SEX, AIDS, SOCIAL WORK AND ME

The narrative tells of my career-long effort to encourage and facilitate professional helpers — especially social workers — to deal directly and comfortably with sexual concerns. It describes and explains my experiences seeking to infuse content on sexuality, sexual oppression, HIV and AIDS into social work education and practice

by Harvey L. Gochros

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Beginning: Teaching sexuality

One advantage of being a social worker for more than forty years is the opportunity to view the slow discernable ebb and flow of social values and perspectives that dramatically impact our work and clients' lives. Such observations belie the assumption that social values always change for the better. They don't, but they do change. This has been especially apparent in the convoluted evolution of society's sexual attitudes as well as in my social work practice.

In the early 1960s my work focused on problems related to sexuality. I have always been fascinated by human sexual behavior. It is primitive, animalistic and physical, yet in its diverse manifestations greatly influenced by complex cultural codes. Like most people, I kept my interest to myself — it was improper, even while working on my MSW, to discuss the various manifestations of this fascinating taboo subject. In those days, sexuality was neither discussed in social work programs, nor in the larger community.

I finally got a chance to bring my sexual curiosity to work when I became chief of psychiatric social work in a midwestern medical school, circa mid 1960s I was assigned the task of "humanizing" medical students on their psychiatry rotation by teaching about the impact of family, work, and environment on behavior and mental status. Part of the assignment was to teach medical students how to interview for a social history.

The students easily discussed medical history, family history, and work history but many of them panicked when their interview outline turned to the patient's sexual history. After a few months of listening to their taped interviews, it was easy to discern when the medical student came to the topic of sex in their social history outline. There would be a noticeable pause, and then a sudden audible elevation of both pitch and speed as they rushed through obligatory questions about masturbation and homosexual behavior (often asked in the same question!) Their patients obviously picked up their interrogators' anxiety for they quickly denied any such sexual quirks.

Here, at last, was an opportunity to give voice to my interest in human sexual problems. In discussion with the psychiatric teaching staff I brought up the obvious void in the medical students' training, noting that there wasn't a single lecture on common sexual concerns in the medical curriculum. The psychiatric staff hinted at their own discomfort with the topic by acknowledging the void, and suggesting that this delicate subject be best handled by a social worker.

Their reaction — and the sexual vacuum in the students' training — challenged my earlier belief that if a client had a sexual problem it should be brought to their worldly-wise physician.

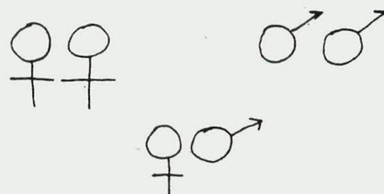
So I initiated what became a career-long effort to encourage and facilitate professional helpers — especially social workers, who were no better prepared in their education then medical students, to deal directly and comfortably with sexual concerns.

A Life Long Career

A couple of years after initiating a seminar on sexuality for the medical students, I was invited to join the faculty of the same university's school of social work, teaching casework and group work.

In discussions with the school's dean I mentioned my interest in teaching a course for social work students with the content similar to what I had been teaching the medical students. The dean expressed discomfort, noting that we were in the middle of the "bible belt." I defended the course by pointing out that in his classic *Sexual Behavior of the Human Male*, Kinsey stated that social workers were among the few professions that treated sexual problems. The Dean relented with the condition that the word "sex" not appear in the course title. He suggested I call my course "Family Relationships." I argued that many of the sex-related concerns that came to the social worker's attention were not experienced in the context of families. He replied that he didn't care what I taught in the course as long as I kept sex out of the title!

There were scary moments teaching sex in the late 60's. I had been convinced by fellow sex educators (not social workers) that the use of sexually explicit films would enhance my teaching effectiveness. It is one thing to talk abstractly about attitudes towards coitus, oral sex, masturbation and homosexuality. It's quite another thing to watch real people doing such things — on a movie screen in front of you.



While I agreed philosophically with this visual approach to the sex education of professionals, I was unsure how the students, faculty and administration would receive this experience — I was still teaching in a state school in the middle of the "bible belt." I even had a minister's and rabbi's wife in the class! When I sought my dean's support, he said he believed in academic freedom, "but be careful, you're on your own." My pedagogical convictions won out. When the day came to show the film, I again announced, with quivering voice, the explicit nature of the film's content. As soon as I turned on the projector, the minister's and the rabbi's wife rose in unison. I panicked — this was the end of my career. But no, they simply got up to move to seats with a better viewing angle. That was the last time I worried about community reactions to dealing honestly and directly with sexual issues. It was also my first lesson that both sexually open and sexually oppressed people can be found in any region or population.

