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Out of the Closet and Into the Trenches: Gay Male Baby Boomers, Aging, and HIV/AIDS

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Regardless of HIV status, all gay male Baby Boomers are aging in a context strongly shaped by HIV/AIDS. For this subcohort within the Baby Boom generation, the disproportionately high volume of AIDS deaths among gay men aged 25–44 years at the epidemic's peak (1987–1996) created a cohort effect, decimating their social networks and shaping their personal and social lives during the epidemic, throughout their life course, and into later years. But despite these lasting effects on an entire cohort of gay men, relevant scholarship narrowly focuses on older HIV-positive gay men using clinical, psychological, and social network approaches. It thus makes inadequate use of the life course perspective, which, by attention to timing, agency, and interdependence, can uncover the myriad interlocking and longitudinal aspects of the epidemic that affect this group. This article argues for the application of this latter approach to research into the lasting impacts of HIV/AIDS on this cohort of gay men. We examine HIV/AIDS mortality within this cohort at the epidemic's height, these deaths' concentration in urban gay communities, and the growing and increasingly diverse population of HIV-positive

gay men born in the Baby Boom Years. Our conclusion suggests that a fuller examination of the role of HIV/AIDS in the lives of gay male Baby Boomers, using a life course perspective, is critical to appreciating this generation's heterogeneity and to expanding knowledge of how later life is shaped by the intersection between historical events, personal biography, and social and community ties.

Key Words: HIV/AIDS, Life course, Gay, Lesbian, Bisexual, Transgender, Sociology of aging/social gerontology, Subcohorts, Demography, Health, Bereavement, Psychosocial, Social networks

To those adopting the life course perspective (Elder, 2003), human lives are shaped not only by such characteristics as sex, ethnicity, and class but also by birth year and cohort status, which represent the distinctive exposure of those born at a certain time to social change (Elder, 1994, p. 5). Instances of social change such as economic upheavals, social movements, and war have cumulative

effects (on e.g., financial, psychological, social, and health status) in later years (see e.g., [Elder, 1974](#)). A fundamental concern in this paradigm is the timing of lives or the life stage principle, according to which the putatively uniform “period effects” ([Settersten, 1999](#), p. 123) of historical events are refracted along birth cohort lines. This transforms period effects into cohort effects—life-long “collective properties” produced by the influence of historical incidents and contexts on persons of similar age ([Settersten, 1999](#), p. 122). Here, then, macro-social forces resonate on micro-social, personal levels by shaping resources and circumstances in which people live, thus helping to direct the paths they take as they move toward later life. Similarly, the social timing of roles and the synchronous or asynchronous “scheduling of multiple trajectories” ([Elder, 1994](#), p. 6) such as marriage and work encourage or disrupt the expected flow of life across age transitions. Other “key mechanisms by which environmental change and pathways influence the course and the substance of human lives” ([Elder, 1994](#), p. 5) are agency, whereby actors make reflective choices within concrete constraints (*ibid*), and interdependence, through which the consequences of such personal events as unemployment, divorce, and ill health radiate outward to shape the lives of others. Thus, the temporal placement of a cohort in relation to historical events strongly influences their consequences for members of that cohort and for others enmeshed in those members’ lives, although these consequences are actively managed within the context of real and perceived constraints.

Given its analytic access to the interpenetration of history, biography, and life course location, this approach is particularly useful for examining the experiences and circumstances of birth cohorts sharing a distinctive position in the course of social change. However, just as events affect different cohorts in different ways, they also differentially affect subgroups within cohorts. Consider, for example, the 1964 Civil Rights Act, the identity politics of the 1960s–1970s, the Vietnam and other wars, and the collapse of the banking industry. All U.S. Baby Boomers lived through these changes. But particular groups did so through the lens of their own age (as the Baby Boom took place between 1946 and 1964, Baby Boomers differ in age by up to 18 years; see [Mutchler & Burr, 2009](#), p. 2), distinctive social positions, and histories and events relevant to their own communities, but not necessarily to those of others. This distinguishes these groups

within their birth cohort to make them “subcohorts distinguished by gender, race, social class, and regional location” ([Uhlenberg, 1996](#), p. 228). If, as [Alwin, McCammon, and Hofer \(2006, p. 50\)](#) write, we must avoid viewing cohorts “as if they were monolithic, homogenous groupings of individuals,” then examining the experiences of subcohorts within the Baby Boom generation can yield a richer understanding of this generation and of human development in the context of social change more generally.

