Much HIV-related social research looks at sociodemographic variables—age, race, sex—which are less descriptions of individuals than sketched indications of social inequalities. These inequalities are not simply about having more or less of something; they reflect how people engage each other in their everyday lives, and they have a particularly profound impact on our sexual relations.

The first survey of the sexual and social responses to HIV infection of Australian gay men and other homosexually active men found that higher levels of “gay community attachment” were significant predictors of greater change toward safe sex.1 While pencil and paper surveys almost always produce a bias toward the better educated, it was surprising to find that 40 percent of men who participated in the survey had university degrees. The study found less risk reduction among those men with fewer cultural resources—that is, less education, with precarious access to stable, interesting, validated, and well-paid employment, and with far fewer material resources as a result of restricted or unstable incomes. These men—like the mass of ordinary citizens in most Western societies—were labeled “working-class,” as they relied solely on their wages or forms of government income support.*

This article presents some results of a 1989-90 study, which followed the original survey done in 1986-87 and which focused specifically on working-class men who are homosexually active. In seeking to understand the relationship between working-class lives and the responses of working-class men to HIV disease, the small-scale comparative study investigated the sexuality of these men and the sexual communities they inhabit. To avoid the bias of written surveys, researchers conducted intensive life history interviews and focus groups in two large industrial regions in and near Sydney.

The detailed findings from the study have been published elsewhere.2,3 Two questions, however, are of particular importance in terms of HIV prevention. First, what is the response of working-class men to the prevention education materials available to them, materials designed and disseminated by gay community-based AIDS service organizations? Second, how do these men relate to established and recognizable gay communities?

Response to Prevention Education Materials

In the original survey, working-class men were, in general, less accurate in their HIV-related knowledge than more affluent or privileged men. In face-to-face interviews some working-class men continued to be confused. Many drew on their own experience of the epidemic rather than on formal information sources. The overall impression was one of approximation rather than precision. This does not reflect illiteracy in the strictest sense; it is more a “social illiteracy,” often revealed in differences in idiom and in usage—simpler vocabulary, and informal or poor expression and syntax.

These findings suggest the need for HIV educators to consult adult and community educators, such as those who specialize in adult literacy training or technical education, and teachers who specialize in remedial education or experiential learning. In addition, educators should bring to bear on prevention campaigns the large literature on class inequality in education in the United States, Canada, Australia and Britain.

*Most post-industrial societies are similar to Australia in having large populations of working-class people whose inequality extends to lower health status and limited access to health care. These effects are reflected in the international inequalities between North and South, and lie at the base of many countries’ incapacity to respond to the pandemic.
Editorial: Class Distinctions

Robert Marks, Editor

Class is one of the last frontiers in the movement towards social equality, if such a destiny is even possible. Society at the very least pays lip service to the principles of racial and ethnic, sexual, and religious equality. The gay and lesbian movement has made sexual orientation an unavoidable issue, even if there is no consensus about whether the rights of gay men and lesbians deserve legal protection. But class seems to be a stepchild in this family of diversity, neither embraced nor abused, simply ignored.

As one of the Recent Reports in this issue shows, however, differences in knowledge, attitudes and behaviors, often attributed to race or ethnicity, are in fact related to class and education. And, while race, ethnicity, and gender are correlated to income and opportunity—and certainly have profound effects—it is differences in class and education that frequently determine whether a person succeeds or fails in U.S. society.

Concrete Therapeutic Approach

In this issue of FOCUS, Gary Dowsett, an Australian researcher, reports on his original research regarding working-class gay men and HIV disease. He describes how working-class gay men relate to one another and to the community of middle-class gay men. It is notable that—according to our literature searches—Dowsett and his associates seem to be the only researchers who have published substantial work on this issue. This is particularly disconcerting since they have found significant differences between working-class and middle-class gay men in terms of attitudes about sexuality, community, and HIV disease, and since identifying these differences is crucial to developing appropriate HIV education interventions.

Barry Chersky and Michael Seaver look at how these differences affect HIV-related therapy. They suggest that introspective therapy is by nature middle class, and that working-class gay men—as well as all working-class people—are best served by a more concrete therapeutic approach.

