

Were We There to Talk about AIDS, or Not?¹

In January of 1990 I was shocked when the Korean immigrant and Harvard-educated molecular biologist I had recently begun dating said he had something to tell me: he was HIV-positive. The shock never really subsided, but Hyung Goo and I got married anyway, in June of 1991. We knew we wouldn't have long. These were still the plague years of the AIDS epidemic, with average time from diagnosis to death measured in months. Hyung Goo, who had tested positive for HIV five years earlier, was already a "long survivor." Fear of HIV and AIDS was intense, as was social stigma and discrimination against those living with HIV and AIDS, and against the gay men who were seen as primarily at risk for HIV and AIDS.

In the midst of this, and largely because of it, I entered psychotherapy in the summer of 1992. The six-year, 400-hour therapy that followed was in some sense all about AIDS, as had it not been for the medically and socially catastrophic nature of my husband's diagnosis I might never have sought therapy. In another sense it was hardly about AIDS at all. I announced to the therapist in the first session that I did not want to spend time talking about my mother and my childhood, and proceeded in subsequent sessions to glare at him in angry silence punctuated every so often by a remark about my mother or my childhood. So were we there to talk about AIDS, or not?

By the time that therapy concluded in the summer of 1998, a lot had changed. Hyung Goo's health had gradually declined as one by one he made his way through the parade of acronyms associated with AIDS: KS, CMV, PCP, MAI. He died in September of 1995. By that time I had mostly moved from regarding my therapist as an enemy to recognizing him as an ally. We had begun meeting twice a week, and continued to do so for two years before stepping back to once a week for a final year. And AIDS itself was changing. New drug regimens had become available; death rates were declining precipitously. It was all too late for Hyung Goo, whose death, it turned out, had come almost precisely at the peak of the epidemic.

Almost twenty years later, even more has changed. HIV/AIDS has become a manageable chronic condition as strongly related to factors of race and class as to specific sexual or drug-related behaviors. Sexuality in general is increasingly understood as existing across multiple spectra rather than in rigidly binary terms, and LGBT identities are broadly affirmed, and contested, both socially and legally. Among those grappling with these rapid intellectual, social and political changes are religious organizations and religiously-oriented educational institutions like the one at which I teach. And I have found my own attitudes and engagement shifting in ways that are deeply informed by my experiences with AIDS and in psychotherapy.

I

¹ This essay is offered in loving memory of Hyung Goo Kim and with enduring gratitude to Dan Grandstaff, Martha Zimmerman, John and Patricia Bartlett, and all the staff and patients of the Duke University Infectious Diseases Clinic from 1991 to 1995 and beyond.

During my marriage to Hyung Goo I was a doctoral student in theology and ethics at Duke University. Hyung Goo worked in a laboratory associated with the university and received his medical care at the Infectious Diseases Clinic at Duke University Medical Center. His case manager was one of the clinic's two social workers. We were all so young. I was 28 when Hyung Goo told me of his HIV status, and 29 when I married him. Hyung Goo was four years older. Our professional caregivers—doctors, therapists, social workers, so many others—were in their thirties and forties. We look back, those of us who are still living, on a vanished world, the world of AIDS in the eighties and early nineties.

In the months and years before AIDS became a part of my life, Ryan White had been much in the news. White was a teenage hemophiliac who had been infected with HIV through tainted blood products, and who was a target of all of the AIDS-related hostility then current: barred from school, despite it already being well-established that AIDS could not be spread by casual contact; accused of being gay, since AIDS was a “gay disease”; told that he must have done something very bad to deserve this, since AIDS was an infallible indication of God's judgment; hounded out of town—by means of a gunshot through the window—by a community bent on making itself an AIDS-free zone.

I had heard about all this, and had been appalled. I didn't think AIDS was God's judgment on anybody, and I had what I now realize was an unusually accurate understanding of how HIV could and could not be transmitted. I had resolved that if I ever met anyone who had AIDS, I would not rush screaming from the room. But I didn't think it would ever happen. I didn't know any hemophiliacs, or any gay men, or any IV drug users, or at least I thought I didn't. In retrospect, I realize I knew quite a few gay men. I was even related to some of them. But everybody was more or less in the closet, and it was easy for the rest of us not to notice, or to pretend not to notice.

