Chapter 14
Reflections on the HIV/AIDS Crisis, COVID-19, and Resilience in Gay Men: Ghosts of Our Past, Demons of Our Present

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Introduction

In March 2020 panic radiated throughout the world as it became clear that a novel flu-like illness, COVID-19, was spreading unchecked. Cities, towns, and whole countries were encouraged to engage in quarantine protocol, wear masks, and limit any social interaction outside their households to slow the rate of infection. Many Americans did not heed the warnings of public health officials, in part because of minimal solid information on the treatment of this virus and political leaders minimizing its danger. As infection and death rates started to climb in New York City, families were unable to participate in their mourning rituals for lost loved ones. Disturbing images emerged of body bags being hoisted into refrigerated trucks summoned once the morgues had reached capacity. Empty city streets resembled a post-apocalyptic landscape.

Some aspects of this scenario felt familiar to those who had been alive long enough to remember the HIV pandemic. Approximately 40 years ago HIV emerged, a pandemic that, at the time, seemed to target gay men. The headlines declared it a cancer among gay men and medical professions coined the diagnosis Gay Related Immunodeficiency (GRID) (Cervini 2020; Shernoff 1999). People diagnosed with the virus were subject to openly homophobic and transphobic attitudes from health-care providers (Shernoff 1999). Government officials refused to make public statements regarding its spread or to address it in a humane and ethical manner (Cervini 2020). Eventually, largely through the efforts of activists, scientists learned more about the spread of HIV/AIDS. The public came to understand that it was not simply “a gay men’s disease,” and treatment advanced so dramatically that it is now
possible to manage HIV with medication. However, the emotional impact of the HIV crisis on gay men who lived through it was deep and far-reaching.

How does a group of people survive a deadly virus with little to no help from those sworn to protect and serve its citizens? The gay men who lived through the HIV/AIDS crisis had to show resilience. Nonetheless, they bear the scars of that time, particularly the pain of watching their community’s dread, being neglected by those in power, and being publicly shamed for their sexual identity because of its connection to a contagion. This chapter will briefly discuss the commonalities between the handling of the HIV/AIDS and the COVID-19 pandemics, then address the emotional and behavioral impact of COVID-19 on gay-identifying men through the lens of expectations and violation of expectations.

**HIV/AIDS and COVID-19 Mishandled**

When HIV emerged into public awareness in 1981, the virus was directly tied to gay men. The government was slow to respond to the climbing infection rates of what was first known as gay cancer, then GRID, and now HIV/AIDS (Cervini 2020). The lesbian, gay, bisexual, transgender, and queer (LGBTQ) community was already marginalized and faced adversity on multiple fronts: discrimination in the workplace that could result in termination; violence from fellow citizens and law enforcement; and automatic discharge from the armed services upon being “outed,” to name a few. The perception of deviancy was projected onto LGBTQ people, creating an environment where dehumanization was generally considered acceptable. Instances of dehumanization included public officials calling for the tattooing of gay people living with AIDS as an identifier; a vote in California to quarantine and isolate AIDS patients; government’s preoccupation with testing gay men only; and hospitals’ disposing of the deceased in garbage bags (Cervini 2020). “Silence = Death” became an advocacy motto for the thousands affected by the virus who demanded political action for improved care. Several organizations emerged from this crisis, made up of the people affected who fought for change and sought to treat, educate, and advocate: Gay Men’s Health Crisis (GMHC), People Living with AIDS (PLA), and AIDS Coalition to Unleash Power (ACT UP) (Cervini 2020). These organizations stepped in where the government failed.

As with the emergence of HIV/AIDS, the government was slow to respond to the COVID-19 pandemic. Government officials, including the President, made numerous public statements denying the severity of the virus, and many made dehumanizing statements, such as one public official suggesting that older people risk their lives by returning to work for the sake of the economy (Levin 2020). The Trump administration demonstrated xenophobic and racist attitudes in calling the virus the “China virus” (Chiu 2020) and callously deflected the demands for federal assistance from governors (Martin 2020). Each state had to fight for assistance and develop their own policies and procedures to contain the spread of the virus.
It seems clear that the United States’ conspicuously severe infection and death rates from COVID-19 are directly tied to this government mishandling (Yong 2020). It has resulted in difficulties gaining access to testing (Siegler 2020); certain communities of people (particularly Black and brown communities) being disproportionately affected by the virus’ impacts (i.e., health, financial, and social) (Godoy and Wood 2020); overflowing hospitals with death rates in the hundreds per day, and as mentioned previously, images of bodies in black bags being hauled onto refrigerated trucks due to insufficient space in morgues. The COVID-19 pandemic is far from over. At the time of this writing, the United States continues to have the highest infection rates. In addition to, and in part because of, government mishandling, many members of the public did not adhere to public health safety recommendations issued by the Centers for Disease Control and Prevention (CDC).