It was interesting to observe faculty's reactions to the course's popularity. Many thought it frivolous and not worthy of a place in the school's curriculum. This was the 1960's when educators believed that the sole emphasis in social work and social work education should be overcoming racism and poverty. Sex was okay for Woodstock types, but there were far more urgent areas for the social work curriculum.

I felt then as I do now that sexual matters can cause as much pain for many people, rich or poor, young or old, black or white — as poverty, racism and sexism. Indeed, sexual oppression (a term I later developed as a focus for the course) intimately connects with racism, classism, sexism, looksism, ageism, etc.

It was during this period that I decided to articulate a social work perspective on sexual matters. This was the era of Masters and Johnson's emergence. I was concerned that professional sexual interests were narrowly defined and focused on sexual dysfunction. It was safe and socially acceptable to try to "fix" the sexual disorders ("frigidity," "anorgasmia," "impotence," "premature ejaculation," etc.) of married, heterosexual, white, young adult middle-class Americans. This narrow focus reflected sexual discrimination in practice. Yet students and workers wanted to jump on Masters' and Johnson's new band-wagon. I called them sexual plumbers.

A Social Work Perspective

My evolving concern was different. Experiences and attributes shape how social scientists view the world. Significantly, the two most influential writers on sex in this century, Alfred Kinsey and William Masters were white, middle aged men. These characteristics — and others — color a "sex expert's" perspective. Every discipline offers a unique world view. The experts popularized sexual perspectives framed by their professional training and subsequent work. Thus, Kinsey, a biologist focused on counting discrete sexual behaviors. This preoccupation led inevitably to his readers viewing numbers and frequencies as clues to normalcy and sexual well-being.

William Masters was an obstetrician-gynecologist. His profession lead him and his followers to see sexual "health" in terms of physical functioning: if the body does its job (and if the mind lets it) then all is well. These observations raised the question: What was — or should be — social work's perspective on sexual well-being?

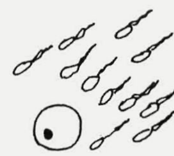
As a social worker I believed the sexual focus in education and practice should be compatible with the basic purposes and values of the profession. Specifically, the interplay and consequences of the individual's sexual expression as it touches the limits and sanctions of their social and cultural environment.

I recalled the Family Service Society of America's (FSSA) definition of social work as a profession whose major concerns were the restoration, maintenance and enhancement of social functioning. Certainly, I considered sexuality a major component of "social functioning," As social workers we were not to be overly concerned with enforcing "normalcy". Our focus in sexuality, had to be broader than improving the sexual mechanics of married, young, affluent, healthy, white, heterosexual couples.

Social workers, I believed, had a primary responsibility to oppressed groups. And, I found, that most of these groups experience part of their oppression through society's repressive attitudes and actions regarding their social-sexual functioning.

I chose to focus on the sexual needs, rights and problems of those populations whose sexuality was ignored or suppressed by society including many professional helpers. As I talked to practicing social workers my list of the sexually oppressed grew: the old and the young; the physically and mentally disabled; gays, lesbians and bisexuals; members of ethnic minorities; victims of sexual assault; and virtually anyone who is a resident of any institution.

I soon became aware that my emphasis on oppressed groups in my teaching and writing needed a focus — a conceptual framework that would lead to understanding the reasons for the oppression of the sexual expression of these diverse groups. Was there some unifying concept, I wondered, that would clarify why some people were given conditional societal support for their sexuality while others sexual needs were ignored or oppressed?



Reproductive Bias

In the early 1970's I stumbled across a theme that helped explain the oppression and sexual biases inherent in many religions' view of "sin"; local and state laws on victimless sexual "crimes"; concepts of sexual "pathology"; and the general public's ideas about good and bad sex. That central concept was the "reproductive

bias." The more I thought about it, discussed it, taught and wrote about it, the more it made sense.

The reproductive bias suggests that the only sexual behaviors considered healthy, normal, moral and generally acceptable (all subjective terms) approximate what it takes to bring about a socially approved pregnancy. The more remote the sexual acts — and actors — are from those associated with socially approved pregnancies, the more they were considered deviant, immoral, pathological and perhaps illegal.

