

CONFRONTING AIDS IN THE COMMUNITY

A NEIGHBORHOOD DIVIDED: COMMUNITY RESISTANCE TO AN AIDS CARE FACILITY. By Jane Balin.* Ithaca and London: Cornell University Press, 1999. Pp. 158.

*Reviewed by Elizabeth A. Stull***

*A Neighborhood Divided*¹ is Jane Balin's engaging and insightful eyewitness account of a community's response to a proposed nursing facility for Acquired Immune Deficiency Syndrome (AIDS) patients. By examining the concerns of both supporters and opponents of the facility, Balin reveals how social issues, especially class status anxiety, influence individual responses to AIDS. Balin looks beyond common explanations for community response to undesirable land uses, exploring the fear and alienation that underlie the contemporary AIDS debate. Although Balin's policy recommendations fail to adequately resolve many of the dilemmas she describes, her insights should be considered by AIDS activists and policy makers alike.

I

AIDS: A HISTORICAL OVERVIEW

AIDS poses a difficult challenge to policy makers at the turn of the twenty-first century. A very brief history of AIDS in America will help put Balin's study into context and provide a better understanding of her policy recommendations and the difficulties they pose.

The AIDS epidemic first entered the national consciousness in the mid-1980s:

[F]rom 1980, when the first isolated gay men began falling ill from strange and exotic ailments, nearly five years passed before all these institutions—medicine, public health, the federal and private scientific research establishments, the mass media, and the gay community's leadership—mobilized the way they should in a time

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1. JANE BALIN, *A NEIGHBORHOOD DIVIDED: COMMUNITY RESISTANCE TO AN AIDS CARE FACILITY* (1999).

of threat. The story of these first five years of AIDS in America is a drama of national failure, played out against a backdrop of need-less death.²

There are several reasons for America's delayed reaction to the AIDS epidemic, all of which involve, directly or indirectly, the fact that AIDS was quickly labeled a "gay disease." First, the Center for Disease Control (CDC), the nerve center of federal public health monitoring, published the first report on the AIDS epidemic in June 1981.³ Pragmatic CDC staffers "knew that gays were not the most beloved minority in or out of the medical world."⁴ As a result, the CDC minimized the importance of the disease and its link to homosexuality.⁵ Furthermore, the Reagan Administration's war on domestic spending slashed the CDC budget and grants to the National Institutes of Health,⁶ leaving many AIDS research proposals and projects unfinished due to lack of funding.⁷ Nevertheless, the first "congressional probe" was engineered in April 1982 to draw media attention to the "gay cancer" and to get federal bureaucrats on record.⁸ At the hearing, Congressman Henry Waxman read a prepared opening statement which compared the generous funding for Legionnaire's disease to the minimal attention and funding given to AIDS:

What society judged was not the severity of the disease but the social acceptability of the individuals affected with it I intend to fight any effort by anyone at any level to make public health policy . . . on the basis of his or her personal prejudices regarding other people's sexual preferences or life-styles.⁹

Although the efforts of Congressman Waxman and others gradually led to increased federal funding for AIDS research, it was often too little too late.¹⁰

2. RANDY SHILTS, *AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC* at xxii (1987); *see also* MARY ELLEN HOMBS, *AIDS CRISIS IN AMERICA: A REFERENCE HANDBOOK* 114 (1992).

3. *See* SHILTS, *supra* note 2, at 54, 68 (describing the CDC's policy regarding AIDS epidemic as "Don't offend the gays and don't inflame the homophobes.").

4. *Id.* at 68.

5. *See id.* at 68-69 (referring to CDC's decision to print report on page two of its weekly newsletter rather than page one, and to remove any mention of homosexuals from title).

6. *See id.* at 55.

7. *See id.* at 136.

8. *See id.* at 143.

9. *Id.* Congressman Waxman kept his word. Most of the federally funded research regarding the AIDS epidemic between 1982 and 1984 was financed by bills sponsored by Congressmen Waxman and Phil Burton. *See id.* at 187.

10. *See id.* at 136.

When Balin's study took place in 1987-89, little was known about AIDS and less was said. By this time, the Reagan Administration had cut spending for all medical research.¹¹ These cuts exemplified America's attitude toward social ills in the 1980s. As described by Professor Elinor Burkett, a former *Miami Herald* reporter: "America seemed intent on ignoring dozens of problems, from crumbling highways to the burgeoning number of homeless. The truth of poverty, racism, and corporate greed was disguised in euphemism. The reality of a plague was a mere whisper."¹² Both the government and the media largely ignored AIDS as an epidemic of economically (and morally) disfavored groups.¹³ Professor Burkett suggests that the media's failure to cover the AIDS crisis was based on news judgment and the complexities of the issues raised by AIDS.¹⁴ In response to accusations of racism¹⁵ and conspiracy by the press, Professor Burkett suggests that the media should not be blamed for reflecting the disinterest of American audiences; the initial reports that AIDS was a disease of sexually active (licentious) white gay men made the epidemic irrelevant to heterosexual editors and readers.¹⁶ When this myth was challenged by the appearance of AIDS in heterosexuals,

11. *See id.* at 54-55.

