness. The sanction for guilt is punishment. Shame arises from the failure to live up to an internal ideal image of oneself. Its sanction is rejection or abandonment. Both guilt and shame are negative judgments, but while guilt is limited to a particular act, shame reflects upon one’s total being.

### **Triggers of Shame**

There are many triggers of shame for gay men with HIV disease. Even without HIV disease, gay men are set up for a shamed identity, experiencing heterosexism, homophobia, and religious condemnation. Becoming infected with HIV makes many gay men feel like “damaged goods.” Some feel shame because they knew about safer sex when they became infected. Others feel judged about how they became infected, suffering from the division between “innocent victims”—women, children, recipients of blood transfusions—and “guilty victims”—gay men who “brought this upon themselves” by their “promiscuous” sexual behavior. “Coming out” as HIV-infected may lead to rejection by co-workers, family members, lovers, or friends. This is especially shame-inducing when the relationship was good prior to the revelation. Conversely,

not having the courage to reveal yourself as you really are may also feel shameful. These feelings also arise for uninfected gay men or families, who may be hesitant to disclose that they are caring for HIV-infected people or grieving for those who have died.

Changes in physical appearance and functioning—ranging from rashes and incontinence to wasting syndrome and Kaposi's sarcoma—may overwhelm an HIV-infected gay man with shame about his body. Medical procedures such as the insertion of a Hickman catheter may add to this feeling. As people become physically disabled or cognitively impaired and dependent on others for personal care, loss of privacy and exposure of their deteriorating bodies may aggravate shame, as can the gay community's "body beautiful" imperative or a partner's AIDS-phobic reaction during sex.

HIV disease can undermine the ability to live up to social values for American men, including independence, power, work, financial success, competitiveness, and emotional control. In doing so, it may lead to shame. Traditional religion may shame by defining HIV disease as "divine retribution" for homosexual behavior. Ironically, New Age spiritual movements, which are supportive and inspirational in many ways, may inspire shame because they may connect disease progression to a person's failure to think positively and control emotion and behavior.<sup>4</sup> Finally, according to Francis Broucek, "It is when one is trying to relate to the other as a subject but feels [treated as an object] that one is apt to experience shame."<sup>3</sup> Such objectification is a common result of media coverage of "AIDS victims" and the medical response to people as "cases."

Even in the face of these triggers, a strong sense of self protects a person from shame. But most people living with HIV disease find that at least in some situations or with certain people, shame does arise.

### **The Pathology of Shame**

The negative effects of shame go far beyond experiencing discomfort or embarrassment. In its wake may follow withdrawal, substance abuse, depression, denial, rage and grandiosity, lack of entitlement, and perfectionism. When shame is internalized, normal defenses, useful for coping with a passing experience of shame, can become rigid, chronic, or extreme.

**Withdrawal.** The simplest way to avoid shame is to remove oneself from people or situations that evoke this feeling. This withdrawal, stemming from the fear that rejection will follow once shamefulness is revealed, blocks intimacy. It can result in social isolation, celibacy, and being "in the closet" about being HIV-infected. In order to avoid exposing "defects" or "unworthiness," people dealing with unrelieved shame may also avoid therapy or support groups. Shame may also lead to depression and substance abuse, which blunt the emotional response to shame,<sup>5</sup> and to suicide, the ultimate withdrawal from shame.

**Denial.** Denial enables a person to avoid shame by claiming that the issues that evoke it do not exist or are of no significance. Denial is particularly problematic when people at risk for HIV infection refuse to be tested for fear of finding out they are positive, or when HIV-infected people do not take care of their health or continue to practice unsafe sex.

**Rage.** Shame-related rage protects by transferring the shame from self to others. Grandiosity, exaggerated feelings of entitlement, arrogance, and contempt, often accompany this rage, requiring that all needs be met immediately and at any cost. Unlike productive assertiveness and a social action response to the AIDS epidemic, overly demanding shame-based rage can become self-defeating, alienating those who might be in a position to help.

Lack of Entitlement. The opposite of rage and grandiosity, feeling a lack of entitlement to one's feelings and needs, is also a typical response to shame. It is a form of "hiding"—not daring to express one's needs for fear they will be unnoticed or rejected. It results in a lack of assertiveness and difficulties in setting limits in personal relationships.

Perfectionism. Perfectionism is a form of shame prevention. If one is perfect, there will never be cause for shame. But perfectionism is usually based on an unattainable, over-idealized self-image, resulting in further shame for not succeeding.

