Too Close for Comfort

Single HIVer looking for love but struggling with intimacy issues. Sound familiar? Don't blame the virus. Psychotherapy can get you past HIV to the root of the problem.

August 1, 2001 By Arthur Fox, PhD

If you feel that sex and love will never (again) be yours because of HIV, it may surprise you to hear that it's probably *not* because of HIV. As formidable as the physical and social hazards of the virus are, many HIVers do find the romance and relationship they desire. But keeping HIV from interfering with your ability to be intimate with others is one of the most critical aspects of surviving AIDS -- and also one of the most complex.

In this, psychotherapy can help. As a clinical psychologist in New York City, I see many people -- gay and straight, HIV negative, positive and untested -- whose relationships are haunted by the specter of HIV. By the time they call me, they can usually explain exactly how HIV has affected them and their outlook on love and sex. But often this information doesn't help them much. However, once they start therapy, their sense of alienation often subsides. It's then that other issues arise -- ones that predate HIV but color and complicate it. And that's when the real work begins.

Carlos and Chris, two of my gay patients (all names have been changed), came to me with problems that are central to the experience of many HIVers: Carlos felt that the world saw him as toxic, and that no one would ever want to get near him again. Chris also felt alienated, shut down sexually and uncomfortable when around men he liked. Through discipline and introspection, both men had successfully mastered many challenges of life with HIV. But restoring intimacy was something they couldn't do alone. Therapy can create a relationship where HIV-related intimacy problems -- and the subtler and sometimes more painful issues that underlie them -- can be brought to light and fixed.

Carlos is a wiry Wall Streeter in his early 40s with thick black hair, a lantern jaw and a keen sense of irony. He came to therapy a year after his AIDS diagnosis, a crisis that began with a bout of PCP and ended with a nasty breakup. Carlos and James had spent six years together -- the last four full of fights, police calls, drug rehab, tearful reunions and wild sex. James had been Carlos' soulmate, the boisterous "other half" of cautious, meticulous Carlos. Carlos believed that James infected him "almost on purpose." Of course, he felt bitter. But he also yearned for the sense of peace and completeness he had felt falling asleep in James' arms.

When we first met, Carlos felt certain that no one could look at him and see anything but AIDS:

hollow lipo cheeks (his face looked fine to me), contagion (he practiced celibacy as if it were his civic duty), impending gruesome death (he was taking meds and doing well). Many HIVers at some point feel that the world stares in horror and wraps itself in latex when they walk by. Other people's fears and stigmas inevitably take their toll on you.

But when fantasies about the virus go so far as to distort your sense of self -- as they did for Carlos, who believed that his body's toxicity was visible and revolting -- the source is often deep in childhood. The stress of testing positive can cause powerful feelings -- ones that were too painful, threatening or confusing for childhood awareness -- to resurface. Like anger: Therapy can show how repressing rage -- a coping skill from childhood that is automatic in many adults -- can lead to great anxiety about sexual risk and safety. Or how early-life doubts about how loveable you are can return, using HIV as a touchstone.

During our first year of work together, Carlos did little in our sessions but pelt me with a kind of negative propaganda about his condition: A life full of good friends and parties had become a death march organized around side effects and medical procedures. A body that had once been a source of pride and pleasure was now a pestilence. Although he was still working (and doing well), he was obsessed with the idea that at any moment he could become disabled. Carlos' tirades were his way of letting me know that he was in pain -- without allowing any strong feelings to actually emerge in our sessions. To him, the notion that therapy could help him was absurd: "This is life with AIDS," he would announce, "and it is ugly. Therapy can't change that."

Oddly, Carlos attended his sessions religiously, implicitly challenging me to end his psychological self-quarantine. But after a year he was still miserable and lonely. Feeling frustrated, I finally stopped listening empathically and started interpreting the anger just beneath the surface. I told him that he was holding tight to his self-disgust as a defense against unconscious rage at others. I also told him that his sense of himself as a public-health hazard was less about transmitting HIV than his fear that others, if they got too close, would be "infected" with his own bitterness.

Certainly people with HIV have a lot to feel angry about, starting with the painful daily realities of AIDS. At a deeper level, rage is the psyche's natural response to a perceived assault on the body's integrity. But people who get HIV from a lover have an especially hard time fully acknowledging their anger -- simply because it's very hard to hate someone you love or have loved. I told Carlos that leftover rage from James' betrayal had built a firewall between himself and other people.

Carlos scoffed at this, but gradually his angry lamentations gave way to childhood memories. Carlos had been the youngest in a large Midwestern family. Both parents worked hard and drank a lot, and "by the time I came along, neither one had a lot of interest in any more kids." Carlos' most vivid early memory was a longing to feel cherished by a strong man who would smile and take pleasure in Carlos' just being himself -- when, in fact, none of the men in his family seemed to even like him. When this sad secret converged with sexual feelings in adolescence, his Catholic background kicked in, casting his desires as a disease of body and soul. He began to hate his wish to be loved by a man.