12. ELINOR BURKETT, *THE GRAVEST SHOW ON EARTH: AMERICA IN THE AGE OF AIDS* 1 (1995).

13. *See* TOM FLYNN & KAREN LOUND, *AIDS: EXAMINING THE CRISIS* 13 (1995) (describing sparse newspaper coverage of AIDS and relating Christian Right criticism of homosexuals in little coverage that appeared); *see also* ALLAN M. BRANDT, *NO MAGIC BULLET: A SOCIAL HISTORY OF VENEREAL DISEASE IN THE UNITED STATES SINCE 1880* at 182 (1985) (citing four *New York Times* articles stating that by 1984 more than 75% of AIDS cases identified were among homosexual males, but that AIDS had "also been reported among intravenous drug users, hemophiliacs, and Haitians").

14. *See* BURKETT, *supra* note 12, at 12-14, 303-04.

15. *See id.* at 171-75. By 1987, almost one-quarter of the nation's people with AIDS were black, even though blacks made up only 12% of the American population; nevertheless, the faces of AIDS that Americans met in the media were white, gay and male throughout the 1980s. *See id.* at 178. In 1989, for every HIV-infected white infant in New York there were eight black ones, and by 1990, almost three-quarters of the women reported to have AIDS were black or Hispanic, although women of color made up just 19% of the female population. *See id.* at 179. *See also* CATHY J. COHEN, *THE BOUNDARIES OF BLACKNESS: AIDS AND THE BREAKDOWN OF BLACK POLITICS* 158-68 (1997) (providing charts and statistics that demonstrate media's failure to report on AIDS in black communities). Cumulatively, between 1981 and 1993, blacks constituted 32% of all AIDS cases, and the black community received 5% of the media coverage on AIDS. *See id.* at 162. Cohen discusses several reasons why AIDS among Latino and black intravenous drug users has been severely undercounted. *See id.* at 127-28.

16. *See* SHILTS, *supra* note 2, at 136.

hemophiliacs, and children, Americans were not just disinterested—they took the moral high road of denial.¹⁷

Infectious diseases, particularly sexually-transmitted diseases, carry a stigma of uncleanness and immorality.¹⁸ In *AIDS and Its Metaphors*, Susan Sontag explains that “[i]nfectious diseases to which sexual fault is attached always inspire fears of easy contagion and bizarre fantasies of transmission by nonvenereal means”¹⁹ In the 1980s, AIDS was associated with the gay male community in which the virus raged uncontrollably.²⁰ Even the experts, experienced medical researchers, blamed the incurable virus on the promiscuity of gay men.²¹ Fear of the deadly disease motivated straight Americans to further alienate the gay population, and to avoid any contact with homosexuals and “their” illness, even to the point of excluding their stories from the news.²²

At the same time, the groups most affected by the AIDS epidemic were ambivalent about discussing it. The gay population, for its part, was angry and unwilling to confront certain facts about this new threat to its sexual freedom.²³ Haitians and Hispanics, already economically and socially marginalized, perceived any attention to the rapid spread of AIDS in their communities as yet another form of racist marginalization.²⁴

17. See *id.* at 103-04, 320-21, 399-400.

18. AIDS is largely perceived to be a consequence of “excesses of . . . ‘life-style,’” and “not just promiscuity but a specific sexual ‘practice’ [anal sex] regarded as unnatural,” so that AIDS victims are blamed for their illness, as it is considered by most people to be a calamity one brings upon oneself. SUSAN SONTAG, *AIDS AND ITS METAPHORS* 25-26 (1989).

19. *Id.* at 27.

20. See, e.g., SHILTS, *supra* note 2, at 351; BURKETT, *supra* note 12, at 290.

21. See DAVID BLACK, *THE PLAGUE YEARS: A CHRONICLE OF AIDS, THE EPIDEMIC OF OUR TIMES* 95-98 (1986).

22. See SONTAG, *supra* note 18, at 27-28; see also SHILTS, *supra* note 2, at 172.

23. See BLACK, *supra* note 21, at 135-44. “[G]ay rights came to mean [engaging in sexual acts] as much as you wanted. Morals were seen as chains to be broken; just as, in some sadomasochistic games, chains were seen as symbols of freedom, proof that one was not limited by straight, middle-class morality.” *Id.* at 136. See generally LARRY KRAMER, *FAGGOTS* (1978) (describing sexually precocious and predatory lifestyle of group of gay men, in novel form); GABRIEL ROTELLO, *Kramer as Prophet, in WE MUST LOVE ONE ANOTHER OR DIE: THE LIFE AND LEGACIES OF LARRY KRAMER* 86-89 (Lawrence D. Mass ed., 1997) (calling Kramer prophet of his people who blamed gay victims of AIDS for their licentiousness).