Providers may find these conclusions unfamiliar, provocative, and increasingly significant. Working-class gay men are likely to comprise a segment of the hidden epidemic; inaccessible by typical routes of outreach, they remain uneducated about HIV prevention and unable to access both mental health and medical services.

When it came to sexual practices working-class men were little different from other men in what they did, but very different in what they meant by and understood as sexuality and homosexuality. Meanings were derived not only from local communities, friendship networks, and popular culture, but also from an experience of less expansive social options and, sometimes, restricted sexual opportunity.

These men highly prized intimacy and rejected representations of gay life that were divorced from intimacy. They preferred educational materials featuring intimate touch between men over those featuring “hot” scenes and nudity. They rejected some very explicit safe sex material out of hand, as it contravened deeply held beliefs about and the private nature of sexual relations. These men were not prudes or closeted; they simply lived within cultural constraints, economic limitations, and social expectations different from those men who were immersed in gay community life. In light of these findings, HIV prevention aimed at working-class gay men must be more subtle in depicting sex. Images of sexuality, however, are not as significant to HIV prevention as is the relationship between the urban, affluent gay community and other communities of working-class gay men.

Relationship to Gay Community Life

The working-class men in the study maintained close links with birth families and communities, living in poorly serviced, long-standing, working-class suburbs or new outlying housing developments. They lived in modest houses or apartments with cheap rent, either very close to public transportation or far away from it. They took what unskilled work was available. This was not the affluent, urban, up-to-date modernity of contemporary gay life, situated in loft apartments or renovated townhouses in identifiable gay precincts.

Within this general context, the study found two different patterns of what might be called “working-class gay communities.” In one city there was an existing homosexual subculture built on long-standing friendships, secretive (or, at least, unobtrusive) networking, and a small number of social institutions (one or two clubs, two bars, a newsletter, and an annual Gay Fiesta). For men coming anew to male-to-male sex, these modes provid-
Working-class gay men had an ambivalent relationship with the notion of “gay,” as it was experienced in the Gay Community.

References
Sydney’s internationally famous Gay and Lesbian Mardi Gras, hopping on floats or wearing drag in the parade. Most, however, rarely attended the all-night dance party at the festival’s culmination. It was this ambivalent relationship with the notion of “gay,” as experienced in the Gay Community, that was featured in the life histories of the working-class men.

The sexual partners of these men, as often as not, were not gay-identified. Indeed, many were married men who had retained an interest in casual sex with other men from a sexually adventurous youth. The study revealed a distinct history and persistent pattern of sex between men in one city that defied any enclosure within “gay” or even “homosexual.” These partners were not members of the identifiable local gay community. Occasional sex with another man bore no relation to any concept of being gay or homosexual. It became clear as the research progressed that there are men—who could perhaps be identified as suffering from a masculine “sexual (dis)order,” whose sexual desire is unrelated to, and unreliant upon, notions of sexual identity—desire that challenges simplistic notions of heterosexual and homosexual as two distinct and different domains.

Conclusion
“Gay community attachment,” so vital in sustained behavior change, is not an individual act but a collective identity and practice. Educators need to mobilize what is positive in working-class gay men’s collective experience of “gay,” rather than relying on educators’ own, often ghetto-ized vision of gay life. This is a task premised on a community development model of prevention, aimed at trying to bridge the gap between Gay Community and other gay communities. What is the best way to legitimate working-class sexual communities without "colonizing" them as “gay,” so that working-class men take responsibility for their sexual behavior?

How can prevention campaigns use the sexual meanings and expectations of working-class, homosexually active men to portray the language, images, and representations of their sexuality? How can educators reach the sexual partners of working-class men if they cannot use sexual identity to establish a recognition of personal risk?

What kind of training and resources do AIDS educators from gay community-based service organizations need to transcend their own experiences of being part of the Gay Community, in order to understand different ways of living a homosexual life? What might researchers contribute from the academic domain of social theory about class and other social inequalities to assist in the training of educators? These are not insoluble dilemmas and, using the research reported here and in other sources, many gay community-based AIDS service organizations have developed various programs of outreach to provide better-targeted preventive education to working-class men in Australia.

