TRANSFORMING A SPOILED IDENTITY:
AN EXPLORATION OF INTERNALIZED AIDS-RELATED STIGMA

by

RACHEL GARDNER

A clinical case study
submitted in partial fulfillment
of the requirements for the degree of

DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

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The Holy One does not reject a single creature. Rather all are acceptable to God. The gates are open at all times, and all who wish may enter.

Exodus Rabbah (19.4)

Now, therefore, we honor those of every race and continent: the innocent, the victims, all our companions in death, and our partners in grief. Them we honor, them we mourn: may they never be forgotten, may a better world grow out of their suffering.

Isaiah 53
ABSTRACT

TRANSFORMING A SPOILED IDENTITY:
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by

Rachel Gardner

People living with HIV/AIDS are subject to a distinct and virulent form of stigmatization. AIDS-related stigma conveys the animosity, ostracism, discrediting, and blame directed at those who are, or are believed to be, HIV-positive. When people living with HIV/AIDS internalize AIDS-related stigma it is evidence that they have incorporated society’s negative views of the disease, and of themselves, into their own identity. This Clinical Case Study describes the psychotherapy of a gay man living with AIDS who endured the long-term intrapsychic and social consequences of internalized AIDS-related stigma. During his 18-month therapy journey, he worked to liberate himself, and his “spoiled identity,” from its confines.

The literature suggests that AIDS-related stigma is the combined consequence of biological, cognitive/behavioral, psychodynamic, sociocultural, and archetypal forces. The qualitative experience of people targeted by AIDS-related stigma is inadequately addressed in the topic’s literature. This study attempts to remedy this gap by presenting a subjective account of an individual’s struggle with internalized AIDS-related stigma and his endeavor, in psychotherapy, to heal.

The treatment entailed guiding the client to identify and shed a multitude of negative familial and cultural messages about homosexuality and HIV/AIDS that had
taken root in his psyche and influenced his persona and identity. As he began to free himself from this negative internalized imagery, he gained a more positive and fluid sense of his identity beyond HIV/AIDS as well as increased optimism about his future.

The study’s major learning involved discovering the reciprocal relationship between the client’s imaginal structures and his internalization of AIDS-related stigma. His self-critical and shaming imaginal structures clearly reflected and personified negative cultural messages about homosexuality and AIDS, while they further predisposed him to internalize stigmatizing imagery.

The Scapegoat story is presented as a mythic backdrop for conveying the essence of the client’s personal journey as well as the broader meanings and consequences of AIDS-related stigma for the wider community and culture. Applying Imaginal Psychology to psychotherapy is shown to offer creative potential for facilitating the resolution of internalized AIDS-related stigma, one of countless forms that scapegoating takes in our culture.
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CHAPTER 1

INTRODUCTION

Clinical Topic

This Clinical Case Study explores the phenomenon of AIDS-related stigma, with a focus on the psychological impact and treatment of the internalization of AIDS-related stigma as experienced by a gay man living with AIDS. Gregory M. Herek defines AIDS-related stigma as the “prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV and the individuals, groups, and communities with which they are associated.” ¹ Internalized AIDS-related stigma, according to Pierre Brouard and Caroline Wills, is the internalization of the shame, blame, guilt, hatred, hopelessness, and fear associated with being HIV-positive.² Rachel S. Lee, Arlene Kochman, and Kathleen J. Sikkema maintain that the experience of internalizing AIDS-related stigma serves as evidence that people living with HIV/AIDS have integrated society’s negative views of the disease, and of themselves, into their own identity.³

Erving Goffman, in his seminal work on stigma and social identity, proposed that a stigma signifies an attribute that is undesirable and “deeply discrediting.”⁴ According to Goffman, those who are stigmatized are left with a contaminated, or spoiled, identity. John F. Dovidio, Brenda Major, and Jennifer Crocker elaborate that individuals bearing such a mark are considered spoiled, deviant, and flawed, and less than fully human.⁵ Those who are stigmatized, they continue, suffer from a loss of status, are devalued in the eyes of society, and are seen to deserve ostracism, animosity, and punishment. Stigmas
are associated with a wide range of characteristics and circumstances, including a number of chronic physical and mental disorders. It is widely held that people living with HIV/AIDS are subject to a distinct and virulent form of stigmatization. Harriet Deacon, for example, notes that AIDS-related stigma links disease stigma with already existing social stereotypes and prejudices held toward marginalized groups – homosexuals, intravenous drug users, and sex workers – who are associated with negatively valued behaviors and traits and are thus viewed as deviant and blame-worthy.6

According to Kari Lorentzen, stigma negatively affects the physical and emotional well being of people living with HIV/AIDS and increases the impact of the disease on individuals, families, communities, and nations.7 Lorentzen’s research demonstrates that AIDS-related stigma prevents people from getting tested for HIV, disclosing their HIV-status, practicing safer sex, accessing and adhering to treatments, and seeking crucial social support. The psychological consequences of AIDS-related stigma, Lorentzen found, include a decrease in self-esteem, social participation, and health seeking behaviors, and increased depression, anxiety, and suicidality.8

To facilitate a comprehensive understanding of AIDS-related stigma, this work presents a review of literature from various perspectives – biological, cognitive/behavioral, psychodynamic, and sociocultural – as well as imaginal approaches to the topic. With the intention of providing a useful foundation and context, the Literature Review also includes ideas about general stigma and disease stigma, and it begins with a brief overview of the history, epidemiology, and treatment of HIV/AIDS in the United States. The biological perspective describes how the roots of stigma are understood by evolutionary psychologists and affect theorists, and how the visible
manifestations of HIV disease and its treatment protocols particularly evoke AIDS-related stigma. The cognitive/behavioral perspective explains the psychological processes believed to generate stereotypes and prejudices, highlights the role of cognition in the dynamics of stigma, and evaluates cognitive interventions that aim to minimize the consequences of AIDS-related stigma. The psychodynamic perspective explains the intrapsychic basis of stigma and the dynamics and consequences of internalizing AIDS-related stigma. The sociocultural section discusses the stigmatization of AIDS as a socially constructed and culturally relative phenomenon; elucidates its political, religious, and historical contexts; and links it directly to homophobia. The section on Imaginal Approaches introduces ideas from Aftab Omer’s Imaginal Transformation Praxis, offers scapegoat mythology as a mythic backdrop, and presents considerations of AIDS-related stigma as a potentially transformative journey.

In addition to presenting a wide range of theoretical perspectives on AIDS-related stigma, the Literature Review highlights significant concepts and issues related to its internalization – such as psychological predispositions to stigma, layering of stigmas, and stigma’s disruption to and infiltration of an individual’s biography and identity – that reflect the actual problematic experiences and conflicts suffered by the client featured in this Clinical Case Study.

While “Victor Stevens” (pseudonym), the subject of this Clinical Case Study, presented in therapy with a number of clinical issues that might have become its topic of focus, it soon became obvious that his internalized AIDS-related stigma was the most significant, encompassing, and germane. Victor exhibited anxiety, depression, and self-defeating feelings and behaviors during his course of treatment, and at each turn, it struck
me that the source of his suffering could be directly linked to his experience growing up and dwelling in a homophobic and AIDS-phobic world. As we worked together to identify the negative images and messages that were woven through his psyche and persona, it was clear that the disparaging notions he had internalized about being gay and having AIDS were the most potent, intractable, and insidious.

Victor introduced me to the phrase AIDS-related stigma in one of our earliest sessions. He uttered it very casually, as though it was a familiar term commonly used in conversation. This sparked my curiosity and led me on a path of inquiry. I found that the phrase described and explained a terrain of suffering that the vast majority of my HIV-positive clients have told me they inhabit. The ideas I encountered about AIDS-related stigma strongly fit and enhanced my understanding of Victor’s experience, and provided me a conduit and a context for approaching our therapeutic work together.

**Exploration of Subject/Clinical Topic**

Ever since I was a young girl, I have been infused with a sense of fear and alienation. I grew up keenly aware that, as a Jew, my people had historically been treated as vile, ‘other,’ and often, less-than-human. While never fathoming why, I knew that Jewish people were largely despised and held responsible – and horrendously punished – for the myriad evils and woes of the world. I lived with an underlying, foreboding sense that my current experience of safety and calm was just a temporary condition. For me, this was an obvious conclusion to draw, having been exposed to images of menace and atrocity at a very young age. By the time I was six or seven years old, I had seen films – shown by Holocaust-survivor teachers – of dead, emaciated Jews who had been thrown
down chutes and piled into open graves. I had heard frightening stories from my grandmother about growing up in Poland, forbidden to go outdoors or stand by a window because Russian Cossacks would shoot up at Jews whenever they came into view. As I grew older, I was preoccupied with the Holocaust and read endlessly about the roundups, the betrayals, the cattle cars, the concentration camps, the showers, and the ovens. I tried as best I could to comprehend the notions and hatreds that propelled people to do such horrible things to people just like me.

When I was 16, I came out as a lesbian. Having grown up surrounded by the mainstream culture’s homophobic imagery, I understood that gay people were considered perverted and disgusting, a danger to children, and a threat to the culture-at-large. While I did not consciously believe these messages nor that there was anything wrong with me, I did grasp that, being homosexual, my future life would likely include a unique set of limitations, vulnerabilities, and estrangements. Though surely not naïve about the presence of hatred in the world, I was still shocked and puzzled by the revulsion, rejection, and vitriol aimed at people just like me.

As a young adult, I struggled to subdue the anxieties and submerge the images that continued to pervade me. While I lived a moderately successful, mainstream, and un-closeted life, I continued to feel assaulted by hateful images and had my share of harrowing encounters – as both target and as witness – with anti-Semitic and homophobic activities. I also experienced, in a deeply personal way, the early days of AIDS: I lost many dear friends, witnessed some friends lose their entire communities, and cringed at the hateful, heartless ways that the culture reacted to, and rejected, those who were – or were assumed to be – afflicted.
Throughout the years, I remained fascinated by, and determined to comprehend, the human inclination to label and persecute others as well as the psychological impact wreaked upon those who are targeted. Moreover, I became curious about how my own outlook and experience had been shaped by having internalized such disparaging and condemning images. I came to recognize that identifying as a marginalized, victimized other had become a central theme in my life, defining and limiting my sense of identity and esteem. I wanted to break out of these grips for my own well-being, but even more so because I saw how they kept me from being of service to others.

About 15 years ago, I returned to school to study psychology, and began my own journey with depth psychotherapy. During this time I have also worked professionally – as Client Services Manager at an AIDS food bank, and as a group facilitator, educator, and counselor – with hundreds of men and women who are living with the stigma of HIV/AIDS. These combined endeavors have afforded me the sufficient experience and insight to begin the work of liberating myself from the stigmatizing images of Jews and lesbians that I have internalized since my youth. As my own sense of identity and potential continues to expand, I find I am more able to help my clients cope with – and free themselves from – the crippling shame, self-hatred, and hopelessness that come from having internalized the stigma of AIDS.

**Framework of Treatment**

Victor and I met for therapy in my office at Food For Thought, Sonoma County AIDS Food Bank, in Forestville California, where I work as Client Services Manager. Food For Thought provides over 650 men, women and children infected and affected by
HIV/AIDS in Sonoma County with nutrition and other services, including support groups, creative art and healing workshops, social gatherings, and a volunteer program. I completed my doctoral fieldwork requirement at this placement, and saw clients for counseling as part of this effort.

During his initial appointment, Victor told me that he was exploring his options for returning to work, and in the process of applying to a graduate level credential program in school counseling at a local university. He named his anxiety about returning to “the real world” after being disabled, unemployed, and isolated for many years as his main reason for wanting to be in therapy. Victor told me that he had a very strong “inner critic” and often felt too “pitiful” to even leave the house. He was concerned that disclosing to his teachers and classmates that he was gay and HIV-positive would lead them to judge, ridicule, and reject him; he worried that being subjected to the stigma of AIDS would make him feel even worse about himself than he already did.

Victor’s treatment spanned 18 months beginning in early 2007; we met weekly for a total of 55 one-hour sessions. A few times when called for by his therapy, Victor and I had email or phone contact between sessions. Occasionally, I would encounter Victor in the lobby of the food bank, where he came weekly to receive services, and he once attended a workshop I facilitated there for clients. While I did not experience this atypical setting as creating constraints for the therapy, I was aware – and frequently anxious about – the potential problems it could pose. Toward the end of his treatment, I offered Victor a book by Pema Chödrön, which he accepted and referred to in a subsequent session; no other adjunctive materials were used in the therapy.
Confidentiality and Ethical Concerns

To safeguard the identity and confidentiality of my client, he is referred to throughout this Clinical Case Study by a pseudonym. In addition, several biographical features and contextual details have been altered or removed for his protection.

In February 2008, I introduced to Victor the possibility of his becoming the subject of this Clinical Case Study. I informed him of the topic and of potential ways that he and his treatment might be impacted by his participation. Victor immediately agreed, expressing no ambivalence or concern. I suggested we discuss it again the following week, and gave him a copy of the consent form to take with him and read through. Victor read the form right then, signed it, and handed it back to me, saying he was certain it was something he wanted to do. While Victor seemed to take this invitation in stride, I was left feeling anxious and remorseful; what if asking him to be a subject of a study on AIDS-related stigma was demeaning or objectifying or could have the effect of further stigmatizing him? In that moment, I became aware not only of the protective and loving feelings I had toward Victor, but of the enormous responsibility I had to him as well.

Throughout Victor’s treatment, I was under the supervision of Connie Beall, a Licensed Marriage and Family Therapist (MFT). I met with her weekly, for 90-minute, individual clinical supervision sessions, from December 2006 through June 2008. Connie’s orientation is eclectic with a strong emphasis on the psychodynamic and transpersonal realms of experience. As this was my first experience doing clinical work, my sessions with Connie included a lot of basic training and hand-holding. She coached me on therapy protocols, gave me specific advice about approaching sessions, counseled
me when I was anxious, and helped me separate out my own issues from those of Victor. Connie modeled caring and good technical and ethical practices.

There were a few occasions in which ethical, legal, and cultural issues called for my attention. In one of our earliest sessions, Victor informed me that he was seeing another therapist, a psychologist who was part of his primary care doctor’s HIV medical practice; their sessions consisted of mutual conversation held over lunch, and then the office billed Victor’s insurance for full sessions. I knew this arrangement was unethical and illegal, and believed that it hurt Victor more than it helped him. Victor thought so too; it upset him and he was in the process of ending that relationship. However, he was afraid to do anything that might threaten his relationship with his HIV doctor, upon whom Victor felt very dependent. Victor wanted to process this with me, and he asked for my input and advice. This situation challenged me to discern when sharing my opinion and/or disapproval would be of clinical value and in Victor’s best interest. It also showed me how the experience of people living with HIV/AIDS often includes surviving physical and emotional trauma that both renders them vulnerable to exploitation and forges them into a unique and distinct cultural group. I thus realized at this early stage of Victor’s treatment that in order to successfully – and ethically – address his experience of internalized AIDS-related stigma, I would have to work at becoming more culturally competent.

In Victor’s tenth month of treatment he experienced a brief descent into depression which required me to carefully monitor his levels of suicidality and vulnerability. During this time period I consulted with Connie frequently, once calling her immediately after a session with Victor to be certain that I had acted with sufficient
judgment and skill. I also had to continually assess – and recognize the limits of – my capacity to help Victor. Since it was possible that Victor’s complex medical condition and/or treatments might be contributing to his psychological decline, I insisted that he inform his medical doctor about his depression. I also got Victor’s written permission and attempted to consult with his doctor myself though his doctor never responded to my calls.

**Client History and Life Circumstances**

Victor was born in a small Midwestern town into a politically conservative, religiously evangelical family. The third of four brothers, Victor was shy and small in stature, and he took the role of peacemaker and strove for perfection and approval in his family of origin. Victor’s parents were strict and critical; they demanded conformity and obedience from their sons, and dealt punishments that were violent and unpredictable. Victor excelled in school as a boy; he was popular with his peers and active in extracurricular activities.

Victor graduated from college *magna cum laude* with a double major in Psychology and English. As a young adult, he struggled with and then accepted his homosexuality, moving to San Francisco where he became a manager of a savings bank. Two of Victor’s brothers were also gay; the oldest died of AIDS in 2004.

Victor was diagnosed with HIV and Hepatitis B when he was 25 years old. He had two massive esophageal bleeds in 1991 and a cerebral hemorrhage in 1998; both were life-threatening and debilitating episodes resulting from a chronic Hepatitis B infection. In 2003, Victor underwent a liver transplant; after a prolonged recovery period,
he is doing very well, although his kidney function has been impaired and must be closely monitored. Victor takes anti-depressants and numerous dietary supplements and is on an extensive regimen of antiretroviral and post-transplant medications, some of which have debilitating side effects (i.e., chronic diarrhea, fatigue, and sleep disturbances).

Victor had a limited prior history of psychotherapy treatment when we began our sessions. He participated in an HIV-positive men’s group in San Francisco for several years, facilitated by his primary care physician and a psychologist in his practice. For two years, Victor met the psychologist for bi-weekly “therapy” sessions, held over lunch in a restaurant and consisting of casual, mutual conversation. The psychologist paid for lunch and billed Victor’s insurance for the sessions. Victor and the psychologist referred to this experience as psychotherapy, and while Victor was frustrated with this arrangement, he believed it was the best he could have at the time given his inability to pay.

Victor’s financial situation was a major cause of his stress and vulnerability. He was constrained financially and anticipated his circumstances declining considerably in the future. He felt shame in being unemployed and living on disability income, yet was not in a position to return to work, unless offered a benefited position that covered his extensive health care costs. This was an unlikely prospect after being out of the work force for so long and given his medical condition, leaving Victor feeling angry, trapped, and insecure.

At the start of therapy, Victor was 47 years old. He was a single gay man, Caucasian, and an avowed atheist. He was living alone, in a subsidized studio apartment, in a small Northern California town. Victor’s last partnered relationship ended in 1999,
and he had no offspring. He worked in the banking industry until becoming disabled by AIDS in 1991. He has not been gainfully employed since that time, and now survives on a limited income from social security, housing support, and a private disability policy that is set to expire the day he turns sixty. Victor had been an active volunteer in the HIV/AIDS community in the town where he lived, serving in various leadership and supportive capacities. Despite his health issues, Victor appeared to be in fairly good stead: He was spending a significant amount of time working out at a gym, and was quite fit and muscular. The HIV disease was currently being held in check, and he considered himself to be in overall good health.

During the course of therapy, Victor’s life circumstance changed in a few notable ways. First, while he did not get accepted to the graduate program, he did begin taking introductory and prerequisite courses at a local junior college toward a career in mental health. He also completed an internship at the local County Public Health Department’s HIV clinic, and began volunteering as a big-brother in a community-based mentoring program. Victor’s intention was to reapply to the graduate program, and he was hopeful that these activities would help him gain admittance.

Another significant shift is that Victor severed communication with his parents during the time he was in treatment. Victor took this action after it became clear to him that his parents’ continual expressions of contempt and disapproval toward him were contributing to his feelings of self-hatred and inadequacy. While it remained a painful situation, Victor was proud of his decision, one he attributed to gains he made in the therapy.
**Progression of the Treatment**

Victor came into treatment burdened by feelings of alienation, self-loathing, and shame that had accumulated from his early relationship with disapproving, punitive parents into his adult years as a gay man living with the stigma of AIDS. Increasingly isolated and fearful about the future, Victor was pushing himself to return to school and work, and the prospect was causing him tremendous stress and anxiety. When denied admittance to graduate school, he took it as a stinging personal rejection. This setback, and his parents’ continual insults and criticism, furthered Victor’s feelings that he was damaged and defeated, and that he deserved everything bad that had happened to him. It also activated his own “intense inner critic,” a manifestation of self-censure and resignation that Victor attributed to “my internalized stigma.”

I was especially attuned to pick up on the significance of Victor’s self-criticism because this was a core focus of my clinical training at Meridian. So while we addressed, as necessary, Victor’s practical concerns about his future education and employment, the central focus of his treatment was exploring his experience of, and potential liberation from his ”Inner Critic” and his internalization of AIDS-related stigma. This meant identifying the multitude of negative familial and cultural messages about homosexuality and HIV/AIDS that had taken root in Victor’s psyche and influenced his personality and development. For Victor, this entailed courageous and strenuous work, during which he frequently experienced feelings of agitation, frustration, and vulnerability, as well as a brief episode of depression.

Over the course of treatment, however, Victor began to free himself from this negative internalized imagery and to gain a more positive and fluid sense of his identity
beyond HIV/AIDS, as well as his future potential. He gained a greater capacity for compassion and self-acceptance, and a wider range of choices as to how to interpret his ongoing experience. Victor continued to pursue his goal of returning to the work-world, by attending school and completing two career-related internships. This provided him with some satisfaction and momentum, and was a further example of how Victor may have benefited from therapy.

**Learnings**

The Learnings in this Clinical Case Study describe the process I undertook to make meaning from Victor’s psychotherapy journey. These Learnings were gleaned by identifying and interpreting the primary imaginal structures evoked for both Victor and me during the treatment. Aftab Omer defines imaginal structures as “assemblies of sensory, affective, and cognitive experience constellated into images; they both mediate and constitute experience. The specifics of an imaginal structure are determined by an interaction of personal, cultural, and archetypal influences.” Exploring our individual imaginal structures, as well as their complex interplay, served to illuminate what happened in the therapy, as well as the mechanics underlying the internalization of AIDS-related stigma. My reflections on these Learnings gave me an enhanced understanding of the potential for addressing the impact of stigma in the therapeutic setting.

For example, identifying Victor’s primary imaginal structures allowed me to discern how clearly they reflected and personified his internalization of AIDS-related stigma. The negative homophobic and AIDS-phobic messages that Victor had internalized appeared thoroughly woven through his imaginal structures, and to have
permeated and fixed his identity. I could see, as well, how Victor’s imaginal structures were further predisposing him to internalize stigmatizing messages.

This exploration also helped me grasp how transference and countertransference reactions could be understood as an interplay between the therapist’s and the client’s imaginal structures. For both Victor and me, the imaginal structures most active in the therapy were seemingly shaped by our stigma experiences. Tracking the interplay between our imaginal structures allowed me to clearly glimpse how the internalization of stigma operates in relationship, particularly as it comes to light within the therapeutic container.

Perhaps my most significant Learning relates to the potential for psychotherapy to facilitate the resolution of internalized stigma. The arcs that Victor travelled during his treatment revealed not just the negative impacts of stigma, but also his achievements, his healing, and his gifts. By bringing his negative self-imagery to light, and working to transform it, the therapy assisted Victor to identify and access realms of his potential that his internalization of stigma had obscured. This learning suggests that psychotherapy can assist those living with internalized AIDS-related stigma to reclaim and expand their sense of their identity and their future.

**Personal and Professional Challenges**

Working on this Clinical Case Study entailed a comprehensive exploration of internalized AIDS-related stigma that posed significant challenges for me, both personally and professionally. While long-standing personal interests initially drew me to choose this case for in-depth study, my intense and intimate relationship to the topic often
served, as well, to obstruct my progress. Throughout the process I struggled with conflicting impulses to complete the project and to turn away. In retrospect, I recognize that completing the Clinical Case Study required that I develop personal and professional capacities that I did not possess when I began.

At the start of this endeavor, I felt ill-equipped on several fronts. On a professional level, I was an inexperienced therapist with little training and an enormous amount to learn. Everything was new to me, including such basics as timekeeping and knowing when to stay quiet and when and how to self-disclose. I often felt clumsy and adrift and in over my head. I also initially lacked the stamina required to maintain a steady focus and presence.

It was the personal challenges, however, that proved to be most daunting. When I embarked upon this journey, I soon became aware that I lacked what felt like the sufficient sense of entitlement, authority, and potency one would need in order to be a therapist and/or to write a Clinical Case Study. My sense of alienation, marginalization, and illegitimacy did not mesh with my image of someone who could successfully complete an advanced degree. I doubted that, as a therapist, I could be a benevolent, healing influence on others, especially if maternal transference were involved. I mainly felt overwhelmed and riddled with anxiety. Through the process of writing this Clinical Case Study, I came to see how my own imaginal structures had been influenced, permeated, and gripped by having internalized stigmatizing images. In order to see the project through to completion, I was challenged to do my own work of navigating and transforming the terrain of my internalized stigma.
CHAPTER 2

LITERATURE REVIEW

Introduction and Overview

In order to illuminate the phenomenon of AIDS-related stigma, this Clinical Case Study presents a review of literature from distinct and diverse perspectives – biological, cognitive/behavioral, psychodynamic, and sociocultural – as well as imaginal approaches to AIDS-related stigma. This chapter begins with a brief overview of each.

According to Stephen C. Ainley, Lerita M. Coleman, and Gaylene Becker, stigma is a highly complex, dynamic, and enigmatic phenomenon best comprehended through a multidisciplinary approach examining its affective, cognitive, social, cultural, and historical components.¹ Such an approach, they believe, can provide a holistic understanding of how stigma evolves, why it persists, how it is experienced, and how its impact can be addressed.² This thinking is in alignment with the review of literature from the various perspectives as well as imaginal approaches as mentioned above.

Literature from a biological perspective on AIDS-related stigma addresses the biological roots of stigmatization and the physiological aspects of HIV disease that can be directly linked to AIDS-related stigma. This section includes ideas on the biological aspects of AIDS-related stigma from the viewpoints of evolutionary psychology, biopsychology, and affect theory.

From a cognitive/behavioral perspective, theorists hold that an individual’s experience of AIDS-related stigma both impacts, and is impacted by, their thought
patterns, belief systems, and personal constructs. This section includes discussion of cognitive-behavioral assessment models and treatment interventions with people living with HIV/AIDS. It will also discuss notions about the cognitive components and foundations of stigma.

In the next section, literature cited from the psychodynamic perspective shows a focus on the intrapsychic dimensions of AIDS-related stigma. This section presents theory that seeks to explain the roots of stigma, and of AIDS-related stigma, through a psychodynamic lens. Included are examinations of the psychological implications, emotional experience, and psychotherapeutic treatment of those living with the trauma of HIV/AIDS and the internalization of its stigma. This perspective offers insights from psychoanalytic self psychologists and attachment, developmental, and object relations theorists.

Theorists from a sociocultural perspective on AIDS-related stigma hold that stigma is socially constructed and culturally relative, and locates the phenomenon within the cultural, historical, political, religious, and social dynamics that initially shaped it, and that impact it to this day. This section features a brief history of the initial response to AIDS in the United States that has been widely blamed for allowing AIDS to become an epidemic both deadly and deeply stigmatized. Randy Shilts’ tome, And the Band Played On: Politics, People, and the AIDS Epidemic, is a central reference for this discussion. This section also reviews literature, from a sociocultural perspective, on the social mechanisms and dynamics that invite and perpetuate stigmatization.

The section on imaginal approaches to AIDS-related stigma highlights ideas on this topic from diverse voices and domains. Concepts from Omer’s Imaginal
Transformation Theory and ideas from Jungian and Archetypal theorists are central to this discussion, as are social critiques of AIDS iconography. A foundation of Imaginal Psychology is care of the soul; thus, this section also includes explorations that consider illness as a transformative journey or a search for meaning from the arenas of post traumatic growth, spirituality, creative arts, and cultural leadership.

As indicated above, this chapter provides a review of literature on the more general topics of stigma and disease stigma as well as literature specific to AIDS-related stigma. There are many foundational and influential insights on stigma written prior to the prevalence of HIV disease and the AIDS epidemic that are relevant here; they can be gainfully applied to the topic of AIDS-related stigma and serve to contextualize and enrich the reader’s understanding of the phenomenon.

The literature presented in this chapter will be best understood and employed if the reader is equipped with a basic understanding of HIV/AIDS. With the intention of providing context and reference for the theory to follow, this chapter begins with a brief summary of the history, epidemiology, and treatment of HIV disease in the United States. Only those facts most relevant to the discussion of AIDS-related stigma will be highlighted. The following has been culled from accounts by Randy Shilts, Glenn J. Treisman, Andrew F. Angelino, and Alan Whiteside.\(^3\)

Acquired Immune Deficiency Syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which Whiteside notes derived from simian immunodeficiency viruses found in West and Central Africa.\(^4\) The virus is thought to have first crossed from primates to humans in the early 1950s; it began spreading in an epidemic way in the United States in the 1970s.
The first cases of AIDS in the United States were publicly reported in June 1981. Physicians were perplexed as young, seemingly healthy homosexual men presented with very virulent forms of extremely rare conditions – such as pneumocystic pneumonia, meningitis, toxoplasmosis, tuberculosis, Kaposi’s sarcoma, and other cancers, infections, and parasitic diseases – that, for the most part, were previously seen only in people with severely compromised immune systems; some of the conditions had never before been seen in humans. As Treisman and Angelino note, it was soon apparent that Haitians, hemophiliacs, intravenous drug users, sex workers, and blood transfusion recipients were also contracting these diseases, as were their infants and partners.5

Initially, it was not known what caused AIDS, or how it was spread. Increasing numbers of patients presented with catastrophic opportunistic infections, for which there were poor prognoses and no successful treatments. Thus, as Treisman and Angelino point out, there was fear of infection among health care workers and the general public, who worried that AIDS could be transmitted through casual contact with someone suffering from the disease.6 According to AIDS InfoNet, what was known about AIDS early on is that which led to its name: 1) that it is acquired, meaning that a person must somehow become infected with it; 2) that it results in the deficiency of the immune system’s ability to function and thus ward off opportunistic infections and cancers; and 3) that it is a syndrome, not a single disease meaning that infected persons experience, and succumb to, a wide range of illnesses and infections.7

In 1983, HIV was identified as the viral agent that causes AIDS. As a virus, HIV consists of genetic material that lacks cell walls, is parasitic, and replicates by invading host cells, Whiteside points out.8 Most viruses replicate via DNA, but HIV is a retrovirus,
meaning that its genetic material consists of RNA; this makes it more complex and able to mutate and thus more difficult to combat, since, as it develops new strains, it becomes resistant to drugs. This has made it difficult to cure, or even adequately treat; thus, AIDS is still a fatal disease.

HIV is also a lentivirus, a type of retrovirus that is slow-acting, resulting in diseases that develop over long periods of time, affecting the immune system and brain. When a person becomes newly infected – called sero-conversion – and the virus takes hold in the body, the person is very infectious. However, there is a window, lasting on average eight years, during which a person is infected (and infectious) but not yet ill. This period without illness is followed by a long incubation period, during which the virus is not detectable, and though it is reproducing and wiping out immune cells, the infected person may be unaware that they are carrying the virus and infecting others.9

In 1985, an antibody test, able to reveal the presence of the HIV virus, was introduced. It was by then understood that AIDS was present in all bodily fluids and transmitted via semen, blood, and breast milk entering the bloodstream. For the next several years, homosexual men continued to be the majority of those infected with and dying from HIV disease, which was now known to be contracted mainly through penetrative anal sex and oral/anal contact (rimming). Four discrete stages of HIV disease were recognized: acute infection, asymptomatic HIV disease, symptomatic HIV disease, and AIDS. Efforts to educate the public as to those at high risk for contracting AIDS, and the behaviors leading to high risk for infection had begun.10

The wearing down of the immune system as a result of HIV disease allows for myriad conditions, opportunistic infections, and cancers to arise, many of which are
visible markers of the disease. In addition to the AIDS-defining illnesses listed above, physical symptoms include extreme weight loss, severe diarrhea, skin lesions, peripheral neuropathy, fungal and staph infections, chills and night sweats, psoriasis and rashes, fatigue, and exhaustion.\(^{11}\)

Infection with HIV can also trigger or exacerbate psychiatric problems. The most common psychiatric disorders found in HIV patients are depression, cognitive-motor disorders, anxiety disorders, adjustment disorders, and substance use disorders. Common psychiatric symptoms include agitation, demoralization, hopelessness, listlessness, cognitive and attention deficits, and disturbed sleep. There is a high degree of overlap between the anxiety, depressive, and somatic symptoms presented by patients, and it can be difficult to assess if they are due to pre-existing conditions, reactions to life circumstances, use of recreational or prescription drugs, or if the source is organic in origin, resulting from HIV’s effect on the brain.

