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.  

Shame is a “family of emotions” ranging from feeling awkward, self-conscious, apologetic, and embarrassed to feeling ridiculous, degraded, humiliated, naked and, unexpectedly exposed. 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
Being a gay man, I've had a lifetime to ponder the function of shame. One could argue that it has been the spiritual and political quest of 20th century western culture to relieve the Judeo-Christian shame that is the foundation of our taboo-ridden society. Everything from psychotherapy to the civil rights movement ultimately seeks to transcend shame by asserting the basic humanity and value of individuals.

The response to HIV disease is riddled with possibilities for shame. Included in its penumbra are the most biblical of all shame objects—sex and homosexuality—and the most American—disability and dependence. As Stephanie Sabar points out in her overview of the topic, this shame can sabotage the therapeutic process by inhibiting the willingness of clients to expose themselves. JD Benson connects HIV-related risk and childhood abuse, whose therapeutic resolution lies deep in the exploration of shame.

In the past month, I've happened upon two descriptions of shame that reflect and magnify Sabar's article. In a montage of photographs and prose exhibited at the San Francisco Museum of Modern Art, Larry Clark compares shame and guilt: "Shame is a public exhibition of wrongdoing or the fear of being exposed in front of the group. Guilt, on the other hand, often drives us to seek exposure... What is hoped for is absolution, but we will even accept punishment... But shame begs for privacy." The challenge for therapy is to get beyond the paradox that shame presents: a client desperate to relieve distress whose distress inhibits any discussion of itself.

The Magic Mountain

In The Magic Mountain, a novel which depicts the world of a turn-of-the-century Swiss tuberculosis sanatorium, Thomas Mann writes about the letting go that shame allows: "He himself had [failed to advance to the next grade in school] and well remembered this situation, of course rather to be ashamed of and yet not without its funny side. In particular he recalled the agreeable sensation of being totally lost and abandoned... He tried to put himself in Herr Albin's place and see how it must feel to be finally relieved of the burden of a respectable life and made free of the infinite realms of shame; and the young man shuddered at the wild wave of sweetness."

Mann is describing the other side of shame, acceptance, a state attained not by fleeing shame but by embracing it. To do so, a person must redefine his or her relationship to expectations, to acknowledge different standards by which to judge his or her sense of self and progress through life. Unless one harnesses a powerful and ultimately unhealthy denial, shame cannot be overcome in the way that hunger is, by feeding it, or injustice is, by challenging it. It is vanquished through obsolescence, the recognition that old standards are inadequate to measure a person's current intellectual, emotional, and physical reality.

In a culture where shame itself is hidden, reinterpreting "failure" is difficult for even the most well-adjusted among us. Psychotherapy provides one of only a very few venues where this crucial growth can occur.
Intervene with the “internal shame spiral,” a process fueled by negative “self-talk” and the recollection of past shame experiences.

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, 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. 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. 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.” 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

References


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, 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. 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." 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.

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." 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." Fischer suggests that clients "make friends' with their shame and learn to value it as a basic part of being human."
Abuse and HIV-Related Risk

JD Benson, MFCC

More than one in three women and one in every 10 men in the United States report experiences of childhood sexual abuse; this is a conservative estimate.¹ Research into the effects of childhood abuse on adult behavior has begun to examine how abuse may lead to HIV risk-taking behaviors in adolescence and adulthood. While there is not enough data to confirm childhood abuse as a root cause of risk-taking, there is evidence of a higher incidence of childhood abuse among HIV-infected individuals and those at highest risk. While research on this topic is in its infancy, a review of the literature begins to define the important connections between psychological trauma and risk, and to suggest therapeutic approaches.

Connecting Abuse and AIDS

In one study of 52 HIV-infected adults, 65 percent of the participants reported childhood sexual abuse, physical abuse, or both.² Other studies have found that sexually abused gay men are more likely than nonabused men to experience early substance use, lack of social support, and skewed sexual identity development.³ This skewing may manifest as confusion in the face of sexual feelings, which may evoke the self-blame consciously or unconsciously associated with the abuse, rather than the self-affirming feelings associated with healthy sexuality. In addition, studies have found that sexually abused gay men are more likely to engage in HIV-related risk behavior, to be HIV-infected, and to have been hospitalized for depression, suicidal thoughts or actions, or psychoactive substance use.⁴ The profile of HIV-infected heterosexually identified survivors of childhood abuse resembles this one.⁵

In a survey of pregnant women with HIV disease, 34 of 64 respondents (53 percent) reported a history of domestic violence in adult relationships. While very few reported histories of childhood abuse, researchers believe that this history was more prevalent than it appeared to be. They attribute underreporting to a combination of factors including normalization of abuse and fear of self-disclosure.⁶,⁷

Finally, the definition of sexual abuse has been expanded recently in ways that make it even more relevant to an epidemic whose focus has been the gay male community. Theorists, clinicians, and survivors have begun to talk about homophobia as part of sexual abuse. The male child verbally berated for being “a sissy,” for example, has an experience akin to any child who is victimized by a verbally seductive adult: both behaviors lay on the continuum of sexual abuse because both focus upon the child’s sense of his or her sexuality.

