"Ghosts from the past": The re-emergence of internalised religious stigma following diagnosis of HIV among Northern Irish gay men

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ABSTRACT

This paper explores how previous exposure to religious homo-negativity features in the sense making process following HIV diagnosis in a homogenous sample of six gay men living in Northern Ireland. Interpretive Phenomenological Analysis was used to identify two key overarching themes: 'Negotiating authenticity in unsafe space' which relates to the experience of negotiating same sex attraction within religious environments and 'Re-emergence of religious shame in diagnosis' which relates to the way in which the men made sense of diagnosis from the position of having been exposed to religious homo-negativity earlier in their lives. Findings demonstrate how the men negotiated their sexual orientation within religious contexts and how a reconstruction of God was necessary to preserve an authentic sense of self. Despite reaching reconciliation, HIV was initially appraised within a retributive religious framework that served to temporarily reinforce previously learned shame-based models of understanding this aspect of the self.

Keywords: HIV; gay men; religion; stigma; Northern Ireland

Traditional religious doctrine has historically condemned 'homosexuality' as sinful. This can perpetuate societal homo-negativity due to the powerful position held by the Church and the influence that religious ideologies can have on an individual's personal belief system (Herek, 2007). For sexual minority youth who are socialised within religious environments and to whom religious practice and faith become important, significant intrapersonal conflict can ensue. This has been attributed to the perceived incompatibility between their emergent same sex attraction and the position taken by religious doctrine (Coyle & Rafalin, 2000; Dahl & Galliher, 2010; Foster at al., 2011; Jaspal & Cinnirella, 2010). Inability to resolve such conflict can result in significant psychological difficulty (Coyle & Rafalin,2000; Garcia et al., 2008).

Gay men continue to represent one of the largest HIV affected groups in the UK according to surveillance data. HIV is often associated with high levels of personal shame and stigma and particularly so for people living in religious contexts (Vance et al., 2007). This has been linked to historical associations of HIV with behaviours considered by religious doctrine to be 'immoral' such as 'homosexuality' (Duffy, 2005).

The ability to use religious resources has been identified as a positive coping factor in adjustment to HIV diagnosis across heterosexual groups (Pargament et al., 2004), but gay men often feel unable to utilise religious coping frameworks due to prior experiences of religious homo-negativity (Ridge et al., 2008). Pre-existing societal belief systems regarding HIV are therefore likely to influence diagnosis appraisal (Jacobson et al., 2006). However, there is limited research exploring the influence of religious negativity on personal appraisal or meaning making processes following HIV diagnosis from the perspective of gay-identified men socialised within traditional religious contexts.

HIV, Religion and Stigma

Despite improvements in treatment and increased life expectancies, living with HIV remains traumatic for many. The impact of stigma accounts for much of this distress (Herek & Capitanio, 1999) with those affected often reporting greater difficulty in coping with the effects of stigma than the physical impact of the illness (Green & Sobo, 2000). It is generally accepted that much of this stigma has emerged as a result of the symbolic merging of HIV with membership of already stigmatised groups, gay men representing one such group. Herek

et al. (2005) suggest that such stigmatising narratives are maintained by powerful social institutions such as the Church and by the extent to which a society endorses a literal interpretation of its teachings.

Religious doctrine often casts same sex sexual behaviour as 'inherent evil' or 'moral flaw'. In some religious communities, HIV is historically portrayed as divine retribution and reflective of God's wrath on 'homosexuals' (Crawford et al., 1992). Recent studies continue to demonstrate that homophobia and degree of religiosity are associated with negative attitudes towards HIV (Walch et al., 2010). Indeed, negativity towards HIV is more prevalent in areas where religious ideology is integrated more fully into the mainstream culture (Lorenz et al., 2005). In turn, many gay men living with HIV feel alienated from mainstream religion due to such non acceptance (Barroso & Powell-Cope, 2000) and consequently feel unable to access religious supports.