In 1996 combination antiretroviral therapies (ARV) were introduced as a way to combat AIDS. ARVs work by reducing viral activity and allowing the immune system to recover, thus, for many, extending life and successfully delaying the onset of AIDS. Treatment protocols, however, are complex regimens, requiring strict adherence. Gaps in adherence trigger the virus to resume replicating, allowing the virus both to renew its attack on immune cells and to mutate into ARV-resistant strains. ARV must be taken for life, as AIDS is not yet curable.\(^{12}\) According to the Centers for Disease Control (CDC), during the decade and a half prior to the introduction of ARV, approximately 570,000 individuals were infected with HIV and over 350,000 died.\(^{13}\)
Since the onset of ARV, AIDS has shifted to a long term, chronic illness, with lower rates of mortality. D. E. Brashers, et al. note that many of those who lived with AIDS prior to 1996, and had resigned themselves to an early death, were now faced with other uncertainties and renewed concerns about their future; they characterized this experience as the **Lazarus Syndrome**.¹⁴

While antiretroviral medications save lives, they can be toxic and produce numerous side effects. Physical symptoms include nausea, diarrhea, headaches, dry mouth, dizziness, fatigue, indigestion, loss of appetite, rashes, muscle aches, and peripheral neuropathy. ARVs also induce psychiatric and neurological side effects, such as sleep disturbances (vivid and disturbing dreams, insomnia), malaise, drowsiness, anxiety, and depression. Interaction between antiretroviral medications and psychotropic medications are common, complicating the effectiveness of both regimens.

Elizabeth Chapman points out that one significant side effect of ARVs is lipodystrophy, a fat distribution disorder that results in patterned bodily changes.¹⁵ These changes are disfiguring, and include peripheral fat loss to the face, limbs, and buttocks and central fat accumulation of the abdomen, breasts, and dorso-cervical spine. Such manifestations are recognized as stemming HIV treatment protocols, consequently revealing one’s HIV status.

The following are the most recent statistics available as of this writing from the CDC on AIDS in the United States, all estimates from 2006: 56,300 people were newly infected with HIV.¹⁶ The number of persons living with AIDS was 448,871. The cumulative number of cases of AIDS since the beginning of the epidemic was 1,014,797. The estimated number of deaths of persons with AIDS in 2006 was 14,627. The
cumulative estimated number of deaths of persons with AIDS since the beginning of the epidemic was 565,927.

**Biological Perspective on AIDS-Related Stigma**

Literature reviewed in this section explores the biological roots of stigma and the aspects of HIV disease that contribute to AIDS-related stigma. Considered here is the work of key stigma theorists and HIV/AIDS researchers, whose ideas elucidate why, from a biological angle, HIV/AIDS has attracted particularly virulent stigma, more so than most other diseases. Included are ideas that can shed light on AIDS-related stigma from the distinct viewpoints of evolutionary, bio-cultural, and affect theorists.

One way, from a biological perspective, to look at AIDS-related stigma is as a form of *disease stigma*, which Deacon defines as an “ideology that identifies and links the presence of a biological disease agent (or any physical signs of a disease) to negatively-defined behaviors or groups in society.”  

While disease stigma is a complex social and intellectual construction, Deacon notes, it is rooted in a biological state and influenced by biological factors. Thus, she concludes, the biology of a given disease is a significant variable that influences the strength, content, and nature of its stigmatization.

According to Herek, HIV/AIDS is a disease that comprises at least four biologically-based characteristics that are predicted to evoke stigma: its primary transmission routes are behaviors that are regarded as voluntary and avoidable; it is considered unalterable, degenerative, and fatal; it is associated with contagion and perceptions of danger; and it affects one’s physical appearance, making it readily apparent – and discomforting – to others. These notions are compatible with, and
drawn from, those of key stigma theorists, who point out the biological factors that contribute to stigmatization. Goffman defined stigma as “an attribute that is deeply discrediting” and that reduces the bearer “from a whole and usual person to a tainted, discounted one.” He stressed the significance of the visibility of stigmatizing attributes, identifying abominations of the body – stigmas associated with conditions that are disfiguring or that entail physical deviations from the social norm – as one of three types of stigma that contribute to the devaluation of others. Goffman made the distinction between those whose stigmatizing marks are observable, who are therefore discredited by others, and those whose condition can be hidden or has not yet been disclosed, who he deemed discreditable and warned were vulnerable to self-stigmatization.

Edward E. Jones, Robert A. Scott, and Hazel Markus, expanding on Goffman’s work, name concealability, course of the mark, disruptiveness, aesthetics, origin, and peril as the six biologically-related dimensions of disease that particularly encourage stigmatization. Concealability relates to a stigma’s degree of visibility and points to Goffman’s distinction between being discredited or discreditable as the result of stigmatization; course of the mark refers to how the stigmatizing attribute may change over time and to its perceived ultimate outcome; disruptiveness concerns the extent to which the stigma upsets social interaction and leads to exclusion; aesthetics refers to subjective appraisals of how ugly or repellant the stigmatizing mark is deemed; origin accounts for the circumstances under which the condition was obtained; and peril addresses the scope, probability, and gravity of the threat the stigma imposes on others.
Chapman echoes Jones, Scott, and Markus in her theory of why such strong and damaging stigma is attached to HIV/AIDS. Chapman posits that AIDS-related stigma is particularly virulent due to its concealability, the unpredictable onset and course of the disease, the development of visible and unattractive skin conditions and body changes, and its terminal nature. According to Chapman, the impact of the disease on the body is not just physical but symbolic. She points to key elements specific to HIV, such as images of contamination and representations of the body as polluted and dangerous, as contributing to both the stigma and internalized stigma of AIDS.

Angela A. Alonzo and Nancy R. Reynolds also posit that the way stigma is experienced by people living with HIV/AIDS is influenced by biophysical dimensions of the disease. They propose a four-stage stigma trajectory, in which the content and intensity of AIDS-related stigma varies over the course of an individual’s illness. According to Alonzo and Reynolds, the four phases of HIV/AIDS that impact the experience of stigmatization are:
1) at risk: pre-stigma and the worried well, 2) diagnosis: confronting an altered identity, 3) latent: living between illness and health, and 4) manifest: passage to social and physical death. Alonzo and Reynolds suggest that the potency of AIDS-related stigma may also change as the epidemic itself evolves over time. Their stigma trajectory may help to explain, for example, how advances in medical knowledge as to how HIV is transmitted, detected, and treated – and how it is now considered a chronic, containable, manageable disease – have contributed to a decrease in stigma toward those living with AIDS.

Utilizing this stigma trajectory, D.E. Brashers et al, demonstrated that the uncertainties and stressors experienced by people living with HIV/AIDS also change
across Alonzo and Reynolds’ four stages. Brashers’ research focused on the experience of long term survivors of AIDS who had reconciled themselves to an early death but due to the advent of antiretroviral therapies experienced a revival (characterized as the Lazarus Syndrome) and are adjusting to the realities of living for longer spans of time. Many of these individuals must face the task of reentering life and renegotiating roles and identities, as well as with a new set of medical, financial, social, and personal uncertainties.

According to Brashers, the challenges for those considering reentry into the workforce and social arenas include a renewed fear of AIDS-related stigma. Many in Brashers’ study state that they anticipate experiencing even more pronounced stigma during their revival, as they encounter the reactions of employers, co-workers, and others. Some expressed concern about the double stigma of also being disabled, or having lived for so long on disability income. This research seems significant in suggesting a fifth stage along the stigma trajectory, and in specifically addressing AIDS-related stigma for those experiencing revival.

As noted above, antiretroviral therapies for HIV disease have improved the health and delayed the onset of AIDS for many individuals, allowing them to anticipate an expanded, albeit uncertain future. These therapies also pose formidable challenges that include daunting adherence schedules and considerable medication side effects. According to Chapman, one of the most significant, visible, and stigmatizing side effects is that of lipodystrophy syndrome.

Lipodystrophy, as explained by Giovani Guaraldi et al, is a fat redistribution disorder characterized by patterned and disfiguring changes in body composition and
appearance.\textsuperscript{32} Its main clinical features are lipoatrophy (peripheral fat loss) to the face, limbs, and buttocks, and central fat accumulation to the abdomen, breasts, and dorso-cervical spine. Guaraldi states that these morphologic changes are easily observed and linked to HIV which often results in forced disclosure and stigmatization.\textsuperscript{33} Numerous studies have explored the psychosocial impact of lipodystrophy. Guaraldi’s research identified facial lipoatrophy (sunken cheeks) as the most visible, representative, and stigmatizing feature of the syndrome.\textsuperscript{34} He concludes that such disfigurement leads to the erosion of self-esteem, to anxiety and depression, and to negative body image perception among those suffering from lipodystrophy. Ana Paula Morais Fernandes, et al. agree, asserting that patients in their studies, believing that lipoatrophy identifies and calls attention to their HIV status, refer to it as “the new face of AIDS.” \textsuperscript{35} Fernandes et al. blame lipodystrophy for “the contamination of body image” and for enhancing the stigma of AIDS. They express concern that, as a manifestation of HIV disease, lipodystrophy triggers disturbances in social relations, leads to extreme isolation, and may influence some patients to discontinue otherwise beneficial antiretroviral regimens as a way of undoing its adverse affects.\textsuperscript{36}

Paul Kunsberg, a long term survivor of AIDS, explains that his own experience of coping with lipodystrophy included the difficult realization that his condition was suddenly evident to all those around him.\textsuperscript{37} Kunsberg describes experiencing rejection and internalized judgment, and feeling subject to a disease stigma “compounded by the fact that HIV is transmitted sexually.” \textsuperscript{38} He writes:

For the first time in what was then my 10-year history with HIV, not only was I experiencing a serious assault on my health, I was also displaying visible evidence of my HIV status. My option to disclose – or not to disclose – had been removed by the obvious: a “look” that disclosed it for me. HIV was literally being
written across my face, and every bit of internalized shame that I had ever felt about being gay and having HIV came rushing in.\(^{39}\)

Robert Marks points out that observable evidence of HIV is not a new phenomenon.\(^{40}\) However, he notes, the visible symptoms of HIV in the days prior to antiretroviral therapies – such as skin lesions, gauntness, frailty, or a noticeably altered gait – were signs of disease progression, not, as with lipodystrophy, of disease control. Marks notes the irony that lipodystrophy, as a side effect of beneficial antiretroviral therapies, often manifests when a patient’s HIV disease is otherwise undetectable, to themselves as well as to those around them. Marks concludes that despite much medical progress, HIV disease is still unfortunately “tied up in stigma and shame, and people with HIV are put at risk, emotionally and physically, by the uncontrolled disclosure of their condition.” \(^{41}\)

In their research on the role of the body in AIDS-related stigma, Nelson Varas-Diaz, José Toro-Alfonso, and Irma Serrano-Garcia found that patients in their study believe that physical manifestations of HIV/AIDS provide evidence of their HIV status to others, and that this negatively impacts their social interactions and fosters their stigmatization.\(^{42}\) Referring to Goffman’s conceptual framework, Varas-Diaz, Toro-Alfonso, and Serrano-Garcia confirm that visible marks resulting from HIV/AIDS are attributes that serve to establish difference and initiate stigma.\(^{43}\) Noting that bodily evidence of HIV disease is both observable and hidden, they conclude by validating Goffman’s notions that stigma is both discrediting and discreditable, and that these abominations of the body serve as the vehicle for both social and self-stigmatization.

The discussion in this section turns next to biologically-based explanations for why humans stigmatize others. A good representation of the biological perspective on
stigma comes from the writings of Steven L. Neuberg, Dylan M. Smith, and Terrilee Asher who assume stigma to be an innate, ubiquitous mechanism that serves humans – who have evolved to depend on group living for both individual and collective survival – as a meaningful adaptive function. The authors posit, from their bio-cultural perspective, that stigma results from the “dual human propensities for prosociality and exploitation that characterize group life.” They view stigmatization as a system that identifies and labels individuals who pose a burden or threat to the group which then motivates group members to deny these individuals the benefits of, and membership in, the group. Neuberg, Smith, and Asher hypothesize that branding and ostracizing individuals characterized as nonreciprocators – such as thieves and the physically disabled – is a strategy for insuring a group’s survival.

Robert Kurzban and Mark Leary offer a theory of AIDS-related stigma based in evolutionary psychology. Explaining stigma as an adaptation designed to address distinct serious negative consequences of group living, Kurzban and Leary propose that as humans have evolved to seek out others for social interactions, they have also evolved the need for discernment. Kurzban and Leary argue that humans developed the exclusionary mechanism of discriminate sociality as a way of putting necessary “brakes” on sociality, and they contend that the phenomenon of stigma is a mechanism that functions to help humans avoid interactions with those carrying diseases, parasites, and other contagions that have fitness costs to the group.

*Parasites*, Kurzban and Leary explain, are small predators – viruses, bacteria, insects and worms – that pose great threat to a species’ survival. Thus it is crucial that individuals avoid infestation and that groups solve the problem of parasites passing from
one host to another. For this reason, Kurzban and Leary argue, humans have adapted specific cognitive systems to detect the correlates and cues of infestation. For example, since parasite infestation can cause deviations to normal appearance and movement, humans have evolved aversions to those whose appearance deviates from local species-typical design. As a form of protection, humans have evolved distinct preferences for unblemished skin, symmetry, and other reliable evidence of health, and the desire to avoid physical contact with, or to be in proximity to, potentially parasitized individuals, who are perceived as repellent and dangerous. Kurzban and Leary further suggest that, due to the potential high cost of mistaking a parasitized individual as healthy, these detection systems are designed to be hyper-vigilant, and biased toward false positives.\(^{50}\)

Kurzban and Leary contend that their contagion theory directly applies to AIDS-related stigma.\(^ {51}\) As evidence, they point to studies revealing people’s desire to have physical as well as social distance from people with AIDS, and to other irrational responses to those living with the disease. While acknowledging that some AIDS-related stigma may be based on moral reasons, Kurzban and Leary are confident that extreme behavioral reactions to those living with AIDS are best understood as resulting from adaptations designed for parasite and disease avoidance.

Affect Theory, specifically the work of Silvan S. Tompkins and Donald Nathanson, may also shed light on the experience of AIDS-related stigmatization.\(^ {52}\) While not directly addressing stigma, affect theory is included here because of its extensive focus on the negative affects that are often linked to the stigma experience. Affects, according Nathanson, refer to the specifically biological aspects of emotion and can account for all emotions and emotion-laden situations.\(^ {53}\) Tompkins initially
described nine *innate affects*, which Nathanson calls *internal scripts* and describes as a “group of hard-wired, pre-programmed, genetically transmitted mechanisms that exist in each of us and are responsible for the earliest forms of emotional life.”\(^{54}\)

Expanding on Tompkins’ work, Nathanson portrays the innate affects in three categories; they include: 1) the positive affects of *interest-excitement* and *enjoyment-joy*; 2) the neutral affect called *surprise-startle*, and 3) the negative affects of *fear-terror, distress-anguish, anger-rage, dissmell, disgust, and shame-humiliation*.\(^{55}\) According to Nathanson, the affects shame, disgust, and dissmell are part of the hard-wired aversion system designed to keep us safe from danger and contamination.\(^{56}\) He names disgust and dissmell as the affects of interpersonal distance – involved when we reject, demean, or are repelled by others – and considers them the affective roots of prejudice and discrimination. Tompkins called shame “the affect of indignity, of transgression and of alienation,” and described the experience of shame as causing one to feel “defeated, alienated, lacking in dignity or worth.”\(^{57}\)

Nathanson offers a model, *the compass of shame*, to describe the repertoire of responses individuals have to the toxicity of the shame experience.\(^{58}\) As points on this compass, Nathanson names *withdrawal, avoidance, attack other*, and *attack self* which are four defensive strategies individuals engage in as a way of managing this often unbearable affect. His model demonstrates the impact that the activation of shame has on both internal and interpersonal experience. In particular, it points to significant consequences of the shaming aspect of stigma – its disruptiveness to social relationships and its equally toxic internalization.
To summarize, a biological perspective on AIDS-related stigma examines the biological factors that contribute to stigmatization. A significant focus of this perspective, which views AIDS-related stigma as a form of disease stigma, is on the physical manifestations of HIV/AIDS that particularly evoke stigma. Special attention is given to specific symptoms of HIV disease and side effects of its treatments that are visible and stigmatizing. This section also discussed the biological roots of stigma from the viewpoints of evolutionary psychologists and affect theorists.

**Cognitive/Behavioral Perspective on AIDS-related Stigma**

This section presents the work of theorists who conceptualize stigma and AIDS-related stigma from a cognitive/behavioral perspective. Such theories explain the foundations and components of stigma as products of the associative and categorization processes that generate stereotypes and prejudices. Also reviewed in this section is research that evaluates various cognitive-behavioral assessment and treatment models designed to improve the mental health and coping skills of people living with HIV/AIDS and its related stigma.

Social scientists have long sought to explain the cognitive and motivational factors that influence how humans interpret their social environment and that engender intergroup biases, stereotypes, and prejudices. Gordon Allport has argued that the tendency to form prejudices is an innate, unavoidable “function of the normal human cognitive apparatus.” 59 According to Allport, humans think with the aid of generalizations and categories – both rational and irrational – that form as related ideas and perceptions cluster and cohere in our minds. These categories, which become the
basis for our judgments and perceptions of others, help us to simplify, order, and comprehend the world, and to construct meaning from what and whom we encounter.\textsuperscript{60}

Susan T. Fiske endorses Allport’s claims, describing \textit{categorization} as a social cognition process that serves to help people make sense of other people, guide their thoughts and actions, and provide groups with socially shared understandings.\textsuperscript{61} Fiske maintains that categories are resistant to change and that our reliance on them is based on the principle of least effort.\textsuperscript{62} She explains that following our initial perceptions and categorizations, psychological elaborations ensue that lead us to make category-consistent interpretations; we tend to incorporate new experiences into preexisting categories. This, Fiske claims, allows our generalizations and categories to remain intact, as we modify our views of others rather than the category itself.

The psychological elaborations that Fiske details help to explain the cognitive foundations of stereotypes and intergroup bias.\textsuperscript{63} First, she offers, inter-group differences become exaggerated while intra-group homogeneity is likewise overestimated. All category members of an out-group are considered to be the same and interchangeable, leading us to treat all member of that social group alike. Members of an in-group are viewed as more variable and more likely to be intrinsically good. Moreover, Fiske states, hierarchical structures are imposed among the categories, leading us to delegate in-groups as superior and out-groups as subordinate.

Jennifer Crocker and Neil Lutsky highlight the significant role of social cognition in the dynamics of stigma.\textsuperscript{64} They hold that while stigma is influenced by cultural, social, and historical forces, it results from how these factors, in turn, impact the perceptions, attitudes, motivations, and behaviors of individual members of society. In Crocker and
Lutsky’s view, a cognitive approach to stigma consists of studying how and what we think about groups and persons who are stigmatized. They further contend that, given the negative consequences of stigma on those stigmatized, it is also crucial to study the cognitive processes involved in belief change.

Crocker and Lutsky veer from Allport and Fiske’s conceptualization of categories as entrenched, monolithic, and systematic. They advocate a schematic view of stigma which holds that preexisting beliefs and attitudes toward those stigmatized are repeatedly reconstructed as people select, organize, and evaluate their own social experiences. According to Crocker and Lutsky, given the range of cognitive possibilities, the study of stigma should focus on when and how we access particular kinds of stored information; how attitudes and behaviors are evoked in response to various circumstances and social encounters; and how previously held and currently received information influence one another.

Bruce G. Link and Jo C. Phelan concur that cognitive processes are necessary, though not sufficient, causes for the production of stigma. As they define it, stigma exists when “elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows these processes to unfold.” Link and Phelan view stigma as the convergence of five interrelated components, the first three of which are cognitive in nature.

The first factor in their model of stigma is that people distinguish and label human differences. Link and Phelan pointedly use the term label in contrast to the terms attribute or mark utilized by Goffman and other stigma theorists. According to Link and Phelan, the latter terms imply that the quality being referred to is located within the
stigmatized person, whereas the term label indicates that it has been affixed, and that its election as significant is the result of social and cognitive processes. Furthermore, they claim, terms like attribute and mark give that designation legitimacy, whereas the term label leaves its validity in question.

The second factor in Link and Phelan’s model is that human differences are associated with negative attributes; here, the affixed label links a person or group to a set of undesirable characteristics or stereotypes. The third cognitive component is that this label comes to denote a separation of “us” from “them”; the socially labeled persons are placed in a distinct category that deems them as different and, in the extreme, not really human.

Link and Phelan point out that while all people engage in these kind of cognitive processes, what really matters is “whose cognitions prevail” – that is, whose cognitions are influential enough to lead to the consequence of stigma for the group labeled as different. In their view, then, there are two ways to impact the outcome of stigma. One is to change the deep seated beliefs and attitudes that lead to the labeling, stereotyping, setting apart, devaluation, and discrimination of others; the alternative is to limit the power of such groups to make their cognitions the culturally dominant ones.

According to Hélène Joffe, attribution theory – a cognitive theory of how people judge the causes of events – can help account for the blame response that is a central feature of AIDS-related stigma. She explains that when faced with an individual in a crisis, other people attempt to determine its cause. If the calamity is attributed to factors outside the individual’s control, a sympathetic response is evoked; otherwise, a negative response results. This, Joffe, notes, is evidenced by the distinct responses toward people
who get AIDS “innocently” – via blood products, mother-to-infant transmission, and heterosexual sex – versus those in out-groups who are assumed to have contracted HIV through their own volition and fault.\textsuperscript{74}

Joffe cites the \textit{Just World Hypothesis}, an attribution theory which holds that people wish to believe that the world is a safe, orderly, and predictable place in which people get what they deserve.\textsuperscript{75} The idea that bad things happen to good people, claims Joffe, produces anxiety and challenges people’s notion that they can stay safe. Thus, others are held responsible for their own misfortune and thought to have brought the difficult circumstances upon themselves, likely due to a fundamental weakness or moral failure. Joffe maintains that this association of “good people” to “good circumstances” and “bad people” to “bad circumstances” often leads to acts of censure or vengeance – both symbolic and violent – toward those associated with causing the misfortune. In the case of AIDS, Joffe notes, these responses have ranged from the use of taunting metaphors, like calling AIDS the “gay plague,” to acts of “gay bashing” that punish and distance those held responsible.\textsuperscript{76}

The psychosocial consequences for people subjected to such stigmatizing responses may also be addressed from a cognitive/behavioral perspective on AIDS-related stigma, as are the clinical treatments that seek to ameliorate them. In cognitive/behavioral therapies, various writers have noted that clinicians focus on the thought patterns, belief systems, and personal constructs that impact an individual’s experience, highlighting the interactions of thoughts, feelings, and behaviors.\textsuperscript{77} A primary goal of their interventions for people living with AIDS, according to Nicole Crepaz, et al., is to modify the irrational cognitions that are linked to the negative affects
and psychological states – such as depression, anxiety, anger, stress, shame, and helplessness – that are common to their experience.⁷⁸

According to Crepaz, et al., considerable research has focused on assessing the cognitive/behavioral interventions designed to improve the mental health of people stigmatized by AIDS.⁷⁹ These analyses have evaluated interventions such as cognitive restructuring, cognitive behavioral stress management, self management, and coping skills training, comparing their overall efficacy as well as their specific impact on the negative affects and psychological states. The studies’ results are generally measured on standard psychological scales, such as the Beck Depression Inventory, Beck Hopelessness Scale, Perceived Stress Scale, Hamilton Anxiety Rating Scale, and Profile of Mood States.

Acknowledging that people living with AIDS “consistently face complex psychological and physical demands of having a highly stigmatized, chronic, and life-threatening illness,” Crepaz, et al. undertook a meta-analysis, synthesizing data from 15 clinical trials, in order to determine whether cognitive/behavioral interventions are as efficacious for this group as has been demonstrated with the non-HIV-infected population.⁸⁰ Their analysis determined that people living with AIDS who were trained to assess and alter irrational thoughts, and who gained adaptive coping skills to manage and reduce stress, experienced reduced symptoms of anxiety, depression, anger, and stress. Crepaz, et al.’s study found, however, that while the interventions were equally effective with this population, they were not as sustained, indicating the need for ongoing behavioral reinforcement to prevent relapse.⁸¹
Christopher R. Martell, Steven A. Safren, and Stacey E. Prince suggest that cognitive-behavioral interventions for people living with HIV/AIDS are especially useful at distinct four stages: (1) soon after initial diagnosis; (2) during times of increased symptomology; (3) during times of symptom remission and normal life resumption; and (4) near the end of life. They claim that in each of these stages patients must make a variety of cognitive shifts to cope with their new life challenges, and they recommend teaching patients coping strategies that can lead to better adjustment as well as to lower levels of both global and illness-related distress.

Martell, Safren, and Prince point out that active coping strategies – such as optimism, control, and interpersonal coping strategies – are particularly crucial for patients just following their diagnosis of HIV/AIDS. Due to societal stigma, they explain, the cognitive shifts involved at this stage frequently include perceiving the self as damaged and helpless and the world as threatening and dangerous. Martell, Safren, and Prince counsel that therapists must keep the realities of prejudice in mind while assisting patients with cognitive restructuring to counter the experiences of hopelessness, dependence, and fear.

To summarize, the cognitive/behavioral perspective offers insight into several aspects of AIDS-related stigma. This section provided an overview of social cognition theory, which explains the categorization processes and psychological elaborations that generate stereotypes and prejudices, and highlighted the role of cognition in the dynamics of stigma. The cognitive components of Link and Phelan’s stigma model, and theories that view stigma through a cognitive lens, such as attribution theory and the Just World Hypothesis, are also presented. Finally, this section discusses clinical aspects of
cognitive/behavioral therapy with people living with HIV/AIDS and reviews research assessing cognitive/behavioral interventions that have been designed to ameliorate the psychosocial consequences of AIDS-related stigma.

**Psychodynamic Perspective on AIDS-related Stigma**

This section begins with an examination of theories that attempt to explain the roots of AIDS-related stigma from a psychodynamic perspective. Psychodynamic approaches consider the stigmatization of AIDS within the context of the unconscious conflicts, defense mechanisms, and emotions that have been aroused by AIDS. Stigma is viewed, in large part, as a means of defending against the anxieties and perceptions of danger that have been posed by the AIDS epidemic. This presentation is followed by a discussion of the intrapsychic implications of AIDS-related stigma, such as the internalization of stigma, for those living with HIV/AIDS and of the goals and challenges of psychotherapeutic treatment.

According to Mark J. Blechner, a psychodynamic approach can offer significant insight into the psychological processes he calls “distortion and myth-making” that have been rampant throughout the AIDS epidemic and that have contributed to AIDS-related stigma. With its focus on exploring the unconscious and irrational realms of experience, he states, psychoanalysis is well-suited to address the illogical and prejudicial responses to HIV/AIDS by individuals, medical scientists, government agencies, the media, and society at large.

Blechner employs Sigmund Freud’s concept of *wish-fulfillment* – defined as unconscious attempts to resolve conflicts by fantasizing things as you wish them to be –
to explain that when people are under considerable emotional stress, their thinking becomes irrational and is distorted by the same primary processes and ego defense mechanisms that make our dreams so absurd.\(^87\) The fear and panic evoked by the AIDS epidemic, he claims, led to this kind of extreme, distorted thinking on the part of individuals, whose illogical ideas then coalesced into distorted group beliefs and societal myths. Blechner maintains that these myths fulfilled strong unconscious psychological needs, so they became deeply entrenched and difficult to dismiss or reverse.\(^88\)

One commonly held myth produced by this process is the idea that AIDS only affects other people, not people “like me.” In the early days of the epidemic, Blechner writes, everyone wished to project its dangers onto someone else; and though it has long been established that heterosexual contact is the most common mode of HIV transmission worldwide, many continue to believe that HIV/AIDS does not affect them, their family, or their communities; it is still largely viewed as a gay male disease.\(^89\) Citing Harry Stack Sullivan’s concept of not me, Blechner proposes that these false perceptions about who is at risk for HIV allows individuals to defend against the personal threat of AIDS by adopting a wishful illusion that the disease is relevant only to “them” and “not me.”\(^90\)

In his existential psychodynamic approach to understanding AIDS-related stigma, Eugene W. Farber also refers to Sullivan’s notion of not me.\(^91\) According to Farber, AIDS has “served as a lightening rod for activating the core existential dilemmas of living,” namely, the concern with death and the existential anxiety it provokes.\(^92\) These dilemmas, he proposes, have been threaded through the fabric of the HIV/AIDS epidemic and have had enormous impact on its psychological dynamics.
Farber elaborates that there are two main psychological defenses against death anxiety: the belief in one’s own specialness, separateness, and exemption from mortality; and the belief in an ultimate savior. These modes of defense, he notes, have been manifest throughout the AIDS epidemic in significant ways. Farber refers to not me as a defensive psychological stance that has enabled people to avoid the anxiety “associated with awareness of susceptibility to annihilation posed by HIV disease.” An extreme expression of this stance, he argues, is AIDS-related stigma, which, in existential terms, can be viewed as a “vehicle through which stigmatizing persons could defend against their existential anxiety by defining themselves as special relative to the ‘less than’ individuals with HIV/AIDS and therefore exempt from its mortal threats.”

Joffe, in her treatise on the human response to risk, applies psychodynamic principles to account for the “not me – others are to blame” response to the crisis of AIDS. To explain why the early stigmatizing response to AIDS by both scientists and the public was to link the disease to foreigners, out-groups, and deviant practices, Joffe references Melanie Klein’s object relations theory. She cites Klein’s concept of splitting, which Joffe calls “an unconscious mechanism of defense…generally associated with taking into the self good experiences and feelings, and the projection outward of bad experiences and feelings. The point of splitting is to keep the bad away from the good in the hope that it will not invade the good and destroy it.”

In Klein’s theory, Joffe notes, anxiety is an organizing principle; splitting – a defense against feelings of dependence and helplessness – is viewed as a way of reducing the anxiety experienced from the earliest moments and relationships of infancy. Klein noted the infant’s tendency to represent “the other” in polarized terms, as either all good
or all bad. In times of increased anxiety, she argued, paranoid feelings are split off and projected outside the self, onto the other, as a form of self-protection. Joffe notes that according to Klein, how individuals construct and organize the self against anxiety, through their maturing process, is a prototype for their subsequent social relationships.99

According to Joffe, traces of the early splitting responses to anxiety remain with people throughout their lives and are re-invoked whenever they feel endangered.100 In times of crisis such as the AIDS epidemic, people tend to split off and locate the threat in the “other” as a way of externalizing their anxiety; this allows them to protect their identity and maintain a sense of being good, secure, and free from danger.” 101

Carol K. Seligman and Louise C. Singleton apply psychoanalytic developmental theory to the study of stigma.102 From this perspective, they explain, researchers examine differences in personality that might explain individual variations in the tendency to stigmatize.103 An overarching premise of this approach is that stigmatization reflects internal personality conflicts rooted in early childhood, and that it is an indication that development has gone awry.

A hypothesis put forth by Seligman and Singleton is that the propensity to stigmatize may stem from a child’s experience of parental punitiveness.104 The internal conflicts engendered by this experience, they argue, can be conveyed through defense mechanisms such as displacement, in which frustrations are directed toward an out-group since they cannot safely be expressed toward the actual source of frustration; and projection, where impulses that cannot be admitted in the self are attributed to others.105 Such painful early experience, they note, can also spawn the development of an
authoritarian personality, characterized by a hostile, rigid, conforming worldview that holds prejudicial attitudes toward others.

In addition to theories explicating the underlying causes of stigma, the psychodynamic perspective offers a range of ideas regarding the intrapsychic implications of AIDS-related stigma for individuals living with HIV/AIDS. It is important to note that most literature investigating the psychology of AIDS-related stigma is directed toward issues concerning its underlying causes and its impact on HIV prevention and care. There is a larger body of general literature on the psychological consequences of AIDS, especially among gay men, though it is not written from their own perspective and is heavily focused on concerns such as depression, anxiety, grief and loss, negotiating safer sex, survivor guilt, cognitive impairment, suicidal ideation, death, and coping with the myriad stressors of living with the medical uncertainties and health fluctuations that mark the clinical course of HIV disease. By contrast, literature addressing the psychological impact of stigma is scarce; research from the subjective experience of people living with AIDS is scarcer still.106

For the purpose of this Clinical Case Study, the subjective experience of AIDS-related stigma on people living with AIDS is referred to as internalized AIDS-related stigma. Prior to introducing a selection of literature relevant to this topic, a description of internalized stigma is offered here. Brouard and Wills maintain that internalized AIDS-related stigma is the internalization of the shame, blame, guilt, hatred, hopelessness, and fear associated with being HIV-positive.107 Lee, Kochman, and Sikkema view it as evidence that people living with HIV/AIDS have integrated society’s negative views of the disease, and of themselves, into their own identity.108 Joffe, portraying the
phenomenon of AIDS-related stigma as “the sedimentation of the ‘we’ in the ‘I,’” argues that those marginalized by AIDS acquire a sense of spoiled identity by internalizing the negative aspersions cast by society’s dominant representations.  

