More and more often, researchers are recognizing that complications related to major loss form the cradle of psychological problems in later life. In order to make use of this insight, therapists must refine theories for specific categories of clients—such as gay men—that are consistent with already existing notions of psychotherapy.

Of the basic grief theories, two are of particular interest when working with gay men: attachment theories and existential theories. When combined, they define a useful paradigm for understanding the experience of gay men facing decline and death and those finding themselves, after the death of their partners, confronted by the struggle for survival. These struggles are no more or less painful than those evoked by loss in the general population. To understand gay bereavement, however, therapists must appreciate gay psychological development and the struggle for identity, and the consequences of these factors for gay men and gay relationships.

Both grief theories suggest that major loss leads to a constant fight to remain unaware of isolation, and that creating relationships is the central strategy in winning this fight. The loss of relationships, on the other hand, increases awareness of isolation and the true horror of loss. This article begins to define issues—regarding gay developmental psychology, gay relationships, gay sexuality, and the social-psychological position of homosexuality—that are important in understanding the gay male experience of grief.

Grief Theories

Attachment theories emphasize the importance of early childhood losses in contributing to the way adults cope with loss and also offer insights into the way gay men select partners. These theories traditionally characterize loss as a painful repetition of the mother-child separation. For gay men, however, recent theories have emphasized the importance of the relationship to the father in gay male development. Grief over the loss of an important relationship will reactivate emotions connected to these developmental experiences.

Existential theories of bereavement, on the other hand, concentrate more on the individual than on relationships, and more on matters of the present and future rather than the past. Applying these notions to a gay specific approach, new questions arise: What does “being in the world” mean for a gay man? What is his responsibility? How can we understand his isolation? How can we understand his freedom? What gives meaning to his life? To respond to grief and the disintegration of a client’s world, counselors must understand how that world is constructed.

Youth and Beauty

To shield themselves from the byproducts of loss, gay men avoid the image of their own decline and death by focusing on youth and, when they are in a relationship, by using “father projection.”

The awareness of isolation and its inescapable twin, sole responsibility, are present in different stages throughout life. The form and the nature of bereavement is also defined by these “stage-themes,” which often become intensified in the face of major loss. In addition, stage-themes are related to the nature and the course of the mourning process and determine whether grief leads to maturing—the successful resolution of the themes—or to stagnation—the psychological immobility resulting from fear of change.
Editorial: Loss Among Gay Men
Robert Marks, Editor

HIV researchers and educators spend a good deal of time reminding a society that prefers to partition humanity into “we” and “they” that the virus does not discriminate and that people of every stripe will respond to infection in similar physical and emotional ways. This perspective is reinforced by the societal myth that the only difference between heterosexual people and gay people—the group that has been most identified with HIV disease—is the gender of sexual partners.

In fact, being gay implies much more profound psychological differences than these approaches imply, and while they may be less relevant in treatment and prevention settings, they are central in dealing with emotional response, particularly the expression of grief. In an unusual FOCUS article, Herman Kaal offers insights into the psychological complexity of this response among gay men in industrialized nations. His piece provides a good example of psychological detective work, laying out in all its intricacy a range of classical psychological theories, which interpret HIV-related loss among gay men.

Loss upon Loss

The most important difference between gay men and others affected by HIV disease, however, is the sociological phenomenon of multiple loss. Three factors determine the conditions that have left gay men in industrialized nations vulnerable to a never-ending grief.

First, HIV disease has killed many more gay men than people in other CDC-defined categories, and the virus has infected a higher proportion of gay men in most places than members of these other groups. Second, among these identifiable groups, gay men have weathered the epidemic for the longest period of time; and third, gay men arguably comprise the group with the strongest sense of community. As Tom Grothe and Leon McKusick point out, the most important result of multiple loss is that it interferes with the abilities of gay men to fully grieve and heal from one loss before being faced with another and another and another.