24. See BURKETT, *supra* note 12, at 3 (stating that “Haitians, targeted early as a ‘risk group,’ refused to heed th[e] early warning. All the attention given to their beleaguered community was simple racism, their leaders argued, and they turned their energies to saving their ethnic reputations rather than their lives.”). See also COHEN, *supra* note 15, at 37-41 (asserting that “categorization as marginal is also directly tied to stigmatized or ‘illegitimate’ social identity that such groups have in the larger or

Finally, black communities of the 1980s were unable or unwilling to recognize that AIDS was a problem affecting their communities.²⁵ A complex political environment confronted black activists when AIDS first came on the scene.²⁶ The Reagan Administration's budgetary cuts and ideological attacks on race-specific policies created crises in black communities that seemed more pressing than AIDS.²⁷ Even as a small number of blacks began to achieve a middle-class standard of living, poverty was increasing in black communities.²⁸ The rising "new Black middle-class" held a tenuous position in a society in which the vast majority of African Americans remained poor with limited opportunities and increasing arrests for, and victimization by, the flow of illegal drugs into their communities.²⁹ AIDS, like welfare, represented an issue that propagated increasing stereotypes, causing the "secondary marginalization" of blacks in AIDS risk groups (for example, gays and intravenous drug users).³⁰

II

AIDS MOVES INTO THE NEIGHBORHOOD

Fear of death and disease, particularly AIDS, and class biases are pervasive in both the local and national community. Balin's case study suggests that these issues are the primary factors motivating community objections to a residential AIDS care facility. Whereas most of the current research in this area relies on quantitative analyses that show a direct relationship between a neighbor's proximity to a facility and his resistance to its presence,³¹ Balin demonstrates the significance of socioeconomic differences within the community.

dominant society."). Early categorization of all Haitians as a "risk group" infuriated many inside and outside Haitian communities. *See id.* at 139-40.

25. *See generally* COHEN, *supra* note 15.

26. *See id.* at 79-85.

27. *See id.* at 83-84.

28. *See id.* at 66-67, 291.

29. *See id.* at 88-89.

30. *See id.* at 70-76, 90.

[A]ny threat to a unified group mobilization puts at risk the advancement of all members of the community except those most integrated into the dominant society If the social isolation [of unprotected members] becomes translated into political isolation, where even other marginal group members are unwilling to take up their cause, we can foresee little prospect for them to find access to and representation within the political system.

Id. at 76.

31. *See, e.g.*, MICHAEL J. DEAR & S. MARTIN TAYLOR, NOT ON OUR STREET: COMMUNITY ATTITUDES TO MENTAL HEALTH CARE 131 (1982) (indicating that "[g]enerally, as proximity to a potential facility increases, so does the perceived unde-

Balin's brief social history of the neighborhood she calls "West Highland" (pseudonyms are used throughout the book) foreshadows her class-based analysis of the research. The clear and succinct background carries us from white Protestant colonial beginnings through the religious and racial integration of the early and mid-twentieth century,³² tracing recognizable urban migrations and socioeconomic changes that have been common in American cities.³³ By 1988, the neighborhood had been racially and ethnically integrated for thirty years, and it was viewed as "a convenient, middle-class 'bedroom community' to Park City."³⁴ The neighborhood had always been liberal and politically active.³⁵ However, as pockets of poverty continued to spread, the prevailing attitude in West Highland changed "from integration to defense."³⁶ One dramatic example is the gradual replacement of the "Neighborhood Walks and Talks" of the 1970s with ever strengthening Neighborhood Watch groups.³⁷ West Highland could be a neighborhood in any American city.

When "AIDS Moves into the Neighborhood,"³⁸ it brings fear, defensiveness, and mistrust. Balin draws the reader into this narrative through the voices of the two men who started the nursing center, which Balin calls "Chaver." Although Chaver's founders, an inner-city doctor and a Lutheran minister,³⁹ initially had no trouble finding a site for the center and securing funding,⁴⁰ they were unprepared for community opposition to their plans.⁴¹ From the beginning, their relationship with the community was strained. At their first meeting with Chaver's founders, the facility's prospective neighbors revealed both their deepest fears about living near terminal illness—particularly

sirability of that facility"), cited in BALIN, *supra* note 1, at 153; David L. Cutler, *Community Residential Options for the Mentally Ill*, 22 *COMMUNITY MENTAL HEALTH J.* 61-64 (1986); Gregory H. Wilmoth et al., *Receptivity and Planned Change: Community Attitudes and Deinstitutionalization*, 72 *J. APPLIED PSYCHOL.* 138-39 (1987). These works are often referred to as the NIMBY ("not in my backyard") literature. See BALIN, *supra* note 1, at 153.

32. See BALIN, *supra* note 1, at 12-24.

33. See *id.* at 16-17 (explaining that post-industrial economy of West Highland, like economy of other cities, became decentralized and deindustrialized and that many communities surrounding West Highland experienced migration of middle-class families to suburbs).