This relationship between researchers and educators allows social theory (about class and sexuality, in particular) and rigorous social science research methods (especially close-focus or qualitative methods) to respond to prevention dilemmas and problems. Conversely, this relationship enables investigators to sharpen the focus of their research. What is clear from the study is that “working-class” is a useful designation to begin to identify and describe a population of gay men that is not being reached effectively through traditional methods of HIV prevention, but which, with further collaboration between researchers and educators, may be reached by other means.4

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**Clearinghouse: Working-Class Life**

**References**


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Gary W. Dowsett, PhD is Deputy Head (Macquarie Unit) of the National Centre for HIV Social Research at Macquarie University in Sydney, Australia. He is co-author of *Sustaining Safe Sex: Gay Communities Respond to AIDS* (The Falmer Press, 1993), and co-editor of *Rethinking Sex: Social Theory and Sexuality Research* (Temple University Press, 1993).

Bob Connell and Mark Davis contributed to this article through their work on the *Class, Homosexuality and AIDS Prevention (CHAP)* Project at Macquarie University. The project was funded by a Commonwealth AIDS Research Grant.
Therapy with working-class gay men dealing with HIV disease is often a cross-class experience, and this may not only raise particular therapeutic issues, but also limit the accessibility of mental health services to these men. The issues these men face relate to their psychological distance from practical help and emotional support outside of their natural support systems. Most significantly, these men may be restrained by the basic working-class value of self-reliance, which, while a positive adaptive skill in so many areas of life, becomes an obstacle to seeking and receiving help or entitlements, such as disability benefits or food stamps. This perspective may also lead to shame or embarrassment when faced with the prospect of receiving help from strangers, including therapists.

The distance becomes greater because many working-class gay men are unfamiliar with and uncomfortable dealing with the bureaucracies with which they must interact to obtain HIV-related care—bureaucracies that are often insensitive to class issues. The humiliation that may result in response to this insensitivity may reinforce feelings of guilt, shame, and self-blame prompted by internalized homophobia and the stigma of HIV infection. In addition, many working-class gay men are skeptical of a middle-class-defined “healthy lifestyle,” and this may interfere with potential substance abuse as well as alternative medical treatment.

This article suggests several responses to these issues and to providing concrete therapy to working-class gay men.

One of the difficulties in addressing class issues in therapy is defining class itself; many factors—for example, income, education, profession/vocation, skill level, culture, and psychology—determine class position and identity. For the purposes of this article, the working class is defined as the non-professional, non-managerial and, therefore, the largest and most diverse segment of the population and is distinguished from other classes by a disproportionate lack of control over its working conditions. Recognizing the diversity of working-class gay men—including race, culture, and ethnicity—and the dangers of stereotyping, some generalizations can be made regarding working-class gay men dealing with HIV-related issues in therapy.

For many working-class gay men, sexual identity is secondary to class identity. Lives are more likely to be organized around a strong working-class ethic based in families of origin, communities, unions, or churches, rather than in the middle class culture, institutions, and values of urban gay communities. Many working-class gay men regard the ability to be “out” as a reflection of middle class privilege, which systematically excludes them from the organized gay community. For middle class gay men with greater education and training, and, therefore, greater control over work opportunities, the expe-
The Therapeutic Frame

The middle-class nature of traditional therapeutic approaches can create barriers for working-class gay men. Conventional therapy seeks to identify internal forces that are responsible for troubling emotional states and maladaptive behaviors in order to help clients adjust to external conditions—for example, a stressful work climate, homophobia, and widespread ignorance and fear about HIV disease—that may be systematically oppressing them and affecting their mental health. The psychodynamic model, in particular, identifies the source of problems within intrapsychic conflict, often excluding the external social forces that shape so much of the experience of working-class life.

In addition, the myth of absolute therapist neutrality and the rigid boundaries associated with the traditional client-therapist relationship can reinforce the unequal power dynamic inherent in the client-therapist hierarchy. This can further alienate clients for whom this approach to human interaction is foreign. While a transference/counter-transference model may be beneficial to individuals of any class, clients who subjectively experience a lack of power in the world because of objective conditions, that is, those who face a class-based experience, may be unreceptive to such an approach.

