

# FOCUS A GUIDE TO AIDS RESEARCH

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## Homophobia, AIDS, and the Health Care Professional

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A number of institutional and personal biases have marked the response to the AIDS epidemic throughout the world. Among these are severe economic disadvantage, racial and sexual discrimination, and homophobia — the fear and loathing of homosexuality or homosexual behavior.

Most cultures in the world sanction the notion that homosexuality is an offensive and, indeed, pathological perversion. This homophobic attitude frequently encourages a spectrum of disapproval, discrimination, and violence against gay men and lesbians. There are many ways that mistreatment of lesbians and gay men have been routinely sanctioned in the United States and around the world. The military spends vast amounts of money to purge suspected lesbians and gay men from the service; churches excommunicate lesbian and gay members and expel their ordained lesbian and gay clergy. Employers terminate, landlords evict, families disinherit, and courts take children away from gay people.

### Historical Roots

Like all phobias, homophobia influences people in all walks of life. The profession of medicine, in particular, has had a major impact on the social, political, and clinical health of gay and lesbian people. Throughout history, helping professionals have recommended extreme and violent measures for gay people to deal with their sexuality — including shock therapy, aversion therapy, lobotomies, clitorectomies, and castration. In many family therapy situations, the homosexual family member has been perceived as the "identified patient" regardless of the family's dysfunction.

In 1974 and 1975 the American Psychological Association and the American Psychiatric Association both removed homosexuality from their lists of mental disorders. The *Diagnostic and Statistical Manual of Mental Disorders* now makes only one reference to "ego-dystonic homosexuality", referring to those people who are poorly adjusted to their homosexuality. These changes in the United States do not indicate that all health care providers now view homosexuality as a normal sexual variant.

R.C. Pillard discussed the psychological ghettoization of gay people which results from avoiding contact with homosexuals so that "feelings of empathy, of shared humanity are not formed and so that pejorative characteristics can be easily ascribed." He adds that information — often inaccurate — about gay people is derived from supposed experts who have little contact or relationship with homosexuals themselves.

Studies conducted during the 1970s and 1980s in the United States have consistently shown significant amounts of negativity among health care professionals toward homosexuality, ranging from indifference to outright hostility. Some of the progress demonstrated between 1975 and the 1980s in these studies began reversing itself with the advent of the AIDS epidemic. One study noted a "disturbingly high" number of health professionals held "overtly hostile" feelings toward gay people. A 1982 study of physicians indicated strong homophobic attitudes among nearly one-quarter of respondents; 30% would not admit qualified homosexual applicants to medical school; 40% would discourage homosexuals from pediatrics and psychiatry; and 40% expressed discomfort with gay and lesbian patients.

### Early Perceptions of AIDS

When the Centers for Disease Control first described the appearance of a peculiar disease indicating immunosuppression

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in gay men, media around the world used terms like "the gay plague," "gay cancer," and even "Gay Related Immune Deficiency" or GRID. Those choices, encouraged by early available epidemiology, set the tone for subsequent national and global responses to the epidemic. As a result, education campaigns continue to emphasize the "AIDS is not just a gay disease" as a necessary means to reach other people at risk.

That this new disease was linked to the first identifiable group in which it was found was not necessarily a homophobic response. What is more telling is how governments, scientists, health care workers, and others responded to AIDS once it was tied to gay men. Not only outside critics but more recently international health officials, government agencies, and professional groups have all acknowledged their profoundly inadequate response to this new epidemic in its first years. When other groups, such as intravenous drug users, Haitians, and sex workers, were identified to be a high risk for AIDS, they too suffered from an official neglect. However, reactions to gay people and homosexuality continue to trigger the most intense emotions during debates about public policy and AIDS prevention.

These ongoing perceptions of the AIDS epidemic have been encouraged by the predominance of the medical model and of medical epidemiology in understanding the new disease. While social epidemiology requires a look at disease as an outcome of a social system and not just individual lifestyle behaviors, the

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# Homophobia and AIDS. . .