34. *Id.* at 24.

35. See *id.*

36. *Id.* at 22.

37. See *id.* at 23.

38. *Id.* at 25 (title of Balin's second chapter).

39. See *id.* at 26.

40. See *id.* at 29-30.

41. See *id.* at 25, 52-58.

AIDS—and their fear of the patients, who, they presumed, would be poor, black, intravenous drug users.⁴² In response, the planners promised cleanliness and a “desirable” patient clientele made up of “middle-class gay professionals.”⁴³ However, the demographics of the city’s AIDS population made this promise unrealistic.⁴⁴

Chaver was supported and advocated by the Lutheran church, which owned a gated nursing home complex on the edge of West Highland. Initially, the church’s minister explained that the AIDS center could not be located within the pre-existing complex because of socialization problems that would result from having both young and elderly patients together in the same facility.⁴⁵ It was only later that his own concerns about property values and a decline in the number of nursing home applicants were revealed.⁴⁶ Although the church had a long presence in the neighborhood, much of the community was not religious.⁴⁷ In addition, the white minister’s advocacy of Chaver was opposed by many African American neighbors, and his religious rationales alienated the non-Lutheran population of West Highland.⁴⁸ All of these factors injured the founders’ credibility.

Balin concludes by suggesting that neighborhood conflict over the proposed facility could have been reduced if its advocates had responded honestly to the needs and concerns of its neighbors, perhaps through candid communication.⁴⁹ Balin notes that it was the West Highland residents with the least personal or professional knowledge of AIDS who opposed Chaver.⁵⁰ Ultimately, Balin defines the controversy as a moral dispute over the neighborhood’s image: Would it be perceived as a “quiet, middle-class, family-centered neighborhood” that protects itself against outside influences, or would it remain “true to its past,” as a “tolerant, caring, socially just, and compassionate community?”⁵¹

When the center opened in 1990, it seemed that Chaver’s supporters had won a great victory. Unfortunately, these gains were lost

42. *See id.* at 48.

43. *See id.*

44. *See id.* at 132 (recognizing that by end of 1989, city statistics and their own feasibility study pointed to growing number of indigent people with AIDS, but Chaver’s presidents did not amend their public portrait of Chaver’s patient population).

45. *See id.* at 54.

46. *See id.*

47. *See id.* at 55.

48. *See id.*

49. *See id.* at 154.

50. *See id.* at 59, 66, 71-72.

51. *Id.* at 75.

in 1997, when the project's funding dried up and Chaver closed its doors.⁵²

III

WHY NEIGHBORS TAKE SIDES

Balin argues that the choice between safety and compassion was essentially predetermined by socioeconomic background. According to her research, while nearly everyone who came from a solidly middle-class background supported Chaver, those who had worked their way up from lower-class backgrounds generally opposed it.⁵³ Although she recognizes several overlapping social identities, Balin divides her subjects into essentially four groups: old middle-class whites, old middle-class African Americans, new middle-class whites, and new middle-class African Americans.⁵⁴

During the period of Balin's study, the old middle-class groups included professionals, business people, and individuals who had spent their whole lives in West Highland. The new middle-class groups included anyone who had moved into the neighborhood since the late 1960s, (including some professionals), and anyone whose family came from a lower social class.⁵⁵ Among the members of the new middle class were secondary school teachers, homemakers, and small business owners.⁵⁶ Most of the African Americans in the neighborhood belonged to the new middle class and lived on a secluded cul-de-sac with its own neighborhood association.⁵⁷ Like other members of the new middle class, their social identity was largely based on the fact that they lived in West Highland, a middle-class neighborhood.⁵⁸

Balin reasons that the strongest opposition to Chaver came from those neighbors who had the most to lose if neighborhood property values and social esteem were to decline.⁵⁹ The neighborhood was, in effect, their ticket to respectability. Therefore, these social groups had a strong interest in keeping out anything that might bring a stigma to their community. Illustrative of this point is the strong resistance found among African American members of the new middle class. In

52. See Fran Smith, *Stories That Shaped the Century: A New Plague Tests Resolve of Our Global Village*, L.A. TIMES, Dec. 19, 1999, at B6 (noting that number of AIDS organizations were reportedly struggling for funding and volunteers).

53. See BALIN, *supra* note 1, at 58, 81, 91.

54. See *id.* at 81-98.

55. See *id.* at 81.

56. See *id.* at 82.

57. See *id.* at 87-89.

58. See *id.* at 89.

59. See *id.* at 43-44, 82, 102-03, 146.

contrast, members of the old middle class, black and white, were secure in their social status and acknowledged a middle-class duty to help the underprivileged.⁶⁰

The self-identified “liberal” residents of West Highland did not discuss class issues in public debates over Chaver.⁶¹ Balin borrows Erving Goffman’s analogy that social interactions are akin to a theatrical performance to describe the contrast between the public and private conversations about Chaver.⁶² In public, there was no meaningful discussion of the race, sexual orientation, or poverty of Chaver’s patients; privately, however, even supporters of the facility expressed concerns about the “type of person” who would be a patient at Chaver.⁶³ Thus, the public debate was a carefully crafted performance whose themes did not necessarily coincide with the real issues on people’s minds.⁶⁴ Through personal interviews, Balin crept backstage of the public debate over Chaver.