Additional research has addressed the secondary effects of childhood abuse, which can be associated with HIV-related risk-taking. For example, research has demonstrated that substance abuse has profound implications for primary, secondary, and tertiary HIV-related risk, and as noted above, that substance abuse in adulthood is a frequent though not universal response to unattended childhood sexual abuse. While research is relatively scarce, sexual compulsivity in adulthood has been connected to HIV-related risk taking both in terms of failure to initiate and to sustain safer sex practices. Compulsivity has also been associated with responses that follow from childhood sexual abuse: engaging in risk behaviors despite best intentions to

References


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See also references cited in articles in this issue.
engage in safer practices, or experiencing one's sexual behavior as "out of control," all of which frequently follow from unattended childhood sexual abuse.

The Trauma of Abuse

Children store abuse memories somatically more readily than consciously, and without therapeutic intervention, many retain these memories only on this visceral level.4 Childhood abuse leads to various levels of dissociation as children, and then adolescents and adults, struggle to cope with the trauma of abuse. Dissociative defenses may lead to amnesia or attention deficit, and information about HIV-related risk, as it touches upon the visceral memory of threat, may interfere with information retention and integration about risk and efforts to implement risk reduction.8 Childhood abuse also damages feelings of self-efficacy, the sense that it is possible to take steps to change life circumstances, for example, to escape abuse or to initiate or insist upon safer sex practices.

Integrating safer sex messages may be problematic, even impossible, if an individual must defend against memories of abuse. The psychological need of survivors to resolve ambiguity makes it difficult for them to accept that sex may be both good and bad. On the other hand, survivors may perceive sex as dirty and degrading, and sexual desire as a source of shame. Attempts to adopt a positive view of sex may be distorted by the memory, conscious or otherwise, of sexual violence.

A client who expresses feelings or appears to act from a place of shame, self-blame, or lack of control is more likely to continue risky behavior. These feelings are often coupled with a history of family dysfunction, early onset substance use and sexual expression, a pattern of seeking love and intimacy through sex alone, and the view that sexual partners are in control of sexual decision-making.

Sadomasochistic sexuality may be an overt attempt to recapitulate earlier struggles and imbalances of power. For some survivors, this expression may help resolve a history of abuse; for others, it may further mask an historical maladaptive process and exacerbate tendencies toward risk.

Conclusion

There seems to be an exceptionally high incidence of histories of childhood abuse among HIV-infected and at-risk individuals. Unattended abuse can lead to low self-esteem, shame, self-punishing behavior patterns, precocious sexuality and substance use, affective disorders, and suicidality. It is important for therapists to be aware of these relationships as they assist clients in making and maintaining behavior change.

Comments and Submissions

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

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Shame and Metaphor

Metaphors serve to objectify people with disabilities by defining them strictly in terms of their disabilities which can lead to shame, according to an essay on stigma. Comparative thinking—applying a word, phrase, or image ordinarily used for one purpose in the context of another—is a normal part of the process of understanding. Metaphors, a form of comparative thinking, have a powerful influence on human perception, shaping both behavior and expectations of the behavior of others. Metaphorical thinking becomes problematic when it robs an individual of all other identifying characteristics, thereby reducing the subject to nothing more than the metaphor. It is particularly troublesome in the case of traditionally stigmatized groups because objectification can easily reinforce the shame evoked by stigma.

Rehabilitation psychology research has demonstrated the detrimental psychological effects of stigma. A person will go to great lengths to conceal the mark of his or her stigma, feeling discredited in the eyes of society as a whole. The result is shame and shrinking of personal identity. Shame can be characterized as a sense of personal defectiveness and a desire to conceal it. Emotional responses such as embarrassment, inferiority, and social discomfort are indicative of shame. Shame is a central component of stigma maintenance because it forces disabled people to see themselves negatively. Guilt, which is characterized by a rational response to a specific transgression, should not be confused with shame; shame is less likely to be dealt with rationally and is far more complicated to resolve.

There are three shame subtypes: class, situational, and narcissistic shame. Class shame is a function of social power that attributes a stigmatizing characteristic to an entire group of people. An individual experiences shame due to his or her perceived membership in this group. Support groups such as Alcoholics Anonymous have been successful in overcoming class shame. Situational shame is a more universal experience; it refers to the shame that results from any occurrence of defeat, rejection, or humiliation. Although everyone experiences situational shame at some point, people with disabilities experience it more frequently. Narcissistic shame is more self-reflective than the other two subtypes because it results from a personal sense of defect or inherent inferiority. A person who suffers from narcissistic shame might see him or herself as wholly defective because of a disability.

