

likely to make sexual adaptations to age, including more frequent celibacy than reported by gay male elders.

Coping mechanisms among gay males include willingness to validate sexuality as pleasurable without orgasm; an increased reliance on **pornography** as stimulant to release (an important factor in both gay and nongay populations, as all moralists and censors should be reminded), and an improved ability to use purchased sex safely.

At least until the possibly reduced income of retirement, seniority in our society generally brings rising income, and thus resources to purchase sexual gratification. But a particularly dangerous form of ageism may be found among gay hustlers. It is built into the social structure of the hustler, who reaches occupational obsolescence long before a hockey player, and is translated into disdain, exploitation, and sometimes violence directed at the older customer.

Another notable adaptation more typical of gay males than lesbians (but this is changing in recent years) is the elaboration of sexual foreplay, and reduced emphasis on genital contact and orgasm, through such means as sexual toys, bondage, uniforms, and scenarios. In most large urban gay communities, there is a marked difference in average age between the "twinkle" or "disco" gay crowds, and the "leather and denim" places. As beauty fades, older homosexuals may learn to continue attracting partners by conveying messages of sexual self-confidence and experience through leather, accessories, and body stance.

It is quite possible to be single and happy in heterosexual old age, but overall, satisfaction with life (and even life expectancy itself) is generally correlated with intimate and enduring partnership. Likewise, gay gerontology indicates that having an intimate partner (not necessarily a "lover" or even a gay person) in homosexual old age is a reliable predictor of general adjustment and satisfaction with life.

Sharing old age with a partner "doubles the joys and halves the sorrows."

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AIDS

Acquired Immunodeficiency Syndrome is a medical condition that produces a radical suppression of the human immune system, permitting the body to be ravaged by a variety of opportunistic diseases. It is believed to be caused by the Human Immunodeficiency Virus (HIV), which can exist in the body indefinitely before symptoms emerge. In advanced industrial countries and in Latin America, AIDS occurs mainly among male homosexuals and intravenous (IV) drug users; in Africa it is found primarily among heterosexuals.

The Emergence of an Epidemic.

The as-yet-unnamed syndrome first came to the attention of the medical community through a report released in June 1981 by the Centers for Disease Control, a Federal agency, concerning five California cases. Because the first cases studied were in homosexual men, the syndrome became associated with homosexuality itself. In fact one of the first suggestions for a name was GRID (Gay-Related Immunodeficiency). Although this was shortly changed to AIDS, a ceaseless flow of media reports about gay men affected by the disorder served to fix the connection in the public mind.

For the first few years the number of cases in the United States doubled annually, and about half as many of those already infected died. Not only was the disease spreading very quickly but it was

highly lethal. While it appears that the earlier idea that it is invariably fatal is mistaken, it is a very difficult disease for a patient to cope with, and even with the most determined and successful strategy no cure is effected—the disease is simply kept at bay. At first the American cases were largely confined to New York City and environs, the San Francisco Bay Area, greater Los Angeles, and Miami. Although AIDS subsequently was found in nearly every state, this pattern of concentration in these metropolises on the two coasts has continued. Foreign physicians found AIDS in Canada, Europe, and Latin America, though the incidences are generally lower than in the United States. (In most countries the American acronym has been used, but French-speaking nations prefer SIDA [Syndrome d'Immunodéficience Acquise]; SIDA is also the Spanish acronym.) By 1988 over 65,000 AIDS cases had appeared in the United States, 64% of the reported total world-wide. However, reliable figures for incidence in Africa are not available; they are said to be high in a number of countries of equatorial Africa.

Transmission and Symptomatology. AIDS cannot be transmitted by any form of casual contact, but must go from blood to blood or from semen to blood. Blood-to-blood transmission occurs when intravenous-drug users share narcotics needles, or occasionally through accidental needle-sticks among health-care givers. It may also occur that a surgeon will nick him or herself with a scalpel, which may cut through gloves. Sexual transmission occurs when a seminal discharge of an infected person passes into the bloodstream of another. The sexual contact that is most at risk is anal penetration; oral and vaginal contacts are unlikely to transmit AIDS unless there is a lesion in the affected part of one or both partners. If it is believed that infection may have occurred, tests can be performed for the presence of the HIV virus in the blood, though they are not absolutely reliable.

A few medical experts have expressed doubts that the HIV virus is the culprit, but they are in a great minority. If not a cause, HIV is at least a good indicator of exposure to whatever is the cause. There has also been discussion of a variety of potential "cofactors," but none has been convincingly isolated.

The majority of persons infected with HIV show no symptoms, and it remains uncertain how many will develop AIDS itself. The emergence of the condition is signaled by night sweats, loss of weight, and other signs of physical distress. In some cases a diagnosis of ARC (AIDS-Related Complex) is made; many of these patients will progress to full-blown AIDS. The patient will usually develop either Kaposi's sarcoma—a previously rare type of cancer producing numerous lesions on the outside or inside of the body—or pneumocystis carinii (PCP), a form of pneumonia that is devastating to the patient. PCP usually requires hospitalization with intensive care and the administering of a variety of drugs prescribed by the physician. However, many patients can return home after the first crisis has been met—if there is a home to return to.