The community members involved in the Chaver debate intuited their enemies’ weaknesses and publicly intimidated each other with accusations of sexism, classism, ignorance, and homophobia, and with alienating labels such as “racist,” “yuppie,” and “bigot.”⁶⁵ In fact, at least two people—a black professional and a white Protestant housewife—kept silent throughout the public debate so that they could live peacefully with their neighbors and not lose any friends.⁶⁶ As is often the case in conversations regarding the AIDS virus, Chaver’s opponents tried diligently to separate their concerns about AIDS and Chaver from those regarding gays and bisexuals. They also tried to separate their concerns about the AIDS patients’ socioeconomic status from the patients’ race.⁶⁷

Privately, neighbors on both sides of the public debate expressed concern about the racial background of the patients and the patients’ friends.⁶⁸ The race of Chaver’s patients was never discussed publicly, and even in private interviews, only African Americans of the old middle class felt free to be highly critical and honest about race rela-

60. *See id.* at 93.

61. *See id.* at 120-21.

62. *See id.* at 100-01 (citing ERVING GOFFMAN, *THE PRESENTATION OF SELF IN EVERYDAY LIFE* 112 (1959)).

63. *See* BALIN, *supra* note 1, at 100.

64. *See id.* at 98, 101.

65. *See id.* at 122-23.

66. *See id.* at 99-100, 135-36.

67. *See id.* at 124, 138.

68. *See id.* at 104, 121-23.

tions in the neighborhood and society at large.⁶⁹ Everyone else felt uncomfortable and feared being labeled a racist.⁷⁰

This silencing of the debate over racial issues paralleled the silencing of the discussions about sexuality.⁷¹ The homosexual members of the community quietly offered support to Chaver's planners, but stayed out of the debate to protect their position in society.⁷² Unwilling or unable to discuss their sexuality, they did not express opinions about the AIDS nursing center for fear that it might implicate their sexual orientation.⁷³ Many of their straight neighbors, on the other hand, privately questioned the effects that a large gay population would have on their children.⁷⁴

One pervasive fear that was never spoken of publicly after the first neighborhood meeting was the fear of death. How would it affect the children to live so close to death? If everyone shared a fear of AIDS as a contagious illness, why was this fear unspeakable? Balin attributes West Highland's public silence about terminal illness to human reverence for rites of passage.⁷⁵ Citing Victor Turner, Emile Durkheim, and others, Balin describes death as a rite of passage, a negative rite, which separates the sacred dying person from the secular life of the neighborhood.⁷⁶ In this context, the presence of a hospice is perceived as breaking the rhythm of the living community.

Balin condemns the silence and euphemism surrounding AIDS and the issues it evokes. She criticizes the planners of Chaver for avoiding issues, for misleading the West Highland community about the patient population, and for creating the impression that no one would die in the facility.⁷⁷ The planners' ambiguous answers to important questions about Chaver heightened neighbors' anxieties.⁷⁸

Balin suggests that in addition to speaking honestly about the expressed fears and concerns of the community, the planners should have used social constructs to further their purpose.⁷⁹ Perhaps if the planners had presented Chaver to the new middle class as a civic re-

69. *See id.* at 126-27.

70. *See id.* at 126-28.

71. *See id.* at 124.

72. *See id.* at 113-15.

73. *See id.*

74. *See id.* at 102-03.

75. *See id.* at 128.

76. *See id.* at 128-29 (citing VICTOR TURNER, *THE RITUAL PROCESS* 69, 94-95 (1969)); *see also id.* at 129-30 (citing EMILE DURKHEIM, *THE ELEMENTARY FORMS OF THE RELIGIOUS LIFE* 56 (Joseph Ward Swain trans., 1915)).

77. *See BALIN, supra* note 1, at 133-35.

78. *See id.* at 156.

79. *See id.* at 152-54.

sponsibility rather than a religious crusade, there would have been less opposition. Balin argues that if status group concerns are the most crucial component in local community responses to AIDS facilities, then they should be addressed as such.⁸⁰ If state and local officials of the same race and social background as the “new middle class” had spoken with Chaver’s opponents from the outset, Balin suggests that there might have been more open dialogue and perhaps greater support for the facility.⁸¹

IV

MOVING BEYOND A FALSE CURE

Balin concludes *A Neighborhood Divided* with an attempt to inject hope into the discussion of AIDS in America. She suggests that it is possible to convince middle-class Americans to overcome their fears by engaging in honest communication and by recognizing status anxieties.⁸² Although Balin’s strategy may be pragmatic in some circumstances, it fails to reach the heart of the issues she identified.

