The Homosexualization of AIDS

Walt Odets, PhD

The "homosexualization of AIDS" describes the psychosocial and social processes through which the personal and social identities of gay men have become unrealistically and destructively entangled with the identities of those who are infected with HIV.* This phenomenon is more easily overlooked in the lives of seronegative, rather than HIV-infected, gay men. This article briefly explores the most serious psychological issues faced by seronegative gay men and examines how these issues are exacerbated by the homosexualization of AIDS.

The Myth of the Worried Well

More San Franciscans have died of AIDS than have died in the four wars of the 20th century—combined and tripled. Most who have died in San Francisco, as in the United States generally, are gay men. Although uninfected men within the gay community are often referred to as the "worried well," it seems unlikely that the survivors of such a social and psychological calamity would be merely worried, or be truly well.

There is, in fact, much evidence that many uninfected gay men are suffering from serious mental health problems. One New York study, for example found that 39 percent of its presumably healthy, HIV-asymptomatic, control subjects had mood or anxiety problems that met the standard diagnostic criteria for mental health disorders. Anxiety, mood, and somatoform (related to the physical expression of psychological conflict) disorders, as well as a range of sexual dysfunctions, are now widely observed in populations of uninfected gay men. Also widely seen, though not as familiar in standard mental health classifications, is survivor guilt.

Guilt is often an important mediating element in both depression and anxiety. Such largely unconscious guilt was first described by Niederland among survivors of the Holocaust. After struggling to build new lives and succeeding in creating them, some survivors inexplicably developed depression, anxiety, and psychosomatic conditions. According to Niederland, these symptoms arose from identifications with loved ones who had not survived. Survivors experienced persistent feelings of guilt for having survived the very calamity to which their loved ones succumbed. While survivor guilt is one of the most destructive of the psychological phenomena seen among gay men, it is also one of the most responsive to psychotherapeutic intervention.

AIDS and Identity

These psychological issues—despite their being often underestimated or overlooked in importance in the gay population—are clinically familiar to mental health workers. Less familiar is the extent to which such psychological issues are exacerbated by the homosexualization of AIDS. Depression, anxiety, and guilt are often seriously complicated by a confusion of identity between being gay and having AIDS. This identity confusion arises from the unconscious feeling that because gay life has come to revolve so much around HIV, to be true to one's sense of self and community, one must have HIV disease. Such identity confusion should be explored particularly in cases of survivor guilt, guilt-mediated depression or anxiety, or self-destructive behaviors.

Certainly gay men are necessarily deeply involved with AIDS. In the United States to date, they have borne the brunt of the HIV epidemic. For many gay men, AIDS has become intricately woven into their professional, social, and personal lives. But these realities do not account for the now common occurrence of gay men "coming out" as gay by talking about the less-taboo subject of AIDS rather than about the feelings, relationships, or sexuality that are a part of being gay. This switch expresses a distortion of identity that has its roots in the confused and often unconscious ideas and feelings that people have about AIDS, in other words, in the meanings of AIDS rather than in its realities.

The homosexualization of AIDS is demonstrated by the ease with which gay men have identified with AIDS and society has identified AIDS with the gay community.

Such confusion underlies the "homosexualization of AIDS." Its existence is demonstrated by the ease with which gay men have identified with AIDS and by the corresponding ease with which society has identified AIDS with the gay community. The homosexualization of AIDS results in an unrealistic and unnecessary entanglement of interests, purposes, and especially identities. It is the entanglement and confusion of identities which is of particular importance to those working psychotherapeutically with gay men.

Homophobia and Identity

The phenomenon of identity confusion is made more intelligible by considering the concept of homophobia, the fear and aversion of homosexuality learned by many in our society. Gay men, themselves socialized in this way, experience an "internalized" homophobia. Both internalized and societal homophobia have played an important role in facilitating the shifting of familiar psychological conflicts from homosexuality to AIDS.