Then Hyung Goo told me he was HIV-positive. He had mentioned earlier that while he was in college he had been unsure of his “identity.” It turned out that the identity in question had been his sexual identity, and that the questioning had begun with anonymous and coercive sexual encounters in the Harvard men's rooms. A great deal of sexual activity had followed upon those initial encounters, some of it with men, some with women, some of it consensual, some of it not. There were only a few truly high-risk sexual encounters. Of the first of these, Hyung Goo said, softly, “I was raped.” I never knew most of the details. “I'll answer any question you ask,” Hyung Goo told me. “But I won't volunteer.”

Why did I stay with him? There are probably a million answers to that question, none of them adequate. He was smart, he was funny, he was handsome. He was a gifted musician. His deeply held Christian piety was similar to my own. He made whoever he was listening to feel like the most important person in the world. Was any of this enough to override the fact that he had the very worst thing in the world wrong with him, a stigmatized and terrible disease, of which he would surely die, which he could give to me, of which I could therefore die? Of course not. I look back from the vantage point of middle age with a mixture of unease, awe, and deepening understanding: unease, at the perils of the journey upon which we embarked together; awe, at our ability to choose one another even under

those circumstances; and a growing appreciation for some of the factors that motivated that choice and for the fruit that it has continued to bear in my life.

So there we were, together, in the world of AIDS. It was a world permeated by stunned disbelief: how could there be an infectious disease for which there was no ready cure? Hadn't that era—of smallpox, polio, syphilis, tuberculosis—ended with the advent of antibiotics and vaccines? The gay men at the center of the epidemic responded to this unimaginable calamity with a paroxysm of collective grief and a determination to care for one another no matter what. Those beyond the visible scope of the epidemic responded with howls of scapegoating and finger-pointing, typically couched in religious terms: AIDS was God's judgment on the sexually immoral, who therefore deserved what they got.

That collective cultural rage and shame was expressed architecturally at Duke University Medical Center, which actually had four infectious diseases (ID) clinics at that time: a pediatric clinic (for childhood diseases), a travel clinic (for vaccines for things like yellow fever and typhoid), a clinic with the then-standard ID focus on pneumonia and wound infections, and a recently-established ID clinic for the patients and the disease that no one wanted anything to do with: gay men and IV drug users with HIV/AIDS, many of them uninsured or underinsured, many without supportive family or friends. That ID clinic, run in its early years by a single physician, was in the basement of the hospital, behind a door without a window.

Behind that door was a kind of alternative universe, where the staff dressed in drag for Halloween, and where the most anticipated guest at the annual clinic holiday party was a real drag queen, Mother Christmas. Gay men and prostitutes sat together in the waiting room chatting about clothes while the phlebotomist asked her signature question of IV drug users whose veins had all collapsed: "Now honey, where did you last shoot up and it worked?" When the medical director of the clinic wasn't seeing patients himself he was on the phone trying to arrange consults with surgery, radiology, infectious disease. No one would talk to him. More than one of these non-conversations ended with the doctor ripping the phone out of the wall in frustration and rage.

The lovers of people with HIV and AIDS had Mother Christmas as their patron saint. The haters had Jesse Helms. In 1988 the five-term senator from North Carolina had opposed federal legislation funding AIDS research and treatment on the grounds that "there is not one single case of AIDS in this country that cannot be traced in origin to sodomy." Even if the premise (that AIDS was somehow intrinsically related to homosexuality) had been true (which it wasn't), the conclusion (that resources should therefore be withheld from persons with AIDS) did not necessarily follow. But the reality was that Helms had more acolytes than Mother Christmas, and there was precious little territory in between.

So I went to therapy. It wasn't as if I had anyone else to talk to. When Hyung Goo first disclosed his HIV status to me I told a few friends. The response was swift and negative: leave this man, and leave him now. I stopped telling people. When we made our decision to marry, we considered whether we should tell our families, and decided against it: too risky. Once married, we clamped our mouths shut tight and settled into a double life. In public, we were a nice young couple with all of the normal activities and involvements of any young couple: work, school, church, friends. In private, our routines and preoccupations revolved around HIV and AIDS: Hyung Goo's falling CD4 cell counts (a measure of immune system strength), his antiretroviral medications, other treatments meant to ward off opportunistic infections, all of it concealed under a cloak of secrecy while we waited for the apocalypse.