Balin’s argument that political correctness is a false cure is strong.⁸³ She quotes Russell Jacoby: “In easing pain, decorous talk may forget the disease.”⁸⁴ Balin is correct to condemn the silence that has ensconced and squelched substantive discussion of race, class, sex, and other controversial subjects since political correctness became the rule. As Balin suggests, changing language will not eliminate the underlying issues.⁸⁵ However, she goes too far when she suggests that honest communication alone could persuade Americans to overcome deep-seated fears.⁸⁶ While a communication and education network is a very important element to community acceptance of a residential AIDS facility,⁸⁷ the success of such a network will also be affected by the community’s receptiveness to new information, as well as the images of AIDS presented in local and national media. Balin must recognize that even after the Clinton Administration’s

80. *See id.*

81. *See id.* at 154.

82. *See id.* at 152-54.

83. *See id.* at 140-41 (discussing confusion and distraction caused in West Highland and throughout America by attempts at political correctness).

84. *Id.* (quoting RUSSELL JACOBY, *DOGMATIC WISDOM: HOW THE CULTURE WARS DIVERT EDUCATION AND DISTRACT AMERICA* 91 (1994)).

85. *See* BALIN, *supra* note 1, at 139-42.

86. *See id.* at 154-58.

87. *See, e.g.*, ROBERT W. BUCKINGHAM, *AMONG FRIENDS, HOSPICE CARE FOR THE PERSON WITH AIDS* 87 (1992).

“new era of frankness,”⁸⁸ misperceptions and anxiety about AIDS will persist.⁸⁹ It is not enough to get the word out; activists must also work toward receptivity and reducing entrenched human fears.

Fear is a natural reaction to the unknown. Whether death is a sacred rite or a biological change, the presence of death reminds us of our own mortality. As poor Yorick’s skull reminded Hamlet of what was to come,⁹⁰ the terminally ill remind us of our own frailty and helplessness in the face of death. The AIDS crisis has also inspired a fear of sexuality.⁹¹

Because AIDS is a slow-moving epidemic with no vaccine, health precautions have become part of social mores.⁹² Not only does AIDS reinforce American moralism about sex, it strengthens the culture of self-interest.⁹³ Compelling self-interested white middle-class institutions to talk about AIDS may not guarantee sympathetic action.⁹⁴ Nevertheless, Balin appropriately criticizes the planners of

88. See, e.g., NEAL ARTHUR DICKERSON, *A PRESCRIPTION FOR PREVENTING AIDS: CURE THE BODY POLITIC OF PREJUDICE* 172-74 (1994) (recognizing that AIDS has become civil rights issue as much as it is health issue, and praising Clinton’s condom ad campaign and increased spending on AIDS research); RONALD BAYER, *PRIVATE ACTS, SOCIAL CONSEQUENCES* 225-31 (1989) (recognizing that education has been frontline defense against AIDS, but that “psychological, social, and cultural” (as opposed to cognitive) resistance remains).

89. See Sheila Stroup, *Education Conquers Fear*, *NEW ORLEANS TIMES-PICAYUNE*, Apr. 13, 1999, at B1 (reporting local opposition to AIDS hospice and medically inaccurate description of dangers involved by local religious leaders); see also *Discomforting the Sick*, *NEW ORLEANS TIMES-PICAYUNE*, Apr. 15, 1999, at B6 (describing neighbors’ opposition to St. Jude’s AIDS hospice because they fear it will endanger their children); Smith, *supra* note 52, at B6 (relating recent experiences by AIDS organizations of public apathy and quoting San Francisco AIDS specialist Dr. Marcus Conant as saying that “[f]rom a social point of view, I don’t think we’ve learned anything”).

90. See WILLIAM SHAKESPEARE, *HAMLET, PRINCE OF DENMARK*, act 5, sc. 1.

91. See SONTAG, *supra* note 18, at 73 (stating that sexuality is “the new, disease-sponsored register of fear in which everyone now lives.”); see also BRANDT, *supra* note 13, at 182-86 (indicating that fear of AIDS has changed or should change sexual behaviors).

92. See SONTAG, *supra* note 18, at 72-73.

93. See *id.* at 73-74 (“Self-interest now receives an added boost as simple medical prudence.”); see also FLYNN & LOUND, *supra* note 13, at 55-57 (describing self-protective attitudes of people who are afraid to work or go to school with persons with AIDS).

94. In 1984, the Reagan Administration called AIDS its “number-one priority,” but failed to designate sufficient resources to fight it. See SHILTS, *supra* note 2, at 297. More recently, medical science has been congratulating itself for effective new drug treatments; however, the expense and complicated regimen limit the patients who may benefit. Compare Jerome Groopman, *Drug Combinations Can Inhibit the AIDS Virus*, in *AIDS: OPPOSING VIEWPOINTS* 151-55 (Tamara L. Roleff et al. eds., 1998) (arguing that drug combinations can inhibit the AIDS virus), with Jeffrey L. Reynolds, *Drug Combinations May Not Inhibit the AIDS Virus*, in *AIDS: OPPOSING VIEW-*

Chaver for misleading the neighbors about the character of its patient population. Balin's first policy recommendation, honest communication without euphemism, would have served well in this context. However, her argument that honest answers would have won supporters is unfounded.