Gil Green and Elisa J. Sobo concur, elaborating that as people living with AIDS internalize the negative socio-cultural attitudes toward them, they begin to feel that they are dangerous, diseased, and despised, and to develop self-hatred and shame; that is, they perceive themselves as tainted, and believe that others will perceive them that way too – a hallmark of stigma as defined by Goffman. In their research, Green and Sobo collected images of AIDS patients’ symbolic self-perceptions; they included depictions such as “Dirty Leper,” “as if I had the plague,” “infectious,” “outcast,” “The Other,” and “AIDS = death row.”

Green and Sobo argue that internalized stigma assaults the individual’s sense of identity and self-worth, and is the aspect of living with AIDS that causes the most biographical disruption. By this, they mean that when stigma is deeply internalized and incorporated, it can attain a “master status” that comes to infiltrate and dominate their own identity as well as the perceptions others have of them; thus stigma involves both the anticipation of bias and the internalization of bias as well. Green and Sobo note that those with high degrees of internalized stigma tend to interpret negative events and interactions as deriving from the stigma itself, as opposed to ascribing them someone else’s bias or intolerance; in this way the negative feedback or outcome is linked with the stigmatized self and the stigma gets more firmly internalized.

Lee, Kochman, and Sikkema’s study of people living with HIV/AIDS found that the majority in their research sample experience internalized stigma related to HIV.
Their results negatively link internalized stigma with effective adaptation to living with the disease, signifying implications regarding both quality of life and survival. For example, they found that internalized AIDS-related stigma has a negative relationship to perceived social support and positive action coping, and that it is positively related to grief, passive problem solving, self-destructive escape coping, and high levels of depression, anxiety, and hopelessness.

Brouard and Wills agree that internalized AIDS-related stigma is dangerous and disempowering, and they identify its six indicators as: self-exclusion, low perception of self, social withdrawal, overcompensation, fear of disclosure, and subterfuge. Brouard and Wills believe that the internalization of AIDS-related stigma is a complex process that is shaped by an individual’s previous experiences of shame and blame; they note that an individual’s health status, level of self-acceptance, spirituality/meaning systems, education level, and resilience/coping mechanisms are other self-level factors that can increase or inhibit the phenomenon. Like the externalized version, internalized AIDS-related stigma becomes layered onto other forms of stigma such as homophobia. Those living with internalized homophobia, Brouard and Wills argue, often believe that they acquired HIV because they are gay, adding to their shame about having AIDS and reviving feelings of shame and anxiety about being gay.

Sharone Abramowitz and Jeffrey Cohen, calling AIDS a profoundly destabilizing crisis of the self, submit that principles from Heinz Kohut’s self psychology can provide a template for understanding and working therapeutically with the intrapsychic crises - including stigma, homophobia, and other assaults on self-esteem – that face gay men living with HIV/AIDS. Based in self-object theory, Abramowitz and Cohen define the
self as an “intrapsychic organization that has stability over time and that provides one with a healthy sense of self, self-esteem and well-being…. [The] self…thrives and depends on a matrix of selfobject functions….the term selfobject describes the intrapsychic experience of a function performed by a relationship to other people, symbols, or ideas.”

According to Abramowitz and Cohen, AIDS poses distinct threats to self-cohesion through disruption of the bodyself, the intrapsychic relationship to the body and a basic source of self-esteem, self-agency, and self-organization. The authors note that several aspects of AIDS threaten the bodyself: the subjective experience of defectiveness, contamination, and lack of control; the highly visible and stigmatizing physical manifestations; its presentation with diffuse, vague, and unpredictable symptoms; and its diverse neuropsychiatric effects that can impair the functioning of the brain.

As a profoundly stigmatizing condition, Abramowitz and Cohen claim, AIDS also threatens the self by traumatically disturbing the fundamental self-object bonds that provide stabilization. These bonds are mirroring, the self’s need for affirmation; alterego or twinship, the need to feel an essential alikeness with others; and idealizing, the self’s experience of being soothed, protected, and accepted by an admired and respected other. A central clinical goal of psychoanalytic self psychology is the restoration of the self and of selfobject bonds through the therapist’s creative use of empathy and of the mirroring, alterego, and idealizing transferences.

Additionally, Abramowitz and Cohen argue that AIDS threatens the self by recapitulating preexisting self issues. They note that when people are diagnosed with HIV/AIDS, they are, in a sense, captured at a distinct moment in their psychological
development, family history, level of coping skills, and background of other traumas and losses. For many, the experience of AIDS and AIDS-related stigma can stir old, even infantile, feelings of inadequacy, abandonment, neglect,emptiness, helplessness, and vulnerability. These experiences, Abramowitz and Cohen maintain, can make “AIDS…feel like a present-day retribution or confirmation that the self is bad, defective, unworthy, and unlovable. This belief may be the core dynamic of internalized homophobia in which AIDS is experienced as a punishment for being homosexual.”

Gil Tunnell proposes that how openly and directly a gay man has dealt with his homosexuality is a strong predictor of how he will cope with AIDS-related stigma. For men who already feel ashamed of being gay, and isolate themselves from others, an AIDS diagnosis will compound their suffering and loneliness. Long before contracting AIDS, Tunnell argues, gay men are aware of their deviant status and what it portends. Persistent ostracizing leads many to assimilate society’s rejection and develop internalized homophobia. An AIDS diagnosis may reactivate feelings of unacceptability that have not yet been addressed, and can confirm for a gay man that he has AIDS because he is bad or has done something wrong.

According to Tunnell, the effects of internalized AIDS-related stigma frequently emerge in psychotherapy with HIV positive gay men. Tunnell observes that when the shame of AIDS leads a client to become significantly alienated from others, any support or affection they receive will seem anomalous and may be discounted or outright rejected. Moreover, the client may act or respond in hostile and off-putting ways that have the effect of pushing a therapist or group members away and making it less likely that they will feel or offer compassionate support in the future. Tunnell explains this
phenomenon as *projective identification*, where a client “projects his own self-hatred onto others and induces them through his contempt to behave in an alienating way toward him.”

By making others the container for his own self-contempt, claims Tunnell, the client is unconsciously attempting to disown that part of him and to rid himself of shame.

Tunnell recommends applying Erik Erikson’s theory of personality development in clinical work with gay men with AIDS, viewing that model as especially useful in helping to understand the fundamental issues clients grapple with. Erikson’s theory of lifelong development holds that individuals, after resolving distinct psychosocial crises, pass through a series of stages over the course of their lifetime. Tunnell argues that these crises – basic trust versus mistrust; autonomy versus shame and doubt; initiative versus guilt; industry versus inferiority; identity versus identity confusion; intimacy versus isolation; generativity versus stagnation; and integrity versus despair – may all be clinically relevant, as are the strengths – hope, will, purpose, competence, fidelity, love, care, and wisdom – their resolution promises. Even those crises that a client resolved in earlier stages of his life may become conflicts again once triggered by the challenges of an AIDS diagnosis. Tunnell proposes that Erikson’s first two stages – those dealing with tensions around trust, dependency, and shame – are relevant regarding AIDS-related stigma as they most closely parallel issues confronting clients who have internalized stigmatization.

Farber suggests that existential therapy is appropriate for clients living with AIDS, as their experience is characterized by the major existential concerns of life and death. He elaborates that AIDS impacts an individual’s core beliefs, central life goals and meaning systems, and sense of self, personal role, and relationship to the world as a
whole. In addition, he states, AIDS-related stigma reinforces feelings of existential alienation and isolation, evoking despair and demoralization, as well as the dread, foreboding, and vulnerability of anxiety. For Farber, a goal of therapy is to help clients discover meaning in their suffering, and learn to deepen their experience, clarify choices, and find opportunity within the limits imposed by HIV/AIDS.\textsuperscript{132}

Steven A. Cadwell emphasizes that both the fact and impact of AIDS-related stigma must be directly confronted in clinical work with gay men living with AIDS.\textsuperscript{133} He argues that therapists should actively acknowledge and validate the existence of stigma and not assume that clients will recognize it on their own. The focus of therapeutic work, according to Cadwell, is to discern various sources of stigma, and to detect and liberate clients from their own internalized self-hatred as well as their “identification with the aggressive, stigmatizing ‘other.’”\textsuperscript{134}

In order to treat the isolation, depression, and damaged self-esteem engendered by stigma, Cadwell advises that therapists must create a refuge for clients that is safe and nurturing; a goal of therapy should be to help clients to become more compassionate and nurturing toward themselves.\textsuperscript{135} He warns that stigma may emerge through transference issues – for example, clients are bound to anticipate stigmatization and shaming in the therapy relationship – and holds that therapists must take an empathetic stance and find ways to explore the stigma- and shame-based motivations underlying clients’ behavior in ways that are nonjudgmental and non-shaming. Cadwell adds that the effects of stigma may also appear in less palpable forms, via therapists’ countertransference reactions. Examples of this are clinicians’ own anxieties and fears regarding contagion, death,
homosexuality, and sex. He maintains that therapists are affected by the contagion of stigma, whereby they feel tainted themselves for treating clients living with AIDS.

To summarize, this section on psychodynamic perspectives on AIDS-related stigma began by discussing theories that seek to explicate the origins of stigma. From this perspective, AIDS-related stigma is considered a largely unconscious defensive stance against the anxieties posed by the AIDS epidemic. Views on the roots of stigma from psychoanalytic, object relations, existential, and developmental psychologists were presented. The discussion then shifted to explore the intrapsychic implications of AIDS-related stigma, with a particular focus on its internalization. This segment presented literature on the psychological indicators, predictors, and consequences of internalized AIDS-related stigma as well as on clinical goals and concerns regarding transference and countertransference issues.

**Sociocultural Perspective on AIDS-related Stigma**

This section presents literature that explores AIDS-related stigma from sociocultural viewpoints. Theorists from this approach regard stigma as a socially constructed and culturally and historically relative phenomenon. AIDS-related stigma, from this perspective, is perceived as resulting from cultural processes and reflecting political, religious, social, and historical contexts and dynamics. After a brief outline of the sociocultural view of stigma this section offers a discussion of the negative response to AIDS in the United States that has been widely blamed for allowing it to reach pandemic proportions; this includes a presentation of theory that accounts for the instantaneous and enduring stigmatization of AIDS by linking AIDS-related stigma to the
stigmatization of homosexuality. Lastly, concepts that elucidate stigma from a
sociocultural perspective will be presented.

According to various authors who hold the sociocultural perspective, personal
thoughts and beliefs are generated and influenced by their social context. Negative
thoughts and beliefs about a stigmatized group are considered aspects of a culture’s
collective knowledge or folkways, and these stereotypes and other social impressions are
conveyed from members of one generation to another through socialization. This process
– which occurs via family life, the education system, the media, religious institutions, and
other cultural channels – ensures conformity as to which, and in what manner, groups are
stigmatized. Stigma, from the sociocultural perspective, is assumed to serve various
functions, such as preserving social cohesion, defining intergroup relations, maintaining
social control, punishing deviance, and justifying exploitation.

There is a vast amount of literature in the fields of sociology and social
psychology on sociocultural dimensions and aspects of stigma; these include discussions
of stigma’s etiology, social functions, mechanisms for perpetuation, and consequences.
Goffman, for example, held that stigma is a social product that is generated by social
interactions and that results from social reactions to designated attributes. The
stigmatized, Goffman states are “not persons but perspectives.” Allport’s work is
central to this perspective, notably his listing of sociocultural conditions that facilitate
prejudice and his view that the historical and sociocultural contexts in which
scapegoating occurs are basic to why certain groups are so maligned. A number of
other authors who add to the discussion are as follows: Gerhard Falk notes that stigma’s
various social functions include group cohesion and the protection of the status quo.
Link and Phelan discuss the impact of stigma on the distribution of life chances and view stigma as an exercise of power over those with lesser status. Lorentzen discusses stigma as an issue of social justice. Finally, Mark C. Stafford and Richard R. Scott explore stigma as a mechanism for addressing deviance and maintaining social control.

Stigma, then, is viewed as both emerging from and serving within a sociocultural context. AIDS-related stigma is perceived as reflecting and arising from the cultural, political, religious, and social contexts and dynamics of its time. This section now presents a discussion of AIDS-related stigma as considered through a sociocultural framework and lens.

AIDS is a global pandemic and, according to Nita Mawar, et al. and Herek, AIDS-related stigma is a nearly universal phenomenon. Around the globe, they agree, AIDS is associated with severe negative social reactions and people living with AIDS are, to varying degrees, stigmatized. AIDS, therefore, has become widely recognized as a social as well as a medical problem. Indeed, Mawar, et al. argue, the biological complexity of AIDS “pales in comparison to the social forces involved in the production and reproduction of AIDS-related stigma.”

Herek notes that the form, expression, tenor, and targets of AIDS-related stigma vary from country to country; each place, Mawar et al. concur, has responded to the AIDS epidemic in a unique way. Both argue that the variations are shaped by the local HIV epidemiology as well as by resident cultural mores, including the prejudices and stigmas that are already in existence. They agree the consistent and common thread is that those most stigmatized by AIDS belong to already marginalized, unpopular groups that are disproportionally affected by local epidemics. While there is a significant
amount of literature on the causes and impacts of AIDS-related stigma around the world, the bulk of this section presents literature that addresses the sociocultural conditions that bred and perpetuated AIDS-related stigma in the United States.

Shilts, in his tome And the Band Played On: Politics, People, and the AIDS Epidemic, offers a detailed portrait of the sociocultural context in which the threat of AIDS first appeared in the United States and rapidly came to develop. Shilts’ report examines the response to AIDS by federal and local governments, public health officials, mass media, medical science, and gay communities; it provides an historical account of how and why the dangers of AIDS were initially denied or ignored and allowed to reach what are now pandemic proportions. Shilts’ work offers compelling evidence that these responses both resulted from and exacerbated the stigma surrounding AIDS.

AIDS in the United States first struck gay men and intravenous drug users in San Francisco, Los Angeles, and New York in 1980; it was soon referred to as gay-related immunodeficiency disease (GRID). Shilts describes these early days as full of confusion and fear, as young healthy gay men, in increasing numbers, came down with bizarre and acute conditions, rapidly deteriorated, and died. He credits individuals who, with virtually no public funding, valiantly attempted to care for the ill and dying, and who tried to research the disease and stem its tide. And the Band Played On, however, also chronicles those whose cynicism and apathy toward what was initially considered a gay disease allowed it to spread virtually unchecked.

Shilts exposes the federal government as avoidant and indifferent about AIDS, and as deceptive about its funding practices. He accuses President Reagan of “ritualistic silence,” noting that by the time Reagan delivered his first address on AIDS in 1987,
36,058 Americans had been diagnosed with the disease and 20,849 had died. While his Secretary of Health and Human Services, Margaret Heckler, publicly called AIDS the government’s “number one priority,” no extra funding was released to facilitate its research and care. Shilts unfavorably compared this response to earlier government responses to the Tylenol crisis in 1972 and the outbreak of Legionnaire’s Disease in 1987, speculating that the vast difference in resource allotment was due to the perception that AIDS was a gay disease that only affected homosexual men.

Shilts claims that few epidemiologists from the Center for Disease Control or scientists from the National Cancer Institute were disposed to concentrate their efforts on AIDS; those who did so were either severely underfunded or consumed with infighting. He also notes that many medical providers – doctors, nurses, and other personnel – were reluctant to treat patients with AIDS; some refused to minister to them at all, not wanting themselves or their practices to be associated with gay men or AIDS. Shilts adds that once AIDS had the moniker of being a “gay disease” it became hard to convince people – including medical doctors, blood banks, hemophiliacs, and others – that individuals who were not gay could contract the disease.

Shilts also criticizes the media, accusing major newspapers, periodicals, and television stations of feeble and slanted coverage of AIDS. Shilts proclaims that AIDS was ignored by the media because it only struck gay men and drug addicts – not people “who mattered” – and because of fears that stories alluding to homosexual sex would offend the public. Stories that did run, Shilts shows, referred to AIDS as a “homosexual disease” or the “gay plague” and only appeared when AIDS surfaced in
novel, heterosexual populations. The Wall Street Journal, for example, did not file a report on AIDS until it produced one from a heterosexual angle.

The significant role that mainstream religious institutions played in stigmatizing AIDS – particularly the virulent public condemnations by the Christian Right – is also documented by Shilts.\textsuperscript{155} In 1983, for example, the Pro Family Christian Coalition took out a full page ad in a Nevada newspaper urging cancellation of an upcoming gay rodeo, avowing that those attending would “spread AIDS throughout Nevada.”\textsuperscript{156} Enlisted in their protest was a doctor who described the gay community as a “living, breathing, cesspool of pathogens,” and a clergyman from Reno’s First Baptist Church who was quoted in the paper as saying, “I think we should do what the bible says we should do and cut their [homosexuals’] throats.”\textsuperscript{157} Also that year, the Reverend Jerry Falwell distributed a Moral Majority Report called “The Gay Plague.”\textsuperscript{158} In an hour-long television show aired on ABC called “AIDS: The Anatomy of a Crisis,” Falwell asserted that he did not hate gays, just their “perverted lifestyle”; he referred to gay bath houses as the sites of “sub-animal behavior” and, referring to AIDS, he averred, “When you violate moral, health, and hygiene laws, you reap the whirlwind.”\textsuperscript{159}

Also revealed by Shilts is the battle between San Francisco public health officials, local politicians, sex club and bath house owners, and gay community factions over how to confront the rising epidemic once certain sexual practices were directly linked to AIDS.\textsuperscript{160} On one side were those who wanted to change bath house operations, either by posting safe sex flyers, providing condoms, monitoring behavior, or shutting them down; they proposed that gay men either cease having sex, disclose their positive HIV-status to sex partners, or practice safe sex. Failure to act, this side held, would allow AIDS to...
ravage and even more deeply stigmatize the gay community. Others, however, viewed their recently won sexual freedom as a way to heal from the stigma of being gay and objected to having their sexuality and sexual practices curtailed and linked with a deadly, contagious disease.

All in all, Shilts portrays a sociocultural milieu that was poised to respond to AIDS in ways that allowed it to become an extremely fatal and stigmatized disease. He demonstrates evidence of AIDS-related stigma at individual, community, and institutional levels of society. Underlying the stigma of AIDS, Shilts reveals a deep-rooted, pervasive stigma of homosexuality that had also been threaded through the fabric of the American culture.

Another major source for literature regarding the stigmas surrounding both homosexuality and AIDS is found in Herek. Herek has researched and written extensively about each, as distinct as well as related phenomena. His research has consisted of detailed national telephone surveys in which he asked participants about their feelings and attitudes toward people living with AIDS. In a report summarizing more than two decades of studies, Herek describes the public’s reaction to AIDS in the early days of the epidemic and how it has evolved over the past 25 years.\textsuperscript{161}

Herek states that since the start of the epidemic, a significant minority of the United States public has consistently expressed negative attitudes toward, and has supported authoritarian and punitive measures – including quarantining, universal mandatory testing, and even tattooing – against people living with AIDS.\textsuperscript{162} Herek notes that these negative attitudes have varied over the years; they peaked in the late 1980’s, and while they have recently diminished, they persist to this day. His 1997 survey, for
example, found that while people’s desire to avoid those living with AIDS, and their support for quarantining, were lower than in 1991, more people perceived those living with AIDS as deserving their condition and overrated the risk of getting AIDS through causal contact; approximately one third of those surveyed expressed discomfort and negative feelings toward people living with AIDS.\textsuperscript{163}

A 1999 study by Herek and John Capitanio revealed that the majority of heterosexuals surveyed still primarily associated AIDS with homosexuality or bisexuality, and that while everyone who contracted AIDS sexually was deemed responsible for becoming infected, gay and bisexual men were blamed more than heterosexual men and women.\textsuperscript{164} A substantial minority associated all male-male sexual behavior – even sex between two HIV-negative men – with AIDS. A sizable percentage also said they would be uncomfortable touching an article of clothing or drinking from a sterilized glass used by a person with AIDS. Herek and Capitanio claim that sexual prejudice was correlated with people’s misconceptions regarding HIV transmission as well as with their various apprehensions of HIV-infected individuals.

For more recent data, Herek points to a Kaiser Family Foundation national survey from 2006. This study found, for example, that more than one-fifth of those surveyed stated they would be uneasy about having an HIV-positive co-worker and 30 percent of parents sampled expressed agitation at the prospect of their child having an HIV-positive teacher.\textsuperscript{165} According to Herek, these responses – and the nature of AID-related stigma overall – is due to the widely perceived association of AIDS with homosexual men; he notes that homophobia – the stigma regarding homosexuality – is intrinsically linked with the stigma of AIDS.\textsuperscript{166} Herek credits George Weinberg with invention of the term
homophobia, which was first published in 1972; Herek quotes a personal correspondence from Weinberg in which he explains, “I coined the word homophobia to mean it was a phobia about homosexuals….It was a fear of homosexuals which seemed to be associated with a fear of contagion, a fear of reducing the things one fought for – home and family. It was a religious fear and it had led to a great brutality as fear always does.” While Herek uses the term widely, he claims that anger and disgust, rather than fear, have been found to be most central to heterosexuals’ emotional response to homosexuality.

Anita Bryant’s 1977 crusade in Dade County to “Save Our Children” – a campaign to overturn a Florida ordinance prohibiting discrimination on the basis of sexual orientation – and California’s 1978 Briggs Initiative are two events that, Herek claims, denote the Christian Right’s emergence as a powerful antigay force. In the ensuing three decades, the movements of both religious and political conservatives have targeted gay individuals and communities, expressing antipathy and describing homosexual acts, desires, and identities as immature, sick, and inferior.

Patricia G. Devine, E. Ashby Plant, and Kristen Harrison concur that AIDS-related stigma is entwined with negative beliefs about homosexuality that hold it to be offensive and hateful; as a threat to core religious and cultural values, AIDS is thus deemed, by many, as deserved punishment for immoral behavior. Devine, Plant, and Harrison recount how in early days of AIDS, the Centers for Disease Control introduced the notion of risk groups to identify those initially most commonly infected, thus encouraging “collectivized rather than individualized” perceptions of people with AIDS and further marginalizing and stigmatizing them. Calling this the “single most destructive social component of the AIDS epidemic,” Devine, Plant, and Harrison note
that since homosexuality and AIDS are so closely linked in the culture’s mind, prejudice toward homosexuals ignites hatred toward people with AIDS and visa versa.\textsuperscript{173}

Deacon agrees, and echoes Mawar and Herek in noting that AIDS-related stigma both depends on and solidifies existing social stereotypes and negative associations of already-defined out-groups.\textsuperscript{174} According to Deacon, the linking of AIDS-related stigma to other forms of prejudice is known as \textit{multiple stigmatization}, or \textit{double-} or \textit{triple-stigmatization}.\textsuperscript{175} She notes that disclosing one’s HIV status can thus reveal membership in another marginalized, despised group, making one vulnerable to being seen as deviant and immoral and more worthy of blame.

Another sociocultural dimension of stigma is described by Goffman’s concept of \textit{courtesy stigma}, defined as the spreading of stigma from stigmatized individuals to those who associate with them.\textsuperscript{176} In courtesy stigma, Goffman notes, these associates – spouses, family members, and friends – are likewise held as deviant and come to share the discredit; even connections once or twice removed may suffer some effects of the stigma. Goffman warns that courtesy stigma can lead to the avoidance or termination of these important social associations. Regarding AIDS-related stigma, Michelle R. Hebl, Jennifer Tickle, and Todd F. Heatherton call the phenomenon of courtesy stigma \textit{social-} or \textit{interpersonal contagion}, which they describe as a contamination, or loss of social status, through contact with those stigmatized by homosexuality or HIV/AIDS.\textsuperscript{177} This, they observe, occurs to family members, partners, caregivers, and even those with professional associations.

To review, this section began by explaining how stigma is viewed from a sociocultural perspective. The bulk of this section was devoted to providing a detailed
portrait of the sociocultural milieu in the United States in the early days of the AIDS epidemic – including responses by government, media, medical science, the religious right, and the gay community – that both resulted from and exacerbated the stigma surrounding AIDS. Shilts’ book, *And the Band Played On* was the central reference for this exploration. Herek’s research on AIDS-stigma and its association with homophobia were also considered in depth. This section also discussed related concepts and principles that contribute to an understanding of AIDS related stigma, such as multiple stigma and courtesy stigma.

**Imaginal Approaches to AIDS-related Stigma**

This section on imaginal approaches to AIDS-related stigma presents ideas that derive from diverse domains and disciplines. It begins with a brief orientation to Imaginal Psychology and its central focus and intent, highlighting concepts and principles from Omer’s Imaginal Transformation Praxis relevant to the topic of AIDS-related stigma. Ideas from archetypal and Jungian psychology are also discussed here, including an exploration of the Scapegoat, a myth that guides this Clinical Case Study. This section also introduces work that examines the iconography of AIDS and concludes with a discussion of imaginal approaches that consider how the experience of AIDS-related stigma may be a potentially transformative journey.

Omer describes Imaginal Psychology as a distinct orientation to psychology in which soul, and care of the soul, are reclaimed as psychology’s foremost concerns. Contending that “soul is an inexhaustible mystery and imagination is its language,” Omer proposes that soul communicates through images; images, then, are the aspect of
experience that is most significant, and care of the soul means “paying close attention to the images we inhabit.” 179

With roots in ancient transformative and initiatory practices, and interests encompassing personal, cultural, and archetypal domains of knowledge and experience, Imaginal Psychology, argues Omer, is a “postmodern-indigenous orientation to psychology” 180 To varying degrees, Imaginal Psychology is congruent and in dialogue with modern orientations to psychology – such as Depth, Cognitive-Behavioral, Humanistic, and Transpersonal Psychology – while also drawing from other realms such as spiritual traditions, expressive arts, somatic practices, deep ecology, mythology, indigenous wisdom, and social critique. 181

Omer’s Imaginal Transformation Praxis can be usefully applied to the topic of AIDS-related stigma. While he rarely employs the term stigma per se, nor refers directly to the stigma of AIDS, several of Omer’s concepts and principles contribute to elucidating the phenomenon’s foundations and dynamics. For example, Omer’s notion of imaginal structures can shed light on the etiology of stigma as well as on the impact and potential resolution of stigmatization upon those targeted. Omer defines imaginal structures as:

assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experience. The specifics of an imaginal structure are determined by an interaction of personal, cultural, and archetypal influences. These influences may be teased apart by attending to the stories that form personal character and the myths that shape cultural life. During the individuation process, imaginal structures are transmuted into emergent and enhanced capacities as well as transformed identity. Any enduring and substantive change in individual or group behavior requires a transmuting of imaginal structures. This transmutation depends upon an affirmative turn toward the passionate nature of the soul. 182
Imaginal structures are a way to conceptualize the core beliefs and personal schemas that are the lenses through which we view ourselves, others, and the world, and that guide our interpretations, responses, and experience. According to Omer, these images become fixed, enmeshed, and habituated and, though they shape our persona and identity, they often remain beyond our conscious awareness. Omer asserts that our imaginal structures dictate what we deem good and bad, and what we claim as “me” and “other”; they lead us to form purified, limited identities that are intolerant of diversity and of the multiplicity inherent in soul’s nature.

Another concept from Imaginal Transformation Praxis that is relevant to understanding stigma is gatekeeping, which “refers to the individual and collective dynamics that resist and restrict experience. The term gatekeeper refers to the personification of these dynamics.” Omer posits that gatekeepers are particular types of internalized images that personify a narrow perspective and vigilance toward what is unknown and perceived by us as “other.” He maintains that gatekeepers are the critical, punitive parts of the self and of the culture that act to limit expression and individuality, as well as the emergence and engagement of difference.

According to Omer, gatekeeping on an institutional level constitutes oppression, and cultural oppression is sustained by gatekeeping. He holds that cultural gatekeepers “personify the restrictive and resisting forces within a culture that maintain the dominant ideology and ensure conformity with that culture’s rules, norms, values, and taboos. They personify a set of beliefs and practices that legitimize the status quo through the influence of political, economic, and media institutions.” The internalization of
personal and cultural gatekeepers may be congruent, in many respects, with the concept of internalized stigma.

The phenomenon of *scapegoating*, while not precisely parallel, is closely related to stigmatization; individuals or groups subjected to stigma have, in effect, been made scapegoats. Omer defines scapegoating as “avoidance through blame,” and considers it a subset of gatekeeping.\(^{188}\) He maintains that scapegoating involves “actions or attributions that preserve and demarcate identity by locating weakness, badness, impurity, and danger elsewhere, and distance us from what we consider toxic.”\(^ {189}\) Cultural scapegoating occurs when – in order for a group to manage its anxiety and protect itself from vulnerability – those who are considered different or impure are marginalized, punished, or exiled. What results, Omer contends, is a delineation of insider/outsider status within the culture and the upholding its center/periphery dynamics.\(^ {190}\)

Because the Scapegoat is a primary mythic backdrop for this Clinical Case Study, a more detailed examination of scapegoating is included here. There is a vast body of literature on scapegoating. Sylvia Brinton Perera’s work on the scapegoat archetype is presented because her study of the psychological dynamics and implications of scapegoating includes individual, relational, clinical, cultural, and mythic perspectives; her work, therefore, contributes to a potentially deeper understanding of both the perpetration and internalization of stigma.\(^ {191}\)

In Perera’s telling, the scapegoat story derives from an ancient Hebraic atonement ceremony, central to Yom Kippur, which is described in the Old Testament.\(^ {192}\) This New Year’s ritual, intended to renew, purge, and heal the community, entailed the sacrifice of two goats. One goat was slaughtered in dedication to Yahweh, its blood offered to
sanctify the ceremonial grounds and to appease, and appeal for pardon from, a god furious at the impurities, sins, and transgressions of the community; the goat’s remains were treated as unclean and burned beyond the grounds. The other goat was dedicated to Azazel, a fallen angel; after a priest ritually burdened the goat by confessing all the sins of the community over its head, the goat, still alive, was removed from the grounds and sent wandering into the wilderness; this “escape goat” carried the guilt and sins of the community with it into the desert.\textsuperscript{193}

According to Perera, this ritualized transfer and expulsion of the community’s evil and ill fortune left its members guiltless and purified and returned to a state of grace and alignment with God.\textsuperscript{194} Noting that, in modern times, the term scapegoat is applied to individuals and groups whom the culture derogates or accuses of causing misfortune, Perera defines the process of scapegoating as “finding the one or ones who can be identified with evil or wrong-doing, blamed for it, and cast out from the community in order to leave the remaining members with a feeling of guiltlessness, atoned (at-one) with the collective standards of behavior.”\textsuperscript{195}

Perera contends that the scapegoat archetype is at the core of a complex, a Jungian term that describes “an emotionally charged group of ideas or images.”\textsuperscript{196} She proposes four positions in the scapegoat complex – Azazel, the Holocausted Goat, the Wandering Goat, and the Priest – that are distinct manifestations of how individuals may identify with the scapegoat archetype.\textsuperscript{197} The Azazel position is the arrogant, condemning accuser, who identifies as superior, moral, virtuous, and irreproachable, and whose job it is to uphold morality and the authority of the status quo, ensure others follow rules and laws, and identify and punish those who transgress the imperatives of mainstream
The Holocausted Goat, or victim-ego, is the figure that identifies with and internalizes Azazel’s accusations and condemnations, and feels powerless, inferior, tabooed, and “radically unacceptable.” Holocausted Goats are passive, filled with existential anxiety and guilt, and fearful of further victimization; they can be grandiose and defiant, feel guilty for both their weakness and their power, and identify both as hated and “Chosen.” The Wandering Goat, or alienated ego, is a rebellious outsider/rescuer figure that has been banished by the mainstream due to its sinful instinctual energies. The Wandering Goat holds all the community’s guilt, and is grandiose, prideful, dutiful, adaptive, and resigned to its martyrdom and outcast status. This figure is dismissive of the mainstream, yet longs for acceptance, and copes by becoming overly responsible, competent, indispensable, and placating. The Priest, or persona-ego, represents the mainstream status quo and colludes with Azazel. This figure models the good, moral, conventional, and culturally and socially acceptable norms; through connection with Azazel, the Priest – who may have once been the target of Azazel’s condemnation – finds acceptance, salvation, safety, identity, belonging and value.