This shifting psychological conflict is seen in many ways. The homosexual man, often considered psychologically "sick" for his sexuality and who homophobically concurs with this conclusion, is now sick with AIDS, an apparent physical validation of the moral and psychological judgements against homosexuality. Once isolated for his sexuality, the gay man is now often threatened with isolation for his virus. Threatened with punishment and homophobically expecting it, he is now, often unconsciously, feeling punished with AIDS. Shunned by society, he now often shuns others because they are infected. Having suffered guilt about his sexuality, he may now feel guilt for having AIDS, for not having AIDS, or for not doing enough to help others survive.

In Second Son, Robert Ferro's last novel before his death from AIDS, a character describes telling his family of his AIDS diagnosis: "Nothing, I see, has much changed: it is still a question of coming out of the closet with something vile about yourself." This dovetailing of AIDS with the common personal and social histories

continued on page 2
Homosexualization of AIDS
continued from cover

of gay men has thus allowed a subtle shifting of old, powerful psychological conflicts from homosexuality to AIDS.

Because the reality of AIDS is so terrible, the motivation for shifting conflicts away from what appears to be the relatively benign fact of homosexuality must be explored. Recently, 11,000 scientists, physicians, mental health practitioners and others gathered at the Sixth International AIDS Conference in San Francisco to discuss AIDS. There has never been a similar gathering to address the serious, often cripping psychological toll exacted by society from men because they were homosexual. AIDS, unlike homosexuality, borrows the respectability of science and medicine; it allows a man to have a disease rather than to be and live one, and to talk about himself without risking disclosure of the emotional, sexual, and interpersonal issues that are for so many too painful and too difficult. AIDS itself, of course, is also often painful and difficult, but if its associations with homosexuality, intravenous drug use, sexual transmission, minority membership, and poverty were discounted, would it attach any more stigma than cancer or cardiovascular disease?

For those gay men accustomed to life on the fringes of a rejecting heterosexual society, the acceptance gained by having AIDS can feel irresistible. Many are finding it easier to be threatened by AIDS, to die of AIDS, or to be guilty for not dying of it, than they have ever found it to be gay. It is this that is often at the heart of the homosexualization of AIDS; AIDS has given many gay men a disease which, in all of its horror, offers a more comfortable identity than that of being homosexual.

Psychological Costs

The cost of such acceptance for the man who becomes infected is his life; but for the uninfected survivor, the entanglement of identity with AIDS exacts serious costs of a different, more subtle kind. Survival may be experienced as a betrayal and abandonment of those who are infected. A gay man may feel that by surviving he is betraying his personal identity as a gay person, and he may feel that he is no longer part of the community—as it now often seems, many of its members sick or already dead—a community which is the only human community in which he has ever been able to be who he truly is.

Such feelings prompted a seronegative patient to say:

I'm pleased of course, but I find myself very sad. I'm actually quite confused and don't know what I feel. When I got the results I felt like crying, though I can't say why, and I didn't. It wasn't just relief. I called Mike with the news and he wanted to go out and celebrate, and I thought, well how can you celebrate this? I couldn't imagine. There are too many positive people, and I can't imagine talking about being negative. It's not the kind of thing you could go around and say, "You know, I'm negative." I've expected for so long...to be positive—I'm talking about allegiance, I guess. I realize that I have to rethink what the gay community is. I don't know anymore what it is because HIV has changed it all, and I have no idea where I fit anymore into whatever it is.

I wonder if it would really be O.K. with [my friends who are positive or sick] if I were negative. I'm thinking of Robert, and I wonder if he will ever forgive me for being negative. I feel as if I've abandoned him.

If gay men cannot clarify their confusion of identity between being gay and having AIDS, cannot reestablish individual and social identities free of this extreme entanglement, and if they cannot discuss the bewildering and painful feelings that everyone, infected and uninfected, is experiencing in response to the epidemic, it will almost surely cost the gay community decades of psychological, social, and political growth. Because of the social and psychological gains made by the gay liberation movement in the 1970s, it is easy to overlook the fact that 25 years ago depression, anxiety, isolation, and loneliness were seen routinely in the lives of a majority of homosexual men. The HIV epidemic, with its death, its ill, and its survivors, has returned depression, anxiety, isolation, and loneliness to the lives of too many in this community.