In addition, while the gay identity Kaal defines is a construct of industrialized nations, according to Grothe and McKusick multiple loss is not so limited. In fact, the most dramatic example of multiple loss is among the general population in African nations, the geographic area where the epidemic is most mature.

Last month, in the first of two issues on this subject, I suggested that grief is the most enduring aspect of the epidemic. It may be the most enduring therapeutic issue as well. Kaal, Grothe, and McKusick alert therapists—and, indeed, educators and medical professionals—to their greatest challenge. In the face of multiple loss, they must heal the community by healing the individual, and in this way, resurrect the sense of community fundamental to the mental health of the individual.

In a study of later life stages, Robert Peck concludes that the themes of this period are centered around body-versus-mind conflicts, for example: valuing physical power or beauty versus wisdom, or valuing sexualizing versus socializing. Using such stage-themes, a gay-specific approach will focus on whether, during the decline of health, a person has shifted from body preoccupation to body transcendence. The individual with HIV disease confronts the question: “What makes me worthwhile if my body is no longer functional and attractive?”

Many gay men have difficulties challenging beliefs and behaviors that emphasize the importance of attractiveness. After the last farewell to health and youth, these men are often dominated by the feeling of being written off by society. The loss of a partner may confront the survivor with an unwelcome and cruel mirror that reflects his own aging in the withered body of his lover. Aging, so long denied, becomes undeniable when a gay man finds himself alone in a community so strongly identified with physical beauty.

Therapists can help clients transcend a focus on the physical level only if they are able to recognize the fears of death and isolation that underlie problems concerning body image and aging. It should be their therapeutic aim to make patients strong and confident enough to face their existential anxieties and to mature. In this light, beauty and youth fulfill multiple functions in the gay male culture.

• They shield both the individual and the community from the terrifying idea of being infertile and thus, “belonging to death.” By identifying strongly with beauty and youth, gay men symbolically deny the fact that they bear no fruit, a psychological route to immortality.*

• Youth symbolizes limitless options. Death is perceived as the end of all options. As their youth recedes, gay
men become more aware that their options are limited, and this leads to awareness of the proximity of death.

• On a social level, emphasizing beauty and youth helps to deny the homophobic accusation that being gay is being sick and filthy.

• Finally, in the context of attachment theory, beauty and youth shield gay men from an acknowledgment of rejection. Richard Isay finds that a gay man’s relationship with his father influences gay psychological development, particularly in terms of self-esteem and intimate relationships with men. The father is often perceived, consciously or unconsciously, as the first man who rejected the gay man. Gay male preoccupation with the exterior, both in an exhibitionistic and a voyeuristic way, creates a barrier to interactions that may lead to the pain of rejection.

Father Projection

Irving Yalom defines two mechanisms that are generally used to deflect the terror of life and death: “specialness”—“I’m special so nothing can harm me,”—and “the ultimate rescuer”—“Someone will come to save me.” These mechanisms interact—“Because I’m special, someone will come to save me”—and enable the denial of death.

When complemented by Isay’s theory of the rejecting father, Yalom’s concepts also apply to intimate relationships between gay men. In the shadow of the perceived rejection by the father, a gay man will look in later life for the security, protection, or closeness that was denied to him in childhood.

According to this synthesis of theories, a “special” partner will have a relationship with someone who needs an “ultimate rescuer.” The first partner shields off the horror of life and death by believing in his own uniqueness, the second partner by comforting himself in the company of a savior. Or using Isay’s terminology, the first will introject the father and will react in a way his father never did; the second will project the father upon his partner and expect from the partner the love, protection, and attention his real father never gave to him. The anticipated or actual loss of a partner can rekindle feelings related to the father’s “primary rejection.” Two possible scenarios may follow:

• The “special” partner becomes ill, and the partner who needed an “ultimate rescuer” has to look after him. For the ailing partner, it will be difficult to trust his lover as a caretaker. He will feel the constant urge to check and recheck his lover’s actions. This response will be fed by the lamentations of the well partner, who may feel that the burden is too heavy for him and that he is isolated, and who will become paralyzed by the future loss, which symbolizes another rejection.