By a year after our marriage I was wild with anxiety. Hyung Goo met weekly for psychotherapy with his ID clinic case manager, Martha, and urged me to seek therapy as well. I started at the Psychiatry Outpatient Clinic at Duke, where I saw a social work intern for a few weeks and was then referred to a therapist, Dan, in the community. Dan was also a social worker, a former pastor and recent graduate of the MSW program at UNC Chapel Hill who was now in private practice. I was extraordinarily lucky in being referred to him, for at least two reasons.

The first was his willingness not to pathologize my choice of spouse. Years after the termination of our work together I asked Dan what he had initially made of the fact that I had deliberately married a man with HIV. "I didn't know what to make of it," he said. I had presented my decision as a matter of my having fallen in love with Hyung Goo. I hadn't seemed particularly defensive about it. Dan felt sure there must have been unconscious elements to my motivation, but as this was not something I could change, and I seemed untroubled by it, he didn't see it as anything that needed to be addressed in therapy.

This contained countertransferential puzzlement stands in sharp contrast to other possible responses. Hyung Goo had also first sought therapy at the Duke Psychiatry Outpatient Clinic, where his intake interview was conducted by a resident in psychiatry. The resident reported the substance of this interview to the senior psychiatrist who was his supervisor, including details of Hyung Goo's complex mental health and sexual history. The senior psychiatrist went straight to Martha, hyperventilating about "these people" (Hyung Goo and me)—we were crazy, irresponsible; he would not allow Hyung Goo to be seen in therapy by anyone in psychiatry, and advised Martha against taking Hyung Goo into treatment either. What could she possibly hope to accomplish? Hyung Goo was just going to die. Martha rolled her eyes and took Hyung Goo into treatment.

Neither Hyung Goo nor I had any idea of this at the time. All Hyung Goo knew was that Martha had offered to meet weekly with him for therapy, and that he had taken her up on this. And all I knew was that every time I saw Dan, his gentle inquiry was the same: "What's going on for you today?" Which is a second reason I was extraordinarily lucky to have ended up with Dan: his willingness to allow the therapy to unfold at its own pace, and to be mostly about things other than AIDS. My consciously held motivation for coming to therapy was a wish for help in managing the stresses and feelings and practical challenges

associated with Hyung Goo's illness. I did need this, but I mostly got it from Martha, who met periodically with Hyung Goo and me together, and occasionally with me individually, as circumstances warranted.

With Dan, I needed and got something much less obviously (to me at the time) related to the daily challenges of my life, and much more deeply rooted in the circumstances of my upbringing. I had grown up in a family where vulnerability was never safe. As a result I both longed for and was terrified of intimacy and emotional experience more generally. I experienced Dan's non-directive therapeutic stance as both passive and predatory, and defended against the terror and shame I felt in his presence by maintaining to myself and to anyone who would listen that I hated him—all the while never missing an appointment, never being late, and always paying my bill. Many years later I read Nancy McWilliams's (2006) paper on schizoid dynamics (a pattern of relating in which issues of closeness and distance are paramount), which explained a lot. At the time, I just felt crazy.

Dan and I did not talk much about AIDS, and when we did, the conversation wasn't much different from what it might have been, had Hyung Goo suffered from any other serious illness—that is, we talked about how his illness was affecting our life together, rather than about the illness itself. In one sense, we didn't need to talk about AIDS. For that I had Martha, who knew everything, and who was always just a phone call away. From another perspective, AIDS got pushed aside as the dynamics of my relationship with Dan took center stage. I could work in a straightforward, present-reality-oriented way with Martha, toward whom I directed all of my positive and less primitive transference feelings; with Dan, I plunged down a rabbit hole of regressive transference rage and terror and longing every time I entered his office. AIDS was relevant to this only in the most peripheral sense.

AIDS may also simply have been too terrifying for me to have tolerated any more focus on it than was required by the circumstances. The four years of my marriage to Hyung Goo were the four worst years of the epidemic. The initial promise of the antiretroviral medication AZT had not been borne out; treatments for opportunistic infections inevitably fell short; death rates were rising inexorably. Talking about AIDS itself would have been like staring at the sun. Instead, I kept the focus on what I cared about—my relationship with Hyung Goo—and whatever therapeutic work it turned out I had to do in order to make that relationship as intimate and satisfying as possible. Given my limitations and challenges, that provided Dan and me with more than enough material to keep us occupied for years.