Gay men living with HIV are more likely to rely on spiritual rather than religious coping frameworks (Ridge et al., 2008). Spirituality and religiosity are overlapping concepts and the relationship between them is complex. Woods & Ironson (1999) conducted interviews about this topic with people with chronic illnesses and noted the following distinction. "[T]hose individuals identifying themselves as spiritual describe the meaning of their spirituality as one of connectedness with God, with others, and with their environment. On the other hand, subjects identifying themselves as religious describe the meaning of their religiosity as one of connectedness to God, ritual, rules, and obedience in the hope of eternal salvation" (p.408). Spirituality is usually defined in the literature as being connected with a power, meaning, purpose or belief that transcends the self often through non-institutionalised practices (Canda & Furman, 1999). Religion or religiosity can be seen as a system, paradigm, or faith which can help facilitate social support and provide moral guidance through institutionalised practices (Vance et al., 2007). Yet many gay men feel excluded from religious systems due to homo-negativity and heteronormativity contained in religious doctrine (Cotton et al., 2006), making access to a religious support network problematic.

In a series of studies with African American gay identified men living with HIV, Miller (2005, 2006, 2007) highlights how the men often found ways to re-negotiate their faith to

both encompass sexuality and HIV status. In a UK study, Ridge et al. (2008) explored the way in which heterosexual Black African people and gay identified men living with HIV use religious and/or spiritual resources to help cope with the condition. Whereas heterosexual Black Africans constructed their spiritual narratives from a Christian foundation, gay identified men were more likely to describe individualistic or New Age understandings of their spirituality. Gay men reported feeling that their sexuality, sexual activities and HIV status were all targets of religious intolerance whereas Black African participants identified their spirituality and religiosity as powerful coping resources. The gay men within the study struggled with religion and many rejected the teachings of mainstream religion completely. However they did not necessarily reject their spirituality. This suggests that gay men may draw upon spirituality in coping efforts but in a way that allows them to negotiate a more personal form of spiritual practice that accommodates their sexuality. For many, spirituality is more likely to be expressed in terms of a God or higher power as opposed to belonging to a religious denomination (Woods & Ironson, 1999).

The Northern Irish Context

Northern Ireland represents a culture historically steeped in religious narrative with devout forms of Christianity being the cultural and historical norm (Conrad, 2001). It is well established that the history of the Northern Irish troubles has been perpetuated by differences in cultural and therefore religious identity. To varying degrees, both the Catholic and Protestant churches agree on issues of perceived 'morality' and remain largely at odds with 'homosexuality'. Both Catholic and mainstream Protestant churches unite on condemnation of same sex sexual "behaviour" as sinful albeit with some variation in understanding of what same sex attraction is and how an individual should approach the experience. The strong historical link between Church and state has sustained a conservative society and a culture heavily laden with religiously informed values and codes of 'moral conduct'. In day to day life, societal homophobic prejudice and bullying remain a reality for many gay people living in the region (O'Doherty, 2009).

Negative religious opinions regarding same sex sexual behaviour have been voiced publicly by a number of politicians from within the majority party of the Northern Ireland assembly. In 2008 a senior Minister broadcast on live radio that 'homosexuality was an abomination in the eyes of God' while recommending psychiatric help for those 'people engaged in this

activity'.

Recent figures suggest that there are 1002 people receiving care for HIV in Northern Ireland and compared with the rest of the UK, Northern Ireland had the largest proportional increase (633%) in new HIV diagnoses between 2000 and 2016 (HSC Public Health Agency, 2017). The category 'men who have sex with men' accounts for 52% of the identified cases, but there is limited research into the experience of receiving an HIV diagnoses in general within this culture.

Narratives regarding sexual morality and divine retribution feature heavily in the experiences of people living with HIV (Schwartzberg, 1993) and in particular for gay men (Ridge et al., 2008). However, there is a lack of research exploring the influence of such narratives on the sense making experience post HIV diagnosis in the conservative religious environment of Northern Ireland. Whereas the authors recognise that contraction of HIV is by no means confined to nor should be associated with one specific population of people over another i.e. gay men, given the difficulties gay men face within religious environments there is a need to explore the idiosyncrasies of experiencing diagnosis within this group. This study aims to address this gap.