Thus, in mainstream American culture the "sexual elite" were those whose sexuality approximated what it takes to create a socially approved pregnancy. Generally they were white, healthy, able-bodied, affluent, heterosexuals of child-bearing years. On the other hand, just about every one else were among the sexually oppressed.

However, even the elite were affected by this bias: if they are in the reproductive elite, they should want sex and be good at it. An example of the effects and pervasiveness of this bias is the widespread concern about "premature ejaculation." Premature to what? A mature ejaculation involves ejaculation at the right time and place. For what? The right time and place to favor fertilization.

Similarly, two other common sexual behaviors: masturbation and homosexuality receive various degrees of condemnation simply because their expression cannot lead to pregnancy, socially approved or not.

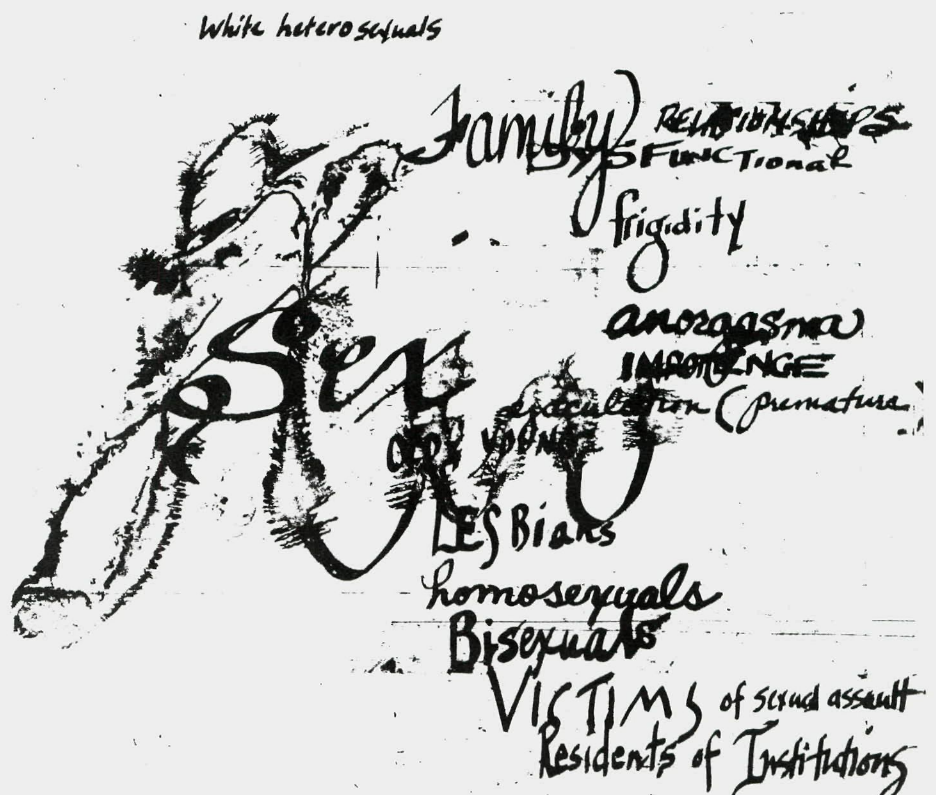
This conceptualization provided a core for my subsequent publications and teachings. When I later got an article called The Sexually Oppressed published in *Social Work* I felt validated. Now here was a social work perspective on sexuality.

As my awareness of the pervasiveness of sexual oppression grew, I became eager to encourage other social workers to be more assertive in working with the sexual concerns of this population.

Legitimizing Social Work Practice with the Sexually Oppressed

Although my hopes to get social workers to become sexual activists now seems grandiose, to some extent it worked. Over the decade of the 1970s I slowly (and haphazardly) evolved a strategy to achieve this goal. In essence, my efforts were directed to legitimizing social work's assertive involvement in dealing with what I called sexual oppression. In retrospect my evolving "strategy" had five components:

First: Publish articles in major social work publications that would identify and justify social workers' areas of interest in sexual matters. My first "success" in this effort was an article in *Social Work* entitled, Social Work's Sexual Blinders. Other hortative articles, and my first book, *Human Sexuality and Social Work* followed. Perhaps the major milestone was a request for me to write the first article on sexuality to appear in the 1977 edition of NASW's *Encyclopedia of Social Work*, (subsequent editions include



articles on sexuality).