AIDS did, however, form the premise and container of that entire therapeutic experience. I cannot imagine circumstances under which I would have entered or remained in therapy, had it not been for the extremity of Hyung Goo's and my situation and the impossibility of accessing adequate support in any other way. "I just want to feel better," I said to Dan in my initial interview. Within weeks I did in fact feel better—which mystified me, as it didn't seem like Dan was doing anything helpful and I felt so terrible while I was there. I was poised to flee when Hyung Goo was diagnosed with his first AIDS-defining opportunistic infection. We decided to disclose his diagnoses (of Kaposi's sarcoma, and thus also of AIDS) to our families (a process that Martha coached us through), and the stress of it all was so

overwhelming that it didn't seem like a good idea to stop seeing Dan, even if I had no idea why or how therapy was benefitting me.

And so it went for the first couple of years at least. Mark Blechner (1997), writing about his psychotherapeutic work with patients with HIV/AIDS, notes that feeling the pressure of time and mortality can motivate patients to seek and to tolerate a more intensive and faster-paced treatment than they might otherwise have done. This both was and wasn't true of me. As with Blechner's HIV-positive patients, AIDS supplied the pressure of time and mortality. If Hyung Goo and I were going to be happy together (and we were, deliriously so), it had to be now. If psychotherapy could help me access the resources I needed in order to see him through, then I was all in.

Given my long-standing reliance on rigidly intellectualizing defenses, however, any therapy at all was more than I would otherwise have tolerated. Psychotherapy was so scary, and so painful; and the clearer it became how much I needed it—like when I began to dream, in vivid color, about seals on broccoli lawns and hedges covered with giant purple flowers like magnolias—the more overwhelmed I felt, and the more obvious it was to Dan that the only hope of keeping me in treatment was to let go of any ideas about speed and intensity and allow the process to unfold at its own pace, however slow that might be.

I had been seeing Dan for three years when Hyung Goo died, after months of critical illness capped by two weeks of hospitalization for an AIDS-related pneumonia. Dan was at the hospital every other day during those last two weeks. Martha was there at the same time on one of those occasions, and we found an empty conference room and talked about Hyung Goo's prognosis. It was the only time I ever met with Dan and Martha together.

The day after Hyung Goo died, Dan visited me at home. He came to the funeral. And then we resumed our in-office psychotherapy, at the twice-weekly frequency that we had moved to a few months previously. I was consciously aware by this time that Dan was for me rather than against me. My profound ambivalence toward him and toward the therapeutic process persisted, as I defended against my deepening attachment to him and the shameful sense of exposure I felt in his presence. By the time I terminated therapy, three years later, I still felt queasy. I also felt more human than ever before.

III

Change was in the wind when Hyung Goo died, although no one knew it yet. The month that Hyung Goo died, the clinic experienced the most patient deaths ever in a single month. The next month, there were more. The month after that, death rates began to drop. Nationwide, the Center for Disease Control and Prevention recorded almost 42,000 deaths from HIV/AIDS in 1995, but only 31,000 in 1996, and 16,000 the year after that. What made the difference? Protease inhibitors, a new class of medications that marked, if not the beginning of the end of AIDS, then at least the end of the beginning. HIV infection (in the United States, at least) was becoming an illness like any other: a chronic condition compatible with many years of high-quality survival.

As AIDS death rates fell, the fortunes of the clinic rose, quite literally. Within a few years of the introduction of protease inhibitors Duke University Hospital moved the clinic from its basement location to a newly renovated space upstairs. The old clinic had had no windows (and no backup generator—when the power went out, staff and patients walked around with flashlights). The new clinic was all glass and windows. At the same time the hospital began consolidating its ID clinics. The clinic in the basement had been for HIV/AIDS alone. Once the clinic was upstairs, other physicians and patients began moving in: first the travel clinic; then wound infections; then the head of infection control.