The director of the National Institute of Allergy and Infectious Diseases, Dr. Anthony Fauci, has noted similarities between HIV/AIDS and the current COVID-19 pandemic (Kim 2020). He has aptly pointed out the disproportionate rate of infection of COVID-19 in Black communities, and its similarities to HIV/AIDS infection in communities of color. The nature of both viruses is non-discriminatory, yet blame and shame has been weaponized as a means to deflect responsibility in both crises (Kim 2020). It remains to be seen to what extent private citizens and organizations must follow in the footsteps of the HIV/AIDS activists and organizers to help ourselves, since the current administration has persistently failed the American people to the tune of approximately 150,000 deaths within 8 months (Craig 2020).

Violation of Expectations and Resilience

The government’s ongoing failure to meet the needs of citizens during a public health crisis can be categorized as a violation of expectations. From birth through the first year of life, we develop expectations of affective responsivity from our caregivers (Lachmann 2006). Violation of expectations occurs when caregivers do not meet our needs. The long-term effects of experiencing violations of expectations can shape the way an individual perceives and interacts with their environment, and in some cases heightening fears, pessimism, and distrust (Lachmann 2006).

In this pandemic, expectations have been violated by the lack of a coherent, empathetic, and competent response to lethal public health issues. The New York City LGBTQ community specifically experienced a violation of expectations when city officials permitted an organization with an anti-LGBTQ agenda to set up a medical camp in Central Park to treat overflow patients from hospitals. According to a New York Times article, “Franklin Graham is taking down his N.Y. hospital, but not going quietly,” the organization required employees and volunteers to sign a statement of faith that affirms their belief in Jesus Christ and that marriage is between a man and a woman (Stack and Fink 2020). News of this arrangement...
violated the expectations that LGBTQ people had for their elected officials to show empathy and solidarity with all citizens equally during a citywide health crisis.

Silence = Death rings true through this troubling experience, while the country is also in the midst of civil unrest. Silence and inaction have incited anger and protest as people of various identities (race, gender, sexual identity) have banded together to fight injustices such as police brutality, inadequate provision of personal protective equipment (PPE), and inadequate guarantees of safety standards for planned school returns. Black Lives Matter has sharply raised its profile and grown its numbers, with support from the LGBTQ community advocating for Black Trans Lives Matter. As with the emergence of HIV/AIDS, injustices during a public health crisis have brought communities together to fight and engage in robust advocacy efforts to be treated with dignity.

The capacity of individuals and communities to come together in this way is evidence of resilience. Resilience is an adaptive behavior defined as the ability of children to function well in the face of adversity (Cummings et al. 2000), and to overcome those conditions through self-care and a recognition of self-efficacy (Bender and Ingram 2018), with a move toward a positive outcome or to reduce a negative one. Prominent LGBTQ figures who have demonstrated resiliency include Marsha P. Johnson, Sylvia Rivera, Marion Banzhaf, Alexis Danzig, Bayard Rustin, Larry Kramer, and Harvey Milk, to name a few. Each of these people displayed acts of courage in their efforts to enact positive change for those suffering, despite their own personal trials. They serve as role models and beacons of hope for the hopeless.

From the start of this pandemic I have noticed themes of guilt and shame regarding sexual identity re-emerge among my gay clients as each passing day brought grim news and sometimes tighter restrictions. The Silence = Death motto resonates today but in a slightly different way. Some have reacted to the quarantine with the thought that closeness may equal death. There is truth to this concern, given the highly contagious nature of this respiratory virus. The psychological impact the COVID-19 crisis has had on those gay men who lived through the HIV/AIDS crisis is a nightmare of expectations being violated, again.

**Case Vignette**

The following case vignette is provided to explore how living through the COVID-19 pandemic has triggering effects on a gay-identifying client who has also lived through the HIV/AIDS crisis. His name and identifying information have been altered in order to maintain confidentiality.
Wayne

Wayne, a gay-identifying male, first moved to New York City in his twenties. HIV/AIDS was already ravaging the LGBTQ community. He struggled with anxiety and shame most of his life. He had a tenuous relationship with his father, who has shamed Wayne’s gay identity when Wayne came out. He recalls a long history of being mocked for not being masculine enough and not participating in “boy” activities like sports throughout his childhood and adolescent development. His arrival in NYC was jarring. On the one hand, a virus was slowly killing people all around him, and on the other hand, the world continued to send rejecting messages of the people affected not being good enough (i.e., good enough for health care, equal rights, etc.). Wayne’s capacity for empathy and compassion for others motivated him to dedicate time to volunteering within the LGBTQ community. Through this experience he established deep, meaningful relationships and tragic loss as friends and people he cared for were passing away.