The Therapeutic Process

All of these factors point to the necessity of a different approach to HIV-related therapy with working-class gay men. Social work case management may offer some alternatives: a model of treatment, based on advice and counseling rather than reflective or interpretive approaches, may be more appropriate. Concrete, strategic problem-solving, information and referral, and a relatively directive and supportive therapy is more likely to be effective.

Recognizing that, despite the therapist’s class perspective or position, the very act of coming to therapy is likely to be awkward and humiliating for the working-class client, therapists should choose interventions with the goal of destigmatizing the therapeutic process. To normalize therapy and respond to feelings of failure, guilt, and self-blame, practitioners can name the range of common and predictable responses and feelings clients may encounter during the processes of seeing a therapist, coping with HIV disease, and dealing with co-workers or family. To demystify the process, minimize the perception of the therapist as “stranger,” and create a more comfortable atmosphere in which clients can express feelings, therapists can meet with clients in settings other than what many clients may perceive as cold and clinical, serve as advocates between clients and various bureaucracies, and employ appropriate therapist self-disclosure.

A cognitive-behavioral approach is probably more useful than a psychodynamic one. Identifying goals and objectives, teaching coping skills, and cognitive reframing—for example, helping a client view HIV infection as an opportunity to re-prioritize his life—are more likely than exploring intrapsychic causes to alleviate client anxiety, shame, grief, and anger. Structured psychoeducational group work, including stress management techniques, and assertiveness and communication skills training, may help to instruct clients on how to manage the stress of HIV infection. Humor can also be an effective intervention, since many working-class people—aware that they have limited control over many life circumstances and practiced in encountering adversity—are already skilled in the use of humor as a coping mechanism.

It is essential to identify and build on client strengths based in class values and life experience. In the course of their work lives, working-class gay men are less likely than their middle-class counterparts to receive recognition for positive accomplishments. As clients confront issues related to facing mortality and drawing closure—to work, relationships, communities, their lives—therapists can play a powerful role in reflecting back the contributions clients have made as productive members of society.

Comments and Submissions

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:

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Class-Based Perceptions of Caregivers
Brown KH. Descriptive and normative ethics: Class, context and confidentiality for mothers with HIV. *Social Science & Medicine*. 1993; 36(3): 195-202. (Creighton University, Omaha, Nebraska.)

Class-based perceptions—rather than normative and objective information about rights and consequences—influenced the decisions practitioners made about maintaining the confidentiality of a patient's HIV-related test results according to a study of interactions between HIV-infected mothers and infants and their advocates and providers.

Between 1990 and 1991, researchers interviewed 72 health, social work, administrative, research, and advocacy professionals working with mothers and infants. They selected nine research sites in the United States and Puerto Rico based on high numbers of maternal/infant AIDS cases. Researchers did not define class; participants based responses on personal perceptions of class.

Mothers with HIV disease who were empowered by "economic, political, or social standing in other areas of their lives" tended to have greater control over the extent to which their confidentiality was respected. On the other hand, subjects already disempowered by lower socioeconomic conditions often fell victim to large, underfunded, and understaffed institutions whose conditions tended to compound the usual institutional strains on patient confidentiality. Fifty-eight percent of respondents believed that breaches of confidentiality occur more frequently for mothers from lower classes who go to public hospitals, and 65 percent believed that a private physician's office affords the greatest degree of confidentiality. Respondents based their assumptions on their beliefs that breaches in confidentiality have different meanings and consequences for members of different social classes. Sixty-nine percent of respondents depicted lower-class patients as more passive, less concerned with confidentiality than with psychosocial economic problems, and more in need of paternalistic advocacy than the autonomy implied by strict confidentiality. Some respondents believed that the primary fear of poorer patients was that breaches in confidentiality would lead to rejection by family and friends, while the primary fear of middle class patients was that such breaches could lead to loss of employment or insurance. In fact, one caregiver reasoned that a middle-class patient, with a higher paying job, and a nicer residence would have more to lose than a lower-class patient if her HIV status were to be revealed.

Race, Class, and AIDS Knowledge

A large Washington, DC study found that socioeconomic and sociodemographic differences had a greater influence than racial differences on AIDS knowledge.