Response. Members of the gay community have charged government agencies with inadequate response to the epidemic. An expression of genuine concern, these complaints are valid only in part. It was the first time in many years that advanced countries had to deal with the outbreak of a hitherto previously unknown disease, and the initial recognition of the problem could not have occurred immediately. Moreover, a few decades earlier, when prudery and censorship kept the whole issue of homosexuality from being discussed publicly at all, the official response would have been either helpless or schizophrenic, as the social locus of the epidemic would have been a taboo subject. Still, there is no doubt that bureaucratic red-tape, as well as jealousies among physicians and officials eager for

the glory of being identified with breakthroughs, have been a handicap. Again, because the disease was new and because there was no treatment, it inspired a whole set of amateur, politically motivated, at worst paranoid explanations of its etiology—and corresponding quack methods of treatment by special diets and medical regimes of the kind held out as a last resort to dying cancer patients. By contrast, the self-medication movement, which has placed possibly effective drugs in the hands of people with AIDS, bypassing government tests that can take years, may be a positive development. Patients abroad, where much of the research and testing was being done, had access to drugs that Americans did not. Here too dangers exist, but the situation has highlighted a serious dilemma of public policy.

Locally some communities handled the crisis better than others. Nonetheless, real progress was made in the middle years of the 1980s against a very cunning viral adversary. The gay press carried warnings of the lethal consequences of unsafe sex practices, and others were reached by leafletting and word of mouth. These campaigns had a noteworthy effect as measured by the decline in cases of all **sexually transmitted diseases**, including syphilis and gonorrhea, among gay men. The climate of the 1970s, characterized for some by a seemingly limitless horizon of sexual experimentation, yielded to a new sense of caution, and many sought long-term, essentially monogamous relationships.

Gay self-help groups specifically concerned with AIDS sprang up, involving many people who in the previous decade had turned a deaf ear to the call for movement work. By the end of the 1980s there were several hundred of these organizations in North America, and many others in Europe. Other groups were formed of people with AIDS (PWAs, the term preferred by those who have the condition). Gay and lesbian lawyers mobilized to meet a host of legal problems triggered by the

spread of the epidemic. This manifold response contrasted with the apathy of the IV-drug user community, which remained unorganized, without media of its own, and therefore almost entirely dependent on public health advocates and facilities.

Gay men and lesbians (the latter little affected by AIDS) rallied to apply pressure on politicians for more funding and to deal with some of the backlash that was developing. In the panic-laden years of the mid-1980s some religious and right-wing leaders obtained support in their calls for quarantine or drastic treatment of those who might be infected. Although these calls generally fell on deaf ears, the general public, which had previously been showing increasing tolerance of homosexuals as measured by opinion polls, now registered a moderate tendency to move in the other direction. Often insensitive reports on the nightly television news, supplemented by rumor and a flood of malicious AIDS jokes, served to spread dismay even among those who had formerly offered a modicum of support for gay rights. The publicity had the side effect of acquainting otherwise cloistered souls with some explicit realities of oral and anal sex. People even suspected of having AIDS found themselves harassed on the job and denied insurance coverage, while dentists and doctors became wary of treating persons with the disease. On the whole, however, the late 1980s showed a decline of these pressures as better information became available and gay organizations showed that they would not bow to hostile pressure.

Cultural Responses. Several plays, notably *As Is* (1985) by William Hoffman and *The Normal Heart* (1985) by Larry Kramer, an early passionate advocate of group action by the gay community to stop the disease, have been successfully presented in the United States and abroad. Fictional responses are more numerous and varied, ranging from the serio-comic fable *Tweeds* (1987) by Clayton R. Graham to the probing stories in *The Darker Proof*

[1988] by Adam Mars-Jones and Edmund White. The poet and novelist Paul Monette has written *Borrowed Time: An AIDS Memoir* (1988), an eloquent account of a decade of living with Paul Horowitz, who died in 1986. Other memoirs include a mother's story, *The Screaming Room* (1986) by Barbara Peabody, that of a wife, *Good-bye, I Love You* (1986) by Carol Lynn Pearson, and those of several persons with AIDS, including *Mortal Embrace: Living with AIDS* (1988) by the Frenchman Emmanuel Dreuilhe. In 1985 NBC Television presented a drama, *An Early Frost*, with Aidan Quinn, which offered a sensitive exploration of the emotional effects of the disease on a person with AIDS and his family. Bill Sherwood's independently made film *Parting Glances* (1986) focused on a relationship between two men, one of whom has AIDS. Several leading contemporary photographers, including Nicholas Nixon, Rosalind Solomon, and Brian Weil, have produced moving portraits of people with AIDS.

The Names Project Quilt began early in 1987 with a single cloth panel to commemorate one person who died of AIDS. In a little over a year the project grew to over 5000 panels, which were exhibited in a national tour. The colorful panels are rectangular and contain the name of the deceased which is painted on or applied. The victim's survivors who make the quilts often add other appliques of cloth, sequins, and the like to suggest favorite residences and avocations of the departed. The quilt, which takes up a long-established American folk tradition, constitutes a collective work of anonymous art. Not only has it provided a moving experience for visitors, it may serve as a salutary challenge to existing elitist notions of art itself.

None of this cultural activity can be construed as a "silver lining" that in any way compensates for the enormous suffering that AIDS has caused, but it gives evidence of a real effort to confront the problem rather than to hide it or to hide from it

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ALAN OF LILLE (CA. 1120-1203)

French theologian and poet. A prolific writer in Latin, Alan was a leading figure in the "Renaissance" of the twelfth century. His surviving works include disquisitions in practical and speculative theology; sermons; a preaching manual; a theological dictionary; a guide for confessors; an attack on heretics; a book of versified parables; and two substantial poetic allegories, *Anticlaudianus* and *The Complaint of Nature*.

In the last-named work Alan offered original variations on the Early Christian polemic against homosexual behavior as a sin against nature. These animadversions were prompted by the prevalence of sodomy among the clergy of his day, which Alan opposed. In a series of ingenious, if bizarre comparisons, Alan likened sexual inversion to grammatical barbarism. This allegory of grammatical "conjugation," licit or illicit, was to have many successors throughout the Middle Ages. In a more general sense, Alan is a link in a chain of