To shed such light onto the important role of subcohorts within generations, this article explores the distinctive experiences of gay male members of the Baby Boom generation. This subcohort experienced two linked historical events in their adult and middle years: the emergence of the gay rights movement and the AIDS pandemic 10 years later ([Cohler, 2007](#), p. 105). For these men, the high number of AIDS deaths at the epidemic’s peak (1987–1996) created a cohort effect, shaping their personal, social, psychological, and community lives, at the time of the epidemic, throughout their life course, and into later years. This cohort effect was exacerbated by the epidemic primarily affecting those in adulthood and early middle age, causing high numbers of premature deaths within an interdependent network of gay men, friends, and family. Furthermore, growing numbers of gay men age with HIV within an increasingly diverse HIV-positive population. These men share clinical features of HIV and often early memories of high rates of AIDS deaths within their communities. But they also differ in their personal histories with HIV, as some were infected well before, and others well after, the introduction of effective medication in 1996.

These experiences have implications for multiple domains of relevance to this generation more widely. These include long-term impacts of economic upheavals and interruptions to career; effects on family, friend, and caregiving relationships; the role of neighborhood and community in the aging experience; and health status and health care utilization in later life. However, despite growing awareness of the aging HIV population and the existence of distinct cohorts of gay men “with unique developmental experiences”, specifically, pre- and post-World War II (WWII), post-Stonewall (The iconic 1969 gay uprising in Manhattan’s Stonewall bar that galvanized an incipient gay liberationist movement—see [Marotta, 1981](#)), AIDS, and post-AIDS ([Hammack, 2005](#), p. 275–276), few gerontologists consider the AIDS

epidemic's effects on this generation of gay men. Most studies of aging and HIV focus on the virus's clinical manifestations (Martin, Fain, & Klotz, 2008) or the psychological effects of having "experienced multiple, repetitive, and sustained losses of persons in their social networks to the disease" (Sikkema, Kochman, DiFranceisco, Kelly, & Hoffmann, 2002, p. 166) and the mental health consequences of living with HIV (e.g., Lyons, Pitts, Grierson, Thorpe, & Powe, 2010). More social-scientific studies of aging and HIV, many with a built-in concern with health outcomes, consider stigma (Emlet, 2006; Foster & Gaskins, 2009), caregiving (Munro & Edward, 2010), and social networks (Mavandadi, Zanjani, Ten Have, & Oslin, 2009; Poindexter & Shippy, 2008; Shippy & Karpiak, 2005; for a recent review of social and behavioral literature on aging and HIV/AIDS, see Sankar, Nevedal, Neufeld, Berry, & Luborsky, 2011). But they do so with little if any sustained attention to the many interlocking social, historical, clinical, psychological, and political elements of the HIV/AIDS epidemic in the lives of older gay men or to the key mechanisms (particularly, timing, agency, and interdependence) through which, life course theory argues, environment affects human lives. Yet, this attention is essential if we are to untangle this epidemic's impact on male Baby Boomers. This impact is so massive because it extends past the bereavements suffered in the 1980s–1990s and past the high numbers of gay male Baby Boomers currently living with HIV-related health conditions. Rather, regardless of their own HIV status, gay male Baby Boomers are aging in a context strongly shaped by these heavy losses and within heavily depleted social networks, with as yet unknown consequences for later life.

To make the case for the expansion of research into aging and HIV beyond the current exclusive focus on HIV-positive elders and for the use of the life course approach in studies of aging and HIV/AIDS, we examine the demography of U.S. AIDS mortality during the epidemic's height (1987–1997), first among male Baby Boomers and then among gay male Baby Boomers. Using the Centers for Disease Control's (CDC, 2011a) compressed mortality file for underlying cause of death, we compile AIDS death rates for men between 1987 and 1997 and age-specific data for men aged 25–34 and 35–44 years, with particular focus on male AIDS deaths in 1990 and 1995 (unless otherwise noted, all statistics appearing here are taken from the CDC, 2011a). These ages translate to cohorts