• The partner who needed an “ultimate rescuer” becomes ill, and the “special” partner will act as caretaker. Since it is consistent with the existing division of roles, this scenario may be successful, unless the division of roles becomes too extreme. Facing the impossible task of “saving” his ailing partner, the “special” partner loses his feeling of uniqueness and the ailing partner loses his savior. This results in aggression from both parties and feelings of guilt for the survivor.

Naturally, reality will be infinitely more complicated. More often than not, gay men will have a combination of interpersonal needs belonging to both the “special” and the “looking for the ultimate rescuer” attitudes, a combination of father projections and father introjections.

Gay Expression of Sexuality

Gay men respond in a variety of ways concerning the visibility of their relationships in the heterosexual world. At one end of the continuum, there are closeted gay men who limit their expression of homosexuality to anonymous sex, secretly fumbling in the dark; at the other end, there are gay men who have transformed sexual preference into personal identity. Several gay therapists have observed that men who are comfortable about their gay identity have less difficulty accepting death.

As early as 1972, Norman O. Brown suggested that the fear of death equals the fear of life.” The opposite is true as well. The essence of any neurotic disorder is the refusal of the loan (life) because of the fear of the anticipated debt (death).

The fear and denial of life is evident in the repression of sexual and aggressive forces. It is the fear of standing out from nature and its inescapable consequence of being isolated. To become an openly gay man demands a battle in which the fear of life must be overcome. If the fear of life triumphs, a gay man will feel existential guilt for staying in the closet.

To approach the grief of gay men, begin by seeking the fear of life and the fear of death in them.
The fear of death, or the fear of losing individuality, is just as strong. To relinquish individuality—one’s personal being—is to surrender to oblivion. If the fear of death triumphs, a gay man will have an overriding need to be “special.” Therapists approaching the grief of gay men must begin by seeking the fear of life in their clients. The ways in which clients relate to other gay men and express sexual identity indicate, like a battle report, the balance—unique to each individual—in the combat between fear of life and fear of death. In response, therapists must empower their patients to assert their individuality and, in terms of the existential theory, overcome the fear of life: the fears of isolation, freedom, responsibility, and the meaningfulness of life. This applies not only to gay men facing death, but also to gay men grieving the actual or anticipated losses of friends or lovers.

Social-Psychological Analysis

The social position of homosexuality also exerts important influences on the way gay men process loss. Research suggests that, after the loss of a loved one, people are shunned by society because they themselves are associated with death. For gay men whose partners have died of HIV disease, this stigma is not merely related to death, but also to homosexuality, AIDS, and, in some cases, their own HIV infection. Feelings of guilt already present as a typical emotion of survival may be intensified by low self-esteem and the reality of homophobia. Another consequence of the social position of homosexuality is the phenomenon of the so-called “feeble network” of familial support. The surviving partner is often without support from his lover’s or his own natural family. To many gay men, the constructed family is often more important than the natural family. Unfortunately, the constructed family frequently consists of independent, working people and is therefore less cohesive and less available than the natural family.

In many hospitals, gay partners, lacking the formal status as family members, are excluded from decision making concerning their lovers and are not able to process anticipated grief. After the ill partner has died, his natural family’s disapproval of the surviving partner may stimulate feelings of abandonment and guilt for that partner.

The implications of these social issues strongly reinforce feelings connected to development and expression of sexuality. When clients live in a disapproving environment, or in the case of an existing but “feeble network,” therapists may encourage them to seek other forms of support. This support may come from the constructed family, from the community, or from other sources, for example, support groups, emotional support volunteers, and additional therapy sessions.