Perera offers a detailed account of why certain individuals become mired in the scapegoat complex and of the impact it has on their lives. She speculates that those who identify with the scapegoat were burdened early in life by being devalued, repressed, judged, moralized, and punished. Then, as adults, scapegoat-identified individuals lack a sense of personal identity, self-confidence, and agency. Having internalized the voice of the rejecting accuser, they are prone to perfectionism, splitting, and self-condemnation; depend on external evaluation; and are plagued by the sense of exile and not belonging.
Perera concludes that individuals who are scapegoat-identified become severed from both “the outer world and their own inner depths,” and that their involvement in the scapegoat complex becomes a central focus of their lives and identities. 202

According to Perera, healing for scapegoat-identified individuals entails disidentifying from the complex and discovering and coming into conscious relationship with the meaning the archetype has had their lives. Resolution of the scapegoat complex is possible, she notes, within a therapeutic relationship; it involves the patient and therapist building an alliance against the accuser, and requires that the patient be met with caring, empathy, acceptance, and objectivity. For resolution to occur, the therapist must remain conscious and vigilant about their own role in the complex as well as the scapegoat-identified material that is evoked by the patient.203

Scapegoating, according to Perera, is viewed in Jungian terms as denial of the shadow, the disowned part of the self that we find reprehensible, shameful, and embarrassing.204 Carl Jung called the shadow “the other in us”; in sum, he wrote, it is “the thing a person has no wish to be.” 205 In Jung’s view, the shadow contains “the animal sphere of instinct,” and the repressed parts of the primitive or archaic psyche.206 He explained that we stifle these parts of ourselves and project them onto others; thus we can continue to see ourselves as superior and good, and understand negative traits as existing only in others. This fosters our belief, Jung wrote, that others are responsible for our difficulties – that “they do this or that, they are wrong, and they must be fought against.” 207

There is a substantial body of literature on shadow projection – linking it with oppression, scapegoating, discrimination, prejudice, enemy-making, genocide, and war –
that can also make a valuable contribution to understanding stigma. Notable examples are
Sam Keen’s survey of enemy images; Jürgen Kremer and Donald Rothberg’s discussion
of the collective shadow; and the works of M. Scott Peck, Audre Lorde, Susan Griffin,
and Andrea Dworkin.\textsuperscript{208}

Another imaginal approach to AIDS-related stigma involves exploring the
\textit{iconography} of AIDS which Deborah Lupton defines as the identification, description,
and interpretation of the content of the images that have arisen – especially in the mass
media – in response to the AIDS epidemic.\textsuperscript{209} She notes that the iconography of an
illness both indicates and impacts the ways in which society conceptualizes and deals
with disease.\textsuperscript{210} She posits that visual images and language serve to construct stereotypes
of an illness and of those suffering from the illness. These stereotypes then influence how
the illness and the patient are perceived and how the patient is treated by others; they are
also internalized by patients in ways that shape their experience of the illness.

Sander L. Gilman concurs, reasoning that the portrayal of the patient is thus the
image of the disease anthropomorphized.\textsuperscript{211} In his analysis of the visual imagery of
AIDS, Gilman concludes that gay men have been depicted in ways that objectify and
stigmatize them, by “linking homosexuality and death as almost inseparable.”\textsuperscript{212} Gilman
reports that portraits of people living with AIDS almost universally show them as
ravaged, disfigured, debilitated, desperate, alone, and resigned to an inevitable death. He
concludes that this visual imagery defines AIDS sufferers as “Other” and creates
stereotypes that lead to their dehumanization.\textsuperscript{213}

Nelson Varas-Diaz and José Toro-Alfonso’s research supports Gilman’s
findings.\textsuperscript{214} Their qualitative survey of the visual images of people living with AIDS –
what they call the *AIDS body* – analyzes those shown in multiple media outlets such as television, the Internet, and the printed press. Varas-Diaz and Toro-Alfonso conclude that despite the current state of the epidemic, these visual images continue to contribute to AIDS-related stigma by associating AIDS only with sickness, contagion, and death.215 By conjuring such negative perspectives of people living with AIDS even when reporting potentially positive news, the images, they claim, evidence the stigmatizing notions attached to the AIDS body. Specifically, their findings categorize visual representations of the AIDS body as falling into three arenas: the dangerous body – invading “healthy” society; the isolated body – restraining social interaction; and the fragmented body – the impossibility of completeness.216

Susan Sontag’s work, *AIDS and Its Metaphors*, is also essential to consider.217 Her review of the images employed regarding AIDS demonstrates how they have served to imbue AIDS with specific and stigmatizing meanings: they associate AIDS with evil, create a spoiled identity, and attach blame to its “victims.” 218 Examples she offers of images that stigmatize both the illness and the ill include the metaphor of the pariah as well as those evoking invasion and pollution. Sontag highlights the stigmatizing impact of military metaphors that name the virus as an enemy that has attacked and must be defeated; commonly used images and phrases, she notes, include “under assault,” “lurking,” “invading agents,” “harboring the virus,” and “spreading insidiously.” According to Sontag, however, “plague” is the principal metaphor by which the AIDS epidemic has become understood which, she suggests, has several stigmatizing connotations, such as viewing the illness as a punishment, a curse, and the wrath of god;
as repulsive, retributive, and collectively invasive; and as linked with immorality, depravity, and foreignness.\textsuperscript{219}

Other imaginal approaches consider the experience of AIDS-related stigma as a potentially transformative journey that can foster the development of personal capacities and spiritual growth. Omer defines a capacity as “a distinct dimension of human development and human evolution that delineates a specific potential for responding to a domain of life experience,” which suggests that many of the affects and conditions experienced by people living with the stigma of AIDS can be transmuted into capacities.\textsuperscript{220} For example, Omer proposes that ”compassion responds to suffering; courage responds to danger; destiny responds to the future; dignity responds to failure; fierceness responds to injustice; faith responds to uncertainty; and reflexivity responds to personal identity.”\textsuperscript{221} Omer has also explained capacities as transmuting from various affects; for example, “grief transmutes into compassion, anger transmutes into fierceness, and shame transmutes into autonomy, humility, gratitude, and dignity.”\textsuperscript{222}

Congruent with Omer’s theory but specifically addressing AIDS is Joel Milam’s review of qualitative research on \textit{posttraumatic growth} among people living with AIDS which finds ample evidence that positive changes – including newly developed capacities and self-transcendence – attributed to being diagnosed and living with HIV/AIDS indeed occur.\textsuperscript{223} According to Milam, posttraumatic growth is the principle that an individual’s encounter with trauma, which contains elements of great suffering and loss, can also lead to highly positive changes.\textsuperscript{224} Milam notes that while the psychological sequelae of HIV infection includes depression, anxiety, fear, guilt, and helplessness, there is also solid evidence that living with AIDS can serve as a developmental trigger that allows
individuals to cultivate altruism and spiritual growth, and to reap an increased sense of identity, belonging, meaning, purpose, and direction in life. He observes that those experiencing posttraumatic growth gain the recognition of being vulnerable yet stronger, and perceive their experience of living with AIDS as a challenge to fully understand themselves, appreciate relationships with others, and improve their overall quality of life.\textsuperscript{225}

Joseph P. Nathans, in his narrative/heuristic study on the impact of HIV/AIDS and the healing effects of compassion upon long-term survivors, explores the potentially transformative impact of enduring AIDS.\textsuperscript{226} According to Nathans, the stigma regarding AIDS can be psychologically overwhelming and shut individuals off from the “needed healing of community: the compassion that restores/engenders wholeness.”\textsuperscript{227} For him, moving beyond the anxiety, alienation, uncertainty, and awareness of being different, in order to remain connected and engaged with life, is the challenge and the gift of AIDS. Nathans contends that AIDS, posing as both crisis and opportunity, can lead individuals to discover their authentic self and inner truth. Ultimately, he writes, “the potential transformation is as though one had gone through death and learned to live fully in life, a rebirthing of consummate totality, beyond the limitation of death, and therefore beyond life’s fear-filled limitations….Having come through the ring of fire, once realized, the blessing is abundant, the gift of everyday now precious and glorious.”\textsuperscript{228}

According to Frank C. Gehr, living with HIV/AIDS has given many gay men the opportunity to move past the barriers of oppression, stigmatization, and victimization, into self-actualization and self-empowerment.\textsuperscript{229} His phenomenological study of the spiritual experiences of gay men living with AIDS found that their spiritual paths served
as ways for them to make sense of and cope with the challenges of a diagnosis that seemed without hope or meaning.\textsuperscript{230} Most of the study’s participants, Gehr notes, consider being diagnosed with HIV/AIDS a spiritual experience and believe it fostered a deeper and more profound understanding of their sense of self, of their spiritual unfolding, and their sense of purpose in life.

Much has been written about the transformative potential inherent in afflictions such as a serious illness. As James Hollis declares, “It is the swamplands of the soul, the savannas of suffering, that provide the context for the stimulation and the attainment of meaning.”\textsuperscript{231} In this context it is important to mention Jean Houston’s contribution of the notion of \textit{sacred wounding} – the idea that exploring one’s story of personal suffering invites rebirth and the revelation of the \textit{sacred myth} that is held in a larger, unitive story.\textsuperscript{232} Thomas Moore’s tome, \textit{Care of the Soul}, is also vital, as his approach views symptoms as a voice of the soul and highlights the significance of investigating the images that are revealed in the course of one’s suffering.\textsuperscript{233}

Pema Chödrön’s work is also important to include, as her teachings became focal in the course of treatment described in this Clinical Case Study.\textsuperscript{234} Chödrön introduces practices from Tibetan Buddhism that view the difficulties that humans experience – conflict, shame, envy, physical and emotional pain, notions of unworthiness – as seeds of compassion and an awakened heart, and a way of experiencing kinship with all other beings.\textsuperscript{235} Counseling that we befriend the rejected, embarrassing, so-called bad parts of ourselves and others, Chödrön invites us to reverse our usual patterns of splitting and trying to escape our pains and demons, and learn, instead, to endure and embrace them.
“Everything that occurs,” she writes, “is not only usable and workable but is actually the path itself.”

Creative arts therapy is another type of transformative practice relevant to this topic. Essential to include here is body mapping, a technique developed by the National Community of Women Living with AIDS (NACWOLA) in Uganda, which is a tool for communicating about the realities of living with HIV/AIDS and reducing AIDS-related stigma. According to Kimani Njogu and Mary Mugo-Wanjau, body maps are life-size silhouettes that participants trace and then fill with images—such as pictures, words, and symbols—of their inner selves. These include areas with emotional significance—fears, anxieties, shame and grief—as well as symbols of personal power, identification of parts of the self that hold stigma, and representations of the virus and the “experience it leaves on the body.” The process, note Njogu and Mugo-Wanjau, affords participants the chance to explore, record, and review the ways in which they imagine their body, their experience, and their life, and serves as way to share their stories, receive support, shift identity, and leave behind memories for their children.

A final imaginal approach to AIDS-related stigma considered here recognizes the transformative power of cultural leadership. Omer defines cultural leadership as “the creative transgression of taboo that leads to the creation of new meanings.” “Cultural leaders,” he continues, “catalyze the deepening and diversification of experience” that has been restricted by cultural gatekeepers. According to Omer, “If there is no transgression, there is no cultural transformation.”

An example of cultural leadership relevant to this Clinical Case Study is the transgressive, transformational work of AIDS Coalition to Unleash Power (ACT UP), an
influential social justice organization formed by gay men in 1987 with the task of “meeting the challenge of the AIDS epidemic and its crisis of conscience with vigilant acts of political and cultural provocation – thereby giving voice to the essential creative will of our humanity.” According to Joshua Gamson, ACT UP members take direct – and often theatrical, provocative, and boundary crossing – actions to expose and condemn the actions, inactions, statements, and image production that spread AIDS-related stigma, which leads to silence, which results in higher infections rates and more deaths from AIDS. ACT UP’s general strategy, he suggests, is to take the symbols and dominant representations that have been used to stigmatize AIDS – and to oppress, exclude, or render gay men invisible – and invert and reclaim them, or else replace them with alternative representations. Examples Gamson gives of ACT UP’s impact include both shifts in language – from “AIDS victim” to “Person Living with AIDS” and from “risk group” to “risk practices” – and the creation of powerful visual symbols, such as the icon “SILENCE = DEATH” written in bold white-on-black letters beneath a pink triangle, the Nazi badge for homosexuals that marked them for death. ACT UP is also noted for the action called a “die-in,” in which activists draw police-style chalk outlines around bodies of those posing as dead; to Gamson, this has the effect of shifting the conventional associations of AIDS deaths from an individual tragedy or punishment to likening them to murders, “victims not of their own deviance but shot down by people controlling the definition and enforcement of normality.”

Gamson argues that ACT UP’s outrageous, campy, identity-oriented actions – which also include lesbian and gay kiss-ins and singing raunchy safe-sex songs in front of government offices – serve at once to link stigmatization to AIDS deaths, disrupt
conventional deviant labels, and assist members to actively forge a gay identity while challenging the process through which it has previously been formed for them.\textsuperscript{247} Finally, he claims, the resistance of stigma is clearly identified as the key to stopping the AIDS epidemic.\textsuperscript{248}

To summarize, imaginal approaches to AIDS-related stigma are found in diverse and wide-ranging disciplines. Imaginal Transformation Praxis contributes ideas about imaginal structures, gatekeeping, and, scapegoating. The Scapegoat myth, archetype and complex, and the concept of shadow projection, from Jungian psychology are also central to this inquiry. Imaginal approaches also focus on the iconography of AIDS – in both visual image and metaphor – that both indicate and impact its stigmatization. Finally, imaginal approaches that consider the experience of AIDS-related stigma to be a potentially transformative journey were considered. These include literature concerning the cultivation of identity and new capacities through spiritual practices, creative arts therapies, and cultural leadership.

\textbf{Conclusion}

This literature review presented five distinct perspectives on the topic AIDS-related stigma. In order to provide a solid foundation and context for understanding this phenomenon, the chapter included literature on general stigma and disease stigma, and it opened with a brief summary of the history, epidemiology, and treatment of HIV/AIDS in the United States. The discussion from a biological perspective focused on how the visible manifestations of HIV disease and its treatment protocols particularly evoke stigma; views on the biological roots of stigma from evolutionary psychology and affect
theory were also included in this section. The literature from a cognitive/behavioral perspective described the psychological processes believed to generate stereotypes and prejudices, and highlighted the role of cognition in the dynamics of stigma; this section also reviewed cognitive approaches to psychotherapy for people living with HIV/AIDS as well as research assessing interventions designed to ameliorate the psychosocial consequences of AIDS-related stigma. The section on the psychodynamic perspective on AIDS-related stigma explained the intrapsychic basis of stigma and the mechanisms and implications of internalizing AIDS-related stigma. The sociocultural section presented an account of the immediate and enduring stigmatization of AIDS, naming it a socially constructed and culturally relative phenomenon; elucidating its political, religious, social, and historical contexts; and linking it directly to homophobia. This chapter’s final section, Imaginal Approaches to AIDS-related stigma, highlighted concepts from Omer’s Imaginal Transformation Praxis – such as imaginal structures, gatekeeping, the cultivation of capacities, and cultural leadership – that contribute to an understanding of the topic as well as of the trajectory of the treatment and the interpretation of the learnings described in this Clinical Case Study. This section also presented an introduction to the Scapegoat myth, a significant backdrop to this effort, and offered viewpoints suggesting that the traumatic experience of AIDS-related stigma can be a potentially transformative journey.

The perspectives presented in this Literature Review offer diverse and discrete viewpoints on the origins, functions, consequences, and dynamics of AIDS-related stigma. Each approach holds distinct ideas regarding why and by what mechanisms humans stigmatize others. In the literature on stigma, and on AIDS-related stigma, there
is little conversation or overlap between perspectives and so there is little that appears to be in conflict. Each of the perspectives holds particular truths and insights about the topic; when taken together and assimilated, a more comprehensive and compelling understanding of AIDS-related stigma can be generated. It seems clear from the literature that the phenomenon of AIDS-related stigma – as must be true of most all human experiences – is the combined consequence of biological, cognitive/behavioral, psychodynamic, sociocultural, and archetypal forces. Knowledge gathered from each of these domains makes a unique and significant contribution to the field.

Much of the literature on stigma is directed toward understanding its underlying mechanisms and etiology; the bulk of research on AIDS-related stigma, with the goal of directing public policy, is focused on the impact stigma has on HIV prevention and care. Literature on both the perpetuation and consequences of AIDS-related stigma is heavily weighted by theoretical discussion. The qualitative experience of being targeted by AIDS-related stigma is inadequately addressed in the literature on this topic. Studies that investigate the psychological suffering, nonetheless the healing from stigma, are limited, and explorations from the subjective experience of people living with AIDS – and thus with a “spoiled identity” – are even scarcer still.

This Clinical Case Study is an attempt to contribute to the literature in the field of AIDS-related stigma by presenting the details of the psychotherapy treatment of a gay man living with AIDS. A subjective account of the client’s struggle with internalized AIDS-related stigma – and his endeavor to heal – is infused through the discussion of the progression of his therapy and of the learnings gleaned from his treatment. The theoretical perspectives found in this Literature Review provide an essential base and
anchor for the Clinical Case Study; it is hoped that, by presenting the client’s first-person narrative, this work will serve the field by bringing aspects of these theories to life, further illuminating both the details and dynamics of the stigma experience. If it succeeds in doing so, it may also encourage further inclusion of the voices of those stigmatized by AIDS in the burgeoning literature in the field.
CHAPTER 3

PROGRESSION OF THE TREATMENT

The Beginning

As I began to plan and prepare for doing clinical work through my place of employment, I considered who might be effectively served in the setting of a food bank. Since my office is not in a mental health facility or clinic, but rather a bustling community center, I thought it best to identify individuals who were not challenged with serious mental health issues and who could contend with some of the other, less traditional, circumstances that the setting, and my role there, would likely invite. I decided to limit my offer of counseling services to individuals who had participated in the Shanti Learning Immune Function Enhancement (L.I.F.E.) Program, a psycho-educational program for people living with HIV/AIDS that I had facilitated over the previous four years. This provided me with a basic sense of the functioning level of the clients with whom I would meet, as well as a clear parameter to present to others who might learn of my services but who were not appropriate for me to consider treating at this time and venue.

The L.I.F.E. Program offers a biopsychosocial approach to treating HIV disease that addresses, and helps participants improve their performance on, distinct psychological and social factors that affect immune function and disease progression. The program aims to prepare individuals living with HIV/AIDS to regain or improve their physical and psychological health, to build positive social connections with others, and to
increase their hope about – and control over – health progression and survival time. For many, the L.I.F.E. Program served to initiate and support their transition from a sheltered and isolated world of convalescence or withdrawal back into the social world of community; participants were gently guided to explore what might be some of the underlying barriers to their moving forward and to re-imagining their futures. The content and duration of the program allowed me, as the facilitator, to gain a sense of which participants might be good candidates for clinical work.

As I did with other potential clients, I approached Victor and explained that I was in a graduate program in psychology and about to begin my clinical training, and that I was offering a limited number of individual counseling sessions to people wishing to do further work on psychosocial issues similar to those addressed in the L.I.F.E. Program. Victor immediately said that he was interested, and I suggested that he come and meet with me so we could discuss it in more detail: He could tell me about his needs and concerns, I would let him know more about what I could offer, and we would, together, determine if it was a good fit. Victor agreed, and we set an appointment to meet.

At this first meeting, about a week later, I repeated to Victor that I was offering one-on-one psychosocial counseling as part of my training to become a psychologist. I informed him that I would be under the supervision of a licensed Marriage and Family Therapist with whom I would consult on a regular basis. I carefully explained that while we would meet in my office at the food bank, and I would not charge him a fee for our sessions, our work together would have a clinical framing and follow the guidelines of a professional psychotherapy relationship. Victor said that he was very interested in
meeting with me and, in an animated and candid manner he began to tell me why he wanted to be in therapy.

The main problem Victor presented was his anxiety about returning to “the real world” after being disabled and unemployed for many years. Victor was exploring his options for returning to work, mainly fueled by fears of increased poverty when his private disability benefits will cease and he will lose 550 dollars per month from an already limited income. He was in the process of applying to a graduate level credential program in school counseling at a local university. Victor shared that he was having a hard time writing his personal statement and feared that he would not meet the application deadlines.

In addition to anxiety evoked by the application process, the idea of being more engaged in the world stirred fears of scorn and rejection. Victor’s concerns ranged from having to disclose to his classmates that he is gay and HIV-positive to the possibility that living with AIDS for so long may have compromised him cognitively, thus threatening his capacity to succeed in the program. He worried that he would not be admitted and he worried that if he were admitted he would fail. He feared that as a student he would be subject to painful evaluations of himself and of his work that would be hard for him to handle. Significantly, he worried about stigma; how others would judge him and treat him and how this would affect how he feels about himself.

Victor expressed some ambivalence about his choice of programs and about the decision to go back to work at all, which contributed to his fretfulness and procrastination. He said that he wanted me to help him stay on track with the tasks required for successfully returning to school and/or employment; as he put it, he wanted
me to help make him feel guilty and to “kick his butt” so he would meet his deadlines. After listening to Victor express his various concerns, I shared my observation that in spite of his clear expectation and fear that he would be met with criticism and rejection, he had nonetheless chosen to enter a program and profession that would inherently entail a considerable amount of interaction and scrutiny. I said I found it interesting that, given the many options that existed, he was pursuing this particular path in order to replace that chunk of his income. Without missing a beat, Victor quipped, “I guess I’m just a masochist.” I responded that that was one way of looking at it, but that it seemed to me that there were far easier ways of satisfying that kind of urge that didn’t require such an elaborate application process! Besides, I offered, it didn’t sound to me like pain was his intent here, though it could certainly be a result.

Victor smiled, and then began to speak of how he wanted to accomplish something more in his life, and to make a difference. He said, “I’ve never said this to anyone before, but I want to feel I’ve had an effect on people, that when I die I’ll be missed. Not that people can’t live without me, but that they’ve known me, that my absence would be noticed.” I commented that this did not sound masochistic, it sounded soul-affirming and that maybe it was a chance for him to unfold and engage a part of himself that had been dormant and that wanted to emerge, even if opening to scrutiny meant becoming vulnerable. I suggested that maybe the part of him that is pulled toward studying counseling is a part that wants to be seen. Victor paused to reflect on my words and then said that what I described fit for him.

The conversation deepened then. “I want my life to matter,” he said again. “I want to feel like I’ve had an impact.” Then Victor mentioned other factors that contributed to
his stress and unhappiness: he wondered about parts of himself that had never been developed, as he had been isolated for a significant portion of his life. He described himself as having an “intense inner critic.” Victor said, “Sometimes I feel so much shame I hardly leave the house. I feel like having HIV makes me dirty, damaged, and disgusting.”

As he mentioned what his goals for the psychotherapy would include, Victor stated that he wanted to work on getting rid of his inner critic and his self-hatred about being gay, and to heal his low self-esteem, which he attributed to the “stigma of being HIV-positive.” As we began to come to agreement about working together, I let Victor know I would not “kick his butt” in order that he complete his application, but that he could certainly use the sessions to help stay on track with assignments and deadlines. I told him that we would work together on a plan that would include addressing his needs for the application process as well as working with his inner critic and addressing his self-hatred about being gay and having AIDS.

During this initial meeting, Victor provided some general biographical information that included an account of the complex and turbulent history of his physical health. We also talked about some of the basics, such as the pros and cons of therapy, and confidentiality and what circumstances required that I break confidentiality. I suggested that we meet on a weekly basis, for 12 one-hour sessions, and then reevaluate. Victor agreed and signed the required paperwork, and we scheduled to meet the following week. I had several overall impressions from the first session. Victor was animated, verbose, and intense, and he was entertaining – that is, he was engaging, charismatic, and funny. Much of Victor’s humor, though, was self-deprecating; this, I surmised, was evidence of
his strong internal critic. I observed that Victor was self-reflective and revealing, though he remained emotionally guarded and “in his head.” I found it interesting then, that I experienced him as quite vulnerable and that I felt a lot of emotion in his presence. Victor spoke and laughed very loudly, causing me concerns about his privacy, anxiety that our sessions could be disruptive to the food bank, and questions about his possible hearing loss. Overall, Victor struck me as someone who was ready to roll up his sleeves and work hard, and who was ripe to gain insight and make changes. I felt excited that we were embarking on this journey together.

While there were no crisis issues that required immediate attention as the treatment began, an ethical concern arose at our third meeting. My supervisor Connie had suggested that I ask my clients regularly about how they thought the therapy was going. She encouraged me not to be afraid to do so frequently, to explain that I was a new therapist and wanted to be sure I was addressing their needs as well as I could and that I wanted the process to remain relevant and collaborative.

Following Connie’s advice, during the third session with Victor, I made a point of checking in with him about what he thought so far. Victor replied that he was really excited about the process and pleased to be in therapy with me. He said that he felt sure that I could help him and that I was already more helpful than other therapists he had worked with. Victor went on to say that even though I was a student, he had already gotten more in just a few meetings with me than he had gotten in years from “this guy I’ve been seeing who is a psychologist.” He added that he had decided to stop seeing the psychologist but was afraid to hurt his feelings.
I had not been aware that Victor was currently in therapy. When I had inquired about his prior experience with therapy during our initial intake session, Victor had replied simply that yes, he had been in therapy before and understood what it entailed – and I was uncertain and apprehensive about how to respond. I proceeded cautiously; although perplexed, I did at least recognize the dilemma of interfering with work already in progress with another practitioner. (This issue is discussed further in the “Legal and Ethical Issues” section below.) However, what Victor said made me curious and I started to ask further questions.

Victor told me that the psychologist, “Rick,” (pseudonym) worked as part of his primary physician’s HIV practice, which was located in another city about an hour-and-a-half away. This doctor and Rick conducted a monthly HIV support group which Victor attended, and Victor additionally travelled once every other week to visit individually with Rick, who met with him over lunch. According to Victor, these lunch meetings – in which Victor and Rick both talked about their lives and generally would “just shoot the breeze” – were regarded by the physician and Rick as psychotherapy sessions and they billed Victor’s insurance accordingly. Victor said that this troubled him – he considered the billing unethical – and that the situation had not been working for him for a long time. However, Victor wanted to be in therapy and he thought he could not otherwise afford it and that this was the best he could get.

Victor was afraid that he would hurt Rick’s feelings if he stopped going to see him; moreover, he feared that confronting Rick about the arrangement would also mean confronting and possibly alienating his doctor, a risk that Victor was not willing to take. This situation disturbed me deeply. My reaction to Victor’s description of his sessions
with Rick was that they were not really therapy at all – I found the whole enterprise rather galling – but I did not want to say anything to Victor that would demean him or his experience. At the time, I managed to utter something along the lines of, “Gee that sounds sort of unorthodox,” and was extremely relieved when Victor stated that he wanted to find a way to tell Rick that he did not want to see him anymore. We strategized about this for a bit, and the next time we met, Victor brought me a copy of an email that he planned to send to Rick. He chose not to confront Rick or his physician, but said rather simply that he was now seeing someone in the town where he lived because he did not want to drive such a great distance for therapy.

**Treatment Planning**

The primary goal of my initial treatment plan for Victor was to form a therapeutic relationship with him that he would consider safe, trustworthy, and inviting. In this environment, I hoped that Victor would be able to explore the anxieties and frustrations that were hindering his progress toward reentry as well as his overall contentment. I planned to guide Victor to identify the sources of the internal criticism that plagued him, and to begin cultivating self-compassion and acceptance. On a practical level, I intended to assist Victor in meeting his goal of applying to graduate school and reentering the work world.

As a way to support Victor’s autonomy and self-efficacy, I proposed to him that we design the treatment together. Victor’s stated goals were reflected in my eventual plan: In addition to support for the graduate school application process, Victor wanted to work on what he referred to as his “inner critic” and his “internalized stigma.” Connie’s
suggestion that I regularly check in with Victor about how things were going proved to be very useful as it empowered him to say whether or not the therapy was working and to control its direction. Furthermore, it contradicted his experience with Rick: Our work would be collaborative, and Victor’s voice and authority would be encouraged and welcomed.

There was no clear DSM diagnosis at the outset of the work. For the first month of therapy, we focused on Victor’s graduate school application, which necessitated that he write his autobiography and prepare for an intensive interview process. During this time, I became acquainted with myriad aspects of Victor’s life, including his early history and current circumstances as well as his social arena and family relations. I also garnered a general sense of his psychological constructs, which included a profusion of harshly negative self-talk.

Based on our early interactions, I assessed Victor as having an Axis I diagnosis of Adjustment Disorder with mixed features, chronic; no Axis II diagnosis; Axis III diagnoses related to his HIV and Hepatitis infections; Axis IV diagnoses of Phase of Life Problem, Stigma re HIV/AIDS, poverty, and threatened loss of disability income; and a GAF of 70.

Over time, I had several causes to revise this assessment. First, additional issues such as medication complexities, a brief depressive episode, and reports of hoarding behavior emerged over the course of treatment and needed to be included in the analysis. Second, I received further instruction from Connie as well as detailed feedback from the University’s Doctoral Project Committee that called for a new DSM assessment, which I modified as follows:
Axis I 300.00 Anxiety Disorder, Not Otherwise Specified
Rule out Obsessive Compulsive Disorder
Rule out Adverse Effects of Medication, Not Otherwise Specified

Axis II V71.09 No Diagnosis

Axis III 042 HIV infection, symptomatic, associated with specific conditions
042.9 AIDS, unspecified
070.3 Hepatitis, viral B

Axis IV V62.89 Phase of Life Problem
PHIV/AIDS-related stigma, poverty, threatened loss of disability income

GAF: 75 (at discharge)

As therapy progressed, our initial treatment plan expanded to include specific objectives and interventions in response to Victor’s experience of depression, rejection, and hopelessness and of escalating conflict with his parents. Victor introduced and later declined to address the issue of hoarding, saying that he did not consider it a problematic situation.

While we attended to these concerns as they arose, our main focus was examining his experience of, and potential liberation from, intense and punishing self-censure and defeatism. From early on, Victor named the source of this condemnation “my internalized stigma.” Addressing this realm required the strenuous work of identifying a multitude of negative familial and cultural messages about homosexuality and HIV/AIDS, and understanding how they came to take root in Victor’s psyche and to influence his personal development. Toward the end of therapy, the treatment included an exploration of the spiritual dimensions of healing, with an introduction to the teachings of Pema Chödrön.
The Therapy Journey

Two months into the therapy, Victor learned that he was not accepted into graduate school. He took this outcome very hard, and struggled with feeling that the decision was a personal rejection. On future occasions, Victor and I would revisit the discussion of what options he had for graduate school and employment; however, that fell to the background as we began to work more with his inner critic and internalized stigma, which were intensified by his experience of having his application denied. Victor had become discouraged about his future prospects, and the language he used to describe himself was peppered with such phrases as “I’m a loser,” “I’m damaged goods,” “I’m trapped,” and “I get what I deserve.” While most of our sessions consisted of Victor regaling me with current event stories and complaints, I attempted to engage him in the work of exploring, and trying to lessen the power of this inner critical voice.

One day, to entice him, I mentioned that a benefit of this effort was that these disparaging, punitive aspects of himself might no longer be the ones determining what he deserves and what his future could hold. As Victor was already comfortable with the idea of multiplicity – he casually referred to different aspects of himself as the Critic, the Cynic, the Big Baby, the Loser, the Pariah, and the Nice Wimpy Guy – I introduced him to a model I had encountered in the core curriculum during my coursework years at Meridian (discussed in the Literature Review) that I thought might be useful to him. The practice entails imagining the myriad parts of the self on a bus, and noticing who is present, how they are positioned and interacting and, significantly, who is in the driver’s seat, or “at the wheel.” Victor’s first reaction to this image was a resounding, “I don’t want to be at the wheel! I want someone else to drive! I don’t even want to be on the
bus!” He laughed wildly for a bit, then grew quiet and somber for a moment, and then began chatting again about a host of unrelated things. When I asked him to tell me about the quiet moment, he said that he did realize that he had to be on the bus, “pitiful as it is.” He said that he had been trying to get rid of his Critic for years, “but it has only gotten louder,” Victor said, “and that’s who’s been driving.”

While I was not certain that it was best to do so, I found myself sharing with Victor one of my personal beliefs about psychological healing. Staying with the image, I said that these parts of ourselves, like our Critics, may never actually get off the bus and completely go away; at best, our efforts may just move them farther to the rear where they have much less presence, volume, and authority. I suggested that cultivating a compassionate yet trustworthy internal figure – who is sometimes conceptualized as the Friend (I said, “The friend with a capital F”) – can sometimes help to counter the Critic’s voice and diminish its power, thus making room for other more benevolent figures on the bus as well. Victor seemed intrigued by this, yet made it clear that he did not tend to trust opinions of him that were not critical. Over the course of the therapy, Victor and I revisited this image of the bus several times as we attempted to discern and address his various psychological structures. For the first few months, however, Victor mainly came into our sessions full of stories and quips, his Critic at the fore, his vulnerabilities and intricacies unrevealed. I concluded that either he was not disposed to doing deeper work, or that I was not competent to facilitate him in that process.