Hearing about these memories not only enabled me to feel the grief masked by Carlos' self-damning speech. It also helped me pick up on his intuition that these men had not loved him *because he was unlovable* -- an unspoken conviction so central to his personality that he barely ever noticed it. Now, stirred by his betrayal and diagnosis, this unthought conviction had returned. With this understanding, our sessions became sadder and, for a few weeks, closer.

Then Carlos started missing sessions. When he returned, he was openly contemptuous of me and our work together. "You are a living drug," he said. "You sit here and listen and crinkle your eyes, but you only do it because you get paid."

Carlos was clearly trying to fight off the feelings that had emerged in both of us. Like James, I was a flesh-and-blood man who accepted and valued him. "You talk as if you can't imagine that your suffering is meaningful to me, that I might care about you," I told him. I knew this was threatening to Carlos: His HIV diagnosis had made his wish to be loved by a man feel more urgent than ever. And in fact, he wasn't ready to deal with this wish cropping up in our relationship. Soon he quit therapy.

Yet something had clicked. When Carlos came back six months later, he had started dating again. He still held firm to the belief that his intimacy problems came from being infectious and despised for it. But now he was also voicing his confusion about feelings -- specifically, why he kept losing interest in the men he met. This was a striking change: It meant that Carlos was entertaining the possibility that his intimacy issues might be rooted not in irrefutable facts of the epidemic but in psychological problems that we could discuss, understand and change.

Now, Carlos can increasingly "use" me as a confidante rather than a rage receptacle. And as he uses our relationship to understand the ones he is forming outside therapy, he has started expressing curiosity about me and our work: How long do I believe his therapy should continue? Do I feel he is getting better? So far, I have managed to respond without insisting that he recognize that our relationship -- like his other ones -- is both his worst nightmare and his only way out.

Before he could begin to work through his "toxicity," Carlos had to become aware of both the intensity of his anger -- which *was* mostly about HIV -- and its effectiveness as a barrier against closeness. Such anger is common in gay men and others at high risk for HIV. As children, they often experience rejection and ridicule from peers and parents. While both anger and grief are natural responses to these assaults, sorrow is sometimes easier to recognize and express than rage. But unexpressed anger is very uncomfortable; a child may clear it from consciousness by turning it inward. This can create anxiety, which in turn often creates all kinds of physical symptoms, from gastrointestinal problems to sexual dysfunction.

Sexual dysfunction was one of Chris' complaints. A handsome, powerfully built blond in his early 30s with a gentle style and campy sense of humor, Chris is the youngest and brightest son of working-class immigrant parents. He had built up a successful retail business and an exciting life with a wide circle of friends, two nice homes and a lover with whom he had shared two years of

domestic harmony.

“I don’t feel like myself anymore,” Chris told me in our first session. “I want the old Chris back.” He had been diagnosed with AIDS a year before while hospitalized with PCP. Since then, his life had been a farrago of losses: livelihood (his stores went out of business when he was too sick to run them), homes (he couldn’t keep up payments) and lover (a “dear Chris” message on the answering machine greeted him when he got home from the hospital).

Chris’ response to these losses was a sort of protracted shock. He felt more numb than sad, and although he could be irritable -- “I can be an unbelievable bitch lately” -- he didn’t spend much time dwelling on the past. His way of coping, he said, was to take his meds, work hard and try to rebuild. But nothing felt right anymore, especially sex.

Before his diagnosis, Chris had relished sexual and emotional intimacy -- whether with his partner (they had been happily monogamous for two years) or, before that, a hot stranger from a local S/M club. Now sex was better than ever with a stranger, but when he was with someone he felt he could get serious about -- in a bedroom rather than a backroom -- he couldn’t get an erection without Viagra or ejaculate. Since learning of his serostatus, he said, “I can’t relax. I can’t let go. I can’t just be myself.”

After making sure that his sexual dysfunction was not the result of an undiagnosed medical condition (Chris had routine checkups and was on antidepressants and testosterone patches), I figured that Chris, like Carlos, was feeling alienated because he had been unable to complete the painful work of mourning. Unfinished mourning is common among people with multiple catastrophic losses. It can make a person feel that some vital part of the self has been lost as well. While Chris could talk to me vividly and compellingly *about* his losses, like Carlos he wasn’t able to feel his grief in our sessions in a way that let me connect with him in his pain and help him move on. Like his sex partners, I was kept at arm’s length.