Wayne has spent time in therapy working through feelings of inadequacy and internalized unresolved issues with his father. As the COVID lockdown wore on, social distancing orders and the frequently revised expectations of the length of time to socially distance began to weigh on Wayne. Days at home grew longer and news more dire. He recalled memories of the losses he witnessed and adverse and discriminatory events that chipped away at his self-worth. Wayne’s first triggering experience was brought on by the sounds of sirens blaring throughout his neighborhood all throughout the day and night; this reminded him of times volunteering when he would sit with someone as they take their last breath and wait for ambulance transport. His anxiety was exacerbated further by imagery of refrigerated trucks at local hospitals. Wayne felt a swelling of helplessness. That feeling reigned a narrative of lack of self-worth. Treatment moved toward deeper exploration of those experiences as memories continued to resurface. At one point, he recalled some journal entries which he later found and shared in session. The entries revealed similar themes of lack of self-worth and helplessness, while also highlighting, unknowingly to Wayne, his resilience. Therapy focused on the role those experiences played in his life and highlighted his resiliency through acts of advocacy and support through troubled times.

Shared Trauma

We do not have to look far back in history to identify various events that mental health clinicians and clients have had a dual exposure to the same collective trauma, such as 9/11 (Tosone et al. 2012). The COVID-19 pandemic, as with HIV/AIDS, is a global crisis that affects clients and clinicians alike. Clinicians have been faced with the task of resolving their anxieties about safety for self and loved ones, while helping clients with similar concerns. Clinicians have also had to contend with
transitions to remote practice, as well as providing a secure, remote space for effective psychotherapeutic treatment of trauma, both past and present.

The relational aspect of this traumatic event removes the autonomous choice for clinician self-disclosure. Client inquiry into my affective experience has been an interesting turn of events in treatment. Self-disclosure is always a personal choice that should be made carefully and yet during a worldwide crisis, it can be difficult to avoid. I found that after careful self-exploration, my decision to selectively self-disclose to clients has been met with a deepening of the therapeutic process. The sense of unity can also foster a sense of shared resiliency (Nuttman-Shwartz 2014); the dual exposure experience may temporarily quell the feelings of isolation. My self-disclosure included feelings of worry for the health of loved ones, adjustment to safety protocols, and at times, confusion as it pertains to receiving conflicting safety information. While this level of self-disclosure may seem to scratch the surface, it is what lies beneath that became truly challenging.

A close heterosexual cousin of mine died of HIV/AIDS-related complications in the late 1990s. I was an adolescent when I became aware of and had my first exposure to death due to HIV/AIDS. My final memory of him is vividly etched into my brain. My parents told me of his diagnosis, and spoke to me about its severity and the toll it took on his physical appearance compared to last seeing him during the holidays. After answering my many questions, we decided that I could visit his bedside, unknowingly for the last time. My cousin looked frail, pale, and had scars on his skin that I had never noticed before. Surprisingly, he maintained his strong sense of humor and warmth despite his weakness. Not much time passed after that visit when we received word of his passing. I remember feeling helpless and a deep sadness; it was a loss that I could not understand.

My adolescent mind desperately sought answers. I spent time researching HIV/AIDS in my spare time and, with approval from certain teachers, even wrote about the topic for some assignments. I started to develop a deeper sense of shame and anxiety as I learned more about how gay people were treated unfairly and inhumanely in a critical time of need. I may not have lived through the experience like my client, but I got a glimpse into the pain and despair of the time. I carry this experience with me to my sessions. This personal memory helped me to attune to my client’s experience in a deep way. It also helped me to further realize my resiliency and its usefulness in treatment.

Conclusion

The similarities between the HIV/AIDS crisis and the COVID-19 pandemic are unsettling. History is repeating itself with devastating consequences and little evidence of progress. Current events have stirred up similar traumas experienced by gay men who lived through the HIV/AIDS crisis. Their anxieties about safety, nurturance, and acceptance were reignited by this global traumatic event. Marginalized groups are especially feeling the impact of the virus, and recognizing anew the great
disparities woven into the fabric of this country. Those with lesbian, bisexual, trans-
gender, and other intersecting identities are faced with their unique challenges
throughout this pandemic, and clinicians working with them need to be mindful of
the ghosts and demons that may remain.

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