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medical epidemiological model applied to AIDS has emphasized the transmission and potential containment of the disease within "deviant" communities. The consequences of this approach have often been significant. For example, little attention has been paid to the ways in which stereotyping, prejudice, and discrimination can have a "risk-imposing" effect on minority communities. With AIDS prevention now acquiring greater attention worldwide, health officials must begin to look beyond policies and strategies based solely on the dominant lifestyle.

## Possible Causes of Fear of AIDS

Throughout history some health professionals have refused to serve patients with various diseases, including Hansen's disease (leprosy), cholera, black plague, smallpox, influenza, and cancer for fear of contagion. AIDS is simply the most recent example of this response. AIDS also prompts recriminations and fear because of its perceived connection with sexuality and homosexuality and because a full understanding — much less a cure — for AIDS has eluded modern medical technology.

Despite the fact that AIDS is not spread by casual contact, some helping professionals continue to mistreat or refuse to treat people with AIDS or HIV infection. These individuals are usually dealing with — consciously or unconsciously — additional issues of homophobia, racism, sexism, or any one of a number of other fears that can complicate an otherwise simple response to a human need.

## Unlearning Homophobia

Ricky Sherover-Marcuse, author of the recently-published *Emancipation and Consciousness*, has developed a useful model for tempering personal biases. She calls this process "unlearning" and has successfully applied its principles to racist, sexist, anti-Semitic, and homophobic attitudes. One of the basic premises of Marcuse's work is that no one is born with racist, sexist, or homophobic feelings.

One of the first steps in gaining freedom from these attitudes, according to Marcuse, is to forgive ourselves retroactively for colluding with the cultural stereotypes that have always reinforced these prejudices. We become responsible for these attitudes only when we have become aware of them and persist in the behavior.

When individuals are told and believe lies about other people as a group, they are often being told lies about themselves as well. If individuals are being taught to hate and fear, certainly not to *become* homosexual and they *are*, then they will likely internalize a high degree of negative feelings about being lesbian or gay. Groups subject to a society's phobic responses usually must confront low self-esteem. Some mental health practitioners have found gay men to present more frequently with self-esteem problems since the onset of public attitudes that link "immorality" with AIDS.

Marcuse asserts that most people will never free themselves completely of their learned prejudices, but that much progress can be made in unlearning these attitudes. She suggests that helping professionals study their own attitudes so the quality and compassion of their professional services is not affected.

Practitioners can also learn about the issues and lifestyle of the person with AIDS; they can learn when and how to use supervision to deal with homophobia; and they can contact homosexual health care providers or consultants to help them clarify information and better understand their own feelings.

Part of the unlearning process involves developing a willingness to confront the lies not only within ourselves, but also those of our peers — in our families, churches, neighborhoods, and workplaces. This dedication to unlearning does not require that an individual be constantly angry or combative. Much can be accomplished by being understanding and persuasive, challenging as inaccurate phobic behavior and then making allies of those individuals.

When the health care professional detects internalized homophobia in a patient, it is useful to confront those attitudes. If a patient remarks, "I guess I got what I deserved; everyone else says so," a sensitive response might include reiterating that AIDS is caused by a virus and that people of both sexes, of all ages, races, backgrounds, and sexual preferences have been diagnosed with the disease. The practitioner may want to use the patient's remark to explore his or her general attitudes about sexuality and personal behaviors.

Practitioners should also be alert to the tendency to "blame the victim," a phenomenon that often occurs when morality becomes interwoven with disease. When individuals are diagnosed with a life-threatening disease, they may experience some guilt. This is especially true for some groups, such as smokers who develop emphysema or drinkers who find they have liver disease. Yet many in society do not blame these individuals for the behavior which led to this illness. AIDS, however, is a disease in which many misinformed people agree that there *should* be guilt.

This blaming the victim posture takes a considerable psychological and social toll on HIV-infected individuals, their families and friends. Some have neglected to seek medical attention for fear of mistreatment. Others have been disowned by their families who fear contagion or ostracism for being associated with an unacceptable member of society. Health care providers can counter this attitude and help affirm the value of their client's lives.