Historically these responses have had to do with the difficulties of being homosexual in a disapproving and discriminating society and the fact that gay men were not able to talk openly about their feelings. Now these problems also arise out of the additional psychological burden of living in an epidemic. While gay men are more "out" these days, they are often more open about their involvement with AIDS than about their homosexuality, which may remain merely implied. When this is the case, homosexuality is no more easily discussed than it was before the advances of gay liberation, and this silence is still destructive to both individual lives and the collective life of the gay community. Furthermore, many of the special problems of living during and surviving the epidemic are also forbidden material. Unhappiness and guilt about survival, difficulties with safe sex, and self-destructive behaviors are all challenging to talk about openly in the gay community. These prohibitions further exacerbate an already serious mental health concern.

Conclusion

It does not seem likely that on a large scale gays are at risk of going back into the social and political closet. AIDS and the notoriety it has given the gay community has allowed many more gay men to come out by making the fact of homosexuality simply unavoidable to the general public. This is true even if many who are out are identified more as victims and potential victims of AIDS than as gay. There is no reason why these social and political gains should be reversed.

The psychological closet, however, may be altogether another matter, and many uninfected gay men are at great risk in this psychological sense. Too many are retreating in the face of this plague, its real world horrors and its psychological ones, into the historically, if not personally, familiar psychological closet of depression, isolation, and loneliness.

The words of a 23-year-old gay man, having recently discovered that he was seropositive, are haunting: "I'm sometimes glad to think that in ten years I'll be dead. By then the only gay people left will be those whose lives were ruined by watching the rest of us die." It is a horrible thought, and surely an exaggeration, but there is also some truth in his words. Mental health workers should not underestimate the depth of this feeling in the gay community and can provide a safe environment in which to address it.

Walt Odets, PhD is a clinical psychologist and psychotherapist in private practice in Berkeley, California.

References


Request for Submissions and Comments

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

Editor, FOCUS: A Guide to AIDS Research and Counseling
UCSF AIDS Health Project, Box 0884
San Francisco, CA 94143-0884
Gay Men and Negotiating Safer Sex

Andy Handler, MA

An ongoing challenge for AIDS counselors during the second decade of the epidemic is to enhance ways of helping those who view themselves at risk (and those who do not) to incorporate risk-reducing behaviors into their lives. To accomplish this, many educators have begun to train clients and group participants in the use of negotiation techniques, including assertiveness training and active listening, and in negotiation models that have worked in other interpersonal situations. The goal of successful negotiation is for both individuals to weigh their needs with the needs of their partners and come up with a win-win situation. To do this, counselors may also encourage participants to clarify their intentions so that both partners have a better idea about what they want and, equally important, what they do not want.

Obstacles to Negotiation

In addition to the lack of accurate information about HIV disease, the biggest obstacle to negotiation is that most people are not taught about negotiating within a relationship, particularly within a sexual relationship. Partners may rely on perceptions of their parents' sexual and interpersonal relationship and attempt to emulate that relationship. What may result are reproductions of mother/father roles. With two gay men in a relationship, there is a great potential for a father/father system to develop, bringing with it a double dose of male socialization, including direct aggression and, possibly, lack of nurturing.

Existing sexual fantasy can be another obstacle to successful negotiation. If a person is inflexible about the behaviors that he finds erotic, the likelihood of his adopting safer behaviors is lessened. Men wishing to engage in lower-risk activities have had to learn to eroticize new behaviors. Changing behaviors requires intra- and interpersonal adjustment. A man must make a decision to take actions to lower his risk: a change in social norms also helps to maintain behavioral changes. As a result, it can be difficult for some people to make changes, particularly if they live outside of a community that offers risk reduction information, training, and role modeling. These difficulties are compounded by the fact that not all men who have sex with men identify or interact with a gay community and, therefore, may not have access to new ideas and information.

Romantic ideas, surprisingly, can present a formidable barrier to negotiation and successful safer sexual behaviors. In pursuit of emotional intimacy, some men might stray from guidelines they had previously embraced because of the romantic notion that, "I love this man, and I want to give myself to him totally." Safer sex negotiation skills can reframe this thinking so that the previous statement might read, "I love him so, therefore it's even more important that we behave safely."