The clinic's clientele appreciated the lessening of stigma and increase in privacy that came with sharing their space with other patients. Anyone who entered the door of the basement clinic could be presumed to have HIV/AIDS. At the new clinic, no one could know why any individual patient was there. But the intimacy and camaraderie of the old clinic were gone. So were the magazines. Downstairs, the waiting room had been stocked with issues of POZ (tagline "Health, Life, and HIV"). Upstairs, that wouldn't do, not as far as the clinic's other tenants, and the hospital administration, were concerned. Out went POZ, to be replaced by titles on subjects acceptable to corporate medicine: money, sports, guns.

The demographics of AIDS were changing, too. When the clinic first opened, most of its patients were gay and bisexual men of relatively high socioeconomic and educational levels. By the late nineties the common theme was no longer homosexuality but poverty. The northern and urban locations where AIDS first emerged had made money and education available for treatment and prevention. In the rural Southeast, the reverse was true. In 1996 the North Carolina state legislature passed a law requiring public schools to promote abstinence until marriage. The result was twofold: less sex education, and rising rates of HIV infection in young people, gay and straight, male and female, African American and Hispanic.

Given the way the AIDS crisis had galvanized the gay community, perhaps it was inevitable that as the cultural currents around AIDS shifted, so did the cultural currents around minority sexualities. The stereotype of the effeminately gay man had always been just that: a stereotype. Even the clinic's drag queens dressed in khakis and button-downs most of the time, and the vast majority of gay men were not identifiable as such by either clothing or mannerism. But well into the nineties institutions like marriage and the church were seen by many participants in gay culture as oppressive or irrelevant or both. Gay-friendly churches (like Metropolitan Community Church) were urban aberrations, and same-sex marriage was virtually unimaginable and mostly not even desired. Suburban conformity was something to be escaped, not something to be sought.

But as the death-grip of AIDS loosened and the burden of disease became more broadly distributed, perhaps there was less reason for the gay community to prioritize building internal cohesiveness over against a majority culture that didn't care whether gay people lived or died, and more reason to see itself, at least potentially, as part of that mainstream culture, or at least as having a right to the opportunities and protections accessible to members of mainstream culture. In any event, the aspirations of gay men and lesbians did grow, to include such things as legal marriage, health insurance benefits, non-

discrimination legislation, immigration opportunities, and full inclusion in religious communities.

At the same time both professional and popular understandings of sexuality itself began to be more nuanced and less bound to the rigidly binary categories that had dominated the conversation for years. Well into the nineties the publicly available options were male or female, homosexual or heterosexual, with the supposedly rare person who identified as bisexual regarded as a kind of exotic hybrid, and the supposedly equally rare intersex infant hastily assigned a gender at birth and then surgically modified to suit parents' and physicians' notions of what a boy's or a girl's body should be.

Only twenty years later, the term "homosexual" has a faintly archaic ring to it. The adjective "gay," at least when preceding the word "community," has been succeeded by the acronym LGBT, or sometimes the longer and more inclusive and nuanced LGBTQIA; and sexuality itself is understood not as a matter of a couple of sets of mutually-exclusive categories, but rather as a complexly intertwined series of continua including biological sex, gender identity, gender expression, and sexual orientation, all of them influenced by genetic endowment, prenatal development, and life experience.

Not everyone was or is happy about all this. The so-called religious right was already up in arms about homosexuality in the seventies and eighties, and became more strident once AIDS entered the scene. Rather than responding to the AIDS crisis as (for instance) an opportunity to care for suffering fellow humans in Jesus' name, in the summer of 1994 the evangelical Christian group Focus on the Family took out full-page ads in newspapers nationwide in which they decried condom usage as "potentially suicidal" and represented "abstinence before marriage, then marriage and mutual fidelity for life to an uninfected partner" as "the only safe way to remain healthy in the midst of a sexual revolution."

Twenty years later, toward the end of a series of court cases that would eventually result in a United States Supreme Court decision affirming the constitutionality of the marriage of same-sex couples, and facing the more immediate prospect of an executive order extending non-discrimination protections to members of sexual minorities employed by federal contractors, the leaders of a number of religious organizations signed letters to the president of the United States, requesting exemption from any such order on the grounds that their religion required them to discriminate against LGBT individuals. The president of the Christian college at which I am employed signed one such letter.