## Making Referrals

If a health care professional believes that there *is* a legitimate reason for judging people with AIDS and HIV infection and is unwilling to begin a process of moving beyond this attitude, then it is imperative that a referral be made to another practitioner who can more effectively help the client. Not to do so risks likely mistreatment of the client and inappropriate behavior on the part of the health care provider. People who deal with AIDS as a punishment for being gay do considerable damage — not only to the patient, family, and friends but also to themselves as professionals.

Most countries have networks of professionals that can provide appropriate care for people with AIDS and HIV infection; these can serve as resources for making effective referrals.

## Conclusion

The high profile of the AIDS epidemic has made whole populations much more aware of homosexuality — at times diluting stereotypes and encouraging understanding and at other times providing critics with a new arena for anti-gay activities. Homophobia has had a direct, contributory influence on the slow response to the AIDS epidemic, the spread of HIV infection, and to the deaths of thousands of individuals.

Homophobia, as a learned behavior, can also be unlearned, freeing practitioners and patients from its limiting and dangerous impact. A majority of health care professionals have provided humane and compassionate care for patients with AIDS. As the number of AIDS cases continues to climb, all health professionals need to examine their attitudes, acknowledge homophobia where it exists, and work to make necessary changes.

## References

Pillard, R.C., "Psychotherapeutic Treatment for the Invisible Minority," *American Behavioral Scientist*, 25 (March/April 1982).

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## Diagnosis/Treatment/Prevention

# Homophobia in AIDS Education: Counterproductive to Prevention

Chuck Frutchey

AIDS educators and health officials face an ongoing challenge: how to inform the public about a subject that is often charged with emotion and prejudice. The majority of AIDS prevention messages focus simply on stopping the spread of a disease; others, however, have advanced social and political goals that tend to confuse the issue. Homophobic and anti-sexual messages are the most common among programs with extra agendas. Past experience with health promotion and disease prevention make it clear that this kind of approach is ineffective and counterproductive.

What constitutes a homophobic or anti-sexual message? Homophobia is the irrational fear or hatred of gay people, their lifestyles, or their institutions. Homophobia is endemic in not cultures throughout the world; it is often present in gay people themselves and is then referred to as "internalized homophobia."

Anti-sexual messages are embodied in those attitudes which regard sex as dirty or offensive, not fit for general discussion, or not to be enjoyed fully. Many cultures have anti-sexual values even while public consciousness may be entangled in the images of sexuality. These attitudes often present a mixed message: sex is bad but desirable.

Since homophobic and anti-sexual attitudes are so common, they inevitably appear in AIDS prevention messages that must discuss sex and homosexuality. The most common message is that AIDS is a gay disease. Before the name AIDS was adopted, this disease was called Gay Related Immune Deficiency (GRID) by physicians and the Gay Plague by the media. Even after six years of evidence that AIDS strikes many different people, many prevention messages continue to support the mistaken notion that AIDS is a gay disease. Individuals and political groups with an anti-gay perspective continue to assert on the media and sometimes in legislative bodies that AIDS is a gay disease.

Sometimes educators feel that they are simply responding to current epidemiological data by making such statements as "Do not have sex with gay or bisexual men" or "Avoid sexual contact with anyone in a high risk group." This approach unfairly and incorrectly categorizes whole populations of individuals, many of whom individually are not at risk for HIV infection. The more accurate message would affirm the right to sexual fulfillment of all individuals while emphasizing the need for safe sex practices. At the same time, health officials sometimes worry about being ineffective or ridiculed if they encourage heterosexuals to use condoms.

Other messages are more subtle, such as a brochure for prison inmates that warns against "having sex with infected gays/bisexuals without using a rubber." While this warning correctly advises use of condoms, it implicitly asserts that only gay and bisexual men are infected, ignoring that heterosexual men might also be infected. This kind of message allows heterosexuals who may be at risk to cling to their denial and to continue with unsafe behavior. The message may inadvertently lead individuals to becoming infected rather than preventing further infections.