METHOD and ANALYSIS

From July 2010 to January 2011 six interviews were conducted with gay identified men living with HIV, aged between 30 and 60 and who had grown up within religious families in Northern Ireland. Interviews were conducted by the lead author (a Clinical Psychologist) and took place within a voluntary organisation which serves as a community drop in centre for people living with HIV. The organisation volunteered to support the study by facilitating recruitment of participants by displaying posters inviting participation with the research and providing any aftercare or debriefing if required. A total of eight participants volunteered to take part.

Six participants met the inclusion criteria which were: being over 18; identifying as a gay man who was living with HIV; having been raised within a religious family context (families who devoutly followed a religious faith e.g. regular church attendance, practice, ritual). Time since diagnosis ranged from one to six years. All were in their 30s except Sam (all names

used are pseudonyms) who was 62. All had attended higher education and all but one was working at the time of the study. In terms of religious composition, four participants identified as coming from a Roman Catholic background and two identified as coming from a Protestant background. Two of the men, Fred and Michael had spent time in a seminary, training to become priests in their late teenage years. All six participants reported that they believed they had contracted HIV through sexual contact. Ethical approval was obtained through a University Research Ethics Committee.

This qualitative study draws on Interpretative Phenomenological Analysis (IPA), which aims to explore in detail how individuals make sense of their personal and social world through trying to capture the meanings that particular experiences and events hold for them (Smith et al., 2009). Epistemologically, IPA draws on the traditions of phenomenology and symbolic interactionism and is concerned with the subjective meaning people make of events rather than the event itself (Flowers et al., 2000). It attempts to understand a person's lived experience from within an interpretive psychological model. It is a strongly idiographic approach involving detailed analysis of one case until some degree of closure or gestalt has been achieved before moving to similarly detailed analyses of other cases (Smith, et al., 2009). Cross case analyses are then conducted in order to explore convergence and divergence of themes. In terms of sampling, individuals are recruited purposefully from a homogenous group of participants. Detailed analyses of small numbers are the norm since this allows for the depth of analyses required to produce rich and meaningful accounts (Smith et al., 2009).

A semi-structured interview schedule was developed drawing on the researcher's knowledge and experience of working with this population and driven by the empirical literature. Participants were asked to talk freely about their experiences which they considered to be important or personally relevant for them relating to HIV diagnosis, religious experience, growing up in Northern Ireland, becoming aware of same sex attraction, and the meanings attached to such experiences. Questions were used as topic guides rather than being prescriptive. They included: Can you tell me a bit about your background and your experiences of religion growing up? What was it like for you realising that you were gay in that environment? Can you tell me about your experience of receiving an HIV diagnosis? What were you thinking at the time? How did you make sense of receiving the diagnosis?

Can you tell me what things have been like for you since receiving the diagnosis? A non-directive interview style was employed with particular attention being paid to probing for meaning attached to experiences and inviting reflection. As such, the majority of content was led by each individual participant. Interviews aimed to facilitate the disclosure of participants' perspectives on their experiences of the topic (Flowers et al., 2000). The interviews were recorded and lasted between one and two hours.

Interviews were transcribed verbatim and transcripts were analysed to identify recurrent themes. To ensure credibility, both authors separately conducted analysis on transcript extracts independently. Emergent themes from both analyses were then checked for consistency and discussed with an IPA specialist to ensure rigour and reach agreement regarding the thematic content. This involved a process of reflexive discussion in order to manage any personal bias in the development of themes. A list of main themes for each interview was created. The next stage of analysis focused on drawing out the main themes across all participants to identify master themes that emerged consistently across participant accounts. The analysis attempted to capture the meaning of the experiences to the participants and this necessarily involved interpretive engagement with the data (Smith, et al., 2009). Themes within each transcript and across all six participants emerged based on their significance, prevalence and prominence across participant accounts.

Rigour and quality were based on the four broad principles (sensitivity to context; commitment and rigour; transparency and coherence; impact and importance) in qualitative research outlined by Yardley (2000). Reflexivity was key in particular regarding the impact on the research of the interviewer being a Clinical Psychologist from Northern Ireland who identifies as a gay man. The co-author was a heterosexual woman who did not grow up or reside in Northern Ireland at the time of the research. Frequent discussions took place at regular bi-monthly meetings between the authors regarding roles, boundaries and objectivity.