Finally, other psychological factors determine how effective an individual may be in negotiation. Among these factors are pre-existing conditions such as chronic or situational depression, assertive versus passive personality styles, internalized homophobia, alcohol or drug use, denial as a coping mechanism, fear of intimacy, and a need for impersonal and anonymous sex. These factors may determine the likelihood that an individual will be able to incorporate effective negotiation strategies into his sexual relationships.

The common denominator that connects these obstacles to sexual negotiation is a sense of self-esteem. Positive self-esteem can motivate a man to value himself enough to change and maintain behaviors. In a study of gay men, David Goldberg compared the likelihood for safer sexual behaviors to measures of self-esteem and internalized homophobia. He found a positive correlation between unsafe sexual practices and difficulty identifying with a gay community, internalized homophobia, and lower self-esteem. Men who scored higher on measures of self-esteem who expressed a greater sense of connection with their community and expressed greater comfort with their sexuality were more likely to engage in safer sexual practices.

Interventions

The first and perhaps most important step in teaching negotiation skills is to give an individual the opportunity to define a successful negotiation for himself. This can be done by giving him accurate information. Does he have an adequate knowledge of safer sex guidelines? It helps if he is clear about his sexual limits, and some ideas for safer sex options, when he meets someone who does not share his viewpoint on sexual behaviors. Is he aware of how he can lower the risk involved in some high-risk behaviors while maintaining their eroticism? Has he had the opportunity to explore what those changes entail? His exploration may include discussing anxieties and frustrations surrounding changes in behaviors, the "gray areas" of safer sex, and the possible social risks of limiting sexual activity. In addition, it should include an examination of specific sexual behaviors and options, and of risk-reducing materials, such as condoms, dental dams, and spermicides.

A successful negotiator approaches a situation with a willingness to communicate and flexibility about the ultimate outcome.

Secondly, training must give individuals the chance to explore successful negotiation techniques including communication skills, assertiveness training, and specific actions or negotiation models that they can use to work through a sexual negotiation. A successful negotiator approaches a situation with a willingness to communicate and flexibility about the ultimate outcome. Finally, individuals must also be given a chance to express and explore the fears that occur about being assertive and asking for what they want. These fears may include rejection, giving up immediate gratification, and going home alone. These issues are best addressed through open dialogue or small group work.

Workshop Model

Negotiation skills are best taught in groups, giving participants a chance to practice these new skills in a safe environment. The training must incorporate dialogue and exercises that allow participants to practice the reasons why they have not engaged or felt the need to engage in sexual negotiations. The challenge to educators is to create a workshop that is comprehensive, but not overwhelming, one that leaves the participant with a clear picture of the steps he needs to take to attain his goal.

Participants of established workshops report that training has enabled them to achieve greater intimacy, less impersonal sex, decreased use of drugs and alcohol, more assertive behaviors, and a greater sense of community. In addition, negotiation skills can be a valuable foundation for dealing with non-sexual relationship issues and may help to better integrate intimate relationships.

Andy Handler, MA is Education Director at the AIDS Project Los Angeles. He helped develop "Speaking of Sex...": A Negotiation Skills Workshop.

References


FOCUS October 1990, Page 3
In Review


Gay male culture offers several unique environments, for example, bathhouses and bars, in which to deliver safe sex messages. The most controversial of these are what David Beckstein calls “Public Sex Environments” (PSEs): highway rest stops, public bathrooms, parks, and malls. These settings can be ideal for delivering AIDS prevention messages to populations that may not be responding to other messages.

Beckstein, a community health outreach worker and Coordinator of the Peer Education Program at the Santa Cruz AIDS Project offers a valuable guide to the culture of these environments, and information about providing AIDS education in a sensitive and appropriate manner. He also discusses male sexuality and motivation, and challenges many of the preconceptions about public sex: “Sexual encounters between men in PSEs cannot be fairly called ‘impersonal.’ The language of male-to-male sexuality may be silent but it can be very complex and subtle.” Beckstein is particularly helpful in discussions of behavioral norms in PSEs and dynamics concerning men of color and non-gay identified men.