born in 1945–1956 and 1956–1965 in relation to deaths in 1990 and in 1941–1950 and 1951–1960 in relation to deaths in 1995. Those aged 25–34 years in 1995 were born in 1961–1970, thus falling at the tail end of the Baby Boom, and were excluded from the analysis. Using these and other secondary data, we outline the concentration of AIDS deaths in major cities with thriving gay communities. This concentration further intensified the effects of these deaths on gay men's social worlds. We then briefly summarize the increasingly complex situation of gay men aging with HIV, which often introduces multiple disadvantages to later life. The conclusion argues that a fuller examination of the role of HIV/AIDS in the lives of gay male Baby Boomers, taking account of life course theory's core concepts of timing, agency, and interdependence, is critical to appreciating the Baby Boom generation's heterogeneity and to expanding knowledge of how later life is shaped by the intersection between historical events, personal biography, and social and community ties. Such an examination would complement the clinical, psychological, and social network approaches that currently dominate the field.

Male Baby Boomers and AIDS Deaths

In 1981, the first AIDS case was identified and the syndrome defined by the CDC as "a disease at least moderately predictive of a defect in cell-mediated immunity, occurring in a person with no known case for diminished resistance to that disease" (CDC, 1982, pp. 507–508). AIDS was later linked to the retrovirus known as HIV. In the United States between 1987 and 1998, 324,029 persons died of either AIDS or a cause of death attributable to HIV, with AIDS accounting for 162,667 deaths (CDC, 2011a). Of all AIDS deaths in these years, 84% ($n = 136,257$) were men. The number of AIDS deaths rose from 5,647 in 1987 to a peak of 24,180 in 1995 (Figure 1). After 1996, deaths attributable to HIV and AIDS declined, dropping most rapidly among persons aged 25–44 years (CDC, 2011b). This was due to a combination of the effects of earlier HIV prevention efforts (Holtgrave, 2005) and the introduction of antiretroviral treatments (ART) in 1996. ART transformed HIV from an almost invariably fatal condition to a chronic, manageable one, although one with several comorbidities and medical side effects that severely limit quality of life (e.g., depression, arthritis, neuropathy, hypertension, and diabetes—see Kearney, Moore, Donegan, & Lambert, 2010; Martin et al., 2008).

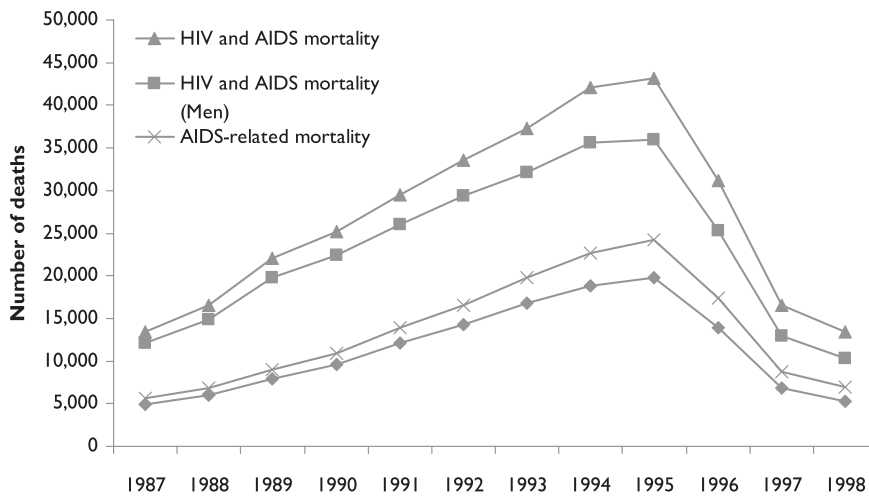


Figure 1. HIV and AIDS deaths in the United States by year of death: 1987–1998.

Beneath these numbers, however, lurks a more complicated picture. First, throughout this period, men aged 25–44 years accounted for 72% of AIDS-related male mortality each year. For this 25- to 44-year age group, HIV disease was the leading cause of death between 1992 and 1995, causing one in four deaths in 1995 (CDC, 2011b). The number of men of this age group born in the Baby Boom years who died of AIDS in the United States equates to approximately 25% of U.S. military casualties in WWII (Clodfelter, 2008). Second (see Figure 2), within the 25–44 age grouping, a higher rate of deaths per 100,000 occurred among African American (hereafter “Black”) men than among White men; in 1995, this was 106.3/100,000 versus 23.9/100,000, respectively.