At the three-month point in the therapy, Victor asked about his options for continuing, since we had, at the beginning, made only a short-term commitment. He said that he felt like he was getting a lot out of the therapy and that I was helping him. I was
not surprised to hear Victor say this, since he frequently complimented my “wisdom” and often mentioned that something that I had said, or that had occurred in a previous week, had had a big impact on him. I noticed, though, that I was somewhat ambivalent about continuing. I found Victor to be rather a chatterbox and somewhat shallow. He often walked in the door in mid-sentence and regaled me nonstop, his delivery rapid and loud, for the entire hour. I was often frustrated in our sessions, or else bored. His weekly tales and laments were not that interesting to me, and I found myself dearly wishing that he would produce an intriguing image, stay with his emotions, or arrive with a juicy dream. I wondered how I could continue for many months more. However, I could not discount that the work held significance for him, nor turn away from the suffering that he had allowed me to glimpse, albeit briefly. So I told Victor I could see clients for a bit over a year longer, when the contract with my fieldwork supervisor would end. With that as the outside limit, we could indeed continue. I assured him that if he chose to remain until that time, we would undertake a process of closure and that I would refer him to another therapist if he wished.

While I continued to find our sessions a bit superficial and disappointing, I did have hints of what deeper work with Victor might be. After several months, I began to observe that in the last few minutes of a session, often as he was practically walking out the door, Victor would say something rich or poignant or compelling. One day, about six months into the therapy, I pointed this out to him right as it was happening. I told him that I found what he said interesting and significant and that I noticed that he often goes to a deepened, seemingly fertile place right at the end of the session. I said I wanted to encourage him, during our sessions, to be more in his feelings than in the story. He
replied, “Yeah, I suppose therapy should be about learning to do things differently.” I realized immediately that I had been clumsy and harsh and that his feelings were hurt. When I discussed what happened that week in supervision, Connie suggested that I bring up that sort of issue near the beginning of a session rather than at the end, and she gave me some ideas as to how I might phrase it in a more artful and effective way. I recognized that while I may have had some good instincts, I had much to learn in terms of timing and technique. As it happens, that interaction seemed to catalyze a turning point in our work together.

The next week, right as he entered, Victor said, rather curtly, “So I know you don’t want me to tell you silly stories anymore, my longwinded, boring, airhead stories, so we can accomplish something here.” I was a bit stunned, and replied, “Well, that’s one way of interpreting what I said; that’s certainly one way of looking at it.” These words were one of my common responses to Victor when it struck me that a particularly self-critical or hostile part of him was speaking. He paused for a few minutes, and then began to tell me, with some emotion, about an argument he had had with his parents during the past week.

Victor proceeded to describe a brewing conflict and rift with them, episodes of which would be threaded throughout the next many months of the therapy. In particular, he began to reveal the punitive, demeaning, and rejecting ways that his parents communicated with him. As Victor recounted something his father had said to him that sounded to me much like his own inner critic, I began to utter another familiar response, “You know, that sort of reminds me of…,” and he cut me off and said, “There you go again, pointing things out, making me look at things, I’m not criticizing you, but damn,
it’s uncomfortable.” Victor was laughing and yelling as he said this, sounding alternately playful and exasperated. I thought to myself, “This is what he wants to happen here, but it’s hard.” Victor quieted down, sat very still, looked directly at me and said, “I just feel so uncertain.” My eyes welled up when he said this and, in response, I just nodded in support, in agreement, in sympathy, and we sat together for some moments, both of us with tears in our eyes, looking at one another, slowly nodding. Then I told Victor that I thought he was doing good work, and that learning to tolerate the feeling of uncertainty was an important step, a sign of healing. He said, “It feels like there’s more room there; it’s almost sort of liberating.” In response, I nodded again, in accord.

Over the next six months of the therapy, there was a marked shift in Victor’s demeanor. While he still came in to most sessions bubbling with stories and gossip, he was able to delve into some deeper and more significant explorations. During this time, however, there were a few interruptions in the treatment. Victor went on vacation for two weeks and then I travelled to Namibia, in southwestern Africa, on a job assignment. I was out of the country for three weeks, and then returned home ill, causing me to miss five sessions in all. Victor and I discussed my departure ahead of time, and he seemed to handle the separation well.

In the session following the one in which I alerted him about my upcoming absence, Victor told me, with some drama, that he had spent time thinking about how he would survive while I was away. He laughed and said that he was going to wear a bracelet printed with the words: “What would Rachel say?” This made me smile and laugh, too. When I probed as to what sorts of things he thought that might include, Victor said that he could imagine a lot of situations where he would react in a very self-critical
way and would be reminded to say, “Well, that’s one way of looking at it!” Victor added that if he were channeling me he would be more gentle and accepting of himself.

In our sessions during months seven through ten, I began, in a more focused way, to guide Victor to identify and reframe some of his harsh self-critical thinking. For the most part, this was done in session, although I sometimes gave him assignments to work on between sessions at home. We began by pinpointing a series of sentences that seemed to comprise the basis of his harsh and negative self-talk. Then we explored where and from whom these ideas and images may have originated and made an effort to shift them into statements that were more compassionate and true. In many cases this entailed my challenging Victor’s thinking about himself, and I frequently got tangled up in trying to reason with or outsmart his cynical, critical constructs. This process was frustrating and exhausting and would sometimes leave me feeling very pessimistic and inept. I recognized the futility of engaging with him in an argumentative manner, but then I would do it again, as though I were falling into some kind of slippery trap. Sometimes I could just not think of anything else to say or do.

After discussing this phenomenon with Connie, I gained some insight into why I was getting caught. My own similar tendencies toward cynicism, hopelessness, and self-censure were clearly being activated and as I became aware of these tendencies in myself, I became a bit freer and more inventive and spontaneous in interactions with Victor. I was then able to expand my repertoire of responses to include using my humor and intuition and a more composed type of resolve. A benefit of having these parallel constructs was that it enabled me to comprehend a lot of what Victor experienced and to communicate a great deal of empathy and compassion.
It became clear early in this work that many of the rampant negative images that lived in Victor’s psyche, especially about being a gay man, were based in teachings from his family and religious upbringing and had been incorporated in his youth. Some of the most vicious and demeaning ideas that Victor held toward himself had been directly communicated to him from his parents. Victor’s experience of revealing these memories and images was especially raw because his interactions with his parents during the time he was in therapy were thorny and painful. For example, there were a number of conversations in which one or both of his parents made critical and degrading comments to Victor about the “ongoing consequences of your homosexual lifestyle.” Victor knew they were referring to his having AIDS. Additionally, his father sent him several emails featuring homophobic comments and jokes.

Over the course of this exploration, Victor shared a host of stories and images detailing what it was like for him growing up in his family. Victor described his father’s frequent violence toward him and his brothers, in which they were beaten with a belt to ensure their good behavior and obedience. Victor’s mother threatened the boys with this punishment, keeping them fearful and divided. Both parents demanded that Victor be dutiful and good at all times, and they criticized him for laughing like a girl, and for being too dramatic, sensitive, and emotional, instructing him that that was not how a boy, or a good Christian, should act. Victor was very small as a child and had been in delicate health since birth. His parents allowed his brothers to tease and bully him, and told him to stop whining and to toughen up. Victor also remembers his parents telling him that his bad behavior and weaknesses would end him up in hell, not in heaven with the rest of the family.
When Victor was a young adult and told his parents he was homosexual, the criticism and rejection became even more potent and pointed, and their attacks were sprinkled with anti-gay Christian doctrine and quotes from the bible. Victor told me that despite this, he felt that he had, over time, come to accept being gay. It helped, he thought, that he moved to San Francisco right after college and found a gay pride movement fully underway. However, he noted, the older feelings of shame and self-hatred were reignited when he was diagnosed with AIDS. His parents’ response when Victor disclosed his diagnosis was that having AIDS was a punishment for being gay and that he had been sinful and gotten what he deserved.

One day, when I asked Victor to share a few of the negative sentences that replayed in his mind, he let out a barrage that included the following: “I really am this tiny damaged person that is just taking up space”; “You are a stupid fucking faggot”; “What do you expect? You get what you deserve”; “Having AIDS proves I’m a disgusting loser”; “I’m worthless”; and “My life is pointless.” As he spoke, I could track the evolution of these phrases from sentiments expressed by his parents, and the culture, to what had developed into an amalgam of internal Critics. When Victor was done with this litany, he sat very still, in silence, looking down. I was flooded with feelings; guilt for putting him through that experience, fear that I had caused him renewed trauma, and an intense, almost breathtaking sadness. I felt like I had been pummeled, and I felt an impulse to wail. I was at a loss as to how to respond and filled with self-doubt, my own inner Critic ridiculing me for supposing that I was up to the task of helping someone with such ugly and entrenched wounding.
Although bewildered, I knew that the moment required me to act. I said the only thing I could think of to say: “You know, Victor, none of those things are true.” Then I asked him if he could locate a part of himself that believes that. He said that yes, there was a part of him; he said, “My ego,” that could be convinced that they were lies. It was the very young part of him, he continued, that was really hurting, the part of him that had been playful and vulnerable and exuberant and loved life until that was all snuffed out in him. I suggested that he take a moment and try to give that young part of himself some comfort. I said to Victor, “I am sorry for your suffering and I believe you can heal. Can you say that to the young precious part of you that is hurting?” He repeated this once aloud, and then said he would rather do it in silence.

Looking back, this session seems pivotal, a significant step in Victor’s process of dis-identifying from the critical figures within him and learning to soothe himself. This work continued sporadically over the next several months. In subsequent sessions, I guided Victor to address one or more of these (or related) individual statements, to challenge their veracity or logic, and to begin reframing and restating them into phrases that were more reasonable and compassionate. These intense sessions were interspersed with ones in which the subject matter remained more on the surface or focused on current events. I took Victor’s lead on this, guessing that it was prudent for him to set the pace. Meanwhile, Victor had decided to reapply for admission to the graduate school program, so he also wanted to spend time in our sessions addressing related practical concerns. Perhaps on both our parts, the few sessions before my trip to Namibia remained relatively light and upbeat.
When I returned from my journey and illness after five weeks, Victor and I had a
good, warm reunion. He said he had done well in my absence, but soon expressed
agitation regarding his degenerating relationship with his parents. He told me that their
conversations had taken a turn for the worse, and that his father had sent him some very
homophobic and “AIDS-phobic” emails. Victor reported that he had less and less
tolerance for his parents “abuse” and was finding their interactions unbearable. He was
stewing about specific things his parents said to him; that he was a deadbeat and not a
contributing member of society, that he was on the dole, he was unwell, he had no family
life, and that he was in this situation because of his immoral lifestyle. The word lifestyle
particularly set Victor off. Their conversations, which had in the past been superficial and
polite, had become confrontational, because Victor was now arguing back and insisting
that they stop saying and sending things that were “ignorant and hurtful.”
He said that he called his parents only out of duty, and that he was seriously considering
not having any more contact with them. The cost was too great, Victor said, and he had
had enough.

In months ten through twelve, while the future of Victor’s relationship with his
parents remained a prominent topic, significant new concerns emerged and called for
attention. In the therapy, this meant addressing fresh, and more serious, subject matter
and being introduced to aspects of Victor’s psyche that I had not yet encountered. In the
first two weeks of this period, Victor reported a number of developments including the
following: Victor’s application to the Department of Rehabilitation to subsidize his
reentry training (the graduate school program) had been rejected. He discovered that his
parents had left on a three month road trip (leaving him with no way to reach them)
without telling him. A man that Victor had met and liked stopped contacting him when Victor disclosed he was HIV-positive. A few of Victor’s buddies, at his apartment to play cards, had teased and scolded Victor “mercilessly” for being a hoarder. Finally, he was nagged by the notion, suggested by his parents and his inner Critic, that “I have no way to prove I have value.” In addition to introducing this new material, Victor’s presentation had changed. This was apparent to me even prior to his entering my office. While before, I could hear his distinctive voice and wild laughter from far down the hall, he was now arriving quietly. Typically energetic, engaged, and eager to begin, Victor now seemed reserved and deflated. I could detect this in his slower pace, his collapsed posture, his somber face, and the flatness of his affect and tone. This unusual demeanor was also reflected in Victor’s words. He described himself as feeling discouraged, hopeless, depressed, and tired. He said that he was sick of being rejected and bullied and that he did not know how much more he could take. In response to my inquiries, Victor stated that he was feeling very pessimistic and demoralized, but he assured me that he was not suicidal. He also let me know that he viewed what he was experiencing as a cyclical event; he said that he usually felt “very down” this time of year, due to diminishing daylight and the loneliness he anticipates feeling around the holidays and his birthday. Plus, he said, being depressed is just part of “being HIV.”

All of a sudden, it seemed, there was so much for me to monitor and address, and I started to feel ineffective and overwhelmed: I was tracking Victor’s depressive symptoms, which became more glaring as the weeks progressed. I was thrown by the sideways revelation of hoarding and wondered how and when to tackle that issue with him. I was afraid that I could not keep Victor safe, and that I had been reckless and was
therefore responsible for his collapse. Moreover, I was having my own descent into feelings of despair and gloom in addition to suffering tremendous anxiety. I brought all of this into my supervision sessions with Connie, who listened with patience and care, and advised me with candor and compassion.

Throughout November, Victor’s despondency was palpable, and his mind was negatively set. In my sessions both with Connie and with Victor, his experience of depression took precedence. Each time we met, I assessed Victor’s suicide risk; while thoughts that he might harm himself continued to make me extremely anxious, I never truly doubted Victor’s assurances to me that he would not. I told Victor that I wanted him to inform his primary care physician that he was depressed.

Victor was on a host of medications for HIV disease as well as kidney and liver conditions that individually and in combination have myriad side effects that include, in most cases, depression. I thought it important that he request a review of his medications, over a dozen in all, in order to rule this possibility out, as well as to determine if a medication adjustment might help to alleviate his suffering. Moreover, depression is a symptom of HIV disease, and I thought that his doctor should be kept abreast of his condition. I emphasized this with Victor, reminding him that he was under the medical care of a physician. Initially he was hesitant, until I suggested that he might simply say, “I’m feeling depressed and need help with it.”

Victor then promised that he would call his doctor that afternoon. In this conversation, I also asked Victor for permission to talk to his doctor myself. I said something along the lines of, “You are on lots of meds that I am not familiar with and it would help me to have an understanding about them and how they may impact you
emotionally.” Victor said that was fine, provided me with permission in writing, and offered to alert his doctor to expect my call. Over the next three weeks, I attempted to make that contact. I left several messages at the physician’s office but never heard back from him. Victor, as agreed, spoke with his doctor by phone the next day; he increased Victor’s dosage of Celexa, the antidepressant he had been taking, and agreed to do a medication review at Victor’s next medical visit which was a month or so away.

Meanwhile, I was finding our sessions difficult to bear. Victor would repeat the same hopeless, cynical, self-loathing rants, and I felt unable to help and that I might drown right alongside him. A few times, I fell back into the mode of arguing with him, and this left us both feeling edgy and exhausted. At other times I joined with him, and this left me concerned that I was confirming his dismal perspective. During these weeks, I depended upon Connie considerably, both to hold hope and to guide me to guide Victor. She counseled me not to underestimate the impact of just being present and witnessing someone’s suffering, and she told me she believed I was actually helping, not hurting, Victor even though it did not feel that way to me. Most importantly, Connie allowed me the space to express my own despair and wild apprehensions, and by her simple act of witnessing me with steadiness, grace, and compassion, she modeled what she had been describing: the deep comfort and mercy that therapy can offer.

Victor began to emerge from his depression at a slow but steady pace. By the fourth week, which coincided with his birthday and holidays he dreaded, he was reporting that he was feeling more upbeat and energetic though he was still “not a happy camper.” I gave up trying to contact his physician, but was grateful that he had taken Victor’s request seriously and adjusted his medication accordingly. When I asked Victor
what he attributed his rebounding to, he replied that he thought it was due to a combination of the new Celexa dosage, the fact that he had decided to stop having contact with his parents, and the fact that I had put up with him even though he had been such a downer.

The issue of hoarding struck me as a much less immediate and less grave concern, but when I reported it to Connie she insisted that I address it without delay. She instructed me that it was a feature of Obsessive Compulsive Disorder (OCD). She said I should read up on it and that if Victor had that diagnosis I would have to consider referring him for more intensive treatment with someone with that area of expertise. I had a viscerally negative reaction to burdening Victor with an OCD diagnosis, and responded that he did not fit what I understood of that profile. Yet, I agreed to broach the topic at our next meeting. When I brought it up to Victor, he was resistant to discussing what he called his “alleged hoarding” behavior, and he was tense and defensive in the conversation that ensued. He said that he did not see himself as a hoarder, that he was hurt that his friends had bullied and harassed him about it, and that he did not consider it a problem in his life. Given his defiance and his overall vulnerability at that time, I decided not to push him. As I backed off a bit, and refrained from using the term hoarding, he was more willing to describe his “collections” to me and to explore his thoughts and feelings on the issue.

Victor began by stating he knew a lot of people who hoarded or collected things and that it was related to having HIV/AIDS. He then offered two explanations for why his house was so full of “clutter.” The first was that he was stocking up now while he still had a bit of extra money on things that he knew he would need in the future. In this
category were things he bought on sale or in bulk, such as large quantities of toiletries, small household items, music CDs, blue jeans, socks, and other clothes. The second explanation was that he could only afford to live in a tiny apartment that had not nearly enough room to store belongings that were too important to him to get rid of. This category included his substantial collection of Christmas ornaments (which contained hundreds of antique Christmas ornaments left to him by a friend) as well as artwork and house wares, all things he still hoped he might have enough room for someday. Victor said that he had not completely given up the hope of having a partner to share holidays and have a “real home” with, a home that was large enough for all his things. He said that getting rid of this “stuff” would be saying that he was giving up on ever have the life that he longed for. Then he said that he really did not want to talk about it anymore.

In supervision that week, I relayed this all to Connie, along with my view that Victor’s behavior and explanations could be considered reasonable coping mechanisms rather than signs of pathology. I also reiterated my resistance to diagnosing Victor with OCD. I had, since our last session, read about OCD in the DSM-IV and had done further research online; I was confident that the diagnosis did not fit. Connie accepted this, and then we talked about my strong reactions concerning this matter. I recognized that I felt protective of Victor and was hesitant to further label or diminish him. I thought that I had given him sufficient diagnoses, and that given his history and circumstances, he had earned the right to be idiosyncratic, even odd. Connie and I continued to debate this issue, wanting to ensure that what I experienced as protecting Victor was indeed serving his interests. In the meantime, I concluded that it was up to him to name tendencies to collect
things as a problem, and I believed he trusted me enough to bring it up in therapy if that was ever the case.

As we entered the last five months of therapy, Victor was still emerging from his depression, and I still grappled with despondency and self-doubt. Something had begun to shift, though, and the parallels in our experience were becoming more productive and less of a hindrance. I leaned on and borrowed heavily from Connie during this time. More than once, I would find myself repeating to Victor something that Connie had offered to me in supervision a few days before. For example, during a session in mid-January, in which I was expressing my despair, Connie suggested that I try to access a guide, an image or figure who might provide me with comfort and counsel. At other times in my life I had worked with guides, but this had not occurred to me in my current state. When I went home that evening I found myself revisiting a text by Pema Chödrön, a Tibetan Buddhist meditation teacher whose ideas on compassion, self-acceptance and facing life’s challenges had always consoled and inspired me.

Later that week, I brought the suggestion of finding a guide to Victor. In response, he said that Mother Theresa had always inspired him and that he knew of a recently published biography of her in which her serious crises of faith were revealed. Victor commented that her works were even more impressive if she accomplished them despite these struggles. He said he would try to find the book. Then Victor asked me who I looked to as a guide, and I mentioned Chödrön. When he asked why, I described some of things she teaches in her books: to accept ourselves despite our flaws; to stop resisting our lack of control over things; to learn, via meditation practice, to expand to hold more discomfort and uncertainty; and to move courageously toward, rather than away from,
what scares and upsets us. Victor asked if I could bring in a book of hers for him to look at and I said that I would. I brought it to him the following week and offered that he could take it home with him. Victor did not mention the book the following week, but he spoke more about Mother Theresa, and I decided not to bring up Chödrön again right away.

During this time period, our conversations became more philosophical and more focused on existential questions and concerns. In a conversation in early February, Victor expressed his opinion that life was not fair and that no matter how much work he did on himself the same “crap” came up again and again. He said that having AIDS “sucked” and kept him from having a decent life, and that he did not think that life has any meaning. In my response to Victor, I acknowledged that I did not have a whole lot of answers, that there were things I really struggled with, and that sometimes all I knew to do was to feel what I was feeling, and to find meaning where and when I could. It was not a matter, I continued, of getting “better” and arriving somewhere and not ever feeling badly or confused anymore; there were just times like that.

Victor expressed surprise at hearing that I sometimes experienced self-doubt and other emotional distress. He said he had thought that I had it all “pulled together” and that he felt better knowing that someone he really looked up to experienced those things too. This session is an example of how my empathy allowed me to join with him in a beneficial way: Victor associated so much of his suffering, his depression, loneliness, rejection, self-hatred, even having an overabundance of clutter, with having HIV/AIDS and in his mind all of these were inherently linked. He did not imagine it possible to have HIV/AIDS and not suffer so he felt doomed to a fate of suffering. Likewise, Victor had been segregated for so long in a world of solely other HIV-positive people that he
somehow came to forget that people who did not have HIV, including those that he admired, were also afflicted. My disclosure helped Victor to reframe and normalize his experience, which are two steps, I believe, in reducing stigma.

Our time together in the next few months alternated between this type of thoughtful conversation and sessions in which we focused on work with the “inner Critic.” I had Victor repeat some of the exercises the he had done six months to a year prior of naming and then mapping the sources of the critical statements, rephrasing them into statements that were compassionate yet still rang true, and I was struck by how much more willing and able he was to sincerely engage in the process. A few times, Victor was able to laugh at the absurdity of some of the Critic’s more extreme sentiments or convoluted logic, and I thought that was good.

There were other times when Victor would still get caught in cynical or viciously critical loops. Occasionally, on impulse, I would address the Critic directly, and say something funny or illogical or absurd, and this seemed to help things shift. For example, in response to a critical barrage I once inquired, “Why do you continue to have such high expectations of someone as flawed as Victor?” Another time I said, “Surely even a poor schlep like Victor should be allowed some comfort!” I also appealed to, and joined with, Victor’s strong sense of social justice. For example, I shared my interpretation that his Critic was colluding with the culture at large to keep him feeling small and undeserving. I offered a few other provocative views: that many of us who are gay have made an unconscious agreement to keep “our end of the bargain” and remain muted and on the margins in return for acceptance and safety; and that since it is expected that people with AIDS who live on disability income will be pathetic, unproductive, and miserable, his
being happy and living an engaged and satisfying life would be a radical, political act. These kinds of interventions really captivated Victor, and his feedback indicated to me that they were effective.

The last three months of treatment were very rich. For the first time in the therapy, remarkable imagery emerged. In one session, Victor declared that he felt like Sisyphus, a figure from Greek mythology who as punishment for angering the gods is condemned, for eternity, to push a giant stone to the top of a steep hill only to have it immediately roll down again. I had thought of Sisyphus numerous times in relation to Victor, but had chosen not to mention him. For Victor, the story was fitting because Sisyphus’ task was grueling, pointless, and without end; he said he related to Sisyphus as a brother in martyrdom. I told Victor what I remembered of the myth and of Albert Camus’ interpretation that Sisyphus’ task was universally human and that while it was absurd, it was still possible that it had meaning and that life was worth living.\(^2\) Then I shared Camus’ conclusion, that “we must believe Sisyphus happy.” This intrigued Victor; he read more about the myth and it became the subject of several future discussions.

Another figure that emerged for Victor was Lazarus. Victor was familiar with the story of Lazarus from the biblical narrative he learned in his early religious education and because the Lazarus Syndrome is a common topic among Victor’s cohort of HIV-positive men. Named for the figure who Jesus, according to the Bible, brought back from the dead after four days in his tomb, the Lazarus Syndrome describes the unique affliction of those who have lived with the disease since before the advent of antiretroviral treatments.\(^3\) Having faced and then been given a reprieve from death, these men, while experiencing renewed health and possibilities, are now gripped by depression and acute anxieties –
especially over financial issues – and face an unknown future with fewer resources, reduced capacities, and enormous uncertainty. Victor mentioned Lazarus several times in this period, and spoke of the experience of coming back into his life and the challenge of how to define it.

In a subsequent session, when I asked Victor what his “stuck-ness” or “lost-ness” felt like, he responded with a potent image of himself in a giant roiling pool, with water too deep for him to stand. He said that with effort he could stay afloat, but he could not reach the edge to climb out. I guided Victor to explore the emotions, thoughts, and physical sensations that came up for him, and he initially described feelings of helplessness, fear, constriction, and a lot of overwhelm. He continued to use the pool as a metaphor, saying that sometimes he felt like he was thrashing around, sometimes the water was too murky to see to the edge, sometimes he floated more calmly, and at other times he thought he would drown. Then I asked him, “So what if life is being in the pool?” Victor replied that the question reminded him of things he read in the “Pema book” I gave him (which was the first time he referred to the book), and he said, “I guess if life is being in the pool, then it’s a good thing I’m in it!”

I thought his insight was brilliant, and said, yes, in that case, managing to stay afloat in the pool and not climb out was a good thing. Playing with the metaphor further, we spoke about the possibility of his finding a shallower, less shadowy spot, where his feet could touch down and he could rest and of how comfort might look like him learning to float. I also reminded Victor that the scary and overwhelming feeling of being in the mucky pool may be similar to those times when feeling crappy is actually a sign that you are getting closer to something, like to some kind of healing. Though such a statement
could have seemed condescending or cliché, thankfully it did not come across that way. Victor seemed quite touched, and said he appreciated the reminder that life was not just about being happy, and that his not being happy did not mean that he was a failure and a loser. This moment is another example of the reframing of Victor’s experience that took place during this last six-month period.

During this period, we also began to discuss how to prepare for the end of the therapy. In our first conversation about closure, Victor brought up “What would Rachel say…,” and when I asked him for examples, he rattled off a few lines off the top of his head. This time, however, the phrases were unfamiliar to me; they were words I was sure I had never said. It struck me as significant that while they were sentiments I might express, they were now in Victor’s own words. As another part of closure, I asked Victor if he thought he would want me to suggest another therapist and he said no, he wanted to be on his own for awhile. We also spoke in detail about his near future plans. Victor said he was applying for entry into a certificate program in human services at the local junior college, as a way both to gain experience in the field and to improve his chances of being accepted into the Master’s program he still desired. In addition, he was about to begin a Spanish language class and a volunteer job mentoring at-risk youth.

The day before our fourth-to-last session, a co-worker with whom I was extremely close and who had been a longtime activist and leader in the HIV/AIDS community, died unexpectedly. In the days and weeks that followed, Victor was witness to my initial shock and deep grief, while he was as well as a member of the community grieving the loss of this leader and to whom I tended. While it was sometimes a challenge to navigate the terrain of boundaries and roles, it ultimately served to facilitate and add
poignancy to our process of coming to closure. The best example of this is that a week after this friend’s death, Victor arrived with the copy of Chödrön’s book, which I could see was bursting with post-it bookmarks. In one of the sweetest acts I could imagine, he opened the book to a well-worn page and read a passage aloud to me. His gesture served to communicate not just that he wished me comfort, but that he now saw himself as someone capable and worthy enough to offer it to me. It showed me that our roles and positions had already begun to shift, and that there was hope that he might one day feel toward himself the enormous esteem and love I felt toward him in that moment.

In our second to last session, I suggested that we do an evaluation of the therapy. Since we had been checking in regularly throughout the treatment and Victor often made spontaneous comments about both my performance and his experience, I already had a sense of what he had found helpful and how he thought he had grown. Still, it seemed important to give him one more structured opportunity to review his trajectory and to give me some final feedback. Victor said that he thought he had changed and made a lot of progress, but that he still felt worried and uncertain about his future. He said that it had been helpful to have me to talk to each week, and that what helped him most was that I was “honest, but still really kind.” I asked what he thought had changed in him, and he said that it was not that he felt better or was happier, but that “I have more room inside.” When I asked what he meant, Victor replied, “There is space for more interpretations,” and “I feel more accepting of myself.” Victor also said that he thought the decision to not have contact with his parents was healthy and that the therapy had made that possible. He concluded that he still expected to have “up and downs,” and to feel “crappy” sometimes, but that working with me had been very useful and liberating.
Legal and Ethical Issues

There were a few occasions in which ethical, legal, and cultural issues called for my attention. For example, I struggled with how to respond when Victor informed me, in an early session, of his relationship with another therapist, a psychologist who took Victor out for lunch and then billed his insurance for full sessions. I believed this practice was unethical and illegal, and that it had hurt Victor by adding to his low esteem more than it helped him. While it was clear right away that Victor was going to end that relationship, I still had to examine if, how, and when communicating my opinion and/or disapproval would be of clinical value and in Victor’s best interest. One of the reasons that Victor did not confront the situation was that the psychologist shared a practice with Victor’s primary care doctor and he did not want to do anything to threaten that relationship. According to Victor, the medical doctor was not only privy to this arrangement, but had distinct ethical shortcomings of his own. This upset him, yet he felt a complex mix of gratitude and an almost primal dependence on his doctor; for Victor, that relationship was sacrosanct and a source of enormous strength, security, and comfort. This dilemma allowed me to glimpse that the magnitude and severity of what people living with HIV/AIDS experience with regard to surviving significant physical and emotional trauma and living with an unpredictable terminal illness not only makes them vulnerable to exploitation, but forges them into a group with distinct cultural characteristics. In my work with Victor, I was frequently called to find new ways to bridge our gap of experience. I particularly struggled with challenging Victor without having him feel judged, and with acknowledging the gravity of his situation while normalizing his experience.
During the period of time when Victor was struggling with depression, it was necessary for me to carefully assess and monitor his level of suicidality to ascertain his level of danger. I consulted with Connie regularly, even calling her immediately after a session with Victor to be certain that my inquiries were comprehensive and that my judgments were accurate. Throughout this time I had, as well, to assess my capacity to help Victor; this meant recognizing that his complex medical condition and medication regimen could be contributing to his declining psychological condition, and that it was imperative that he consult with his doctor. In order to attempt to contact Victor’s medical doctor myself, I needed to get his written permission, and to be clear regarding the boundaries that might steer and limit our conversation.

Asking Victor for consent to be the subject of this Clinical Case Study presented me with an ethical quandary. In a meeting at the beginning of month 13, I introduced the idea to Victor and informed him of the Clinical Case Study’s topic and of what his participation would entail. I suggested that he think about it for a bit and that we could discuss it further in future sessions. Victor immediately said that he would do it. I insisted that he consider all the possible ramifications I had just outlined, but he said that he did not need to think about it any further, and that he was sure. I gave him a copy of the consent form that I had prepared and asked him to read it through. Victor looked over the document – which clearly states that the topic of the Clinical Case Study is “AIDS-related stigma” – and signed it. Immediately after the session I began to have some misgivings. What if Victor thought I was reducing him, and his experience, to “AIDS-Related Stigma”? Would he feel hurt or demeaned? Was I objectifying or exploiting him? What if being my subject was further stigmatizing? In addition to the shame and worry I
felt, I became aware of my feelings for Victor in that moment: fierce protectiveness, enormous responsibility, and tender love. These concerns and sentiments have remained with me, and the duty to remain trustworthy has informed and guided my writing process.

At times during the treatment, I had concerns about dual relationships, as Victor is active in the local HIV/AIDS Community, an arena in which I have a public role and presence. I consulted with Connie when Victor attended a workshop that I facilitated, and I ceased involvement with County planning committees to which I had been assigned. However, given that Victor visited the food bank weekly to pick up his groceries, we had opportunities to glimpse one another outside the container of our therapeutic relationship. No problems emerged because of this, but I was aware of potential concerns.

**Outcomes**

In my estimation, Victor benefited from therapy in several ways, though much of his fundamental suffering and dilemmas still stand. Victor has been steadily meeting his goal of exploring back-to-work possibilities; his current plan and career path give him a measure of pride, momentum, and satisfaction. Victor’s decision to cease having contact with his parents – one he attributes to gains he made in the therapy – strikes him, and me, as constructive. So on a practical level, Victor views his life and his future as somewhat more positive and promising, though still full of limitations. Significant shifts occurred for Victor internally, as well, as he worked to challenge, accept, or shift the various negative constructs that inhabit his psyche. Coming into new awareness and relationship with these structures led Victor to feel he has more choice, more internal spaciousness, and more ways in which to interpret his ongoing experience. Victor also
demonstrated an increased capacity to hold paradox, discomfort, and complexity and to think in metaphorical, rather than in rigid, polarized ways.