RESULTS

Analysis revealed two major overlapping master themes, each of which comprises their corresponding and underlying emergent themes. The first has been termed 'Negotiating authenticity in unsafe space' and the second 'Re-emergence of religious shame in diagnosis'.

Negotiating authenticity in unsafe space

This broad theme relates to the importance placed by all participants on contextualising their stories within a framework of their historical struggle with emergent same sex attraction in homo-negative contexts.

Awareness of an authentic self: Knowing 'who' I am while learning 'what' to be

Germinal feelings of same sex attraction were experienced by all participants from early childhood and were felt to reflect an aspect of an innate 'authentic' or 'true' self. Consistently emerging from the narratives of the men was a strong sense of feeling different to their peers. Participants described the authenticity with which they experienced this difference as being innately determined and beyond choice:

> *I've known I was gay since I was five.[...], I didn't have the language for it but it didn't feel strange, it was me... who I am I mean. I didn't really have a choice (Michael).*

The experience of becoming aware of same sex attraction was universally discussed as being situated within religious contexts that served to 'shape' early experience of the world.

> *I grew up in a very strict religious family upbringing... [...] home was very very, very religiously structured... [...]. We would have been...at...church/meetings[...], three times on a Sunday [...] we would have been in some form of meeting, probably for about 5 other nights of the week[...] It was just my life and it definitely shaped me (Bill).*

Bill's reference to being 'shaped' suggests that he experienced religion and religious practice within a learning framework. Interestingly, religion was often referred to in terms analogous to learning and conditioning. This is in contrast to the way in which the men reported experiencing emergent same sex attraction as inherently part of 'who' they were.

Learning to doubt the authentic self: Struggling with incompatible positions

The men highlighted an emerging awareness that their feelings of difference were in some way undesirable. As they began to understand and identify their feelings with the social labels 'gay' and 'homosexual', they began to associate their inherent sense of 'who' they

experienced themselves to be with the concept of sin. This is well illustrated by Roland's description of how he experienced religious interpretations of same sex attraction when he spoke to his pastor.

> *I took the message from him [the pastor] that I was going to hell and that was it and there was nothing that I could do. Because he said [...] you could change, you could alter, you could set all that to one side and become a good Christian person. You could get a girlfriend, you could get married, you could procreate children. And that was not my experience. I was not like that.*

As a result, Roland questioned his personal integrity. He worried about the prospect of being condemned to hell as a result of 'who' he was and how he appeared to contravene religious doctrine on how one 'should' be. The sense of desperation in his account can be felt in the statement '*there was nothing that I could do*' and reflected how his sexuality was experienced by him as inherent and beyond choice.

For Sam, the authenticity with which he experienced his emergent sexuality as part of who he was caused him to question his faith since, '*the two things were just simply not compatible.*' He coherently associated his 'being gay' with what he '*knew*' to be true about who he was and how this opposed the learning that he had '*acquired*' through religion, saying, '*Being gay was so ingrained that I thought... this [religion] is acquired. It wasn't making any sense at all with what I knew about myself*'.

The shame of authenticity: Internalising stigma and the consequences
Participants reported how they internalised condemnatory messages and how this elicited shame based beliefs about the self. Themes of guilt and self-loathing featured heavily in their accounts. Roland discussed how the sense of shame that he experienced was of such totality that it affected the 'depths' of his being.

> *I can't really put into words the pain of shame that I felt inside ... It was... a... pain... and it started in the depths and bowels of my being and emanated its way up and it affected every aspect of my life.*

In seeking support by disclosing to trusted religious others, the men recounted themes of

rejection and denial which further exacerbated their sense of shame. Fred was training in the seminary and recounted the following when he approached his superiors for support:

> *He said about homosexuality, that it didn't exist, that I was attracted to the feminine qualities of other men around me, um, because there weren't any women [...] But I didn't believe what he said about homosexuality not existing... ... ... because I did.*

Fred's account suggests that he experienced his superior's denial of his sexuality as a denial of his very being. The detrimental impact it had on his sense of self-worth is reflected in the following exert where he recalls, *'a very horrible feeling of being worthless ... especially in the eyes of God, being separate from God, about being bad towards God and that was very painful.'* Most notable is how he associated his feelings of worthlessness with the possibility that his 'being' was contrary to God.