Third, over this time period, male Baby Boomers aged 35–44 years suffered the highest mortality rates of all age groups, although mortality differences between age groups within this subcohort were

more significant for Black than they were for White men. In 1987, 49% of AIDS deaths among Black men within this 25- to 44-year age group were of men aged 35–44 years, growing to 61% by 1994; 52% of White male deaths in this group were of men aged 35–44 years, growing to 62% by 1994. Thus, as Figure 3 shows, between 1987 and 1995, men aged 35–44 years died at increasingly higher rates than did their younger counterparts (aged 25–34 years), regardless of their precise birth year within the 1946–1964 birth cohort time line, with the ratio of deaths among men aged 35–44 years to those aged 25–34 years steadily increasing each year. Moreover, in this period, men aged 35–44 years died at consistently higher rates than their older (aged 45–54 years) counterparts. In 1995, when the youngest members of that birth cohort had entered the 35–44 age range, their death rate became higher than it was among older members of their birth cohort who had entered the 45–54 age range, with

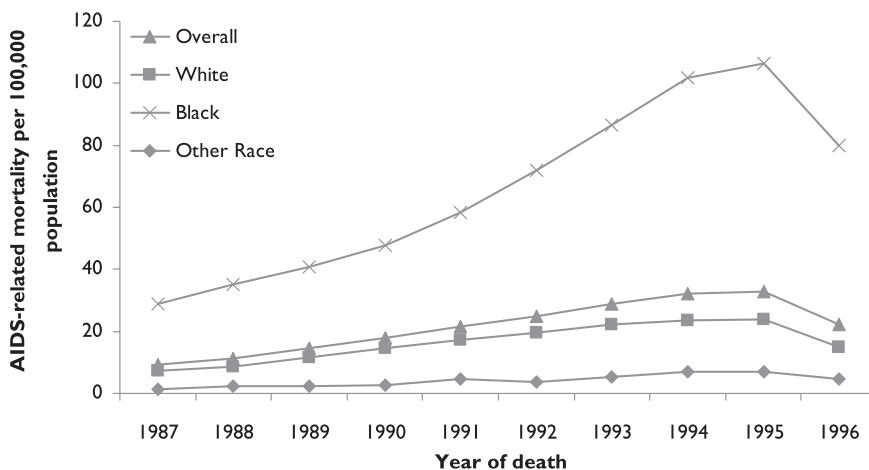
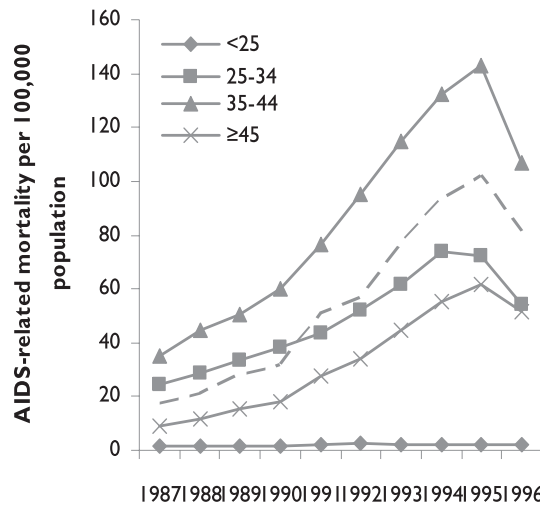


Figure 2. AIDS deaths among men aged 25–44 years in the United States by year of death and race: 1987–1996.

(a) Black men



(b) White men

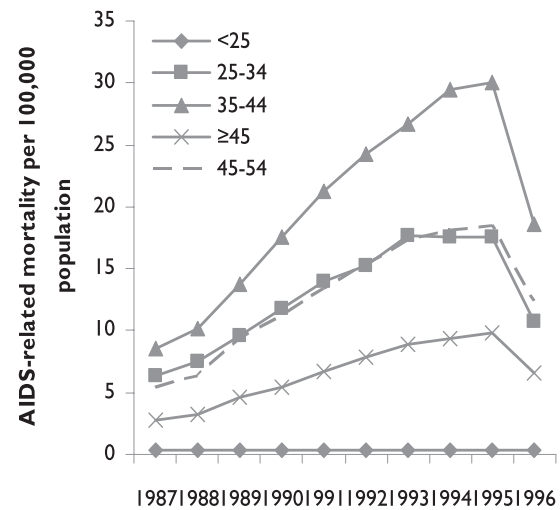


Figure 3. AIDS deaths among men in the United States by year and age of death. (a) Black men; (b) White men.