I think Victor found some healing, too, as a result of our relationship. In discussing his experience in therapy, Victor described me as “honest, but still really kind,” and said he could reveal himself truthfully to me without fear of being judged or demeaned. He also stated that he felt he was becoming more accepting of himself. I strived to meet Victor with openness and compassion, even as I challenged him or when I felt frustrated or disapproving. I believe this may have assisted him to resolve some old wounds – especially with regards to his parenting – as well as to trust more in relationships and to cultivate a more caring voice within him. I think our work, and our relationship, also helped to normalize Victor’s experience. That is, he came to see himself as more of a whole, regular person who is living with the challenges of AIDS, rather than seeing himself as damaged and marked and as “being HIV.” These shifts, which occurred for Victor over the course of the therapy, may ultimately lessen the negatives impacts of AIDS-related stigma upon him.
CHAPTER 4

LEARNINGS

Key Concepts and Major Principles

This chapter discusses the learnings derived from the 18 month psychotherapy journey. It begins by highlighting the key concepts and major principles that have informed my understanding of what happened during the course of Victor’s therapy. This theoretical material has served as a set of lenses through which I viewed the treatment and has guided my subsequent interpretations. Included is a discussion of the imaginal structures – both Victor’s and my own – that were invoked in the therapy and that have been in use during this meaning making process.

A number of the concepts and principles mentioned here are from Omer. His concept of imaginal structures offers a way to understand the core beliefs and personal schemas that influence our perceptions, motivations, and the nature of our experience. Omer defines imaginal structures as “assemblies of sensory, affective, and cognitive experience constellated into images; they both mediate and constitute experience. The specifics of an imaginal structure are determined by an interaction of personal, cultural, and archetypal influences.” ¹

Another concept from Omer concerns the cultivation of capacities. Omer explains capacities as transmuting from various affects; for example, “grief transmutes into compassion, anger transmutes into fierceness, and shame transmutes into autonomy, humility, gratitude, and dignity.” ² Also according to Omer, compassion responds to
suffering; courage responds to danger; destiny responds to the future; dignity responds to failure; fierceness responds to injustice; faith responds to uncertainty; and reflexivity responds to personal identity.” ³

Omer’s concept of gatekeeping “refers to the individual and collective dynamics that resist and restrict experience. The term gatekeeper refers to the personification of these dynamics.” ⁴ For Omer, gatekeepers are particular types of internalized images that personify a narrow perspective and vigilance toward what is unknown and perceived by us as “other”; they are the critical, punitive parts of the self and of the culture that act to limit expression and individuality, as well as the emergence and engagement of difference.⁵

Omer considers scapegoating a type of gatekeeping and defines it as “avoidance through blame.” ⁶ He maintains that scapegoating involves “actions or attributions that preserve and demarcate identity by locating weakness, badness, impurity, and danger elsewhere, and distance us from what we consider toxic.” ⁷ Omer contends that when scapegoating occurs on a cultural level, those considered different or impure are marginalized, punished, or exiled, resulting in a demarcation of insider/outsider status and the upholding of center/periphery dynamics.⁸

Several concepts and principles from stigma theorists are referred to in this chapter. According to Goffman, stigma refers to an attribute that is undesirable and “deeply discrediting.” ⁹ Dovidio, Major, and Crocker add that individuals bearing such a mark are considered spoiled, deviant, and less than fully human; those stigmatized are devalued, suffer from a loss of status, and are seen as deserving ostracism, animosity, and punishment.¹⁰ AIDS-related stigma, according to Herek, refers to the “prejudice,
discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV and the individuals, groups, and communities with which they are associated.”

Deacon adds that AIDS-related stigma can be a multiple, double, or layered stigmatization linking disease stigma with prejudices toward marginalized groups already negatively valued and stereotyped and viewed as deviant and blame-worthy.

The concept of internalized AIDS-related stigma is explained by Brouard and Wills as the internalization of the shame, blame, guilt, hatred, hopelessness, and fear associated with being HIV-positive. Green and Sobo elaborate that as people living with AIDS internalize these negative socio-cultural attitudes, they come to view themselves as dangerous, diseased, and despised, and to develop self-hatred and shame; they perceive themselves as tainted and believe that others will perceive them that way too – a hallmark of stigma as defined by Goffman. Green and Sobo argue that when stigma is deeply internalized and incorporated, it assaults the individual’s sense of identity and self-worth, causing biographical disruption. By this, they mean that the stigma attains a “master status” that infiltrates and dominates the individual’s identity as well as the perceptions others have of them.

Concepts and principles based in self-object theory, from self psychology, are also applied here to shed light on treatment outcomes. Abramowitz and Cohen posit that AIDS, as a profoundly stigmatized condition, poses distinct threats to self-cohesion through the disruption of the bodyself – the intrapsychic relationship to the body and a basic source of self-esteem, self-agency, and self-organization – as well as to the fundamental self-object bonds – mirroring, twinship, and idealizing – that provide the self with stabilization. Their theory holds that a central goal of therapy is the restoration of
the self and selfobject bonds via the therapist’s productive utilization of empathy and of the mirroring, twinship, and idealizing transferences.  

Abramowitz and Cohen argue that AIDS also threatens the self by recapitulating preexisting self issues.  

Noting that people react to an AIDS diagnosis in the context of their current life circumstances and development, they maintain that the experience AIDS-related stigma can ignite old feelings of inadequacy, abandonment, and vulnerability. These experiences can then make “AIDS…feel like a present-day retribution or confirmation that the self is bad, defective, unworthy, and unlovable. This belief may be the core dynamic of internalized homophobia in which AIDS is experienced as a punishment for being homosexual.”  

Tunnell agrees that for a gay man, an AIDS diagnosis may reactivate unhealed feelings of unacceptability and confirm that he has AIDS because he is bad or has done something wrong. Tunnell proposes that how well a man will then cope with AIDS-related stigma is strongly predicted by how well he has dealt with his homosexuality; if a man already feels ashamed of being gay and isolates himself from others, an AIDS diagnosis will compound his suffering and loneliness. Tunnell recommends applying Erikson’s theory of personality development in clinical work with gay men with AIDS. He argues that the crises and strengths delineated in Erikson’s stage model are particularly clinically relevant with gay men, and that it is important to revisit the stages that clients have successfully resolved prior to their AIDS diagnosis since the internalization of AIDS-related stigma can retrigger some developmental conflicts.  

Nathanson’s compass of shame is cited here, as it describes the salient consequences of the shaming aspect of stigma – its disruptiveness to social relationships
and its internalization. Nathanson’s model names withdrawal, avoidance, attack other, and attack self as the four defensive strategies individuals engage in as they attempt to manage the toxicity of shame, demonstrating how the activation of shame impacts both internal and interpersonal experience.

Theory from an existential perspective is also presented in this chapter. Farber claims that existential therapy is fitting and effective for clients living with AIDS, as their experience is characterized by the major existential concerns of life and death, and the existential feelings of vulnerability, anxiety, and alienation. Farber elaborates that the diagnosis of AIDS impacts an individual’s core beliefs, central life goals and meaning systems, and sense of self, personal role, and relationship to the world as a whole; he views AIDS-related stigma as reinforcing existential angst and isolation and evoking despair and demoralization, and foreboding. For Farber, a goal of therapy is to help clients discover meaning in their suffering, and learn to deepen their experience, clarify choices, and find opportunity within the limits imposed by HIV/AIDS.

Posttraumatic growth is another concept referred to here. According to Milam, posttraumatic growth conveys the idea that an individual’s encounter with trauma, which contains elements of significant suffering and loss, can also lead to highly positive changes that include newly developed capacities and self-transcendence. While the psychological sequelae of HIV infection includes depression, anxiety, fear, guilt, and helplessness, Milam presents strong evidence that living with AIDS can also serve as a developmental trigger allowing individuals to cultivate altruism and spiritual growth, to perceive their experience as a challenge to fully understand themselves, and to reap an increased sense of identity, belonging, meaning, purpose, and direction in life.
Chödrön’s work is also touched on in this chapter. Her teachings introduce practices from Tibetan Buddhism that view the difficulties that humans experience – conflict, shame, envy, physical and emotional pain, notions of unworthiness – as seeds of compassion and an awakened heart, and a way of experiencing kinship with all other beings. Chödrön counsels us to befriend the rejected, embarrassing, “bad” parts of ourselves and others; to reverse our usual patterns of splitting and trying to escape our pains and demons; and to learn, instead, to endure and embrace them. “Everything that occurs,” she writes, “is not only usable and workable but is actually the path itself.”

Finally, this chapter draws heavily from Perera’s ideas about the scapegoat. Noting that, in modern times, the term scapegoat is applied to individuals and groups whom the culture derogates or accuses of causing misfortune, Perera defines the process of scapegoating as “finding the one or ones who can be identified with evil or wrongdoing, blamed for it, and cast out from the community in order to leave the remaining members with a feeling of guiltlessness, atoned (at-one) with the collective standards of behavior.”

Perera contends that the scapegoat is at the core of a complex that comprises four positions – Azazel, the Holocausted Goat, the Wandering Goat, and the Priest – that are distinct manifestations of how individuals may identify with that archetype. The Holocausted Goat and the Wandering Goat are the two positions referred to in relation to Victor’s experience and imaginal structures. The Holocausted Goat, or victim-ego, is the figure that identifies with and internalizes accusations and condemnations, and feels powerless, inferior, tabooed, and “radically unacceptable.” Holocausted goats are passive, filled with existential anxiety and guilt, and fearful of further victimization; they
can be grandiose and defiant; feel guilty for both their weakness and their power; and identify both as hated and “Chosen.”  

The Wandering Goat, or alienated ego, is a rebellious outsider/rescuer figure that has been banished by the mainstream due to its sinful instinctual energies. The Wandering Goat holds all the community’s guilt, and is grandiose, prideful, dutiful, adaptive, and resigned to its martyrdom and outcast status. This figure is dismissive of the mainstream, yet longs for acceptance, and copes by becoming overly responsible, competent, indispensable, and placating.

Perera offers a detailed account of why certain individuals become mired in the scapegoat complex and of the impact it has on their lives. She speculates that those who identify with the scapegoat were burdened early in life by being devalued, repressed, judged, moralized, and punished. Then, as adults, scapegoat-identified individuals lack a sense of personal identity, self-confidence, and agency. Having internalized the voice of the rejecting accuser, they are prone to perfectionism, splitting, and self-condemnation; depend on external evaluation; and are plagued by the sense of exile and not belonging. Perera concludes that individuals who are scapegoat-identified become severed from both “the outer world and their own inner depths,” and that their involvement in the scapegoat complex becomes a central focus of their lives and identities.

According to Perera, healing for scapegoat-identified individuals entails disidentifying from the complex and discovering and coming into conscious relationship with the meaning the archetype has had their lives. Resolution of the scapegoat complex is possible, she notes, within a therapeutic relationship; it involves the patient and therapist building an alliance against the accuser, and requires that the patient be met with caring, empathy, acceptance, and objectivity. For resolution to occur, the therapist must
remain conscious and vigilant about their own role in the complex as well as the scapegoat-identified material that is evoked by the patient.40

**What Happened**

The description that follows is based upon my observations and reflections as well as on Victor’s feedback and self-reports. Several notable events – intrapersonal and interpersonal, subtle and tangible – occurred during the 16 month time period that Victor was in therapy. These happenings include discernable shifts in Victor’s self-perceptions, capacities, affiliations, perspectives, and goals for the future. While they are discussed here separately, I view these happenings as linked and as having unfolded interdependently. It seems important to state, as well, that it is not possible to directly, or solely, attribute these outcomes to the treatment. With these caveats in mind, I offer this summary of Victor’s therapeutic journey in terms of four distinct arenas and arcs: Victor’s journey toward reentry into the community; Victor’s relationship with his parents; Victor’s cultivation of capacities; and Victor’s transference relationship with me as his therapist. Each of these events reveals aspects of Victor’s transformation regarding AIDS-related stigma.

Victor’s journey toward reentry is important to include, as exploring options for a return to school and employment was one of his main stated goals for the therapy. When treatment began, Victor was applying to a graduate program in counseling, and several aspects of that process were causing him anxiety. At the time, Victor was living a fairly isolated life, sometimes hardly leaving the house because having HIV made him feel “dirty, damaged, and disgusting.” The prospect of being in graduate school, and in living
a more engaged life, evoked, for Victor, significant fears of rejection, failure, ridicule, and AIDS-related stigma. While going through the application process triggered these concerns, it also allowed Victor, in therapy, to recognize and name his longing to accomplish something more in his life, to have an impact, and to die knowing that he would be missed and that his life had mattered. During the time Victor was in therapy, his applications both to the graduate program and the Department of Rehabilitation were turned down. His initial reaction was to see these as further proof that he was tainted and a loser, and that life was unfair; but Victor persevered, and went on to participate in an internship, volunteer work, and academic coursework related to his desired area of study. At the end of therapy, Victor was embarking upon a certificate program at a local junior college with the hopes that it would lead to his eventual admittance to graduate school.

During the time he was in therapy, a dramatic shift occurred in Victor’s relationship with his parents: he took the significant steps of limiting, and then severing contact with them. When therapy began, Victor, out of perceived duty – and his desire to be a “good son” – made obligatory phone calls to his parents on a biweekly basis. During these contacts, Victor’s parents frequently made comments that were accusatory, demeaning, and homophobic. This pained and angered Victor, but he chose to suffer in silence. Through his work in therapy, Victor came to identify his parents’ condemnation as a major source of his own judgmental inner constructs; and he recognized the ways in which his critical self-talk – “I really am this tiny damaged person that is just taking up space”; “You are a stupid fucking faggot”; “What do you expect - you get what you deserve”; “Having AIDS proves I’m a disgusting loser”; “I’m worthless”; etc. – sprang from and echoed these critical statements made by his parents. Over time, Victor
determined that these contacts were not merely irritating, they were causing him additional harm: his parents’ harsh comments were triggering and reinforcing the hatred he had come to internalize.

Victor’s first move was to begin to challenge his parents, to stick up for himself and stand his ground. The contacts then became thorny and confrontational, leading him to telephone his parents with less frequency. The cost, Victor said, was becoming too great. It bothered him that his parents faulted him for calling less often, yet they made no move to contact him. When his parents went on a trip without telling Victor their plans, and without giving him a way to get in touch should he need them, Victor, angry and hurt, decided that “enough is enough,” he would not call them anymore. Immediately upon making that resolution, Victor felt relieved. While he continued to express hurt and resentment in relation to his parents, that sense of relief continued, and Victor considered that decision to be a central success of the therapy. It seems possible that the absence of his parents’ negative input allowed Victor more space to re-imagine himself as well as to heal some of the old rejections and stigmas that had plagued him since his youth.

Victor’s cultivation of capacities during his time in therapy was also notable. In this category I include Victor’s expanded range and depth of affect; his increased ability to hold paradox, discomfort, and uncertainty; and his fostering of specific capacities such as hope, resilience, self-acceptance, self-soothing, and dignity. In terms of affect, when Victor began therapy, he was, though lively and verbose, emotionally guarded and in his head. While he presented stories with drama and flair, his range of subject matter as well as emotion were limited and remained on the surface. Victor was ditzy, for lack of a better word, and he became serious and reflective for only the briefest of moments.
Although he expressed hurt at the time, I think Victor was relieved when I invited him to show more depth, sensitivity, and reflection, because, as he momentarily revealed at our first session, this part of him had been latent and wanted to emerge; this, I believe, is what drew him to be in therapy. Over time, Victor evolved to reveal more of his suffering as well as his deeper shames, disappointments, vulnerabilities, and longings. During the time of Victor’s brief depressive episode, his affect shifted radically; it was at times extremely flat, and at other times he was racked with pain. At the end of therapy, his affect struck me as more fluid, wide-ranging, and congruent, and he seemed more comfortable showing his emotions spontaneously, as they were evoked in him.

Another evolution was Victor’s movement from polarized, rigid thinking patterns to the ability to hold more complexity, uncertainty, and paradox. Victor came into therapy believing that bad things had happened to him because he was inherently bad, and that he was made bad because of the things that had happened. When he could entertain the possibility that he was not bad, Victor held that others were bad or that life itself was empty and meaningless. Victor was caught in this loop of reasoning – each disappointment further concretizing his beliefs – and he was unwilling to consider new ways of thinking unless he was given future guarantees. Perceivable cracks in these attitudes began to form after the first several months of therapy, and Victor became more open and able to accept the ambiguities and contradictions in him, in others, and in the world. He became more accepting of himself – of both his strengths and his flaws – and was more able to tolerate the discomfort of hoping for things without knowing how they would turn out. He had more options for interpreting what happened to him, more realistic expectations of the future, and more willingness to move forward sans security.
Toward the end of therapy, Victor began to communicate, explore, and enhance his experience via intriguing metaphors, symbolic imagery, transpersonal and existential frameworks, and the use of spiritual guides. His openness to spiritual teachings may in itself denote healing, as Victor’s early experiences with religion and religious teachings had been a potent source of rejection and pain.

Victor’s hard work in therapy also helped him increase his capacities for hope, resilience, self-acceptance, self-soothing, and self-respect. In some part this evolved through the ongoing process of identifying and shifting his critical inner constructs. As Victor recognized the sources of his inner criticism, he was able to challenge some of his negative self-beliefs and then to more accurately view and assess himself. This led to greater self-acceptance and an ability and willingness to self-soothe. Victor moved from feeling enormous shame to experiencing some measure of dignity and pride. His deep cynicism loosened to allow for the experience of compassion. He shifted from seeing himself solely as a victim, a loser, and a pariah to recognizing his enduring capacity to adapt and survive. One thing that especially impressed me is that despite all of Victor’s trials and setbacks, he did not give up. Through the process of therapy, Victor had the chance to consciously experience and acknowledge his capacity for resilience. While Victor may not ever be a “happy camper,” his knowledge that he will suffer ordeals and disappointments no longer precludes his possibilities for hope.

Victor’s relationship with me as his therapist is a significant component of what happened during his course of treatment, and I think that, in substantial ways, aspects of our relationship contributed to Victor’s healing. One facet of this is the nature of the relationship itself. My stated primary goals were to form a therapeutic relationship with
Victor that he would consider safe, trustworthy, and inviting, and to work with him in ways that would support his self-efficacy and autonomy. There were many times when I second guessed myself and severely doubted my ability to help Victor – and when I expected he would question my abilities himself – yet somehow I trusted my basic instinct to remain, simply, an authentic, respectful presence. In particular, it was important to me that Victor feel my esteem, compassion, and affection for him; that he trust I would be direct and honest with him; and that he sense – and directly see – how I was affected and touched by him. This means that I did not always hide my impatience, ire, disapproval, sorrow, or uncertainty. It also means that Victor had the experience of revealing and exposing his inner self to someone while being met with respect, acceptance, and love. This meant a lot to Victor, because he cared what I thought of him and he held me in high esteem. It also helped Victor to trust me. My credibility allowed me to respond candidly to whatever Victor conveyed and to offer him alternative – and generally more charitable and compassionate – ways of interpreting the things that happened to him that he could accept. Overall, this provided Victor with comfort; for example, when I told him that I was sorry he was suffering and believed he could heal. It was a way of holding hope for him that he could not hold for himself, and it was hope that Victor could believe in and trust.

Something I noticed early in the treatment was that Victor would take in everything I said and regard it very seriously. At the outset, this gave me pause and a great sense of the responsibility at hand. As it turned out, Victor’s process was to absorb and convert what I said into words and notions of his own, even though, at least initially, he continued to attribute them solely to me. This was apparent the first time we spoke
about an upcoming trip I was taking abroad when Victor came up with the phrase “What Would Rachel Say” (or “WWRS” – he made it clear it was all to be capitalized.). Here was my first knowledge of how Victor was distilling and incorporating what he gleaned from me, and what he was internalizing from the treatment: to view himself in a less critical way and to be more gentle and accepting of himself. Occasionally, Victor would stop himself in midsentence and rework something he was trying to convey into a less punishing account. Interestingly, when we discussed the ending of therapy, and Victor regaled me with his current version of WWRS, I noted that the words he used had evolved into ones that sounded much more truly like his own. To me, this indicated a way in which our relationship had served Victor as a conduit for his healing and transformation.

Another arc in our relationship relates to Victor’s transference with me as his therapist. At the start, Victor’s projections toward me were highly positive: he liked me, saw me as capable and smart, and believed I could help him. Though I was still a student, and lacking experience, Victor could not believe his good fortune to have me as his therapist. (This may at least partially result from his recent experience with a licensed psychologist, whose treatment of Victor was less than ideal.) While I often felt inept or at a loss in a session, Victor inevitably returned the next week hailing what he had gleaned from our last time together. Over the course of the treatment, Victor’s transference – and experience – included times in which he expressed hurt, irritation, impatience, or frustration toward me, generally due either to some bungling on my part or to my press on him to venture more deeply or into darker terrain. Victor also witnessed some of my own uncertainty, struggles, and sufferings. He was startled to find that I, too, felt despair
and had doubts. At the end of the therapy, Victor witnessed my pain as I grieved the loss of a dear friend and colleague. To my surprise, rather than leading him to devalue me or the therapy, these discoveries served, instead, to elevate Victor; he came to view himself as being more like me, which both equalized and normalized his experience. It also invited a beautiful moment in which Victor offered comfort to me. These experiences seemed to facilitate Victor’s process of reinterpreting himself and his status – and thus his stigmatized identity – both as a gay man, and as a person living with HIV/AIDS.

**Imaginal Structures**

**How I was Affected**

I was affected by what happened in Victor’s therapy in a variety of ways. As a novice clinician, I often felt at a loss during sessions and that I was in over my head. As a result, I experienced a good deal of anxiety and fear and many doubts as to my abilities and potential effectiveness. At times, my apprehension and lack of confidence were intense and unsettling and caused me to wonder about my choice of vocation. Early in the treatment, there were times when I felt bored or frustrated that Victor was not exhibiting more emotion or depth; this led me to question both of our capacities for accomplishing meaningful work together. I had always felt warmly toward Victor, though; and in the moments when he revealed his hurts, his vulnerabilities, and his longings, I found I was deeply moved and that I felt great affection and compassion toward him, as well as the desire to comfort and protect him.

For a while, I vacillated between thinking that nothing was happening in the therapy and the awareness that Victor actually looked up to me as an authority and a
guide. I found this intimidating and humbling, yet it also increased my sense of confidence and responsibility. Much else was activated: my inner criticism and doubts that I could guide him and keep him safe; feelings of impatience and arrogance, which I noticed each time I held myself back from pointing something out insightful, clever, or profound so that Victor could find it himself; and, at times, my own despair, cynicism, uncertainty, and hopelessness, which were called up when Victor himself brought these into the room. I also experienced great satisfaction as the treatment progressed; of witnessing positive shifts and growth in Victor as well as my own increased capacities and evolution as a psychological practitioner.

**My Imaginal Structures**

There were a host of imaginal structures evoked in me during the therapy. It is important to identify these structures as they shed light on my countertransference reactions and serve as core interpretive lenses. The primary imaginal structures in operation for me during the course of treatment were an Inept structure and those I call The Victim, The Public Defender, and The Barren Woman.

The Victim imaginal structure appeared prior to the actual start of the treatment. This is a part of me – one I understand as connected to my Jewish ancestry and gay identity – that is fearful and anxious, and believes that bad things are bound to happen to me. The Victim’s main line is, “The world is unsafe and I am going to get in trouble.” When it is activated, I experience the world as precarious and myself as alien, exposed, and vulnerable; I do not expect to survive, succeed, or fit in. At her most extreme, The Victim can lead me to a state of anxious collapse, convinced that I am in danger, or will
do others harm, and that I will be found out and penalized – even arrested! – at any given moment. This Victim imaginal structure arose, in small ways, even before Victor’s therapy began, as I anxiously prepared to do my fieldwork at a nonclinical site that, while sanctioned by both, was unconventional for the University as well as for my place of employment. Even though I had approval from my supervisor to see clients in my office, I became agitated when Victor’s booming voice and raucous laugh called particular attention to our endeavor. I worried about protecting Victor’s privacy and about being disruptive to the food bank and had an underlying nagging feeling that I was going to get into trouble. This fearful part of me was more vividly evoked when I felt I had made an error or that I was in over my head, and most of all when Victor manifested acute or ominous distress. At these times, I would fill with an anxiety that was difficult for me to manage or assuage.

The Victim imaginal structure was also provoked at times when Victor was himself in a victim-identified place. For example, if he was feeling particularly discouraged, helpless, or wronged, my Victim imaginal structure often arose in response. As described in earlier sections, this had both positive and negative outcomes, depending on my level of awareness at the time. On the one hand, this was the part of me that could best comprehend Victor’s suffering; my own victim experience was an important source of my empathy and compassion, and that we shared this may well have served to strengthen his trust and our bond. At times, though, my Victim imaginal structure colluded with that part of Victor, leading me to join him in his hopelessness and despair as well as his spiraling down. There is also a marginalized aspect of my Victim imaginal structure, which gets evoked when I feel powerless or that I lack credibility or authority,
or that I am outside of and excluded from the mainstream. The poles of this substructure can lead me to feel that either I am special and elevated due to my difference and struggles, or else collapsed and bitter about my lot in life. As when the main Victim imaginal structure is activated, I must be careful that the marginalized one does not initiate an unproductive collusion with a client but rather a positive and fruitful sense of solidarity.

My Inept imaginal structure emerged when I felt incompetent, unskilled, clumsy, and lost. This imaginal structure was evoked periodically during the course of the treatment, and it overlapped and partnered with the anxious Victim one. The Inept imaginal structure manifested early in the therapy when Victor mainly regaled me with detail-filled stories that struck me as superficial and mundane. The Inept one’s reaction was to see this as a failure on my part, to blame his lack of progress and depth on my own lack of experience and competence. This imaginal structure was also called up during the numerous times when I simply felt at a loss as to how to help Victor, or when I judged I had missed something or made a wrong move. The gatekeeping that arose in response to this imaginal structure kept me from feeling a sense of accomplishment or attributing any of Victor’s gains to my own feats or interventions; it has me say, “Who am I kidding, I could never help anyone.”

The Public Defender imaginal structure was also frequently evoked and in attendance throughout the treatment. It represents aspects of me that are deeply affected by, and motivated to ease, the suffering and oppression of others. The Public Defender is a caretaker and guardian, serving and rooting for the underdog. For the most part, when this imaginal structure is evoked, I am generous, empathetic, and genuinely caring; it is
an honorable part that is reliable, steadfast, tolerant, and fiercely protective and loyal. This benevolent pole of Public Defender has inspired my process of becoming a clinician and calls for me to stay on this path even when I feel burdened, discouraged, or exhausted. Its compassionate nature and sense of responsibility, for example, overrode my ambivalence and impatience, and guided my decision to continue to treat Victor beyond our initial contract. Its hunger for healing and justice fed my commitment and kept fire in my belly during difficult and tedious times in the treatment. Its belief in the significance of the topic of AIDS-related stigma serves to drive me still, as I grow weary and discouraged by the process of completing this Clinical Case Study and graduate degree process.

The Public Defender has other, less positive dimensions that are also important to note here. When I am in a less self-aware state, this imaginal structure can lead me to be over-zealous, impatient, and cynical. I can be pushy and arrogant, thinking of myself as a savior and a hero. I can feel overwrought and forget to take care of myself, or I can be codependent and overbearing and not allow the time and space for others to evolve and find things out for themselves. With Victor, I had to catch myself when I felt impatient with his progress. There were times in the treatment when I was frustrated that he was remaining in relationships and situations that were oppressing him and I had to suppress the urge to tell him what I thought he should do. Working with growing awareness with both poles of this structure as they arose has been empowering and humbling and has helped me to become a more trustworthy advocate and practitioner.

The Barren Woman is an imaginal structure that embodies the internalization of negative images and messages about lesbian women – stereotypes that insult the very
core of who I am. When The Barren Woman is activated I accept that I am not manifesting who I should be as an adult and as a woman. When caught here, I feel inadequate and dispossessed. I see myself as incapable of being nurturing and generative – like a mother with no milk in her breasts. Because she has not fulfilled her destiny, The Barren Woman feels she has no place, no standing, and no purpose. She tries to make up for her fundamental lacking and wrongness by fitting in the best she can, being as useful as she can, and contributing what she can. She has no sense of inner authority or ballast, and feels resented, disparaged, and on the outside looking in. When I am aware of this imaginal structure I am aware of having a stigmatized identity.

This imaginal structure has been so in the shadows that I had a hard time differentiating it and sensing it directly. Unlike other imaginal structures, it is as though The Barren Woman became apparent and perceivable to me only as I recognized the absence of something. One result of this imaginal structure is that I can be insecure of my ability to nurture others and slow to let the maternal part of myself come forth. Perhaps to avoid feelings of inadequacy and shame, I sometimes hesitate to act caring or motherly because I am afraid I will seem false or fall short. With Victor, I sometimes failed to notice when nurturing was called for and was slow to perceive and attend to his maternal transferences toward me. I was continually surprised by the extent to which Victor recognized and depended upon my caring, projected “mother” onto me, and seemed to mend his mothering wounds via our relationship. I recognized that this imaginal structure was at play when I would see how blind I had been to something that was going on; for example, I would note that an off hand comment I made had a huge impact upon Victor, and that would reveal how I had failed to recognize his transference upon me. I knew
how deeply Victor had been wounded by his mother and I assumed I could not help him heal that because he would not have that kind of transference with me. One way I interpreted this was that this imaginal structure kept me from acknowledging my potency and my potential for helping Victor to heal.

**The Client’s Imaginal Structures**

There were several primary imaginal structures that were evoked for Victor during the course of treatment. These structures can be understood to reflect Victor’s resistances to the therapy, his transference reactions to me as his therapist, and the shifts that occurred for him regarding AIDS-related stigma as a result of the treatment. Victor’s imaginal structures had a distinct and overarching critical tone; their cultural components were particularly apparent and potent. The associated gatekeeping, which served to keep the imaginal structures in place and active, likewise had markedly cultural dimensions. It is evident that Victor’s imaginal structures arose from both his personal and cultural biographies; as a gay man living with AIDS, his gatekeeping was aimed not just at him personally, but at him as a member of a targeted group; this is the territory of the stigma experience. The primary imaginal structures evoked for Victor during the course of treatment can be referred to as The Drama Queen, *I Am HIV*, The Pariah, and Sisyphus.

Victor exhibited the imaginal structure that I call The Drama Queen primarily in the early part of the treatment. In this mode, Victor was garrulous, witty, and self-deprecating, and he seemed intentionally to act ditsy and inane. He avoided self-reflection and resisted talking about anything serious or substantive, regaling me instead with amusing anecdotes and dramatic tales of woe. Victor would, at times, refer to
himself as an airhead and a silly queen, alerting me that this was an imaginal structure he was conscious of, perhaps even purposely affecting. I found this interesting – that he was simultaneously complaining about the stigma of being gay and delighting in personifying its stereotypes – and became curious about the functions this imaginal structure served, both in and out of the therapy. Knowing that Victor had internalized the stigma directed at gay men, I began to notice the particular ways that it had manifested for him. I was struck by the intricacies of the internalized stigma experience. For example, I discerned how, for Victor, being – and acting – gay was a complex source of identity, encompassing both shame and pride, dislocation and belonging. The experience was at once humiliating and alluring, confining and liberating, something to be hidden and embraced, one of victimhood as well as defiance. At times I interpreted Victor’s behavior as a coping mechanism that lowered expectations and kept him safe from failure and accountability. It was as if he were saying, “It is less humiliating because I am in on the joke,” and thus protected himself from the culture’s rejection. It also seemed to me that this imaginal structure served functions in the therapy, for example as a means of protecting himself from potentially painful revelations and feelings were he to delve more deeply into his authentic experience.

It is possible that by exposing the Drama Queen imaginal structure to me Victor was testing my level of comfort, acceptance, and alliance. That he did so also struck me as an indication that he felt safe with me. As the therapy continued, this imaginal structure began to shift and recede. Perhaps once Victor saw that I was comfortable with the Drama Queen persona – willing both to take him seriously and to join him there in play – he was able to set that imaginal structure aside. One interpretation of this shift is
that my engagement with Victor’s Drama Queen imaginal structure allowed him to experience the affirmation, acceptance, connection, and respect needed to facilitate the restoration of his cohesive self. Specifically, my use of mirroring, twinship, and idealizing transferences in Victor’s therapy served to soothe and repair some of the self-object bonds that had been undermined by the intrapsychic crisis of his stigma experience.41

It also happened that Victor began to realize and express that he wanted to be seen more as having substance and to somehow make an impact on the world; it pained him that he was viewed and demeaned, instead, as someone who was simply exuberant and entertaining. So Victor was caught in this imaginal structure, and needed to find and define, for himself, his authentic experience of enthusiasm, passion, and charm – and to know more clearly when his “drama queen” behavior was play and when it was a way of discounting himself. Over the course of therapy, I saw the Drama Queen imaginal structure much less frequently. At the end of our time together, when Victor was being dramatic or amusing, it struck me more as coming from a grounded and self-respecting place rather than as a parody or stereotype.