Researchers randomly selected 1,237 adults between the ages of 18 and 65 and interviewed them by telephone as part of the 1989 Behavioral Risk Factor Surveillance System. They excluded White and Black individuals of Hispanic origin, Asians, Pacific Islanders, and Native Americans.

To assess knowledge of natural history and transmission, researchers asked participants questions about the differences between an HIV-infected asymptomatic person and a person with AIDS. They assessed knowledge of transmission by asking questions about unproven modes, proven modes, and preventive measures. In general, knowledge about proven methods of transmission was high and did not vary in terms of race or class. But, while Black respondents were twice as likely as White respondents to have low knowledge levels about preventive measures, when unemployment status was included in analysis, the racial difference became statistically insignificant.

Similarly, while Black respondents were three times as likely as White respondents to fail to distinguish between people with AIDS and asymptomatic people, this difference decreased substantially after adjusting for educational level (although it remained statistically significant).

White respondents had a higher level of...
knowledge about unproven transmission modes than Black respondents. These racial disparities remained even after adjustment for educational level. However, racial disparities themselves may be indicators of socioeconomic disparities: Black Americans generally have had less access to education than White Americans.

**Prevention among Working-Class Gay Men**


An Australian study of sexuality and HIV prevention among working-class gay men found that working-class gay communities—disregarded by middle-class HIV education campaigns—have spawned “barefoot educators” to meet prevention challenges.

Between 1989 and 1990 researchers collected information from working-class men in two Australian cities about male-to-male sexuality and its social context. The resulting report—based on 21 tape-recorded life history interviews, a series of group discussions around HIV/AIDS education materials, and some wider field observation—focuses most of its attention on an ethnographic description of working-class gay sexuality and community. [See “HIV Prevention among Working-Class Men” on page 1 of this issue of *FOCUS.*] but also comes to conclusions about HIV prevention.

One of the most significant differences between working- and middle-class gay men is the emphasis among middle-class men on gay community and gay identity. HIV prevention work in the 1980s was successful because it strengthened this emphasis. Ironically, this very success could be expected to increase divisions along class lines and, thus, further undermine prevention work among working-class gay men.

In an effort to meet the concerns of working-class gay men while disseminating crucial HIV prevention information, local men have become “HIV/AIDS activists organic to their own communities,” men who have become “barefoot,” or impromptu, educators. These men lecture on the value of safe sex when they come across unsafe practices in their own encounters or when they witness unsafe practices among friends or at other social settings. For example, one “barefoot” educator is a former sex worker with considerable but uncredentialled expertise about sexuality and an accurate knowledge of safe sex strategy. He successfully disseminates information in this way, even though his “reputation” as a “known homosexual” makes it impossible for him to get an official job as an educator.

This informal education system goes against the trend in HIV work towards professionalism—training, certification, action by formally organized groups—which, combined with the internal imperatives of running expanding and expensive programs, has transformed AIDS groups from loose community-based campaign to formal organizations. Instead “barefoot” educators disregard credentials, and work through relationships and networks. Their efforts result in collective empowerment and the distribution of information without the class put-downs and disempowerment that are the usual consequences of professional intervention. The task facing educators is to find ways to include such men in their programs, not just as participants or clients, but as paid or volunteer staff.

**Next Month**

With so much political rhetoric flying, it is hard to know when and in what form health care reform will occur. It is nonetheless useful to consider how it will affect HIV-related medical and mental health care. In the March issue of *FOCUS,* two AIDS policy experts provide their perspectives on the Clinton health reform plan.

*Warren W. Buckingham III,* Special Assistant for Planning and Development to the National AIDS Policy Coordinator Kristine Gebbie, approaches the subject from the viewpoint of a policy planner and a member of the White House Health Care Reform Task Force. He examines in particular those areas that will have the most immediate and substantive benefit to people with HIV disease.

*Jeffrey Levi,* Director of Public Policy of the AIDS Action Foundation, the Washington, DC, AIDS policy and lobbying group, considers the plan from the perspective of an AIDS activist. He reviews the plan in terms of the basic principles that he says should be part of any reformed health care system.
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