Another form of homophobia that appears in prevention messages is the exclusion of homosexuality altogether. Some nationally distributed brochures produced by government officials do not mention gay people or gay sex at all. A recent brochure targeted to blacks in the United States also failed to

mention gay or bisexual men, an exclusion that carries several messages. First among these is the suggestion that even mentioning gay people is unacceptable: they should remain invisible. Second is the notion that the gay population is isolated sexually from heterosexuals and that bisexual contact does not occur. Third, an idea that is more relevant to the epidemiology of AIDS in the Americas, Europe, and Australia, is that gay people are not important; AIDS is only serious now that heterosexuals are contracting it in higher numbers. These kinds of messages can encourage people to regard the epidemic as less serious than it is and to feel justified in not taking aggressive action to stop AIDS.

Gay men are often scapegoated in AIDS prevention programs. The assumption is that if it had not been for gay men and their sexual practices, AIDS would not be a problem. Thus control of homosexuality, rather than the disease, becomes the solution. Other groups such as prostitutes, Haitians, and Africans have also experienced this treatment.

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Anti-sexual and homophobic messages often go together. A commonly promoted guideline is to reduce one's number of sexual partners. This advice is often emphasized because it is less explicit than talking about safer sex techniques; however, it is dangerous because dozens of safe contacts are better than one high-risk contact. When educators feel uncomfortable discussing sexual activity, they often just say, "Don't do it." In some literature this message is given to gay men while at-risk heterosexuals are advised to use a condom, a distinction with no apparent logic. Abstinence messages have never been effective in sex education, and they are unlikely to be so now. Such messages also fail to give people at risk information they need to avoid infection when they do have sex.

The association of sex with death is a popular anti-sexual tactic to attract attention and to scare people into AIDS prevention. While the images do gain attention, there is no evidence that they lead to sustained behavior change. Many graphic images now incorporate skulls, deathmasks, or warnings that sex can kill. Before the advent of penicillin and other antibiotics, many sexually transmitted diseases resulted in death. The scare tactics employed in those earlier days met with little success.

It is important to be clear about one's purpose when AIDS prevention materials are going developed and reviewed. The primary agenda should be to stop the spread of AIDS. Experience in many countries during the last five years has shown that the most effective campaigns have been those that are frank and explicit about sex and other risk factors. Confusing prevention messages with other political goals or trying to avoid talking about sex when discussing a sexually transmitted disease are the easiest ways to prolong this epidemic.

Health professionals have the responsibility and the opportunity to educate people about AIDS with an open and non-judgmental attitude when discussing sex and homosexuality. They can also insist that education materials be tested for audience acceptance — both the general public and special target groups — before they are distributed. Sometimes taking such a position may require both determination and courage; both qualities are essential in the worldwide efforts to halt this epidemic.

**Chuck Frutchey** is the Assistant Director of Education for the San Francisco AIDS Foundation. He has helped develop most of the Foundation's highly regarded AIDS prevention messages.

# BRIEFS

## Recent Reports

**TB and HIV Infection Among Minorities.** Since 1985 the number of tuberculosis (TB) cases in the United States has risen steadily, and the increase appears to be due, at least in part, to individuals with both TB infection and HIV infection. Immunosuppression caused by HIV infection appears to allow latent TB infection to progress to clinical disease, and data from one study indicate that the risk of developing TB among people with AIDS is 100 times greater than among the general population. The Centers for Disease Control (CDC) estimate that there may be 10 million individuals with latent tuberculosis infection in the United States.

Ethnic and racial minorities in the U.S. have a disproportionate rate of TB cases. In 1985 the TB rate among these populations was six times greater than that for whites, and in 1986 62% of all reported TB cases in the country were among racial and ethnic minorities.

In a paper distributed at the National Conference on AIDS in Minority Populations in the U.S. in August, CDC officials warned that the TB problem may worsen considerably as more TB-infected people become infected with HIV. They also noted that TB is especially serious because it can be spread by airborne transmission. However, available drugs can treat and cure TB, thus blocking its transmission. Preventive therapy for TB is expected to be effective for people with HIV infection, and the CDC recommends preventive therapy (with the drug isoniazid) for people who have the dual infection as well as for close contacts of these individuals.