Another imaginal structure that emerged in Victor’s therapy is one I refer to as I am HIV. While I had heard other clients utter this type of phrase, I remember being taken aback when Victor used this language in a session. Referring to something he was experiencing, Victor would say, “Well, it’s just part of being HIV.” It struck me as profound that Victor was describing, and referencing himself, not as someone living with HIV, or having HIV, but as being HIV. During the course of treatment, there were many occasions when Victor explained to me that the basis for his behavior, emotion, or
thinking was “it’s because I’m HIV.” This, to me, was evidence of the biographical disruption that Victor’s HIV infection has caused and that his identity as someone infected with HIV and living with AIDS had achieved a master status.  

By the time he was in treatment, Victor had been living with AIDS for 25 years; for most of this time, he socialized and interacted almost solely with others who were also living with HIV/AIDS. Victor had come to associate and attribute everything he experienced as connected to HIV/AIDS: his depression, his self-hatred, his clutter, his poverty, his loneliness, his overall ongoing angst. For Victor, “being HIV” sealed his fate and limited his destiny, defining and explaining all aspects of his identity and experience. Further, it seemed to surprise him both that people not diagnosed with HIV/AIDS experienced these things and that it was possible that he could be diagnosed with HIV/AIDS and not experience them.

Self-object theory that explains the suffering of those living with HIV as a profound wounding and disruption to the bodyself – our basic source of self-esteem, self-agency, and self-organization– can be applied to interpret the I am HIV imaginal structure.  

Tunnell’s application of Erikson’s theory of development to clients coping with internalized AIDS-related stigma is also useful to consider here. As Tunnell suggests, revisiting the tasks and resolutions involved in the stages concerning trust and autonomy, and dependency and shame, are especially relevant; I propose that the crisis inherent in Erikson fifth stage – that of identity versus identity confusion – is also significant in adding understanding to the I am HIV imaginal structure.

Over the course of the treatment, this imaginal structure also shifted for Victor. As one of the few individuals Victor related to who was not HIV-positive – and as
someone he strongly admired – I was able, through selective self-disclosure, to demonstrate that some of the experiences he considered unique to those stigmatized by AIDS were in fact acceptable and universal. For example, there were times when I let Victor know that I, too, experienced self-doubt, sadness, longings, and other types of suffering. This use of the mirroring and twinship transferences served both to elevate Victor – he saw himself as being more essentially like me – and to normalize his experience. This, in turn, may have helped him to shift some of the limiting beliefs that reinforced his internalized stigma experience. Over the course of treatment, Victor came to expand his view of himself and his potential, incorporating these new ideas into his growing definition of what it means to be a man living with HIV/AIDS. The I Am HIV imaginal structure evolved to incorporate a recognition of the strengths that also comprise the HIV-positive identity, including resilience, coping and survival skills, faith, and courage.

The Pariah is another imaginal structure that Victor presented in therapy. Victor frequently referred to himself as a pariah, a victim, and a loser, and he was adamant that he was viewed and treated as such by the culture-at-large. He believed that people regarded those living with HIV/AIDS as disgusting, dirty, and disgraceful, and as outcasts the world would be better off without. The presence of the Pariah imaginal structure, and Victor’s voluntary segregation from the mainstream, strike me as evidence that Victor internalized these beliefs.

Victor understood himself and all people living with HIV/AIDS to be pariahs; that is, as stigmatized, and as society’s scapegoats. This perspective influenced and poisoned his experience, and it forged a complex outlook in him that included feelings of
hopelessness, powerlessness, bitterness, cynicism, apathy, and condemnation of the mainstream. Drawing upon Perera’s work, I understand The Pariah as a victim-identified structure which Victor manifested in both its collapsed/depressed and inflated/grandiose forms. This phenomenon is congruent with the holocausted goat and wandering goat positions in the scapegoat complex.\textsuperscript{45}

An additional way of interpreting Victor’s Pariah imaginal structure is by considering Nathanson’s compass of shame.\textsuperscript{46} Via the Pariah, Victor personified this model’s defensive strategies of withdrawal and avoidance as mechanisms for coping with the internalized shame he experienced as a gay man living with AIDS. Understanding Victor’s experience of AIDS-related stigma as a multiple or layered stigmatization is also useful. The works of Tunnell, and of Abramowitz and Cohen, suggest that Victor may have been predisposed sensing himself as Pariah as a result of earlier and ongoing trauma he experienced as a result of homophobia. Victor’s AIDS diagnosis, in other words, may have reignited existing vulnerabilities and rejections, confirming his identity as a deviant and AIDS as his punishment.\textsuperscript{47}

Another imaginal structure that emerged over the time that Victor and I worked together is the one that I refer to as Sisyphus. At various times in the therapy, the image of Sisyphus popped into my mind because of Victor’s existential suffering and his sense and description of life as “a meaningless slog.” He complained, even as he could see that he was making progress, that he was faced with “the same crap over and over to no end.” At the same time, Victor yearned for his life to have direction and purpose, and he continued to struggle on, demonstrating hope, despite disappointments, defeats, and continuous battles uphill. Victor longed to find meaning in his life and in his suffering,
and I believe that the Sisyphus imaginal structure was a part of him that personified his determination to do the work necessary to accomplish this. At the end of the therapy, Victor accepted that he was not and may never be “a happy camper,” but he recognized that his life could have meaning and satisfaction.

A number of theories can help to illuminate and contextualize this aspect of Victor’s experience in the treatment. For example, Farber’s theory suggests that existential therapy is especially appropriate and effective with clients living with AIDS since their experience is characterized by major existential concerns and symptoms. Viewing the goal of therapy as an acceptance of suffering and a search for meaning, Farber states that when clients living with AIDS discover meaning in their suffering they are able to see and make choices, thus finding opportunity and freedom from previous limitations.48

Milam’s study of posttraumatic growth among people living with AIDS likewise finds evidence that the trauma of living with AIDS can trigger positive changes that include newly developed capacities, spiritual growth, and an increased sense of identity, meaning, and direction in life. Finally, Chödrön teaches that the conflicts, shames, pains, and emotional difficulties that we experience can potentially be the seeds of compassion, connection, and awakening if we have the courage to stop avoiding them. Victor’s struggle in therapy to learn to tolerate, face, and even embrace his demons was a small yet significant step in this direction.49
New Learnings About My Imaginal Structures

Writing about my imaginal structures allowed me to learn more about how they function and the role they play in my professional life. I gained a greater overall awareness about the source and composition of my imaginal structures, what circumstances evoke them, and how they interact with the imaginal structures that are evoked for my clients in therapy. It became apparent to me how maintaining a keen sensitivity and attentiveness to the imaginal structures at play in the treatment can assist me as a practitioner in the crucial task of identifying and tracking the transference and countertransference reactions within the therapeutic relationship. I also saw the potential for collusion between therapist and the client when imaginal structures are not detected, engaged with, and challenged; and I learned more about how gatekeeping serves to keep the imaginal structures functioning and in place.

Writing about the imaginal structures evoked in the therapy experience with Victor allowed me to discern when drawing on my empathy was beneficial and productive versus when it was what I call empathy in a tangle – a complicity which was impotent and not in service to his healing. It sometimes seemed that there was a fine line between the two, and I believe that it was my awareness of the imaginal structures that were active between us that made the difference. At a few times in the treatment when Victor was feeling depressed and hopeless, it was especially challenging for me remain aware so that I could tap into a deep well of caring, yet not join him in his despair and downward spiral.

Conceptualizing the Public Defender imaginal structure was new for me in this writing. As I worked, I began to understand more about what motivates me as a clinician.
and to develop an appreciation for my priorities and perseverance regarding the undertaking of this Clinical Case Study. This imaginal structure has helped me to keep on going when I have felt discouraged and hopeless and spent. It feels important to recognize the shift in how much more space this structure is now taking up in me versus the Victim imaginal structure that was more prevalent earlier in this process. It is also crucial for me to remain cognizant of the shadow of this imaginal structure – the potential for me to become arrogant and uncompromising or to come off as an expert. Writing about this imaginal structure has brought these important issues to my awareness.

The most profound new learning was around the Barren Woman, an imaginal structure I had not previously articulated or titled. The act of writing about my experiences in Victor’s therapy allowed me to locate this imaginal structure and to see the clear relationship between the internalized stigma it represents for me and the topic of this Clinical Case Study. Coming to these realizations had a striking effect on me, evoking intense experiences of grief and shame, poignant feelings of humility and self-compassion, and some new and inspiring longings.

The awareness of the Barren Woman imaginal structure illuminates aspects of my reluctance regarding entering this field, including assumptions that I have held about my limitations. I was surprised at how fully I had internalized those limiting images and messages. Given the importance in psychotherapy of healing wounds around mothering, and the significant role played by maternal transference, the existence and pain of this structure has caused me to doubt my ability to successfully do the work of a therapist. It is humbling to see how my internalization of stigma has impacted my expectations and perspective.
The Barren Woman is the imaginal structure that prevented me from sensing and noticing, at points, the impact I was having on Victor in the therapy. I was stunned when I realized that some of his transference on me was mother transference, and that a significant piece of the therapy was related to healing his wounding around how he had been mothered. In response to Victor’s transference, I found myself embodying the maternal presence that he needed in order to heal. Through Victor, I was able to experience mother transference and to see that I can be a part of somebody’s healing in that way. I believe that witnessing Victor’s transformation via that transference and countertransference facilitated my healing from my own particular wounding. What I take with me is the knowledge of the potential for an expanded image of the Mother archetype, one that fits my identity, my characteristics, and my biography – that there can be an image of the mother that looks and acts like me. I had a sense during the treatment that this transformation was occurring in me but it was in the writing that some deeper, richer healing came.

**Primary Myth**

To foster an enhanced understanding of Victor’s therapy journey, it may be useful to consider a mythic backdrop. While a number of myths could serve this purpose, the scapegoat myth strikes me as particularly appropriate and potent. The story of the scapegoat was also quite significant for Victor, as he mentioned it repeatedly and pointedly during the course of therapy.

The scenario at the beginning of the myth of the scapegoat is of a people anxious and afraid of God’s wrath. Believing that they needed to appease their God, who was
angry because of the community’s collective sins, they selected a goat and ritually transferred all of their sins onto the goat. Then the people sent the goat out into the wilderness with the belief that their sins had been removed, the community had been purged, individuals had been purified, and they were back to being safe and in God’s good graces. Another goat was then killed as a sacrifice to honor God. With this ritualizing, the people were atoned and able to carry on for another year.

Victor’s story, both as a gay man and as a person living with AIDS, has many parallels with the scapegoat myth. Even as a child, it was apparent that Victor was different, and the ways that he was different were considered sinful. He was a small, sensitive, emotional child perceived by others as weak, unnatural, and effeminate. These differences made his family anxious and angry and, through criticism, ostracism, and punishment, they tried to purge Victor of those differences. Victor’s parents and brothers shamed, ridiculed, and humiliated him; they disliked and rejected him; and they tried to change him. Like the people in the scapegoat myth seeking God’s benevolent protection, Victor’s family did all they could to stifle or eradicate the frightening differences in him that they deemed sinful. They tried to expel the goat into the wilderness.

Victor was diagnosed with AIDS in the very early days of the epidemic when the culture’s reactions were virulently hateful and rejecting toward those infected with what was, at the time, a deadly, mysterious, and terrifying disease. As someone who already identified as a scapegoat, Victor was particularly vulnerable to and impacted by the culture’s reactions. What happened in the real world at that time was a scapegoat myth enactment, as people in positions of power were literally calling for people infected with HIV to be rounded up and quarantined, or worse. The narrative in the culture at large was
that people infected with HIV were sinful and repellent; they were blamed for their suffering and rejected. HIV was, from day one, a powerfully stigmatized disease, and those infected with it were made scapegoats.

Victor’s life as a gay man and as a man living with AIDS can be understood as the experience of someone living with a stigmatized or scapegoat identity. The myth of the scapegoat describes and parallels the experience of someone suffering from this stigma. Such individuals have been marked in some way: identified as being sinful and unclean, and as having transgressed social norms and endangering the community. They have been blamed for their own suffering and exiled. Victor clearly identified with this mythic scapegoat figure. In our very first session he referred to himself as suffering from the stigma of AIDS, and he described people living with AIDS as scapegoats. Victor frequently described himself as a pariah, and he believed that the majority of the mainstream culture felt it would be better off without people like him.

While all of these things happened to and around Victor externally, there was a parallel process occurring internally for him as well. As a child, Victor was aware of the ways that he was different and he conformed as best he could. He knew what it was about him that made others contemptuous, violent, and critical of him. He worked hard to suppress the behaviors and characteristics that his family and community found to be repugnant and unacceptable. So Victor recognized the objectionable part of himself – the goat in him – and expelled it into a desert inside of him. He, too, came to hate and disparage this part of himself, because he knew that while he had hidden it inside him, it was never truly gone.
As he grew up, Victor came to embody and manifest certain positions in the scapegoat complex, as conceptualized by Perera. The primary position that he occupied was that of the holocausted goat. In Perera’s model, the holocausted goat is the figure that takes on negative projections and becomes collapsed. Victor identified as the scapegoat and he felt victimized, which, in a sense, added to his own victimization. He came to believe what the culture projected onto him: he understood that he was disparaged; he felt himself to be defective, dirty, and disgusting; and he accepted as true that he was to blame for his predicament. Indeed, Victor came to agree that the world would be better off without him. Over time, Victor – and Victor’s sense of place in the world – became smaller and smaller; he was slowly becoming annihilated.

Borrowing again from Perera, it can be said that Victor also embodied the wandering goat from the scapegoat complex. The stance of the wandering goat is to exist and endure at the outskirts, separate from and peripheral to the mainstream world; individuals in this position feel victimized, marginalized, and resentful, yet still long to be part of the community. In this position, the scapegoat responds with a cynical stance, perhaps concluding that the only way to impact the mainstream is to undermine or condemn it. Victor’s identification with this position was evidenced by the way he segregated himself and felt he had no choice but to live in exile from the mainstream. He thought he would only be safe and understood amongst people with similar plights. Although Victor was not actively destructive in any way, he defended himself by holding a contemptuous, superior attitude toward anything having to do with mainstream culture.

Perera points out that the scapegoat myth in and of itself is merely the telling of a story. In the narrative, there is no judgment; it is simply an account of a community
ritualizing its experience of guilt, anxiety, and redemption. Perera holds that it is when we act literally on these mythic impulses – rather than consciously ritualize them – that things go awry; then the positions in the scapegoat complex emerge and become fixed.\textsuperscript{52}

As noted, Victor’s identification with the scapegoat persona had become concretized over time. I propose that his therapy allowed him the chance to ritualize, and thus loosen, some of these bonds, particularly of his identification with the scapegoat and of his internalization of the stigmas surrounding being gay and having AIDS. My contention is that the therapy experience offered Victor a ritual container in which to consciously apprehend and then discard many of the damaging and defining images that he had unconsciously taken in. By suggesting therapy as a ritual container, I am referring to the qualities of therapy that mirror the liminal phase of initiation and facilitate the process of dissolution and reconstitution of identity that is often required for healing and transformation. These include its special setting and timeframe; the unique constraints of the therapeutic relationship; and the aspects of the work that entail travelling to the depths, purging, undoing the wounds, and reemerging as an integrated whole.\textsuperscript{53}

As a result of his opportunity in therapy, Victor was able to begin to release – and to de-literalize – his long- and tightly-held identification with both of the scapegoat positions mentioned above. Victor was then able to recognize that his scapegoat experience had made it possible for him to cultivate some capacities and gifts. He saw that, as painful as it was, his marginalized position outside the mainstream had afforded him a distinct and valuable perspective from which to evaluate and relate to the culture. Victor, over time, also reaped the particular kind of self-assurance that comes from recognizing the capacities and resilience required to have survived his experience. He
began to feel less hostility and alienation from the culture and, at the end of treatment, Victor had a renewed motivation to impact the culture in a positive way. I believe that this may be evidence that as a result of the therapy experience, Victor came to feel some sense of being cleansed of the stigma – and of the sin-laden goat – that he had internalized.

While he has gained some sense of liberation and relief, the scapegoat myth and figures remain among Victor’s companions; and given his fundamental vulnerabilities and the ongoing triggers that his life presents, Victor may never fully step free from the complex. In the scapegoat myth – because human life is inherently full of sin, and dark deeds, and shadows – the atonement ritual is performed annually. Likewise, Victor will benefit from continual opportunities to ritually attend to the suffering generated by his stigma experience.

**Personal and Professional Development**

One significant way that my work with Victor impacted my development is that it gave me the opportunity to recognize capacities that I had not previously been able to see. More precisely, the gatekeeping associated with the Barren Woman and the Public Defender imaginal structures had previously kept me from fully understanding and expressing aspects of my compassion and empathy. Through the work, I began to see myself as a practitioner who could, with integrity, accompany people through their healing, even from early traumatic wounding. The process of incorporating this new awareness and these new images into my identity was a gift.
My work with Victor helped me both to expand and fine-tune these capacities. I have a good deal of compassion and empathy in general and specifically with the populations to which Victor belongs: people who are gay, and those who are living with HIV/AIDS. This affinity has enabled me, over the years, to be dedicated and effective in my work. However, there are myriad potentials dangers in this realm, including dependency, collusion, and overwhelm. For example, one shadow aspect of my empathy is the tendency to not hold others accountable. There were times when I felt the tug to comfort Victor instead, and I had to grapple with the need to be truthful. Working with Victor allowed me to fine-tune my use of empathy, gaining a greater ability to discern when it truly served him, and our alliance, rather than working just to make him feel better and me more popular.

Over the course of the therapy, I recognized that I could hold a lot of Victor’s suffering and not get overwhelmed or lose my footing, as I had feared I might. I was surprised to find that in our sessions, I was able to travel to intense and dark places with Victor, to feel with him, and even at times to show how affected I was by him, while still maintaining a professional, boundaried relationship. This pleased and inspired me, because I could see how much Victor benefited from my demonstrating my empathy and compassion for him; that I cared was a validating and soothing experience for Victor, and it seemed to foster his healing.

Another aspect of my development through the course of this work with Victor was in further cultivating my capacity for reflexivity. One specific way that this capacity was fostered was in relation to my role as a therapist and my feeling the weight of being responsible for another person’s well-being. I recognized the importance of tracking who
was in the room with us, in terms of what imaginal structures of mine were evoked or present at any given moment. At times when Victor was in crisis and I felt myself in that tangle with him, it was especially important to fine-tune that awareness. When I think about reflexivity, I think of being aware of being aware. Experiencing this was like a moment of grace, when a response came from some place deeper and more directly connected to and generated from what was required in the moment. Examples of this were times in which I acted seemingly out of character by saying something humorous or provocative that just seemed to hit the nail on the head and be just what was needed.

My professional development was also broadened in terms of my capacity for responsibility. I tend to be over-responsible, and to have an outsized fear that I am going to be held responsible, so this is an area that has brought up a lot of anxiety for me. The experience of working with Victor and learning to understand what triggered my anxiety allowed me to come into more balance about responsibility. I developed a clearer sense of boundaries and of ways to manage my anxiety so that I could actually show up and be present and thus more truly responsible and effective. This helped me to more accurately assess what level of danger Victor was in and respond to it directly, as opposed to being consumed and immobilized by my own fears.

An area of personal transformation was in terms of my own experience of internalized stigma. There are ways that both as a Jew and as a lesbian, I have been subjected to stigma and have internalized its confining messages. I am aware of how this phenomenon has sullied and limited how I view myself and what is possible for me, of how the stigma has served, in a sense, to imprison me. My experience of working with Victor was that it allowed some of my individuality and potential to unfold. I had the
opportunities to see that I have characteristics and capacities that fall outside of the narrow stereotypes, and that I can freely move beyond their bounds. Further, a central feature of stigma – this is certainly true of the stigmas toward lesbians and Jews – is the experience of being regarded as fundamentally dangerous, defective, and dirty; perhaps for this reason, experiencing myself here as a healing and benevolent force was especially transformative for me.

On a practical level, I gained some new skills as well as a continuing awareness of how much I have yet to learn and improve. I was struck, in particular, by the stamina – emotional, mental, and physical – that doing clinical work entails in order to maintain sufficient presence, concentration, and focus. Skills I have further developed include some of the basics such as active listening, understanding self-disclosure and when to give advice, and time management. To some extent these were mainly fostered through practice, much like strengthening a muscle, although circumstances occasionally necessitated that I asked for specific tutoring during sessions with my supervisor.

**Applying Imaginal Approaches to Psychotherapy**

Applying an Imaginal approach to psychotherapy with Victor centered, and relied on, my basic stance as a therapist. In simple terms this meant applying Moore’s principle of caring for the soul. From this standpoint, my aim as a therapist was to care rather than to cure; to recognize symptoms, sufferings, and longings as meaningful communications to be addressed rather than suppressed; and to accompany Victor through his soul’s journey rather than seeking to fix him or absolve him of his problems. Other important tenets of Imaginal Psychology that I applied clinically include drawing
on images and metaphor, inviting multiplicity, welcoming transpersonal aspects of experience, and encouraging the process of cultivating capacities.

According to this approach, psychotherapy works best when it is participatory, meaning that as a therapist, I was most successful when I was aware of and engaged with my own symptoms, sufferings, and longings; my own souls’ journey; my own imaginal structures; and the wealth of images that dwell inside me. When things went well, I was able to apply these experiences and awarenesses in the service of Victor’s transformation and healing. Another facet of an Imaginal approach to psychotherapy is that as therapist I did not see my role with Victor as that of an expert but rather as that of helping to activate his own inherent healing potential. An imaginal approach also meant understanding transference and countertransference as an interplay of imaginal structures as well as perhaps other archetypal or mythic forces.

The inclusion of social awareness and engagement – and the commitment to recognize and address the role that social oppression plays in psychological suffering – has always been, for me, a significant and redeeming aspect of Imaginal Psychology. As I understand it, a thread underlying the concepts, objectives, and practices of Imaginal Psychology is the quest for liberation and justice. In the therapy with Victor, incorporating considerations of social oppression and social justice were particularly important and these were woven throughout the treatment. This stance and intention reflect a central way in which I applied an Imaginal approach to Victor’s psychotherapy.
CHAPTER 5

REFLECTIONS

Personal Development and Transformation

This Clinical Case Study on AIDS-related stigma is the culmination of a long, circuitous, and challenging process of meeting the academic requirements for a doctoral degree in clinical psychology. It also signifies an evolutionary step in my personal quest to achieve some understanding regarding phenomena that are integral to the topic – such as scapegoating, bigotry, and the perpetration of atrocity – that have captivated and disturbed me throughout my life. As I reflect on the Clinical Case Study process, I can see how my intense and intimate personal connection to the topic of stigma served both as an inspiration and an obstacle to its progress. In order to see the project through to completion, this required that I navigate and transform the terrain of my own internalized stigma. This product, then, might be considered a symbol of my burgeoning liberation from those shackles.

As I indicated in the Introduction, throughout my life I have felt a pervasive sense of fear and alienation that I came to associate with belonging – as a Jew and a lesbian – to groups that have long been the targets of contempt and persecution. This aroused a deep curiosity in me, regarding both the human propensity to label and persecute “others” and the psychological effects of being directly and indirectly subjected to the disparaging and hateful images that accompany such intolerance. I carried these fascinations into
adulthood, along with a mounting, nagging awareness that my own sense of identity and potential had somehow been tarnished and limited by having been subjected to these negative ideas. Over time, as a result of studies in psychology and of my own inner world, I became certain that this insight was true. Increasingly, I attributed certain of my symptoms and traits – a deficient sense of entitlement and inner authority; a feeling of being basically defective and objectionable; and a disabling sense of despair, anxiety, and impotence – to my having internalized the demeaning and contemptuous cultural messages directed at people who are just like me. Still, attributing my experience in this way – that is, to being a member of a group subjected to cultural hatred and disgust – did not feel quite legitimate, and its mechanisms and antidotes remained nebulous and remote.

In a number of ways, the Clinical Case Study process served to alter that. It helped me to transform what felt like a vague and questionable – albeit persistent – dilemma into something I could experience as concrete, valid, and accessible. By inviting me, at each stage of the work, to identify and engage with my own relationship to stigma, the Clinical Case Study process has allowed me to gain some measure of the clarity and resolution I have longed for.

The therapy journey with Victor set the stage for my own journey of exploration with this challenging material. As I have described, even prior to actually meeting with Victor I began to experience considerable anxiety and self-doubt, and an indistinct, yet familiar, sense of illegitimacy and trepidation. As I sat with these feelings during our first therapy session, I was struck by Victor’s blunt, pungent, and daring way of conveying his experience as a gay man living with AIDS. He unabashedly articulated the ways in which
he believed that prejudices toward gays and people with AIDS had negatively impacted
him, and he referred to it as “AIDS-related stigma.” On that day and throughout his
therapy, Victor’s brave and generous way of sharing his story – and of allowing me to see
and soothe his pain – gave me an exquisite and excruciating window into the realm of
internalized stigma. Victor not only offered me a name for that experience, he held up a
mirror for me, allowing me to see my own reflection there. As we worked to ease his
suffering, the basis for my own became more distinct and decipherable.

The process of completing the Literature Review, while overwhelming, also had
the effect of explaining and validating my experience. The source material on AIDS-
related stigma was more extensive than I had anticipated, allowing me to grasp that I was
pursuing a field of inquiry both worthy and significant. The amount of literature on
general stigma was vast and unanimous in affirming and detailing the terrible, insidious
damage it wreaks on individuals, communities, and nations. In reviewing parts of the
literature, I saw aspects of my own story being told; the Sociocultural section was
particularly potent, as it recounted recent historical events – demonstrating virulent,
damaging homophobia – that I had, myself, lived through.

Writing about the Progression of Treatment required that I take an honest look at
the ways in which my work with Victor highlighted my parallel tendencies toward
cynicism, hopelessness, and self-censure. It was painful to recognize how the therapy
activated my fear and self-doubt, and how close these came to immobilizing me and
obstructing my ability to be present and effective. On the other hand, reflecting on the
treatment allowed me to notice the times when I did rise to the occasion and respond
well, and where I was able to use this shared experience to Victor’s benefit, as well as to
glimpse the moments where I made space for grace to come through. Working on this chapter helped me identify the significance of our work together and recognize the positive impact I had on Victor’s life and my potential as a therapist.

The Learnings chapter provided me an opportunity to further investigate and integrate what I had gleaned thus far. While painful and humbling, it was also enlightening to discern how my imaginal structures have been influenced and gripped by stigmatizing images. Identifying the Barren Woman imaginal structure – an internalization of shaming imagery of lesbians – evoked dread and despair in me, and I was very resistant to acknowledging her existence. It soon, however, became apparent that I could not continue writing without doing so. I kept finding myself turning away, but once detected, what the Barren Woman represented just had to be exposed; and I experienced this as a piercing, crumbling process. Recently, while writing about the Barren Woman, I had a very intense somatic reaction that I described in my journal as follows:

She is stuck in my throat, choking me. I cannot breathe but will not spit her out because I cannot bear to look at her. She is suffocating me. She is the only thing that protects me. I gasp for breath, then a sort of roar bursts out of me, and I begin to sob. I cry for several minutes and then become calm. I think: What a vivid expression of my struggle to expel what I have swallowed. What an excruciating battle, between my desperation for change and my terror of it.

This encounter reveals a way in which I continue to grapple with the internalized stigma that permeates my imaginal structures. It is also a reflection of how the process of exploring my learnings has served to stimulate some important new insight and movement.

While my journey and effort toward freedom remain ongoing, I credit the Clinical Case Study process with enabling me to take great leaps forward. As a result of this
endeavor, I have located and/or cultivated sufficient stores of self-regard, agency, inner authority, and confidence to bring this project to fruition and Victor’s story to light. I have come to see myself as having the expertise, perseverance, and generativity to contribute something to the world. What this suggests is that by working to decontaminate and re-legitimize my own identity, I may have reduced – even neutralized – the potency of my internalized stigma. As I believe that stigma operates by hijacking and tainting an individual’s sense of self, I propose that the radical act of consciously reclaiming one’s own identity may be its ultimate, perhaps only, antidote.

**Impact of the Learnings on my Understanding of the Topic**

There are several ways in which my new learnings impacted and shifted my prior understanding of AIDS-related stigma. What I initially carried into the project were my personal experiences and intuitive notions about the phenomenon of stigma along with an array of academic theories concerning stigma and associated topics. Working on the Clinical Case Study helped me to further develop and consolidate my knowledge in this area by providing me an opportunity to directly relate these ideas to an actual clinical case. The therapy with Victor served to enhance my grasp of the topic in two ways. First, while it triggered and highlighted my own grappling with internalized stigma, the focus was firmly on Victor’s; this divide provided me with sufficient distance, and a functional perch, from which to apprehend what was often thorny, daunting, and intimate material. Secondly, reflecting upon the treatment brought the theoretical material genuinely to life, adding a profound depth and dimensionality to my comprehension of how stigma appears and operates. For example, through my work with Victor, I gained a more lucid and felt
sense of central aspects of the stigma experience such as its internalization, its layering, and its development as a master status. I observed how stigma insidiously weaves through all aspects of an individual’s experience and how it infiltrates and restricts – and actually comes to comprise – an individual’s identity.

A significant effect of my new learnings is my recognition that the aspect of AIDS-related stigma I am most compelled by concerns the psychological consequences of its internalization. My understanding of this realm was deepened by the process of identifying and interpreting the primary imaginal structures that were evoked for both Victor and me during the course of treatment. My new learnings served to enhance my comprehension of the mechanisms underlying the internalization of stigma, and provided me with insights regarding the potential for addressing the impact of stigma in the therapeutic setting.

For example, while working to name the primary imaginal structures evoked for Victor in the treatment I was able to perceive the clear link, and the active interplay, between his imaginal structures and his internalization of stigma. I recognized that each of these imaginal structures – which I identified as The Drama Queen, I Am HIV, The Pariah, and Sisyphus – either personified aspects of how Victor had internalized stigmatizing messages or reflected the ways that he was grappling with his resultant tainted identity. The negative homophobic and AIDS-phobic messages that Victor had internalized appeared to be thoroughly woven through his imaginal structures, and to have permeated and concretized his identity. In turn, his imaginal structures were further predisposing Victor to internalize stigmatizing messages. While reflecting on this, I had
the image that these internal aspects of Victor’s were feeding, and feeding upon, one another.

Another important aspect of my learnings was grasping how transference and countertransference reactions could be understood as an interplay between the therapist’s and the client’s imaginal structures. For both Victor and me, the imaginal structures most activated in the therapy seemed particularly to have been shaped by our stigma experiences. Therefore, the process of distinguishing and tracking the relationship between our imaginal structures allowed me to more clearly glimpse how the mechanisms of stigma, and particularly its internalization, can operate in, and sometimes complicate, therapeutic container.

That said, my learnings also revealed ways in which psychotherapy can have a positive impact upon those suffering from the internalization of stigma. Though psychological healing may be complicated by the weight and imposition of stigma, it is still, largely, possible. In reflecting on his treatment, I conclude that healing did, in fact, occur for both Victor and for me. In my case, the Barren Woman imaginal structure was both evoked and transformed as a result of our work together. Exposed in the process was the unconscious shame I held for not fitting the culture’s vision of what it means for a woman to be feminine, maternal, and productive. I was repelled by this part of myself, but I recognized how my avoidance of it kept me from showing up and bringing myself forth as a therapist in ways that would serve my clients. This imaginal structure kept me from seeing how important my kindness and caring could be to a client, and from believing that I could ever receive their maternal transference. With this material so central to the endeavor of therapy, I was convinced that I could never be a truly
competent, effective practitioner. However, much to my surprise, Victor did have a maternal transference toward me. I believe he healed some of his early mother wounding, and his sense of being unworthy and unlovable, via the therapy. The awareness that Victor experienced this level of maternal comfort and healing through our relationship inspired a vital piece of my own healing and transformation.