IV

During the years of my marriage to Hyung Goo, I lived in uneasy tension between the Christian faith community and the world of AIDS and HIV. The loudest public voices coming from the church proclaimed that AIDS was something that happened to other people, bad people, who deserved what they got. The loudest public voices coming from the world of AIDS were those of activists who strongly identified with the gay community, and who had a hard time imagining why any decent person would want anything to do with such a

hateful bunch of hypocrites. As my first clinical supervisor put it many years later: “Christians follow Jesus, right? And Jesus was all about love. And they hate gay people?”

Mostly I just kept my head down. I didn’t talk about AIDS at church, where because of our policy of secrecy no one knew about Hyung Goo’s HIV status anyway. I didn’t talk about faith at the ID clinic, where there were always plenty of other things to worry about. And I didn’t talk about homosexuality anywhere. I was theologically traditional enough to have conventional opinions about Christian sexual morality, which wasn’t really allowed in the world of AIDS. I attended a support group once, for family members of persons with AIDS. Every other person there was the mother of a gay son, and the entire conversation was about homosexuality and how it wasn’t a choice, like we had to get that clear before we could talk about AIDS. But I didn’t want to talk about homosexuality. I only wanted to talk about AIDS. I never went back.

I didn’t talk about homosexuality with Dan, either. My sense was that Dan was much more progressive than I was on matters related to sexuality; and indeed he would almost have had to be in order to work non-reactively with a person in my situation—a fact that I managed quite successfully to keep out of awareness at the time. What I was aware of was a disinclination to “have that argument” with Dan. Given the intense ambivalence of my feelings for Dan—it was as if every session I climbed into a boxing ring and tried to kill him, only to return precisely on time the next week to try again—I am now inclined to frame this as an effort to hold Dan close by steering away from a highly-charged subject that I was sure he and I disagreed about.

The subject of sexuality could not be avoided at the Durham County Health Department, where I went periodically for anonymous HIV testing, the only genuinely secure option available at the time. (In so-called “confidential” testing, if you tested positive your name was sent to the state and entered into a computer database, which didn’t strike me as all that confidential.) The HIV counselors at the health department, upon hearing that I had had sex only with my husband, and never “unsafely,” would respond with skepticism or outright disbelief. “Well, try to keep the numbers down,” one of them said to me. I would come away from these encounters feeling repelled and disoriented. What on earth was wrong with these people?

Hyung Goo was diagnosed with Kaposi’s sarcoma, and thus with AIDS, about a year and a half into our marriage. We decided to tell our families at that point, reasoning that the potential for reconciliation and growth was greater now than if we waited until he was on his deathbed. Over the next couple of years we disclosed his diagnosis to expanding circles of friends. In the spring of 1995 Hyung Goo had an almost fatal reaction to a new medication. We decided it was time for everyone to know, and asked our pastor to announce from the pulpit, as a congregational concern, that Hyung Goo was in the hospital with kidney failure as a complication of AIDS. The response from the congregation (someone told me later) was an audible gasp.

At the time, all this disclosure seemed mostly like the path of least resistance. The sicker Hyung Goo got, the more trouble it was to make up plausible cover stories, and the easier it

was just to tell the truth. Decades later I can see our truthfulness more clearly as the political act that it was. What was intentionally political at the time was our decision not to disclose Hyung Goo's risk factor for HIV infection. Hyung Goo did feel some shame about this, which influenced our decision. Mostly, though, we felt that this was nobody's business but ours, and that any disclosure of risk factors played into an existing hierarchy of blame in which HIV-positive IV drug users were most guilty, infants and hemophiliacs were innocent, and victims of various sexual modes of transmission were somewhere in between. We wanted no part of this, and intentionally declined to disclose any information that might invite anyone to rank Hyung Goo as more or less guilty than anyone else.

Within a few years after Hyung Goo's death I had remarried, finished my degree, and moved to another state, where my new husband and I had accepted faculty positions in the same department at the same school. In what ways was I still connected to the world of AIDS? It wasn't clear. I did continue with my practice of disclosure, partly to provide some sense of continuity for myself, and partly as a deliberately political act. I knew that my students' lives had undoubtedly been touched by AIDS in one way or another, and that many of them might not feel free to be truthful about that. By alluding to my own story, I gave them permission to tell their own stories. "I am married to the other Dr Peterson," I would say to each new class of students. "I also had a first husband, who died of AIDS in 1995, at the peak of the AIDS epidemic." One day a student asked to meet with me. It turned out her father had died of AIDS when she was a small child. She still sends me Christmas cards.