When I finally asked him what he did feel during our sessions, he grinned bashfully -- and told me that when he was at a leather bar, he often would see a figure in a leather mask and wonder if that was me. “That would kill me,” he said. “It would be like ’Now I’m caught. I’m out here showing off and flirting and suddenly you’re there and it’s all over.”

“So what am I thinking as I watch you?” I asked.

He giggled, rattled his legs and looked away. “Something very disapproving.”

This fantasy of being caught showing off sexually seemed a good clue to Chris’ psychological world. Chris had enjoyed S/M games as an “accent” to his relationships before he tested positive. Since then, however, these public games of surrender with strangers were the only times he could function. At first I took this to be Chris’ unconscious strategy for keeping things light: As much as Chris wanted a lover, he was still gun shy from his ex’s abandonment. Plus, one-night stands enabled him to avoid the stressful issues of serodisclosure and possible rejection.

But why was he incorporating me into the scene? I wondered if Chris’ commitment to the fantasy

of surrender signaled that, in the wake of his losses, a shift had occurred in his sexual agenda -- from the mutuality and affection of adult intimacy to a more childlike position of seeking haven in an omnipotent parental figure. But the punitive, angry quality of Chris's father fantasy puzzled me. Chris had described both his parents as hard working, dedicated, tolerant. Yet his fantasies suggested that in early life, the idea of safety had become fused with the risk of violence. Chris' white-knuckled grip on the "surrender" side of the frightened child/angry parent fantasy puzzled me, too: Sexual wishes often travel in pairs, one conscious, the other -- often its "evil twin" -- lurking in the unconscious. I wondered if Chris had painful memories of his parents -- and aggressive feelings of his own -- that we hadn't begun to face yet.

As with Carlos, I shifted from focusing on grief to asking about anger. Immediately, Chris started talking about his early relationship with his father: Although his father was kind, if distant, at home, outside he could be explosive, getting into fights that ended in bloodshed and broken bones. Revolted by this, Chris had resolved early on that his anger would never get the better of him. He became a master of forgiving.

But speaking these memories in our sessions, Chris grew visibly anxious, blushing, equal parts excited and scared. He began to talk about his more recent past with deeper emotion -- about relatives who rejected him for being gay and friends who took advantage of his generosity and patience. Although Chris denied feeling anger at the man who he believed had infected him (a stranger and a broken condom), he greatly resented the doctors who had misdiagnosed him, the bankers who denied him a break on his mortgage payments and, above all, the man who had been his beloved companion for two years and was never heard from again after Chris got sick. Sometimes Chris even raised his voice or pounded his fist as he spoke about a moment in which he had felt abused or belittled. As anger that had been stored tightly in his body became transformed into emotions and words, Chris found that his life outside therapy was changing as well: He was sleeping better, exercising more and feeling "more like the old Chris."

Then he met someone in a bookstore and had great sex: kissing, caressing, the intense wish to give pleasure. When I remarked that the sex seemed to have skipped the S/M routine, Chris smiled broadly and said that instead of staying locked in the surrender position, he had let the "power" roles pass back and forth between his partner and himself. But as he said this, a shadow of confusion passed across his face. Suddenly he recalled a thought he had had during the sex. "If we were home, I would have lost control," he said. Meaning? "I wanted to fuck him something terrible, condom or no condom. At home, there's no telling what I could have done to him."

This thought troubled Chris. Like Carlos and every other HIVer I have treated in psychotherapy, Chris felt certain that he would never want to pass the virus to anyone. The strange hunch that he could lose control in the heat of passion felt ugly and alien to him. But the following week, Chris had a second date with this partner, at home, and found it safe, hot, all systems go -- erection, ejaculation, condoms. Reporting this, Chris was delighted, and then bewildered about why his body had waited so long to function sexually. I suggested that the light had turned green when he acknowledged his fear -- and unconscious wish -- of losing control and fucking someone "something terrible" with no thought of safety.

Realizing that this was only a fantasy reassured him. Soon Chris came to understand it as a product of anger that had collected around his multitude of losses, recent and old. He also realized that the better he got at recognizing and voicing his angry feelings, the less his unconscious would use HIV -- and its dangerous potential -- to express it. And the more Chris accepted that feeling angry was natural, even healthy, the less the fantasy of his own destructiveness came between Chris and the men he wanted to be close to.

Both Chris and Carlos came to therapy certain that they already knew how HIV had transformed them. But in fact the virus had affected them in ways that came to light only once some aspect of a destructive old dynamic emerged, as if by accident, in the relationship with me, their therapist. HIV is as wily at raising these early issues as it is at developing resistance to drugs. But as patient and therapist work together to understand and tame these dynamics, they lose their power to keep you from the connectedness that you long for outside therapy.

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