Another reflection further confirmed for me how psychotherapy can work to facilitate the resolution of internalized stigma. Through the process of determining my learnings I identified several arcs that Victor travelled during the course of the treatment. These arcs included not just the negative consequences of stigma, but also areas in which Victor had achieved clear measures of progress and healing. This realization taught me that in addition to wounding Victor, his stigma experience allowed, even required, that he cultivate significant life-saving capacities. Victor’s suffering had kept him from recognizing his gifts, and at the start of the treatment they seemed mostly latent and obscured. The process of therapy activated Victor’s ability to identify and access this realm of his human potential. I learned that the process of bringing their negative self-imagery to light, and working to transform it, psychotherapy can assist those living with internalized AIDS-related stigma to reclaim and expand their own sense of their identity and future.

**Mythic Implications of the Learnings**

As a means of communicating the mythic implications of my learnings about AIDS-related stigma, I return to the story of the scapegoat. In an earlier section I presented the biblical scapegoat myth as a backdrop for conveying the essence of
Victor’s therapy journey. Here I offer the scapegoat story as a way to explore the broader meanings and consequences of my learnings, beyond the individual experience and toward the wider community and culture.

The enduring potency and prevalence of the biblical scapegoat myth suggests that it may reveal certain fundamental truths about the human experience. The phenomenon of scapegoating – that is, blaming and punishing others for our own individual or collective misfortune – has come to be considered innate and universal. One explanation, offered by theorists in a range of disciplines, is that scapegoating is an unconscious strategy for managing the existential fears and anxieties that arise from our experience of living in a world filled with uncertainties, dangers, and the occasional, unexplainable calamity. By projecting our sinfulness upon others, be they individuals or groups, we retain the illusion that the threats lie outside of us, and that we, as an individual or a group, are good and right and pure and will, therefore, be protected and kept safe from harm. When, in this way, we reject and banish a part of ourselves, a member of our group, or a group within our society, we may indeed feel more secure; but this often comes at great cost, both to the individual and to the community. The damage done to individuals and groups who are targeted by scapegoating is pervasive, ranging from alienation within a system or family to significant suffering resulting from acts of discrimination, enemy-making, and atrocity.

As delineated in the Literature Review, it has been powerfully argued that the culture’s initial reaction to AIDS – the denial, ignorance, and condemnation that allowed it to reach what are now pandemic proportions – resulted from and exacerbated the scapegoating of homosexual men and members of other groups who were initially
infected with HIV. It can be inferred, here, that the culture’s fundamental discomfort,
disgust, and fear of those considered different, dangerous, and sinful allowed – even
caused – nearly an entire generation of gay men, whose potential contributions to our
world can only be imagined, to suffer or perish from AIDS. Furthermore, despite great
efforts on many fronts – and despite all reason and logic – the virulent scapegoating of
millions of people living with HIV/AIDS throughout the world continues to this day.
Even so, it is but one example of how, throughout time, we have projected our sins onto
those we blame for our woes, wreaking tremendous and undue suffering, while leaving us
no more secure, no less anxious, and no more immune to catastrophe.

The biblical scapegoat myth presents an ancient people’s approach to addressing
aspects of these complex and shadowy human dilemmas. According to Perera, the Old
Testament story describes a New Year’s atonement ritual – involving the sacrifice of two
goats – intended to renew, purge, and heal the community.¹ The scene is of a people
anxious and afraid of the wrath of their God, Yahweh, who is infuriated by their
collective impurities, transgressions, and sins. The people select one of the goats and
slaughter it in honor of Yahweh, to appease Him and appeal for His pardon. The other
goat is “ritually burdened” as a priest confesses all the sins of the community over its
head and then, still alive, it is sent wandering into the wilderness, carrying off the
people’s guilt and impurities, leaving them purged and atoned and back in the good
graces of God.²

Drawing on Perera’s work, there are a number of elements that are interesting to
consider here.³ To begin, it seems significant that in the myth, the community’s
experience of existential anxiety and its fear of future catastrophe are acknowledged
openly, addressed consciously, and attended to with reverence. This turn toward anxiety and fear is a major step in bringing discomforting aspects of a community’s shadow to light. That such experience is ritually performed, annually, and with the guidance of a priest, is also telling. This ritualizing suggests an awareness that safeguarding the community requires that the ceremony be repeated cyclically and within the container of a structured, and hallowed, event. Such ritual shows that the gesture of transferring guilt to the goat is understood as symbolic, and that the priest’s role is to facilitate this symbolic burdening. Moreover, it implies that the people participating in the ceremony knew that this ritual expelling of sins was meant to leave them cleansed and unburdened and acknowledged that the sins being sent off into the wilderness were their own.

While it may seem absurd, even ironic, to compare an anomalous chronicle from the 20th century with an archetypal biblical tale, the culture’s shameful, destructive, and seemingly primitive response to AIDS offers invitation to do so. Therefore, highlighting a few contrasting elements between the myth and the story of the emergence of AIDS may be of use here. The emergence of AIDS was a calamity that evoked enormous fear, confusion, and anxiety. Quite suddenly, increasing numbers of young, otherwise healthy gay men came down with bizarre and acute conditions, rapidly deteriorated, and died. Since this disaster predominantly struck gay men – it was then considered a gay disease – the virus responsible was allowed to spread, virtually unchecked, until it reached epidemic proportions. As thousands upon thousands died, AIDS was ignored by the media and government, except when scapegoating and vilifying those who were or who might be afflicted. Mainstream politicians and religious leaders played significant roles in stigmatizing AIDS, claiming it as proof of gay men’s perversion and immorality. The
culture, faced as it was with enormous fear and confusion, had no mechanism or
leadership to help it manage its anxiety nor to address the suffering openly and with
reverence. In contrast to the scapegoat myth, which positions the priest as facilitating the
ritual transfer of guilt, in the early days of the AIDS epidemic religious leaders were at
the forefront of directly laying blame and guilt on those who were already afflicted and
marginalized. Whereas in the scapegoat myth the community is provided ongoing,
structured, and symbolical ways of addressing its guilt and its terrors, in this modern
time, the culture’s terrors of uncertainty, of calamity, and of the other were left in the
shadow of its unconscious, projected upon others, and literally acted out instead.

As if pointing to this phenomenon related to AIDS, Perera explains that “in the
modern age…the scapegoat ritual has gone bad….its deeper meaning is unconscious.”
The scapegoat archetype, she continues, has been perverted and has “produced a
pathology that is widespread.” Perera’s work demonstrates the essential role that the
ancient’s scapegoat ritual played in bringing the community’s anxieties, as well as its
magical thinking, to consciousness; she explains that in a secularized culture there is little
opportunity to consciously address and purge unconscious shadow material, resulting in a
collective denial and projection of the shadow. Differences, Perera warns, are then
ignored, rejected, and condemned, rather than a positive confrontation of anomalies; one
result is the scapegoating of minority groups. I propose that the stigmatization of people
living with HIV/AIDS is a clear case in point.

The scapegoat myth has provided a useful lens for interpreting the cultural
response to AIDS and the phenomenon of AIDS-related stigma. Reflecting on this
material allows me to extract what may be considered mythic implication of my
learnings. One conclusion I draw from the scapegoat story as analyzed by Perera, is that through ritual a community can be enabled to discover, explore, and manage its existential anxieties by having the opportunity to symbolically, rather than literally, enact them. By bringing its shadow material to consciousness and light in this way, the community may be effectively served, even healed. Likewise, in the absence of such ritual, shadow phenomena, such as the scapegoat archetype, are likely to become concretized and to remain dangerously unconscious, thus harming and diminishing the group.

That homophobia and AIDS-related stigma still flourish invites the call for us to find new ways to deal with the shadow material that continues to fester in the cultural unconscious. As this is just one of countless forms that scapegoating takes, the costs are simply too high to ignore. The scapegoat myth demonstrates the importance, even necessity, for the human community to return to practices that consciously engage its collective shadow, through some form of facilitated ritual designed to offer healing and repair. However, just as Perera claims that the scapegoat archetype has been perverted, I would argue that the archetype of the priest has been distorted and spoiled as well. The question arises, then, as to who is positioned to lead.

I have suggested previously that the psychotherapy relationship can serve as a ritual container for exploring and healing an individual’s suffering from stigma. It seems, as well, that psychologists can assist individuals to work with their own shadow material, potentially reducing their particular likelihood of unconsciously acting it out. The dilemma that remains, though, is how to address these issues on a broader cultural level.
It is possible that in the absence of other leadership, psychologists may be called, and best suited, facilitate this undertaking.

**Significance of the Learnings**

The learnings presented in this Clinical Case Study may contribute to the literature on both general stigma and AIDS-related stigma in a few significant ways. First, as the Literature Review demonstrates, academic material in this realm, while varied and vast, is generally discussed from distinct and segregated, rather than broad and integrated, perspectives. Theory and research are presented as useful but isolated threads, leaving the reader with many possible ways to understand stigma, but no comprehensive or synthesized way to fully apprehend it. Second, as discussed in that chapter, there is a grave lack of research and literature written from the unique perspective of people who are themselves experiencing stigma, and in particular, stigma related to HIV/AIDS.

In contrast, this Clinical Case Study, by offering research and theory from diverse arenas, as well as detailing the subjective experience of a gay man living with AIDS, has attempted to present a multidimensional and dynamic portrait of the internalized stigma experience. While this work confirms the literature in the field, it strives to go beyond delineating the biological, cognitive, psychodynamic, and sociocultural dimensions of stigma, to demonstrating the complexities, dynamics, and consequences of their interplay. The inclusion of Imaginal approaches to AIDS-related stigma itself makes a contribution to this field of study. Such inclusion does so, in particular, by offering mythic perspectives on the topic that are otherwise lacking in the literature. The participatory nature of this work – that is, the writer’s exploration of her own experience engaging both
with the client and the phenomenon of stigma – is another distinct aspect of an Imaginal approach to research and clinical work; the addition of this element further contributes to the literature in the field.

The potential contributions offered by this Clinical Case Study are, to a great extent, attributable to Victor’s courage and openness, and his willingness and ability to articulate both the flavor and the details of his painful, first-hand experience. Victor’s solid trust in the therapeutic relationship and his tremendous personal efforts throughout the treatment made it possible for this Clinical Case Study to present a narrative which demonstrates that even for those in the grips of crippling stigma, there is hope for transformation and healing.

**The Application of Imaginal Psychology to Psychotherapy**

The learnings gleaned from this Clinical Case Study indicate the value of applying Imaginal Psychology to psychotherapy. Imaginal Psychology, as shown in this Clinical Case Study, invites an inclusive and expansive framework for approaching and understanding human experience. The general stance from which I conducted and interpreted Victor’s treatment was grounded in an Imaginal approach to psychotherapy. Taking such a stance meant, for example, that I understood the endeavor of therapy as a process of caring for the soul and my task as a therapist as accompanying Victor through the course of his self-directed growth and healing. An Imaginal approach entailed considering not just the personal, but also the sociocultural and mythic aspects of Victor’s journey. It assumed that the seeds of his transformation, and of his capacities and gifts, could be found in his suffering. For me, applying Imaginal Psychology to psychotherapy
implied, further, that as a practitioner, my work with Victor was meant to serve beyond him, that his liberation might somehow ripple out into the wider community.

In particular, the learnings in this Clinical Case Study illustrate the usefulness of interpreting the progression of treatment through the lens of imaginal structures – a concept both central and unique to Omer’s theoretical approach to Imaginal Psychology. While the investigation of the cultural and archetypal aspects of identity and experience was especially potent in Victor’s case, the inclusion of these influences in the consideration of any client’s journey would add enrichment and value. Moreover, these learnings demonstrated how exploring the imaginal structures evoked for Victor and me, as well as their complex interplay, contributed both clarity and meaning to the crucial transference and countertransference reactions at play in the therapeutic relationship. This exploration was central to shedding light on what happened in the treatment as well as on the phenomenon of AIDS-related stigma. I suggest that the possibility of working with imaginal structures is a particular contribution of applying Imaginal Psychology to psychotherapy and has implications beyond this particular study and topic area.

**Bridging Imaginal Psychology**

The treatment described in this Clinical Case Study may be considered a good illustration of how to employ an Imaginal Approach to psychotherapy with mainstream clients and settings. While Victor had a strong desire to be in therapy, he expressed to me early on his discomfort and contempt for anything he considered even remotely creative, irrational, or spiritual. He wanted to deal with matters in ways that were practical, cerebral, and concrete. Yet, somehow his resistance was not all that challenging to
bridge. The key, for me, was to build a strong alliance with Victor, and to convey my stance and conceptions in ways that were clear, comfortable, and accessible to him. In most cases this was a matter of translating key concepts such as imaginal structures and gatekeeping into language that was more conventional and familiar and that would not strike him as bogus or as jargon. As Victor came to trust me, to know that I would embrace him without judgment, and to become more accepting of his own range of experience, he began, on his own, to reveal the imagery and mystery that lived in him as well as his latent spiritual longings.

Areas for Future Research

Early in the course of the Clinical Case Study process I became aware of the dearth of literature on AIDS-related stigma from the subjective perspective of those suffering from the impact of having a “spoiled identity.” The overall experience has shown me the valuable contribution that studying those who suffer from having internalized this stigma, and who are working to release themselves from its grip, can make to the knowledge in the field. It further strikes me that, since the evidence and consequences of stigma are so clearly evoked and revealed in relationship, research that employs a participatory methodology may be best suited to illuminate both the details and dynamics of the stigma phenomenon. In general, then, I recommend that future research be done with a focus on first-person narrative accounts of people living with HIV, particularly individuals who are grappling with the internalization of AIDS-related stigma and endeavoring to enhance and reclaim their identities.
In my work with Victor, I was able to recognize many of the phenomena that have been described in the literature on stigma from a solely theoretical perspective. During his treatment, for example, concepts such as internalization, predisposition, master status, and layering of stigma were given real form and were brought, acutely, to life. Many questions remain, however, and each of these strikes me as a fertile area for more thorough investigation. Moreover, it is my hope that much more work will be done to alleviate the suffering of those who have been marked by AIDS-related stigma. Extensive research is required in order to better understand how to assist those who have been stigmatized as they journey toward liberation and healing. For example, what particular approaches and formats might prove most effective in combating both the conscious and unconscious impacts of internalized stigma?

It is my hope that any new research on AIDS-related stigmas will be included as part of general stigma and/or disease stigma literature, rather than continuing to segregate it in volumes specific to AIDS- or to gay-related studies. I suggest that this move, in itself, would begin the necessary work of addressing and diminishing the stigmas attached to both homosexuality and AIDS.
APPENDIX
APPENDIX 1

INFORMED CONSENT

To ______________:

You are invited to be the subject of, or referred to in, a Clinical Case Study on AIDS-Related stigma. This study’s general purpose is to better understand the particular experience of those who have been subjected this stigma.

For the protection of your privacy, all of my notes will be kept confidential and your identity will be protected. In the reporting of information in published materials, any and all information that could serve to identify you will be altered to ensure your anonymity.

This study is of a research nature and may offer no direct benefit to you. The published findings, however, may be useful to individuals living with HIV/AIDS and may benefit the understanding of AIDS-Related stigma.

The Clinical Case Study does not directly require your involvement. However, it is possible that simply knowing you are the subject of the study could affect you in ways which could potentially distract you from your primary focus in therapy. If at any time you develop concerns or questions, I will make every effort to discuss these with you.

If you decide to participate in this Clinical Case Study, you may withdraw your consent and discontinue your participation at any time and for any reason. Please note as well that I may need to terminate your being the subject of the study at any point and for any reason; I will inform you of this change, should I need to make it.

If you have any questions or concerns, you may discuss these with me, or you may contact the Clinical Case Study Coordinator at the Institute of Imaginal Studies, 47 Sixth Street, Petaluma, CA, 94952, telephone: (707) 765-1836.

I, ______________, understand and consent to be the subject of, or to be referred to in, the Clinical Case Study written by Rachel Gardner, on the topic of AIDS-related stigma. I understand private and confidential information may be discussed or disclosed in this Clinical Case Study. I have had this study explained to me by Rachel Gardner. Any questions of mine about this Clinical Case Study have been answered, and I have received a copy of the Informed Consent form. My participation in this study is entirely voluntary.
I knowingly and voluntarily give my unconditional consent for use of both my clinical case history, as well as for disclosure of all other information about me including, but not limited to, information which may be considered private or confidential. I understand that Rachel Gardner will not disclose my name or the names of any person involved with me, in this Clinical Case Study.

I hereby unconditionally forever release Rachel Gardner and the Institute of Imaginal Studies (and all of its trustees, officers, employees, agents, faculty, successors, and assigns) from any and all claims, demands, and legal causer of action whether known or unknown, arising out of the mention, use and disclosure of my clinical case history, and all information concerning me including, but not limited to, information which may be considered private and confidential. The Institute of Imaginal Studies assumes no responsibility for any psychological injury that may result from this study.

The terms and provisions of this consent shall be binding upon my heirs, representatives, successors, and assigns. The terms and provisions of this consent shall be construed and interpreted pursuant to the laws of the State of California.

Signed this _______ day of ______________, 20____, at __________________, _____ Day                                     Month                    Year
City                             State

By: ______________________________________________________

Client’s signature

_____________________________________________________________________________
Print client’s name legibly and clearly on this line
APPENDIX 2

CLIENT HISTORY AND LIFE CIRCUMSTANCES DURING THERAPY
OUTLINE

I. Victor’s early childhood and school years
   A. Born in Midwestern city into traditional, conservative, evangelical, Republican family
   B. Difficult pregnancy, premature birth in emergency room
   C. Third of four brothers, took role of peace-maker, strove to be perfect and problem-free
   D. Parents strict and critical, approval rare, frequent punishment, obedience demanded
   E. Loved school, excelled, popular with classmates and teachers
   F. Smallest child in class, played with younger children
   G. Father violent, unpredictable, intimidating; beat Victor and brothers with belt

II. Teen years
   A. Felt invisible at home, except when criticized or punished
      1. Not close with brothers, who were pitted against one another
      2. Mother threatened sons with father’s beatings
   B. “Blossomed” in high school, popular, extra-curricular activities, gained confidence
   C. Excelled academically, National Honor Society, graduated in top two percent of class

III. Young adult
   A. Attended small, top ranked, liberal arts college on scholarship
      1. Wanted and needed to get away, parents objected
      2. Graduated magna cum laude with double major in Psychology and English
   B. Struggled, then came to terms with, homosexual orientation
      1. Became more secure with identity
2. Came out to family
   a. Two other brothers are gay, but have not disclosed
   b. Object of parents upset and disappointment, no longer the “no trouble” son
C. Moved to San Francisco
D. Employed as banker

IV. Mid-twenties to early thirties
A. Established self in city life, involved politically and socially, sexually active
B. Felt accomplished in career, bank branch manager by 25
   1. Met, fell in love with, developed relationship with Nate (pseudonym)
   2. Tested for HIV together with Nate
      a. Victor diagnosed positive, Nate negative
      b. Felt dirty, damaged, less than, undesirable
   3. Serious health problems, due to HIV and Hepatitis B, starting at age 30
      a. Massive esophageal bleed in intensive care, given six months to live
      b. Liver biopsy revealed cirrhosis
      c. Second massive bleed
   4. Put on permanent disability at age 31
      a. Difficulty adjusting to fixed income and loss of career
      b. Heavy toll on self-esteem

V. Mid-thirties to early forties
A. Moved to Northern California town to “retire” and/or die
B. Suffered cerebral hemorrhage, coma, not expected to survive, very slow recovery
C. Twelve-year relationship with Nate dissolves
   1. Blow to self-esteem
   2. Alone; financial circumstances worsened
D. Got bored with free time; decided to join local Commission on AIDS
   1. Learned new skill set
   2. Served six years
   3. Became Commission’s Chair
E. Liver ultra-sound revealed spots, beginning stage of cancer, on list for transplant
F. Liver transplant in 2003, slow and difficult recovery

G. Older brother died of AIDS

H. Participated in HIV-positive men’s group; saw psychologist (part of his medical doctor’s practice) for bi-weekly therapy
   1. Therapy sessions consisted of going out to lunch and having casual conversation with psychologist
   2. Victor is not charged, but psychologist billed for insurance

VI. Just before therapy began
   A. Became anxious about pending loss of disability income, experienced lack of meaning and direction; began exploring options for his future
      1. Took career counseling class at local community college
      2. Participated in Shanti L.I.F.E. Program
   B. Decided to end relationship with psychologist

VII. As therapy began
   A. Began process of applying to counseling program at local college
   B. Application was denied
   C. Ended relationship with psychologist

VIII. Second six months of therapy
   A. Conflict with parents; contact becomes infrequent and strained
   B. Friends visit his apartment and accuse/tease him about hoarding
   C. Department of Rehabilitation denies him funding to go back to school
   D. Takes computer and conversational Spanish classes at local college
   E. New medication for kidney function makes him feel weak and dizzy
   F. Four week episode of depression; primary care/HIV doctor adjusts medication

IX. Final six months of therapy
   A. Internship with local HIV clinic; national presentations
   B. Ends contact with parents
   C. Discontinues Zyprexa
   D. Enrolls in certificate program at college
APPENDIX 3

PROGRESSION OF THE TREATMENT OUTLINE

I. The beginning
   A. The first session
      1. Initial impressions
         a. Physical appearance
            i. Muscular and fit
            ii. Clean cut, neatly dressed
         b. Affective presentation
            i. Animated, charismatic; funny; some humor is self-deprecating
            ii. Open to revealing about himself
            iii. Intense, but not emotional
      2. The client’s description of the problem
         a. Anxiety regarding applying to graduate school
            i. Procrastination and uncertainty about direction
            ii. Concern about potential shame and rejection
         b. Contending with intense self-criticism and internalized stigma

II. The first six months
   A. Clinical Issues
      1. Deteriorating relationship with parents
         a. Mother extremely critical
         b. Memories of father beating him
      2. Rejection of application to graduate school
      3. Intense internal criticism and imagery around being HIV+, gay, unemployed
   B. Clinical Impressions
      1. Self-aware and articulate; humorous, hyperbolic, verbose
      2. “In his head”; does not engage with emotion; I am often bored
3. Self-critical, black-and-white thinking, perfectionistic

III. The second six months

A. Clinical Issues
   1. Increased conflict with parents
   2. Friends visit his apartment and accuse him of hoarding
   3. Multiple experiences of rejection
   4. Stigma
   5. Depression
      a. Feelings of hopelessness, dejection, “tired of it all”
      b. Identifies seasonal components and cyclical triggers (winter, holidays, birthday)

B. Clinical Interventions
   1. Depression
      a. Assessment of suicide
      b. Attempt to contact primary care/prescribing physician; suggested client alert physician and review medications and dosages
      c. Helped client identify resources and made safety contract
   2. Hoarding
      a. Ruled out OCD
      b. Discussed motivation; client does not identify it as problem; calls it “manageable”

C. Clinical Impressions
   1. Client is more emotive; subject matter is deeper
   2. November/December: low energy, appears tired and despondent
   3. Development of maternal co-transference

IV. The final six months

A. Clinical Issues
   1. Severs contact with parents
   2. Begins internship with local HIV clinic
   3. Consents to be subject of this Clinical Case Study
   4. Work with internal critic and stigmatization
B. Termination

C. Clinical Impressions

1. Wider range of emotion; openness to working with imagery and somatic focusing

2. Allows self-forgiveness and soothing; more tolerance for discomfort and uncertainty
NOTES

Chapter 1


8. Ibid.

9. As discussed in the Literature Review, Aftab Omer’s Imaginal Transformation Praxis introduces the term gatekeeper to describe the critical, punitive parts of the self and of the culture. While my clinical work was strongly informed and influenced by my training at Meridian, rather than use this term with Victor, I chose to use the more mainstream and familiar term “Inner Critic” throughout his treatment.

10. Aftab Omer, Email communication from Andrea Lambert regarding Definition for Imaginal Structures and Other Key Terms (Petaluma, CA: Meridian University, October 11, 2002).

Chapter 2


5. Treisman and Angelino, The Psychiatry of AIDS, 8.

6. Ibid.


9. Ibid.


11. “InfoNet Fact Sheet Number 101,”


18. Deacon, Understanding HIV/AIDS Stigma, 28. According to Deacon, disease stigma entails myriad processes by which people distance themselves and their in-group from the risks of contracting an illness and blame those who have it for their own infection, deeming them as undeserving of help and support.


21. Goffman, Stigma, 4-5; the other two types of stigma that contribute to the devaluation of others, according to Goffman, are blemishes of individual character and tribal stigmas.
22. Ibid.


24. Ibid.


27. Ibid.


30. Ibid., 206-213.


33. Ibid., 153-4.

34. Ibid., 160.


36. Ibid., 1042.


38. Ibid.

39. Ibid., 5.


41. Ibid.


43. Ibid.

45. Ibid.

46. Ibid., 36.


48. Ibid., 188, 192.

49. Ibid., 197.

50. Ibid., 197-8.

51. Ibid., 199.


54. Ibid., 63, 310.

55. Ibid., 59.

56. Ibid., 132.

57. Ibid., 146. Tompkins as quoted by Nathanson.

58. Ibid., 311-14.


60. Ibid., 171 and 176.


62. Ibid., 38.

63. Ibid., 37-42.


65. Ibid., 95.

66. Ibid., 98-100.

68. Ibid.

69. Ibid., 368.

70. Ibid., 370.

71. Ibid., 378.

72. Ibid., 381.

73. Hélène Joffe, *Risk and “the Other”* (Cambridge, UK: Cambridge University Press, 1999), 64.

74. Ibid., 65.

75. Ibid., 67.

76. Ibid. See also Crocker and Lutsky, “Stigma and the Dynamics of Social Cognition,” 103 for a discussion of the *Just World Hypothesis*.


80. Ibid., 5.

81. Ibid., 10.


83. Ibid.

84. Ibid.


86. Ibid., 4-6.

87. Ibid., 4-5. Freud first introduced the concept of wish fulfillment in *The Interpretation of Dreams*. In interpreting his dream of Irma, Freud writes, “The dream represented a particular state of affairs as I should have wished them to be. Thus its content was the fulfillment of a wish and its motive was a wish.” See Sigmund Freud, “The Interpretation of Dreams,” in *The Freud Reader*, ed. Peter Gay (New York: W.W. Norton, 1989), 140.

89. Ibid., 5.

90. Ibid.


92. Ibid., 309.

93. Ibid., 310.

94. Ibid.

95. Ibid.

96. Joffe, Risk and “the Other,” 44, 73-83.

97. Ibid., 74.

98. Ibid., 73.

99. Ibid., 74.

100. Ibid., 75.

101. Ibid., 76.


103. Ibid., 187.

104. Ibid.

105. Ibid., 188.

106. Several of those who write about AIDS-related stigma comment upon the lack of literature and research that focuses on the subjective experience of AIDS-related stigma, or the psychological impacts of stigma from the perspective of people living with HIV. Gil Green and Elisa J. Sobo [The Endangered Self: Managing the Social Risks of HIV (London: Routledge, 2000), 11] discuss this in terms of a lack of material specifically in relation to identity processes such as the ongoing crafting, negotiating and redefinition of context-specific selves. They mention the disappointing lack of academic research re subjective side of AIDS. They do comment that much of what little we know specifically about the concrete links between seropositivity and identity comes from studies carried out with bisexual and homosexual men. [Green and Sobo, 72]. Lee, Kochman, and Sikkema also note that that research on HIV stigma has focused mostly on attitudes by non-infected toward infected and on understanding why HIV is so stigmatized. Despite potential significance of internalized stigma, there it limited research on it. [Lee, Kochman, and Sikkema, “Internalized Stigma”: 310].


109. Joffe, *Risk and “the Other,”* 86.


111. Ibid., 76.

112. Ibid., 70.

113. Ibid., 16.


116. Ibid., 5-7.


118. Ibid., 206-7. The term, *cohesive self,* describes a state of self that remains steady and dependable, providing one with a sense of stability. When it is disrupted by rapid changes and narcissistic threats, a fragments self arises.

119. Ibid., 206.

120. Ibid., 208.

121. Ibid., 206-214.

122. Ibid., 216.

123. Ibid., 215.

124. Ibid.


126. Ibid., 240.

127. Ibid.

128. Ibid., 241.

129. Ibid., 250-253.


132. Ibid., 315.

134. Ibid., 16.

135. Ibid., 16-17.


137. Ibid.

138. Goffman, Stigma, 2-5. See also Green and Sobo, The Endangered Self. 13-17


141. Link and Phelan, “Conceptualizing Stigma,” 370, 381.


145. Ibid.


148. Shilts, And the Band Played On. Shilts’ title refers to the way that it was business as usual while the Titanic was sinking.

149. Ibid.

150. Ibid., 596.

151. Ibid., 90, 191.

152. Ibid., 150, 321-2, 374-5, 386-8, 220-3.

153. Ibid., 136, 353-4.

154. Ibid.

155. Ibid., 352.
156. Ibid.

157. Ibid., 352.

158. Ibid., 351-2.

159. Ibid., 370, 347-8.

160. Ibid., throughout.


162. Ibid.

163. Ibid.


168. Ibid., 9.

169. Ibid., 13.

170. Ibid. Herek notes, “Gay people and gay community replaced communism as favorite target of us religious and political conservatives. As Christian right increasingly demonized gay people in the 1990’s, being born again Christian became for many Americans who embraced it an identity that carried with it a deep antipathy toward homosexuals.”


172. Ibid.

173. Ibid.


175. Ibid.


179. Ibid. Also, Aftab Omer, *Cultural Leadership* course at the Institute of Imaginal Studies, author’s notes, December 10, 2002.


182. Aftab Omer, Personal Communication with author, October 11, 2002.


185. Aftab Omer, *Imaginal Process* course at Meridian University, author’s notes, September 24-6, 1999; and Aftab Omer, *Integrative Seminar* course at Meridian University, author’s notes, May 14, 2000 and September 26, 2000.


192. Ibid., 11.

193. Ibid., 16-17.

194. Ibid., 9 and 12.

195. Ibid., 9.

196. Ibid., 117.

197. Ibid., 18.

198. Ibid., 18-21.
199. Ibid., 21-2, 27.
200. Ibid., 22.
201. Ibid., 19-24.
202. Ibid., 98 and 13-14.
203. Ibid., 83.


210. Ibid.


212. Lupton, *Medicine as Culture*, 78.

213. Ibid., 79.


215. Ibid., par. 58.

216. Ibid., par. 52-56.

218. Ibid., 104.


220. Omer. “Key Definitions.” Revised 8/05. Meridian University, 2.

221. Ibid., 2.

222. Aftab Omer, *Imaginal Process* course at Meridian University, author’s notes, April 16, 2000; and Aftab Omer, Personal Communication with author, March 2008.


224. Ibid., 215.

225. Ibid., 214, 221.


227. Ibid., 40.

228. Ibid., 34.


230. Ibid., 12 and 90.


233. Moore, *Care of the Soul*.


235. Ibid.


238. Ibid., 200-202.
239. Ibid.


241. Ibid.

242. Ibid.


245. Ibid.

246. Ibid., 40.

247. Ibid., 48-50.

248. Ibid.

Chapter 3

1. Aftab Omer, *Imaginal Process* 1-4 courses at Meridian University, author’s notes.


Chapter 4

1. Aftab Omer, personal communication with the author, October 11, 2002.

2. Omer, *Imaginal Process* course at Meridian University, author’s notes, April 16, 2000; and Omer, personal communication with the author, March 2008.

3. Ibid., 2


5. Omer, *Imaginal Process* course at Meridian University, author’s notes, September 24-6, 1999; and Aftab Omer, *Integrative Seminar* course at Meridian University, author’s notes, May 14, 2000 and September 26, 2000.


8. Omer, *Cultural Leadership* course at Meridian University, author’s notes, December 10, 2002.


15. Ibid., 70.

16. Ibid., 16.


18. Ibid., 216.

19. Ibid., 215.

20. Ibid., 215.


22. Ibid., 239.

23. Ibid., 250 -253.


25. Ibid.


27. Ibid., 315.


29. Ibid., 214, 221.


31. Ibid.

33. Perera, *Scapegoat Complex*.

34. Ibid., 9.

35. Ibid., 18.

36. Ibid., 21-2, 27.

37. Ibid., 22.

38. Ibid.

39. Ibid., 98 and 13-14.

40. Ibid., 83.


51. Ibid., 22-3. My understanding of this position especially draws on teaching from Aftab Omer, *Integrative Seminar* course at Meridian University, author’s notes, October 14, 2000.


53. Priscilla Taylor, conversation with the author.

54. Moore, *Care of the Soul*.

Chapter 5

2. Ibid., 9 and 12, 16-17

3. Ibid., 19.

4. Ibid.

5. Ibid., 8-9, 30-32.

6. Ibid., 32.
REFERENCES