To treat and monitor cases of dual TB and HIV infections, the CDC recommends confidential testing and counseling of people with TB in high-risk areas with risk factors for AIDS. The federal agency advises health departments and other providers to employ minority outreach workers to help conduct these AIDS and TB prevention programs.

**WHO Expects 150,000 Cases in 1988.** The World Health Organization (WHO) anticipates that 1988 will see an additional 150,000 cases of AIDS, bringing the total number of reported cases to 300,000 by the end of the year. Last month 129 countries had reported more than 71,000 cases of the disease, but WHO believes more complete surveillance and reporting would bring the total closer to 150,000. During 1987 the number of countries agreeing to report AIDS cases doubled, from 80 to 160. The countries with the highest number of reported cases are led by the United States (nearly 50,000) and France (more than 2500). Others with more than 1000 cases are, in order of rank, Uganda, Brazil, Tanzania, West Germany, Canada, the United Kingdom, and Italy.

In its end of the year report on AIDS, WHO estimated that from five to ten million people are infected with HIV and that from 500,000 to three million new AIDS cases will occur over the next five years.

In an accompanying policy statement, WHO condemned discrimination against those infected with the disease. It also advocated the need for informed consent for HIV antibody testing, counseling for those who choose to be tested, and guaranteed confidentiality for all participants.

**New Survival Statistics.** Scientists from the New York City Department of Health and the Centers for Disease Control (CDC) have reported (*The New England Journal of Medicine*, November 19, 1987) that 15 percent of people with AIDS in New York City survived for at least five years after diagnosis. This is a higher than expected finding, leading the researchers to comment that less than a decade's experience with the disease was too soon to conclude that AIDS was uniformly fatal. Gay white men fared the best in these statistics; the data showed that I.V. drug users, women, blacks, and Hispanics with AIDS tended to have much shorter life spans after diagnosis.

In San Francisco a related study of the 3600 people diagnosed with AIDS between 1981 and 1986 found that the median life span had extended four months. This means that those individuals diagnosed with AIDS in 1987 and later have a statistically better chance to survive longer than those diagnosed in earlier years. The median length of survival has risen from 10.2 months to 14.14 months during the first five years of the disease in that city. Health officials noted that this was the first time that improved survival has been noted for San Francisco.

Another study in San Francisco led researchers to estimate that 57 percent of people infected with HIV will develop AIDS within 16 years of their initial infection. Although this is still grim news, it is better than earlier predictions that saw 36 percent of HIV seropositives developing AIDS within seven years. Other officials have suggested that the rate would increase sharply each year. One of the San Francisco researchers concluded during an AIDS conference in that city, "It's possible people could live their lives infected and die without ever getting AIDS."

## Next Month

Worldwide epidemiology has confirmed that HIV can be transmitted between heterosexuals who engage in unprotected sex. Yet few other facets of the epidemic elicit so many questions: How efficient is heterosexual transmission? Is the natural history of the disease any different for men or women? What is the effect of HIV infection on pregnancy, birth, and infants? How quickly will AIDS spread among this population? Can heterosexuals adopt the necessary behavior changes? What is the best way to reach people who believe they are not at risk?

In the February issue of **FOCUS**, epidemiologist **Nancy Padian, PhD** will provide an update on AIDS among heterosexuals and will address these and other questions from the vantage of current epidemiology. Padian is the project director of the California Partners Study at the University of California in Berkeley.

In addition, **Marsha Blackman, LCSW** will discuss AIDS prevention and counseling strategies for women who are seropositive. Blackman provides clinical services for women at the AIDS Health Project in San Francisco.

## FOCUS A GUIDE TO AIDS RESEARCH

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The amount of research information now appearing in the medical and lay press staggers most AIDS health care and service providers. The goal of **FOCUS** is to place the data and medical reports in a context that is meaningful and useful to its readers.

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