Interestingly, the results of Balin's study suggest that aside from the few long-term residents who supported the AIDS facility on principle,⁹⁵ the supporters were defined by their lack of investment in the neighborhood rather than by their liberal beliefs. The people who spent the largest portion of their daily lives in the neighborhood, and whose social status or identity was most connected to the neighborhood, opposed the AIDS facility; the neighbors with the least day-to-day interest and involvement in the community supported it.⁹⁶ As one supporter, a white professional, told Balin, "I just come in the house and close the door . . ." ⁹⁷ In other words, he did not truly support Chaver; he simply had no reason to oppose it. Although Balin's vision of a "moral battleground" is engaging, the author would paint a more accurate picture if she acknowledged the moral vacuity that had grown out of the fear of alienation and the association of one's identity with social and economic status.

Perhaps Balin is right to avoid taking a cynical view of the AIDS facility debate. It would be unfair, for example, to accuse a homosexual couple of moral vacuity when the couple hides their homosexuality in order to keep their jobs. However, Balin does point out clear instances of vacuity in the failure of some West Highland residents to uphold their own professed beliefs. For instance, the "integrated public school" is now only integrated until the third grade, because at that point, white parents put their children into private schools.⁹⁸ In this case, the parents' lack of faith in their neighborhood school reveals the hypocrisy of their proclaimed dedication to liberal ideals. As one gay West Highland resident confided in Balin, he fears what his neighbors do not say about sexuality more than what they say in public.⁹⁹ The euphemistic language they spout in public seems to justify the fear of this gay resident, who has no way of gauging the actual opinions and intentions of his neighbors.

POINTS, *supra*, at 156-62 (indicating that drugs are not always effective, have terrible side-effects, and are unavailable and unmanageable for poor).

95. See BALIN, *supra* note 1, at 93-94.

96. See *id.* at 92.

97. *Id.* at 92.

98. See *id.* at 23.

99. See *id.* at 112-13.

Finally, Balin's recommendation that society adopt a policy consistent with the middle class script of "status oblige" is problematic.¹⁰⁰ This social strategy would have the same muzzling effect as politically correct rules for language. We may attempt to "overcome" or sublimate the fear of stigmatized persons and illness, but the underlying prejudice and stigma remain, reinforced by the tacit agreement that these feelings should not be expressed. The stigmatized group suffers further alienation from the "good" people of society, rather than acceptance as equals.

Whereas Balin believes that the new black middle class could be convinced of its civic responsibility to help the less fortunate,¹⁰¹ Cathy J. Cohen, in her work on AIDS and the African American community, reports that this strategy is not only ineffective, but harmful.¹⁰² In the late 1980s, a number of black media sources did in fact urge members of the black middle class to help those "other" blacks suffering from AIDS.¹⁰³ However, this effort only created a system of secondary marginalization, negating the relationship between those black people with AIDS and the larger black community.¹⁰⁴ Cohen's observations reveal that status oblige is inextricably linked to the moral distinction between "good and moral" citizens and the "tainted . . . faulty and inferior" victims of AIDS.¹⁰⁵ By using class status to motivate support for AIDS, Balin's strategy only reinforces class differences and a middle-class morality that excludes disadvantaged and "at risk" groups from the larger society.

Although Balin's strategic recommendations for sponsors of an AIDS facility may be useful in particular situations (such as negotiating for an AIDS nursing center), focusing on such pragmatic political strategies may undermine the possibility of alleviating the anxiety and fear of alienation shared by all members of society. Balin surely did not intend to advance the prejudices and stigmatization that she discusses throughout her book. The unfortunate implications of status oblige¹⁰⁶ indicate the complexity of the issues raised by AIDS and the difficulty of finding satisfactory solutions.

100. See *id.* at 93 (defining "status oblige" as "a feeling that, as middle class citizens, they had a moral obligation to care for those who were less fortunate than themselves").

101. See *id.* at 93, 154.

102. See generally COHEN, *supra* note 15.

103. See *id.* at 90.

104. See *id.*

105. See *id.*

106. I have no objection to her first policy recommendation: honest communication without euphemism.

V

THE COMMUNITY REMAINS DIVIDED

Although twelve years have passed since Balin began interviewing residents of the neighborhood she calls "West Highland," her study remains highly relevant. In spite of widely publicized fund-raising efforts, public education campaigns, and hopeful new drug research, AIDS remains a feared and misunderstood epidemic in America.¹⁰⁷ As such, AIDS is both a concern that cuts across social groups¹⁰⁸ and a crucible for issues of race, class, and sex. Balin's study opens a window to a new understanding of the multifaceted anxieties that drive responses to AIDS at both the local and national levels.