Preserving the authentic self: Re-constructing God

All of the men described reaching a point in the struggle where they could not find a compromise between religious teachings on 'homosexuality' and the strong sense of authenticity with which they experienced their identity. All re-examined the teachings of their childhood and described a process of gradual deconstruction of their relationship with religion which resulted in a radical change in belief system whereby they dislocated partially or completely from church based environments. As a result, new relationships with religion and God emerged that facilitated acceptance of their identity.

Sam was unable to negotiate a compromise and abandoned religion altogether.

> *I came to the conclusion that the church had nothing to offer me [...], when the break came I stopped going to mass, I stopped attending any of the services of the Catholic Church... [...] ...as far as I was concerned religion had to go because I just couldn't see any middle way in that.*

Others described a process whereby they re-evaluated their relationship with God. For Fred, this happened after leaving the oppressive environment of the seminary following which he

viewed himself as being 'in credit' with God and as such, was being provided with the opportunity to have something for himself.

> *I felt that because I had given so much of my life and time and everything to God in that environment, I felt I had credit or brownie points with God. [...] ... God has given me a chance for a different kind of life and that you can please God in a different way.*

Adopting this position allowed him to explore his sexuality while maintaining a personal relationship with God. The theme of constructing an individualised spiritual identity as a means of self-preservation was prominent.

Re-emergence of religious shame in HIV diagnosis

The second major theme relates to the ways in which the men in the study attempted to process and understand HIV diagnosis. What was notable was that even after reaching reconciliation between religious teaching and sexuality earlier in their lives, the men initially made negative religious appraisals of diagnosis. Religious stigma also appeared to shape help seeking behaviour and restrict access to otherwise supportive others.

'That lingering presence'

When describing the way in which they made sense of HIV, the men reflected on their previous experiences of religious socialisation and discussed how they initially made religious interpretations of diagnosis. Three of the men described initially appraising HIV diagnosis as retributive action taken by the God of their childhood to punish them for having sex with other men. Bill, who had endeavoured to construct a more accepting version of God that could accommodate his sexuality, described how his immediate thoughts at the point of diagnosis focused on religious teachings regarding sin and the inevitability of retribution from God. He noted that his thoughts went, *'back to my upbringing where be sure your sin will find you out.'* Bill also commented on how he felt like he had no other framework from which to understand his experience and that in the absence of such, he was left with no choice but to view his diagnosis as punishment for 'wrong behaviour'.

> *At that point I think, when you're hit with something like that... you accept what you've been reared with as being true. Because it's all you can hold on to. ... I just accepted it,*

that that was right and I was wrong. And I was being made to pay for it, for what I had done.

Despite having also renegotiated his faith, Pat described how diagnosis represented a point in his life in which he questioned his resolve regarding his sexuality as a valid and acceptable aspect of himself.

[I]t made me start to think, well... Maybe it is God who is saying look... it is wrong and [...] I started to think to myself 'Right well this is it. This is what it is. It's the gay plague. It's God's way of ridding the world of gay people'.

Furthermore, he outlined how his relationship with prayer, previously representing a valuable coping resource, became strained as a result of his beginning to entertain diagnosis as punishment for being gay and for his sexual behaviour.

The more I prayed to God sometimes the worse it made it because I was just thinking to myself... this is his punishment for me being wrong and being gay and being unfaithful and maybe infecting other people and hurting other people and making other people suffer this. [...] I just thought this is his way of saying 'this is your punishment. This is what you deserve.'