Beatrice Wright's theories on adjusting to disability, the basis for much current rehabilitation psychology practice, describe two responses: succumbing versus coping behaviors. Succumbing behaviors—such as concealing disabilities, idolizing normal standards, or attempting to overcompensate for perceived shortcomings—impede positive adjustment to disability. Coping behaviors aim at reducing stigma, resolving personal self-hatred, and facilitating growth and positive adjustment.

Containment of metaphorical characterization should prevent the substitution of disability for the entire individual. To achieve this, society and individuals must be sensitive in the use of metaphor in relation to disabled people, and counselors should pay attention to the incidence of shame in the lives of people with disabilities.

Shame in Victims of Sexual Abuse

Shame, common among survivors of sexual abuse, is a natural response to exposure that impels one to hide. A study of sexual abuse treatment concludes that therapists have ignored the importance of shame for too long.

Shame involves both physiological and cognitive experience. A series of biological mechanisms trigger analogous emotional responses. Even the admission of shame is uncomfortable, as if it, in and of itself, was shameful.

Sexual behavior is often framed by feelings of shame about body and behavior. Sexual abuse magnifies this shame because it represents disempowerment and humiliation. It is essential to the therapeutic process that the relationship between shame and sexual abuse be recog-
nized, in part because the fear of exposure will also arise in the course of therapy.

The sexual exploitation of children presents a complicated scenario for the study of shame. Often a child who has been drawn into sexual activity, unlike a victim of rape, is ambivalent about such behavior, confused about what is good and bad as he or she struggles with his or her own sexual impulses. Abuse also represents a humiliating loss of control for a child.

Evaluation and treatment of people who have been sexually abused or exploited should include a deeper understanding of the complexities of shame. The nature of shame is such that it can sometimes be as embarrassing for the therapist who uncovers it as it is for the client, but this should not deter the therapeutic process. Therapists should focus on the series of defenses each person musters in response to shame. They should define these defenses and encourage clients to use them in expressing and processing shameful experiences.

Cultural Values of Secretiveness and Shame


The underlying assumption of most of the current literature on shame is that it is an undesirable phenomenon that should be resolved through therapy. The positive value assigned to shame in Japanese culture, however, challenges this Western psychological assumption, according to a comparison of Japanese and U.S. cultures. Nonetheless both approaches lead to “social phobia,” a pathological shame response.

Japanese culture promotes not the feeling of shame itself, but the outward manifestations of shame: signs that mimic sociophobic symptoms, for example, self-effacing behavior like verbal submissiveness and avoiding direct eye contact. It is also taboo to be out of touch with one’s own feelings of shame; those who are, are considered unfit for society. The most obvious function of this response is to reduce jealousy and competitiveness among people. It is also consistent with the Japanese cultural belief that what is hidden is powerful and what is manifest has already lost power or value.

Since Japanese norms reward the display of sociophobic signs, the true incidence of social phobia is hard to detect. The abundance of pseudo-sociophobic attitudes among the Japanese, however, tends to lead to dysfunctional sociophobic symptoms. At the same time, sociophobic individuals most likely will not seek treatment as long as their behavior suits social expectations.

American culture, by contrast, rewards narcissistic tendencies, encouraging overt displays of strength and ability. This forces people to hide vulnerability by denying experiences of shame. American psychiatry has fostered this phenomenon by focusing on revealing what is hidden. In particular, the psychoanalytical tradition encourages disclosure of feelings about sexuality, violence, and death, and labels the secretive nature of shame as counterproductive to the therapeutic process. Consequently, shame is commonly suppressed or denied, and symptoms of social phobia go unrecognized.

Both the Japanese and the American approaches define what is hidden as either positive or negative. But the act of hiding is neither good nor bad. Hiding does not become pathological until an individual becomes unaware of what he or she is hiding and why. The greatest flaw in the current approaches is that they are inflexible in their response to shame. If Americans were able to moderate absolute beliefs about the positive value of the visible and the negative value of secretiveness, they would be able to maintain a sense of self-worth even if evidence of it were hidden.

Next Month

At the root of much HIV-related prevention and support counseling is sex: understanding it, negotiating with partners about it, changing behaviors related to it, feeling good about it, and fearing it. But counseling education traditionally overlooks this concept. In the May issue of *FOCUS*, *James Fishman, LCSW* and *Tom Holt, MFCC*, two Bay Area therapists, explore the nature of sexuality in the therapeutic arena. How does it manifest in HIV-related therapy? What issues does it raise for clients, and perhaps less obviously, what issues does it raise for counselors?

Most modern cultures veil sex behind a screen of discomfort, one that is present even in therapy. Also in May, *Beck Young*, a New York sex educator, defines some of the barriers and approaches to talking about sex in the counseling session. She discusses HIV-related issues including language, pleasure, and abuse.
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