Black men now aged 34–44 years accounting for 69% of the AIDS deaths in their cohort in 1995, 67% in 1996, and 65% in 1997. These proportions are almost identical for White men. Moving into the 35–44 age group, then, significantly increased the likelihood of dying from AIDS. AIDS deaths among men aged 35–44 years remained highest within this birth cohort even when they consisted of those who had matured from the relatively protected age group of 25–34 years into this older group.

Thus, by 1995, men aged 35–44 years (born 1951–1960) were dying, and/or witnessing other men in their communities dying, in record numbers. Between 1990 and 1995, these men increasingly comprised a higher proportion of AIDS deaths among the Baby Boom generation. This, then, was the age group around which AIDS deaths increasingly clustered, even though AIDS deaths among men aged 25–34 years also tripled in these 5 years (AIDS deaths among Black and White men aged 45+ years quadrupled and tripled, respectively). However, the impact of HIV/AIDS on gay male Baby Boomers was even more intensive and unrelenting than it was on the male population more generally.

Gay Male Baby Boomers and HIV/AIDS: Communities Under Siege

It is challenging to determine the absolute number of gay men who died of AIDS or who are currently HIV positive, as many men who have sex with men (MSM) decline to declare their sexual practice, and many MSM do not identify as gay. Estimates of gay male AIDS deaths are extrapolations using a presumed percentage of the U.S. male population that is gay (usually 3%–10%).

Given the complexity of sexual identity and identification (Fenton, Johnson, McManus, & Erens, 2001; Sell, 1997), this is a problematic practice. These challenges notwithstanding, it is clear that gay men suffered the most AIDS deaths by far at the epidemic's height. Hogg and colleagues (1997, p. 659) found that AIDS deaths caused the life expectancy for gay and bisexual men in Vancouver to drop to a considerably lower level than the life expectancy of 54.3 years for all men. Gagnon and Nardi (1997, pp. 11–12) wrote that in the United States, one gay man in nine had been diagnosed with AIDS, 1 in 15 had died, and that 10% of the 1,600,000 men aged 25–44 years who identified as gay had died by 1995. Such figures point to a decimation of this cohort of gay men born 1951–1970. Moreover, although AIDS deaths among Black men exceeded those among White men, approximately half of the former occurred among MSM (Gagnon & Nardi, 1997, p. 10). Thus, despite the challenges to the precise quantification noted above, “It would be reasonable to say that virtually every gay person” in their later and middle years “alive today has been touched by the AIDS epidemic in one form or another” through personal illness, infection, loss, and/or caring for those sick from AIDS (Gorman & Nelson, 2004, p. 79).

The magnitude of these deaths is further compounded by the fact that they generally occurred within major cities with thriving gay cultures rather than being evenly distributed across the country. This distinguishes these deaths from, for

example, the 404,000 U.S. combat-related deaths in the Second World War (Gorman & Nelson, 2004, p. 76). Selik, Chu, and Buehler (1993, p. 2994) note the correlation between HIV-related deaths and city population size, identifying HIV infection on aggregate as the leading cause of death among young adults in cities with a 250,000+ population, the second leading cause of death in cities with a population of 100,000–250,000 and the fifth leading cause of death in smaller cities and nonurban areas. HIV caused 23%, 14%, and 8% of deaths, “respectively, in these three categories of cities.” They also found that in 1990, AIDS caused 61% of all deaths of men aged 25–44 years (born 1946–1965) in San Francisco, 35% in New York, 51% in Ft. Lauderdale, 32% in Boston, 33% in Washington, DC, 39% in Seattle, 34% in Dallas, 38% in Atlanta, 43% in Miami, and 25% in Portland, OR. AIDS was the leading cause of death for White men in 45%, and of Black men in 32%, of cities with 100,000+ inhabitants. At the epidemic’s height, then, AIDS deaths among Baby Boom men were an essentially urban phenomenon. These deaths, compressed as they were into a single generation and a single decade, were further distilled into a small number of large cities, with devastating effects on local networks and communities.