In a similar vein, despite having negotiated a 'God of his own understanding', Roland described the way in which his previous experiences of religious homo-negativity initially affected diagnosis appraisal, saying, *'it was there, it was that lingering presence'*. He initially reflected on his diagnosis as divine consequence for perceived shameful conduct and invoked powerful language to describe how his primary appraisals reflected a sin and consequence model of understanding HIV. This was linked in his mind to previous experiences of struggling with condemnation.

Those ghosts from the past.... hell, fire and damnation heaped upon my head and I couldn't... I just didn't have the strength for it... the diagnosis... after everything I had went through [...]...the tanks were empty... there wasn't anything left.

Fred and Sam reflected on their experience of religious struggle and the implications they

believed this difficult journey had for them. Despite having embraced atheism, Sam recounted how old religious frameworks of understanding intruded into his consciousness briefly, noting, *'It flickered for a second, and then it was gone.'* Fred questioned the role of his religious upbringing regarding his sexuality and the impact it had on his attitude towards sex and sexual decision-making.

> *[B]ut I did wonder if I'd been brought up different... in a different environment [...] where I could speak about fears about being gay [...] where I didn't feel guilty about it, I didn't feel that it was hurtful to God, [...]that I didn't have to make a choice of loving God or loving man that... I might have acted differently... I might have had less casual sex. [...] Umm I might have had a more healthy attitude towards my own sexual health.*

Compromised ability to seek support

There was a general theme of feeling alienated from significant others due to knowledge of their religious beliefs and predictions of potential rejection. Although all the men discussed distress about HIV disclosure in general, there appeared to remain specific fears relating to how others' religious beliefs would influence how they reacted to diagnosis. Diagnosis was appraised in terms of the reactions of religious others, often resulting in feelings of desperation.

> *I felt like a failure. I wasn't able to keep the principles that I was reared with. So HIV...let's jump from the bridge because I couldn't go home and tell them that. It would upset them so much because I knew how strong their religious beliefs were and I'd feel as if I'd let them down. (Bill)*

Some felt that they had already put their loved ones through enough by 'being gay' and initial reactions to diagnosis were characterised by fears about the distress they would impose on others. As Pat said, *'I can't put mum through any more. I've already come out and that was hard enough for her... I mean... How is she going to cope with this? She would put it down to being gay. I had got the wrath of God... that's how she would deal with it'.*

As a result, most preferred not to seek support from friends whom they knew to be of a religious faith. Some men took a risk and told relatives whom they believed would be

understanding, only to find that support was not forthcoming and as a result their fears were realised.

I told an aunt who was a nurse because I thought that she would be sympathetic. She is very religious...[...]...she hasn't spoken to me since... ... she obviously couldn't deal with it because of the religious thing (Michael).

Interestingly, sustained connection to a church environment through carrying out church related duties was experienced as supportive for one participant. However he did not feel he could disclose any information regarding HIV status or seek support directly therein for the difficulties he was experiencing in processing this. He eventually discontinued his connection. This shows the limitations of social support from the Church because HIV diagnosis was associated with homosexuality and was deeply stigmatized.

DISCUSSION

Consistent with the methodology and goals of IPA the findings in the current study highlight the way in which six gay men from religious backgrounds in Northern Ireland made sense of HIV diagnosis. The ideographic nature of the IPA approach facilitated an in depth examination of this process focusing on a small sample. Although the findings from the current study are based on retrospective accounts and constructing personal narrative in retrospection may be questionable, research does suggest that retrospective reports are not inevitably inaccurate and unstable (Blane, 1996). Findings demonstrate how the early internalisation of negative religious appraisals regarding same sex attraction emerged in the adjustment process.   All the men in the study chose to position their retelling of diagnosis experience within the context of having managed earlier conflict between their sexuality and homo-negative religious narratives. Linking this previous experience to that of learning of an HIV diagnosis makes an important contribution to the literature.

Negotiating an authentic self

All participants struggled to find a compromise between their religious upbringing and sexual orientation identity. Emergent same sex attraction was experienced by the men as reflecting an authentic sense of 'who' they experienced themselves to be and indicative of their true selves. The many definitions of an 'authentic self' (Winnicott, 1960) converge on the fact that it is reflective of an honest portrayal of how one experiences oneself to be regardless of expectations and social rules. This idea of an 'authentic self' and its counterpart the 'false self' has particular relevance for the current study given how participants discussed their emergent same sex attraction as something that they felt reflected an aspect of 'who' they were, yet was actively condemned within the ideologies that were so powerfully influencing and shaping their value base of 'how' to live.