Once in a while I had occasion to speak publicly out of my experience with AIDS. In December of 2006 I was invited to give a talk at my institution on World AIDS Day. After the lecture I encountered a faculty colleague in the copy room. "Your husband worked in the medical field, didn't he?" he said. "Was he infected through an accident in the lab?" It had been so long since I had even thought about Hyung Goo's risk factor, let alone encountered anyone fishing for information, that I was caught off guard and said the first thing that came to mind, which was the truth: "No; it was sex with other men." My colleague blanched and backed slowly out of the copy room. It was years before he met my eye again. My own feelings were a reversed echo of that long-ago experience at the Durham County Health Department: what on earth is wrong with you?

In 2009 I went back to school to get a master's degree in marriage and family therapy. I did my internship in integrated behavioral health at a federally qualified health care center in Philadelphia, where the work done by the behavioral health consultants was more than a little reminiscent of the work that Martha had done with me and Hyung Goo and countless others at the Duke University Infectious Diseases Clinic. One day that spring (by now it was 2012) I found myself with a student in tow, knocking on the door of an exam room and entering to meet my next patient, known to me to that point only by his name and date of birth.

The patient, it turned out, was a flamboyantly gay man with a long history of polysubstance abuse and a range of other health issues including infection with HIV. He and I were quickly absorbed in conversation about his concerns and his goals for his health. Eventually the

provider arrived and the consult was over. I left the room with my student, whose presence I had more or less forgotten about in my focus on the patient. “Well, that was interesting,” I remarked. “It certainly was,” the student agreed, fervently. Something in her tone of voice made me realize: she had been a little startled by this patient. Her reaction shed a sudden light upon my own: I had responded to this patient as if he were an old friend.

Since when did I feel this sense of deep kinship with flamboyantly gay HIV-positive men? Since my days at the ID clinic, that’s when—except that when I was there, I hadn’t felt that kinship. I had noticed the radical acceptance that the clinic practiced toward all of its patients, but I had never recognized myself as among the recipients of that radical acceptance. I hadn’t thought I needed it, not in the sense that the clinic’s patients did. I didn’t have AIDS; I wasn’t gay; I wasn’t “one of them.” Except that I was one of them: a fellow human being who needed unconditional welcome just as much as the next person, and who was just as fundamentally changed by that acceptance as anyone else. What was that connection I felt with my HIV-positive patient? It was the love of the ID clinic, come back to envelop us both.

In the summer of 2014 the president of my institution signed that letter requesting exemption from federal non-discrimination legislation as this might apply to LGBT individuals. Some community members applauded; others were appalled. From the ensuing furor came a two-year long process including dozens of community-wide events: an initial series related to the detailed complexity of human sexuality itself, another series oriented toward ethical questions, and a final series having to do with institutional policy. I went to them all.

As I did so, I noticed something I found weirdly, and increasingly, unsettling: AIDS was never mentioned. Only twenty years earlier, homosexuality (the then-current term) and AIDS had been so intertwined in the cultural consciousness that it was impossible for anyone to mention one without mentioning the other. Now it was possible to put large groups of mostly white evangelicals in a room together and talk about LGBT issues for hours upon end without having the subject of AIDS come up. The underlying dynamic, though, was all too familiar: on the part of some, a wish to condemn and extrude a despised minority defined in sexual terms, and on the part of others, a wish to treat everyone as an equally valued member of the human race.

My decades-long wish to advocate by word and example for persons with AIDS while mostly sidestepping issues related to sexuality began to appear in a new light, as less a solution than a problem. I had imagined that if I focused my attention on AIDS, I could distance myself from Jesse Helms without quite having to throw in my lot with Mother Christmas. But I had been loved through AIDS by people who saw no difference between me and Mother Christmas. It was time, I realized, to honor them and myself by letting go of the notion that LGBT people were not my people, and instead to step forward as an ally, as someone who listens first and foremost, and who makes every effort to do so with respect and gentleness and an honest regard for the value and the integrity of the other, whoever that other might be.