Second: Provide a rationale as well as a conceptual framework for social work's focus on sexual oppression. Indeed, my second article in *Social Work* and second book were called *The Sexually Oppressed*.

Third: Identify the need for more better education for social work students on sexuality.

I quoted Kinsey's statements about the extensive and important role of social workers in dealing with sexual matters. I also wrote articles for the *Social Work Education Reporter* (1970) and *The Journal of Social Work Education* (1974) outlining approaches to social work education in human sexual problems. During this period I also facilitated Council on Social Work Education, Annual Program Meeting workshops for social work educators interested in introducing sexual content into the curricula.

Fourth: Serve as a "hired gun" for motivated faculty. As an increasing number of faculty became committed to introducing content on sexual matters in their schools, I was invited to speak to students and faculty. As a visiting "expert" I could get away with proselytizing their faculty to accept sexuality not as a frivolous diversion (as many saw it), but as a basic component of students' education.

Fifth: Get governmental acknowledgement of the legitimacy and importance of social work education in human sexuality. From 1975 to 1980 I received an NIMH grant to further develop a social work approach to common sexual problems and a format to present it to students. Each year a different group of social work educators interested in teaching about social work practice with sexual problems were brought together to Hawaii to enhance their teaching skills in this area. This "Social Work Program for the Study of Sex" served to enhance the participants' skills and legitimized — by its federal funding — the need to teach this content.

There have been some developments in social work that have been encouraging. For example, in 1979 the California legislature passed a bill requiring social workers to show evidence that they had completed a ten hour course in human sexuality to be licensed to practice. This was the first content area mandated by the legislature.

Indeed, my teaching career over the last thirty years has allowed me to see evolving academic attitudes about the place of sexuality in the social work curriculum. While many in the 1960's and 70's may have overplayed the joys of sex and sexual emancipation: "if it feels good, do it," androgyny, the quest for the perfect sexual encounter and the ultimate orgasm; the 1980's and 1990's swung the pendulum back to the dark side of sex.

To the extent that schools of social work still teach sex (and I am inclined to think there are fewer and fewer that do), the focus has shifted largely to the evils and dangers of sex: rape, incest, harassment, and of course, AIDS.

I do not diminish the seriousness of these areas — I have worked with them all — but the existence of these problems and hazards do not negate the importance, and the potential joys of a responsible sexual life. My more recent teaching and publications have attempted to challenge the anti-sex beliefs that have accompanied our awareness of sex-related issues — especially AIDS. In, The Risks of Abstinence, *Social Work*, I argued that while certain sexual behaviors are risky, abstinence has its risks too, and is a wasted recommendation for most people of any age who are already sexually active.

In a more recent article in *Social Work* I explored the sexuality of gay men who are already HIV positive. I pointed out that there is much that keeps these men from continuing their sexual lives. Yet these men still have sexual needs; indeed, based on its benefits, responsible, safe sexual activities for this population should be encouraged.

These articles provided a conceptual bridge that led from dealing in my teaching with sexual oppression and distress to the sexual aspects of AIDS. (There is no more sexually oppressed group then people infected with HIV.)

I must admit that when I first heard about this alleged "gay cancer" I dismissed it and thought it was anti-sex propaganda and that eventually it would go away. It was interfering with my crusade to free the sexually oppressed.

AIDS seemed just another vehicle to pull sexuality back into a moral snake pit.

But it wouldn't go away. So bit by bit I allowed the subject to creep into my sex classes, spoke with the local pioneers working with AIDS (especially the social workers attached to our local general hospital's "AIDS Ward.") Ultimately I accepted a position on the AIDS service agency board (later became president), was appointed to our Governor's advisory committee on AIDS, and seven years ago initiated a graduate course on "AIDS and the Human Condition" in conjunction with the School of Public Health, which attracts more and more students every year.

My recent publications have argued for a sane, reasonable approach to human sexuality in the context of AIDS.

But most important, in 1986 I started to facilitate the state's first support group for HIV infected men. Facilitating this group taught me about the issues that these men were facing: stigma, physical and psychic pain and a multitude of losses. I soon recognized the wisdom of the oft- repeated saying: "it's not what happens to you, but what you tell yourself about it that matters."

In addition to individual differences in how men and their lovers, families and friends deal with the disease's progress, there are significant cultural differences in the way people deal with sex and death.