The men came to fear that an aspect of their authentic selves condemned them to eternal damnation and described the 'struggle' that they experienced in trying to make sense of the obvious contradictions. This struggle resonates with findings from a number of studies and indeed 'coming out' models identified in the literature (e.g. Cass, 1979). It particularly encapsulates the 'narrative of struggle and success' as described by Cohler & Hammock (2007) in that it highlights the challenges of managing a particular form of stigma on the journey to reaching some form of resolution regarding sexual identity. The current study confirms the depth of personal struggle experienced by the men with regards to religious identity and the creative renegotiation required to sustain a sense of cohesion. For the men in the current study, shame based beliefs featured strongly throughout much of their lives. This suggests that the process of coming out is particularly challenging in the cultural context of Northern Ireland where 'religious identity' is often regarded also as a cultural heritage and subsequently holds extra significance for Northern Irish people from both Protestant and

Catholic faith backgrounds. It perhaps demonstrates a further intersection of stigma within this context since religious homo-negativity is also present as a cultural reality.

In the face of psychological adversity, the participants demonstrated their resilience by re-evaluating their religious beliefs and their perception of God. This reappraisal resulted in a need to remove the self from religion as an oppressive system through a process of gradual dislocation from Church-based environments. This seemed like a necessary pre-requisite as it was only after this that new systems of meaning could be drawn. Coyle & Rafalin (2000) report a similar process among Jewish gay men in Britain noting that "many reconstructed their Jewish identity in cultural and social terms and decreased or ceased their religious involvement" (p38). It also echoes the struggle of British Pakastani men who identify as Muslim and gay who attempt to reconcile both aspects of themselves (Jaspal & Cinnirella (2010). Their response was to either attach a negative value and meaning to their sexual orientation identity or to attach negative value to the institutional component (but not necessarily the spiritual dimension) of religious identity. In the current study the men eventually all adopted the latter path to some degree.

The dislocation from organised religious environments is not uncommon in sexual minority individuals (Miller, 2005; Shallenberger, 1996). Following the 'coming out to self' process, individuals experiencing religious conflict often undergo a process where they distinguish between the terms religion and spirituality. Making this distinction is said to act as a buffer from homo-negative messages inherent in church doctrine (Rodriguez, 2010). This was evidenced in the current study as was the finding reported by Ridge et al. (2008) that HIV positive gay men were more likely to highlight the development of personal spiritualities.

Re-emergence of shame

HIV diagnosis elicited a period whereby the men revisited the negative condemnatory

narratives of their past. For some, HIV was appraised in terms of punishment for same sex sexual behaviour which highlighted how the men in the study had learned to associate HIV with being gay, a process known as symbolic stigmatisation (Herek, et al., 2005). The role of internalised religious stigma can be seen throughout the sense-making process following diagnosis and the men experienced deep psychological conflict as a result of such shame. This is consistent with research demonstrating higher rates of depression in people living with HIV which is particularly pronounced for those who live in stigmatising contexts (Lorenz et al., 2005).

Lee et al., (2001) propose a model of shame in the context of reactions to traumatic life events. Although not explicitly relating to HIV diagnosis, this model is a useful descriptive framework from which to capture the experiences in the current study as the model posits that schematic representations of the self as shameful may be activated via attributional processes in the aftermath of a traumatic event. Shame is said to emerge in the aftermath of a traumatic event as an individual seeks to understand the meaning of the event via cognitive appraisal processes. The implications for an individual who has learned to appraise their authentic self as shameful based on prior learning are evident in that if the meaning of the event (HIV is shameful/punishment for being gay etc) is congruent with a deeper meaning about the self (gay is sin therefore I am bad) then core shame schemas are activated and confirmed. This causes them to strive to hide the shamed identity from further scrutiny and further exacerbations of shame. The resultant effect is the avoidance of thoughts, behaviours and cues related to the traumatic event and blocked emotional processing.