In response to the shunning, therapists may encourage grieving clients to become as active as possible in the gay community where they are most likely to find appropriate social support, acceptance, and understanding. Becoming involved in the gay community also fosters a renewed appreciation of gay identity and offers grieving partners a mirror that reflects their connection to this positive image of community.

Conclusion

The purpose of therapy is to help surviving partners mourn in a way that resolves their grief. To achieve this end, therapy often aims at resurrecting damaged self-esteem and, so, must be fundamentally gay affirmative. Crucial to this process is the larger context of gay psychology, gay sexual expression, and gay sociology, for all these aspects influence a gay man’s “being-in-the-world.”

Clearinghouse: Gay Male Grief

References


Authors

Herman Kaal is a clinical psychologist at the Schorer Foundation, an institute for gay and lesbian mental health in Amsterdam, Holland. At the foundation and in his private practice, Kaal has worked with gay men with HIV disease since 1984. Kaal is currently writing a book on homosexuality and existentialism.

References

Many people engulfed by the AIDS epidemic can no longer tally the number who have died. Mothers who have seen HIV spread through their families, friends close to a gay community besieged by the epidemic, health care workers who have watched dozens of their patients die: all have struggled with this continuing pain. In Africa, where whole families and lineages have been wiped out, grief affects entire countries.

Urban gay men, in particular, are subject to multiple loss, and mourn not only those who have died, but also all the ways their lives have been diminished by the deaths of so many. They have lost leaders and role models; their fondness for their past—the time before the epidemic; and their hopes for the future. And, of course, many gay men mourn the loss of health even before they become ill.

Research on gay men in San Francisco reveals increasing levels of depression with each year of the epidemic, and also a greater likelihood of depression among men experiencing a higher number of deaths and among men who are HIV-infected and symptomatic. Another study indicates that social support is crucial in mitigating symptoms of depression in men with AIDS; ironically, the deaths that cause the depression also deplete the social support networks necessary to deal with multiple loss. In response to such data, health professionals are developing ways to help those overwhelmed by multiple loss.

Bereavement Theory
Bereavement theory offers insights when searching for tools to alleviate the turmoil of multiple loss. For example, William Worden identifies four progressive tasks of bereavement: to accept the reality of the loss; to experience the pain of grief; to adjust to an environment in which the deceased is missing; and to withdraw emotional energy and reinvest it in another relationship. While these tasks are essential, they are based, like most bereavement theories, on the experience of one death, causing pain and followed by healing. With AIDS, however, the dying continues, and if the bereaved were to feel the ongoing pain of multiple losses, they would never get beyond acute grief.

In some cases, this psychological flooding of emotion incapacitates rather than heals, and to defend against this flooding, some people become emotionally numb. These alternatives to coping with massive loss have been identified before as the two phases of post-traumatic stress syndrome: intrusive-repetitive and denial-numbing. While in most cases multiple loss does not cause post-traumatic stress syndrome, the similarities of these phases

By searching for and exploring past moments of joy and connection, clients are able to recreate these emotions.
can offer ways to work with the multiply bereaved.

Mardi Horowitz suggests that mental health practitioners encourage individuals in the denial-numbing phase to reexperience their feelings by retelling the traumatic events. To respond to the intrusive-repetitive phase, during which clients may feel overwhelmed with emotion, therapists should provide leadership and external structure. They should encourage clients to reduce stresses and even suppress painful emotions.

While suppressing emotion may seem to limit psychological work, Verena Kast suggests a way therapists can continue ongoing, in-depth work without focusing on a client’s pain. She believes people can learn as much about themselves by examining their joys as they do by examining their sorrows, and she encourages therapists to help clients create autobiographies of joy. By searching for and exploring past moments of joy and connection, clients are able to recreate these emotions. Kast also notes that even during hard and painful times, there are quiet joys to be cherished.