Leading the group also allowed me to track this epidemic. Over the years the very definition of AIDS changed, the life expectancy increased at the same time the likelihood of surviving steadily decreased. I have seen medications go in and out of style. I have also seen the characteristics of those infected change. In the early days (roughly 1986 - 90), most of the support group members hadn't really known that their sexual behavior could lead to their death. At worst, all they thought they would need was an antibiotic fix. (note: In Hawaii approximately 85% of those infected with HIV were infected from man-to-man sex as contrasted with roughly 60% of the mainland states.) This population would probably not become infected if they were living today. Slowly that group is being replaced by a population aware of the risk but somehow denied or overlooked it. That group is more likely to suffer from guilt and stigma than those that died before them.

I have made good use of my experiences with this group in teaching social work practice courses. As I noted elsewhere: "AIDS is quintessential social work." What better example do we have to teach students how to overcome the taboos that frequently keep us from openly, honestly and empathetically exploring clients' (and our own) beliefs and feelings about the two biggest taboos: sex and death.

Even beyond these two taboos are the sub-categories — even more taboo — homosexuality and suicide. For example, it is our work with persons with AIDS that has made social workers deal candidly with the idea that suicide can be rational and be understood and even supported by social workers.

I rarely teach a sex course now. I offer an occasional sex workshop and do an occasional book review on sex-related topics. I decided several years ago to focus my efforts on AIDS for "the duration," — however long that lasts.

I used to be shocked when some of my support group members "thanked" AIDS. But I am impressed with how much it has taught me about the human condition, sex, love, death, fatigue and endurance. It has also fueled my frustration with the way particular moral biases infused America's public health response to AIDS. I am angry that national egotism keeps us from learning how to save countless lives by tapping the experiences of other societies which are less influenced by the belligerence of religious fanatics.

In the Netherlands, for example, prostitution is legal but carefully guided and regulated by the state. The age of consent is 12. But honest, explicit sex education is compulsory and includes detailed information about safer-sex practices, as do frequent, detailed safer-sex commercials on television. And yet according to WHO statistics, the Netherlands has the lowest incidence of AIDS among Western nations. It has the lowest rate of teen-age pregnancy in the West and the lowest incidence of abortions in the world! "Just say no" isn't enough and generally doesn't —

and needn't — work; it only brings misery and death.

It was much more fun working with sex than with AIDS. I don't like having clients die. I have never had real "burn-out"... whatever that is. But I did go through a period, after mourning the deaths of dozens of men who went through my group, in which my emotions were drained out of me. I kept on meeting with the group and I guess I kept on saying the right things, but I didn't let myself really care. Finally I stopped, got my act together and now I lead the group again — with more emotional moderation.

When I facilitate the group now, I think about all those things concerning group process that I would in any group. But there are other thoughts that race through my head: I wonder when will this nightmare end? Will it be in time to save any of the men sitting in front of me? What were each of these men like before they were infected? How did their lives before infection mold the way they have responded to the virus? And what keeps them going?"

At other times I think about how AIDS has brought homosexuality into the spotlight and earned greater acceptance for gays and lesbians, and I wonder how will gays and lesbians be treated if a day dawns when HIV becomes just a frightening memory, and all people can love without fear.

In my most sober moments I wonder whether I and other "sex is good" sex educators of the 1960s and 1970s unwittingly contributed to this epidemic.

I hope not. □

SEEDS OF FAITH
(to lori)

skinny as a scarecrow
with stuffing half-spilled
you fell into my classroom
a frightened lost bird
your gorgeous older sister
dazzling queen of golden dreams
your stiff impeccable father
impossible to please
squeezed you in the corner
brittle—bleeding with loneliness
starving for a drop of nectar

but you couldn't even stay after class
too strangled with self-consciousness
to let us(even after six semesters)
a few minutes alone to talk
yet in your spiral notebooks
heart-to heart we met
discovering in the words between us
ideas more real than reality
wrestling with identity
struggling to unravel
(in humanity and your own mind)
a little more of the mystery
beneath your searching words i confessed
"you could be a psychologist"

now I get your letter
about your dissertation
and wonder as that sly magician
truth
(always dropping hints never proof)
in your life gratefully
i seemed to alter history
(and if in you
then who knows who else)

we touch each others souls so invisibly
never knowing what kind word or act
might stir the sleeping bud to blossom
might ignite the dormant flame
to keep the fire burning
and blossoms ever blossoming
in others invisible far away waiting
crushed in some parched empty corner
starving for a drop of nectar

by Ron Hertz

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