This model of understanding a traumatic event is consistent with the experiences of the men in this study not only in terms of reaction to diagnosis but also accommodates the impact and effect of prior experiences of being devalued and shamed. Given the popular cultural association of HIV with gay men, shame-based schemas may become reactivated in the event of diagnosis. These are the 'ghosts from the past' whereby HIV diagnosis elicits an immediate experience of punishment appraisals, a theme associated with their earlier experience of conflict. Therefore personal appraisals of HIV as associated with sexuality could be said to have activated shame schemas associated with previous experiences of religious homo-negativity.

The men in this study all gave retrospective accounts having been diagnosed one to six years

before the interviews took place. The study focused in particular on the experience of diagnosis. It is however important to note that these experiences happened as part of an on-going process and whereas religious shame was present in the adjustment and sense making processes in the aftermath of diagnosis, all of the men creatively re-negotiated a way to reconcile this conflict. Nevertheless, a key feature of the management of shame related to HIV diagnosis is the fragility and fluidity of the process. Even many years later, the reconciliation that they had achieved could be threatened, often requiring unusual compromises such as one participant who remained involved in specific Church activities despite having disassociated himself from many of the Church's teachings and another who continued to incorporate religious ritual into coping efforts when negotiating specific life challenges unrelated to diagnosis, despite feeling more inclined towards an atheistic framework.

Clinical and Social Implications

This research was clinically driven by the need to understand the sense making process following HIV diagnosis in gay men who grew up in religious contexts in order to inform models of service delivery. The findings suggest that clinicians need to be mindful of the influence of religion or faith on individual clients and resist the temptation to assume that because they are gay, they either do not utilise a religious framework or face no difficulties in this regard. The current research demonstrates how an HIV diagnosis may trigger condemnatory religious appraisals and, as a result, some of the men were unable to access religious or perhaps more accurately, spiritual coping resources at a time of personal crisis. Clinicians may also need to be mindful of how otherwise available social and community supports may seem unobtainable for people in such situations. This is a potential area to be explored in therapeutic interventions both aimed at reducing distress but also in enhancing coping post diagnosis.

It is vital that clinicians working with gay men (and indeed sexual minority individuals in general) who have been diagnosed with HIV, at least consider the personal meaning attached by individuals to their sexual orientation and the experiences they have had in coming to terms with this aspect of themselves, particularly those who grew up within conservative religious contexts. The ways in which individuals have come to appraise themselves as a result of such experiences would seem to influence the way in which they appraise HIV

diagnosis.

Therapists too will also have been exposed to the same hetero-normative assumptions and have a professional obligation to their clients to consider their own blind spots and inherent biases in this regard. It is important that when providing care to people living with HIV, they do not collude with and subscribe to (no matter how unconsciously) heterosexist mentalities, religiously driven or otherwise.

The findings of the current study strongly suggest that change needs to occur at the social and political level within Northern Ireland. The men in the study all consistently discussed how the endorsement of religious messages regarding their emergent same sex attraction exacerbated their sense of shame and had detrimental effects on self concept and degree of vulnerability. The public health implications of such are evident.

Conclusions

This study highlights the difficulties faced by an overtly stigmatised group of people living in Northern Ireland, an area that has been the focus of little HIV research. Whereas relationships between religious oppression, internalised homophobia and reactions to diagnosis cannot be made explicit from the current study, it highlights how shame based self-beliefs regarding one's sexuality can develop within religious contexts that condemn an aspect of how an individual experiences themselves to authentically be. It also highlights how the presence of negative shame based self-beliefs can influence the way in which some gay men who grow up in religious cultures come to appraise HIV diagnosis and how the meaning attached to such may place them at an increased vulnerability for psychological difficulty. For the men in the current study, condemnatory religious influence resulted in shameful self-appraisals following HIV diagnosis. Findings therefore offer some insight into the significance of religiously informed shame based beliefs about the self in the experience of HIV diagnosis for gay identified men.

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