Victor Frankl, a concentration camp survivor who lost his family in the Nazi holocaust, developed a school of existential psychotherapy to respond to questions like, “What is the purpose of my suffering?” His theories may be particularly meaningful to those who are multiply bereaved. Frankl believes meaning in life is derived in three ways: creating a work or doing a deed; experiencing something or encountering someone; and, when we can no longer act, being aware of the attitude we take toward unavoidable suffering, the courage and grace we are able to summon when all else is lost.

Each of Frankl’s meanings moves a person beyond a focus on self and pain. Through creativity or human connection, they can help those overwhelmed by multiple loss, have a tremendous need to tell their stories. Expressing the pain allows catharsis and healing.

2. Help clients stay involved. Anything that focuses a client outside of him or herself can promote involvement: work, social contact, education about HIV, activism, and protest.

3. Assist people in creating meaningful rituals. Ritual allows people to express feelings while connecting them to spirituality. Rituals also bind people together in a common expression of grief. The AIDS Memorial Quilt, funerals, and memorial marches are examples of rituals that bring people together.

4. Provide structure and support when emotional flooding overwhelms clients. Instuct clients in ways to divert attention from flooding by using activity and relaxation. Action, instead of immobility and fear, can promote a sense of mastery and control, and improves coping.

5. Refocus individual clients on the elevating emotions—joy and hope—by assisting with the development of an autobiography of joy. Encourage individuals to focus collective efforts to honor all that is good in a community overwhelmed by loss, perhaps by developing a community autobiography of joy.

The multiple losses that people experience as a result of HIV disease can be overwhelming and depressing. Therapists need to help individuals and communities

References

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Social Support Alleviates Grief

Gay men who lose a lover or close friend to HIV disease experience grief similar to that reported in studies of bereaved spouses and parents. A study of 180 gay men found that those who took care of their dying partners experienced more grief than those who did not, and the intensity of this grief was lessened if survivors perceived that they had adequate emotional and practical support.

Researchers interviewed gay men living in New York in April 1985 who had lost a lover or close friend between 1980 and 1985. The average age of respondents was 37; 81 percent were college educated; and 14 percent were Black or Hispanic. Structured interviews covered demographic characteristics, coping methods, and bereavement experiences.

Caregivers had significantly higher levels of grief reaction than men who did not take care of their dying lovers. Perceived adequacy of support was central in mitigating grief, since respondents who reported available but inadequate support had grief reaction scores significantly higher than those who reported available and adequate support. Support was adequate if there were enough people to respond to emotional or practical needs.

Surviving the Death of a Lover
Sowell RL, Bramlett MH, Gueldner SH, et al. The lived experience of survival and bereavement following the death of a lover from AIDS. *IMAGE: Journal of Nursing Scholarship.* 1991; 23(2): 89-94. (Medical College of Georgia; Grady Memorial Hospital, Atlanta; University of California San Francisco.)

When a lover dies from AIDS, the survivor experiences feelings of isolation and emotional confusion, and waivers between accepting and denying the reality of the loss. An analysis of the experiences of eight gay men from the southern United States indicates that normal bereavement is confounded by limited social support, by the social stigma surrounding the diagnosis and the gay lifestyle itself, and by the survivor's own at-risk status.

Eight survivors, who had lost a lover within the preceding 18 months, described the events and feelings they experienced prior to and after the death of their lovers, for whom all had provided some care. Six of the eight were diagnosed or presumed HIV infected. Participants were from urban areas in three southern states, were mostly college educated, and ranged in age between 25 and 53. Interviewers audiotaped responses and organized them into theme clusters and statements of phenomenon including isolation/disconnectedness, emotional confusion, and acceptance/denial.

Survivors felt isolated from family and friends, and from themselves: they reported going through the motions of life without feeling connected to it. Family members on both sides and work associates were uncomfortable with the issues of AIDS and homosexuality and this undermined the positive effects of their emotional support. Survivors perceived only close friends as able to understand their losses.