Even if Balin's analysis and policy recommendations fall short of the mark, the sociological study of a "liberal community" facing a false choice¹⁰⁹ between "respectability" and its "liberal traditions" is compelling. Her research demonstrates the reality of status anxieties, even among neighbors who appear similarly situated. While Balin's theory of status anxieties seems neatly tailored to this particular community, a theory which incorporates the racial tensions and sexuality issues might inspire Balin to create more insightful policy recommendations. Whether her theory of class status anxiety could explain or predict the response of other American middle-class communities remains to be seen. The composition of the neighborhood—including race, gender, age, and class—and the specific history of the area is likely to play a significant role in this analysis. Finally, Balin's call for honest communication about AIDS and the issues it raises is an obvious first step toward understanding and acceptance.

107. See Smith, *supra* note 52, at B6 (reporting that in spite of new drugs, people have continued to die and that after rapid advancements in AIDS research "[t]he epidemic . . . shifted to poorer communities, to African Americans and Latinos."). Nationally, AIDS deaths fell 42% from 1996 to 1997, but only 20% the following year. See *id.* See also Sheila Stroup, *supra* note 89, at B1 (reporting that local church leaders opposed Hospice of St. Jude's plans to build AIDS hospice nearby on grounds that "[i]t exposes the children to too much danger of sickness'") (quoting Rev. El-dridge Hunter, local pastor). "Anything could happen," warned Rev. John R. Cupit, also a local pastor. *Id.* See also *Discomforting the Sick*, *supra* note 89, at B6 (editorial noting opposition to St. Jude's AIDS hospice by church leaders and neighbors based on fears that it will endanger their children).

108. See COHEN, *supra* note 15, at 9-10 (calling AIDS and welfare "cross-cutting issues" because of way they split black communities).

109. See Teresa Talerico, *Melting Pot is a Study In Contrasts*, SEATTLE POST-INTELLIGENCER, Feb. 20, 1999, at D1 available in 1999 WL 6582760 (noting that AIDS nursing center opened in 1992 in liberal, racially and ethnically integrated Seattle neighborhood and neighborhood continues to thrive).

Limitations of the Study

Balin admits that her study is limited in some respects.¹¹⁰ By focusing on the community members who were active in the debate, Balin may have learned the terms of the debate without a full understanding of its motivating forces. The author devotes a chapter toward the end of the book to the meaning of silences, and the harm that can be done by failing to represent people “on the margins” of a debate or community.¹¹¹ Had Balin followed her own advice and interviewed more of the less involved West Highland residents, her study would have been more complete, as the few uninvolved neighbors Balin did interview provided important context for the public debate.¹¹²

While *A Neighborhood Divided* is not heavily footnoted, occasional references to sociologists such as Clarence Spigner, C. Wright Mills, and Bert Landry support Balin’s arguments. This book is a good read, and sheds new light on the significance of socioeconomic power in public morality and policy decisions.

CONCLUSION

The body of literature about AIDS in America increased incrementally in the 1990s. The decade resulted in several chronicles of the epidemic and dozens of personal narratives by AIDS patients.¹¹³ Balin’s *A Neighborhood Divided* stands out among this literature as a unique sociological study and a useful tool for understanding Americans’ mixed reactions to the continuing AIDS crisis. While the author attributes the split reactions of the West Highland residents to the proposed AIDS facility to “status anxiety,” it seems more accurate to describe the reactions as a reflection of the many layers of marginalization in the West Highland community. Although Balin is right to suggest that the silence imposed on society by fear and political correctness must be broken, the first twenty years of AIDS in

110. See BALIN, *supra* note 1, at 9.

111. See *id.* at 137-42.

112. See, e.g., *id.* at 135-37 (revealing that several neighbors who took neutral position on Chaver controversy had thoughts and feelings about matter, but feared negative ramifications of disagreeing with their spouses and neighbors and that several other West Highland residents supported Chaver privately, but remained quiet so that they would not incur “the wrath of their neighbors”).

113. See, e.g., BUCKINGHAM, *supra* note 87; BURKETT, *supra* note 12; COHEN, *supra* note 15; ELAINE DEPRINCE, *CRY BLOODY MURDER: A TALE OF TAINTED BLOOD* (1997); DICKERSON, *supra* note 88; MARY FISHER, *MY NAME IS MARY, A MEMOIR* (1996); FLYNN & LOUND, *supra* note 13; ROTELLO, *supra* note 23.

America have shown that imposing a class-based status oblige¹¹⁴ only serves to deepen the fissures in society.

A new public policy regarding AIDS is much needed. Unfortunately, Balin fails to recommend a policy that will help solve the underlying problems of AIDS discrimination in America. Nevertheless, her insightful study should inform the development of strategies and policy by activists and policy makers.

114. See *supra* note 100 and accompanying text.