One of the last events of my institution's human sexuality process was a forum for faculty on the subject of institutional policy, specifically the theological implications of removing or retaining two anti-gay words in the behavioral covenant governing faculty conduct. I was one of a half-dozen theologians invited to participate in a panel discussion, and one of only two to accept. A few days before the event the other panelist unearthed and forwarded to me and the organizers another sexuality-related policy, one that none of us had hitherto realized existed, that was explicitly and elaborately anti-gay, going well beyond the document we were aware of in dictating what faculty were and were not allowed not only to do but to think.

What was the history of this document? A few questions of a high-ranking retired faculty member and we had answers, and a timeline: it had been gestated from about 1986 to 1995, and had been put into effect in 1996. No one else in the email thread grasped the significance of those dates, but I did: they were identical with the rise of the AIDS epidemic. I could feel myself turning white with rage: while gay men were dying in the tens of thousands, a division of my institution was issuing prim statements about "rampant moral relativism" and condemning "homosexual forms of sexual intimacy," and congratulating itself on having thereby done its Christian duty.

I was already stressed almost out of my mind. There was serious illness in my home. At school I was well known as the most left-leaning theologian around, and all of the similarly left-leaning non-theologians were counting on me to make their case at this event (which I knew because they kept stopping me in the hallway and asking, "Are you ready?"). And now this. I had a therapist whom I had been seeing for several years, but in that moment it felt like there was only one person who could contain my fury. I emailed Dan. He emailed back. I pulled myself together and prepared my remarks. I had a lot to say, and when the day and time arrived, I said it. After the event, the only openly gay man present followed me out of the building, threw himself into my arms and burst into tears.

V

Were Dan and I there to talk about AIDS, all those many years ago? No, we weren't; not at the time. We were there to talk about me, to replay the dynamics of my early relationships and to explore what I wanted and whether I could tolerate getting it. Dan's eventual hypothesis about my decision to marry Hyung Goo was that the combination of Hyung Goo's personality and ill health had provided me with a solution to the problem of intimacy: his health condition required that I push through my terror to seek intimacy now, while there was still time, while his very private nature guaranteed I wouldn't get more than I bargained for.

Decades later, this makes perfect sense to me. But I could never have entered into the transformative—if bounded and time-limited—intimacy that I found with Hyung Goo without the therapeutic work I did with Dan. And I cannot imagine that I would either have entered or have stayed with therapy, had Hyung Goo been sick with anything other than AIDS. What else could have had this effect? Any other illness or difficult circumstance would have lent itself to standard sorts of coping, which for me would have meant clinging

to the inadequate but familiar defenses I had been relying upon all my life. Only AIDS was so disintegratively terrible, so stigmatized, so certain to end in catastrophe, so far outside the realm of anything even potentially manageable, that therapy seemed simply inescapable. It was a useful fiction. I was not, in fact, being held in therapy against my will; but the idea that I was served well as a defense against the feelings of neediness and desire that had actually brought me to therapy and were keeping me there.

By the time I ended my therapy with Dan, I knew I owed him my life. Neither of us had any idea that our work together had in a real sense only just begun. Part of that post-therapeutic process has involved the gradual and eventually dramatic changes in my thoughts and feelings and engagement around issues related to AIDS and human sexuality. Jonathan Shedler (2010) has amply and elegantly documented the potential for and reality of therapeutic growth long after the termination of analytically-oriented psychotherapies. My experience is in that sense not that unusual. I still feel a sense of awe as I look back to that long-ago therapy with Dan, and trace ways in which our work together continues to bear fruit. I am awed as well as I reflect on the moral courage and compassion of the staff of the infectious diseases clinic in the eighties and nineties and beyond. I will always be in their debt.

References

- Blechner, M. J. (1997). Psychodynamic Approaches to AIDS and HIV. In M. J. Blechner, Ed., *Hope and Mortality: Psychodynamic Approaches to AIDS and HIV*, (pp. 3-62). Hillsdale, NJ: The Analytic Press.
- McWilliams, N. (2006). Some thoughts about schizoid dynamics. *Psychoanalytic Review*, 93(1), 1-24. DOI: 10.1521/prev.2006.93.1.1
- Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, 65(2), 98-109. DOI: 10.1037/a0018378