Emotional confusion, manifested by feelings of guilt and vulnerability, was common among survivors. Survivors felt guilty because they were relieved both that their partners no longer suffered and that they themselves were free of the burden of caregiving. Establishing new relationships evoked more guilt, and this guilt led to ambivalence about sexuality itself. As survivors vacillated between denying and accepting the loss of a lover, they perceived the threat of loss in new relationships and alternately denied or accepted the possibility of their own mortality from HIV disease.

Although this study did not include survivors living outside of urban areas, those with strong support from families and friends, and those who did not remain to care for their lovers, the results proved consistent with theories of bereavement.

Multiple Loss and Grief

Because each loss is compounded by preceding losses and time for recovery from loss is relatively brief, survivors who...
experience multiple losses are unable to resolve their grief. According to an exploratory case study with seven respondents, the stages of grief—avoidance, confrontation, and reestablishment—happen simultaneously in response to each loss and the boundaries between the stages are unclear.

Interviews were conducted with five gay men and two lesbians from Long Beach, California who had experienced two or more HIV-related deaths of friends, lovers, or relatives. Interviewers asked subjects about their backgrounds and about ways they had dealt with their grief.

Subjects confirmed the hypothesis that the response to multiple loss is comparable to the response to an acute disaster after which survivors experience post-traumatic stress. Survivors are bereft not only of close friends and lovers, but of entire personal support networks and of the community itself. The normal process of grieving is further undermined by society’s lack of acceptance of the gay identity and the resulting breakdown in familial and community support.

The response to multiple loss is different from other grief responses in terms of the range and amount of emotions experienced. As a result, support groups should encourage participants to fully express their feelings in a context that recognizes the magnitude and complexity of multiple loss as well as the stigma that surrounds HIV disease and a gay identity. Practitioners can also encourage survivors to take time alone to grieve openly, to use personal support networks, to participate in funerals and other grieving rituals, and to seek individual counseling.

Gay Community Response to Multiple Loss

A study of two Australian gay communities, based on a “personal construct psychology” model, found that there was increased anxiety and anger, but not depression, in the community that experienced more deaths and a more public response to loss.

Researchers conducted structured interviews with 215 gay men, 141 in Sydney and 74 in Melbourne. Ranging in age from 23 to 55 years old, 85 percent of the seropositive gay men in Sydney and 75 percent of those in Melbourne participated in the study. Interviewers collected data on emotional response at a time when the Sydney community had experienced many more deaths and had developed more informal and formal care organizations.

The Sydney community experienced higher levels of anger and anxiety, characterized by fears of separation, death, and bodily mutilation. The Melbourne community, however, had higher levels of depression, and anxiety there was characterized by guilt and helplessness. This may indicate that the less bereaved community—aware of the scope of the epidemic in other communities—was anticipating future losses.

According to personal construct psychology, each person develops a system of concepts to anticipate and interpret events. Multiple loss challenges personal constructs that anticipate life span. The authors urge gay men to adapt construct systems to accommodate this reality. For example, gay men might include in their social networks people less at risk for death from AIDS, such as lesbians and heterosexual men. This might affirm for them that life does not always end prematurely and might lead to availability of more consistent support.

Next Month
As HIV disease runs its course, it may raise issues that have significant practical and emotional ramifications, but which are seen as secondary to treatment and as a result often overlooked. Primary among these is the potential of catastrophic financial loss as people with HIV disease lose their jobs and become disabled. In the June issue of *FOCUS, John E. Yarling*, Executive Director of AIDS Benefits Counselors in San Francisco defines the psychosocial issues regarding financial stability and loss, discusses how to obtain and use government and private benefits, and how to counsel about them, and outlines the range of benefits available to people with HIV disease.

Practical medical issues extend beyond the basics of treatment and diagnosis. Also in the June issue, *Susan Hunt, MD*, Medical Director of the Pittsburgh AIDS Center for Treatment, discusses the practitioner’s role in helping patients develop documents such as advance directives and powers of attorney for health care.
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