The manual, which includes a training module and evaluation measures, exudes the confidence of having grown out of a successful program, and incorporates discussions of volunteer recruitment, behavioral and ethical standards for PSE educators, and exercises for exploring PSEs and the prejudices educators may have about them. Also of note is an analysis of objections to PSE programs and suggested strategies for answering these objections.

It is obvious that Beckstein has considerable experience doing this work, and more examples of actual educational encounters in PSEs would reflect that experience in the text. Also, the quality of the content deserves better editing: there are spelling, grammar, punctuation, and formatting errors throughout. Despite these problems, the manual is valuable for educators in any community.

Chuck Frutchey is the Director of Education at the San Francisco AIDS Foundation.

Recent Reports


In a large New York study that evaluated the effects of AIDS-related stressors on mental health, sexual behavior, and substance abuse patterns, researchers found that symptoms of post-traumatic stress disorder (PTSD) have become more prevalent, while alcohol and drug use, and depressive symptomatology have declined.

Between 1985 and 1987, researchers conducted annual interviews of 746 gay men, many of whom were recruited based on their membership in gay organizations, and none of whom had an AIDS diagnosis when the study began. Of the 624 subjects whose data is included in this report, in 1987, 42 percent were coupled with a lover, 50 percent lived alone, 10 percent were Black or Hispanic, and subjects had a mean age of 38.

The number of individuals abstaining from drug use increased from 16 percent in 1981 to 39 percent in 1987, while the average

use of drugs declined significantly, and by 1987, illicit drug use was limited largely to marijuana. It appears that there was a decrease in the problems associated with alcohol abuse. Subjects also reported a dramatic reduction in unsafe sex between 1981 and 1987: bathhouse use was down from 50 to 8 percent; avoiding unprotected insertive and receptive anal intercourse was up from less than 25 percent to greater than 75 percent.

The incidence of psychological distress symptoms, such as demoralization, sleep problems, guilt, and suicidal ideation, declined from 1985 to 1987, while PTSD symptoms increased. Correlations among this data included: demoralization was lower among people with better education and among men with partners; White men were more likely to experience PTSD than Black and Hispanic men; both PTSD and drug use increased as age of subjects decreased; and men in relationships were more likely to have unprotected anal intercourse. Increased frequency of bereavement—defined by the death of close friend—was directly related to PTSD, demoralization, and drug use. Finally, men who knew they were seropositive had higher levels of PTSD symptoms and drug use than men who did not know their antibody status.

The researchers conclude that AIDS-related bereavement and suicide among gay men is a result of their directly related to increased psychological distress, but these stressors do not appear to predict levels of sexual risk-taking. They also state that this preliminary data calls into question the theory that antibody testing is useful or efficacious in changing risky behavior among gay men.

Sexual Response to AIDS: Statens Seruminstitut, Copenhagen, Denmark (Social Science and Medicine, Vol. 30, No. 6, 1990).

Basing their study on a transactional theory of coping with stress, by which people interact reciprocally with their environment, researchers conducted in-depth interviews with 10 Danish gay or bisexual men who had not been tested for HIV antibody. The article explores the relationship of sexual behavior—safe and unsafe—and the following themes: education, job history, and coping methods for health and sexual concerns, the use of a social network for emotional support, and the role of traumatic experiences in determining safer sex practice.

Next Month

As inner city minority neighborhoods in the United States have deteriorated, other urban areas have been reclaimed by a variety of groups including the gay and lesbian communities. In the November issue of FOCUS, Mindy T. Fullilove, MD and Robert E. Fullilove, EdD, both at the HIV Center for Clinical and Behavioral Studies in New York, propose that the abilities of these groups to deal with HIV disease is connected to the condition of their neighborhoods and housing. They explore the implications of these findings on approaches to AIDS in these communities.

HIV disease manifests itself differently in different communities. Also in the November issue, Eric Goosby, MD, Assistant Clinical Professor of Medicine at UCSF, discusses HIV infection among Black people in the United States.