## **Treatment**

It is tragic enough when a young person has to face a terminal illness, even more so when he is condemned as deserving of this disease because of who he is. Therapists can play a vital role in helping HIV-infected gay men feel pride in who they are and how they cope with the indignities of this illness. The following guidelines are basic to successful treatment of shame.

Gershen Kaufman sees the origins of shame as interpersonal, arising from the internalization of negative mirroring by family or society.<sup>1</sup> Hence its dissolution must occur between people as well. The client-therapist relationship must be crucial here. It is an authentic human relationship that can convince the client that he is valued by the therapist. This "power of caring" enables the development of trust and improved self-esteem by allowing the client to risk revealing his "shameful" self, and encouraging him to identify with the therapist, who provides an emotionally corrective experience of positive mirroring.

Once the client-therapist relationship is firmly established, the goal of counseling is to bring shame and its defenses to the client's awareness.<sup>5</sup> Identify shame as it appears in the present, helping the client see that certain words or behaviors indicate that he may be experiencing shame. This must be done respectfully, by description, rather than interpretation. Bruce Fischer suggests, "I see you looking down...I wonder if you are feeling ashamed."<sup>5</sup> Openly validate shame when the client acknowledges it. Avoid false reassurance. Challenge the client to experience the shame while maintaining a connection to the therapist, for example, by sustaining eye contact, so that he learns that the therapist will not shame or reject him.

Validate the client's defenses as adaptive for survival when coping with severe shame. Later, evaluate whether these defenses currently serve the client's needs. If not, help him find more useful alternatives. For example, hiding his gay identity as an adolescent may have helped the client survive, but is hiding his identity as gay or HIV-infected helping him as an adult? It is more useful now for him to learn to discriminate when it is safe to reveal himself and when it is not.

Therapy can reduce self-blame by examining the origins of shame, whether it be narcissistic shame, arising from parental neglect of the child's basic needs of dependency, attention, protection, and positive mirroring,<sup>6</sup> or social or religious shame. This enables the client to see that he does not "own" the problem and to return the shame to its rightful owner. For example, he may learn to view the stigma of HIV disease as the result of people's discomfort with homosexuality, sex, and death, rather than a reflection of his self-worth.

Intervene with the "internal shame spiral," a process fueled by negative "self-talk" and the recollection of past shame experiences.<sup>1</sup> Draw attention to the process and its effects. By developing an awareness of the spiral, clients can learn to recognize and terminate this process.

Discourage perfectionism. Remind clients that being human involves imperfection, limitation, neediness, vulnerability, and mortality, and that one can be both human and worthy, accepted, and loved. Point out that striving for an unattainable idealized self-image is

doomed to failure, resulting in more shame. Stress the greater benefit of being what Karen Horney calls the “real self.”<sup>7</sup> Also introduce the concept of “learning time,” which gives the client permission to make mistakes, look foolish, even fail when in a new situation or learning new skills.<sup>1</sup>

Redefine as “losses” what clients perceive as “defects.” People with HIV disease face a variety of losses, including social role and status, money, relationships, health, body image, hopes and dreams for the future, and ultimately life itself. Encourage grief work and mourning to resolve these losses.

People who have been shamed assume that their needs and feelings are unimportant, unwarranted, or even nonexistent. Guide clients to an awareness of their true needs and feelings, and help them trust the validity of their perceptions of these needs and feelings. Give them permission to experience the emotional aspect of shame and its related rage, hatred, fear, pain, and sadness. Empathize with and validate these emotions, while helping clients to put their reactions into the context of the origins of these emotions. To enable them to affirm themselves, help clients identify their good qualities or those qualities they would like to develop. These strategies will help clients feel entitled to be who they are without apology and without having to take care of others at the cost of their own identities.

## **Conclusion**

It is important to remember that there is healthy shame, a feeling that enhances a person’s capacity “to be modest. . .to have character, nobility, honor, discretion. . .to be respectful of social standards, of the boundaries of others, of one’s own limitations. . .of one’s need for privacy.”<sup>8</sup> These are worthwhile qualities for people with HIV disease as well as those who work with them. Even the painful negative shame has its value. Helen Lynd writes, “If you have the capacity to reflect on the causes of shame experiences. . .they become a spur to growth and the basis for a stronger identity.”<sup>7</sup> Fischer suggests that clients “‘make friends’ with their shame and learn to value it as a basic part of being human.”<sup>5</sup>

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