Critically, these were cities with openly gay neighborhoods and social networks, and with a far higher proportion of MSM than the national average. Using 1990 census data, Black, Gates, Sanders, and Taylor (2000, p. 149) found that “a randomly selected gay man from our sample is about 12 times more likely to live in San Francisco than are other individuals in the U.S. population” and identified Los Angeles, Washington, DC, and Atlanta as examples of other cities with particularly high concentrations of gay inhabitants. Drawn to the thriving gay life they hosted and to their relatively long histories of increasingly open gay networks, venues, media, and political organizing, many gay men had moved to these cities in earlier years. Such gay environments had been available, albeit more secretly, before WWII (Chauncey, 1994). But many U.S. cities that suffered significant rates of AIDS deaths during the epidemic’s height had undergone a burgeoning of public gay culture at the outset of the Baby Boom, as “The post-War urban culture, increasingly populated by hordes of soldiers who had engaged in homosexual behaviour, witnessed the birth of urban gay communities, with more gay men choosing to live a nonheterosexual lifestyle” (Hammack, 2005, p. 276).

This postwar culture, extremely hostile to homosexuals (see D’Emilio, 1998), saw reformist homophile organizations give way to more radical gay liberationist groups in the 1960s–1970s. These groups, key actors in a growing countercultural movement, used such slogans as “out of the closet and into the streets” to refashion homosexuality from a private, sexual matter to a public, political one (see Marrota, 1981; Rosenfeld, 2003, 2009). By the early 1980s, a public gay culture in which increasing numbers of people could publicly identify as gay or lesbian emerged in major U.S. cities, attracting large numbers of gay men in particular (Gagnon & Nardi, 1997). These urban communities offered engagement and support on social, sexual, neighborhood, and community levels. Largely driven by consumption, they also formed strong gay friendship and support networks often serving as “families of choice” (see Weston, 1991). These “families” offered essential support to gay men and women whose relations with their families of origin were often fractious.

It was these communities that were, as we have seen, decimated by AIDS in 1987–1997. Given the far higher rate of HIV infection and AIDS deaths among MSM than among exclusively heterosexual men, these cities had very high AIDS-related mortality within their large gay male communities. Holmberg (1996) noted that in the United States’ 96 largest metropolitan statistical areas, estimated HIV infection was vastly higher among MSM than it was among men solely engaged in heterosexual relations. In San Francisco, for example, 1.5% of the latter group was estimated to be HIV infected, versus 40.7% of MSM. In Houston, these percentages were 1.1% versus 27.1%. Holmberg also found that estimated HIV seroprevalence and seroincidence among MSM was highest in San Francisco (40.7%), Miami (31.4%), New York (29.2%), Atlanta (28.6%), Houston (27.1%), Dallas (26.6%), Washington, DC (24.2%), Los Angeles-Long Beach (22.6%), Philadelphia (21%), Newark (17.9%), Chicago (16.3%), and the Seattle area (14.1%). But given the shift that had occurred from the oppressive, secretive gay world of the postwar era to an increasingly open and public one, these urban gay communities were better placed to respond to the epidemic than they would have been a mere decade earlier. With HIV/AIDS mortality skyrocketing, government responses to the epidemic lackluster at best, health care providers too often lacking in the quantity and quality of care, and the new conservative

politics of the Reagan era often attacking gay persons (and “AIDS victims” in particular) as immoral (Cole, 1996), these communities lobbied for scientific breakthroughs (Epstein, 1989), agitated for appropriate state and federal responses to the crisis, conducted HIV/AIDS information campaigns, and cared for and helped those affected by HIV/AIDS (Brier, 2009; Chambré, 2006). As Gorman and Nelson (2004, pp. 75–76) noted:

Paradoxically, as AIDS decimated the gay community, it became a rallying point for the legitimization of gay rights because the HIV virus became a symbol of the irrational nature of homophobia and sharpened the historical realization that gays and lesbians could not depend on the presumed beneficence of government as far as their lives were concerned.

The Continuing Story: Aging With HIV

At the epidemic’s height, then, AIDS deaths were massive, unrelenting, targeted, and localized. But the impact of such a history on gay male Baby Boomers is further complicated by the fact that many are themselves now aging with HIV in the context of an enduring high incidence and prevalence of HIV infection and AIDS deaths among their gay male contemporaries, now aged 47–65 years. As Martin and colleagues (2008, p. 1033) write, older MSM have “alarming” rates of HIV infection, with two studies of older men in four large cities reporting HIV prevalence of 19% and of Black MSM in particular of 29%—a prevalence rate “attenuated by a remarkably high 69% mortality rate.” Karpiak (2011) found that U.S. AIDS cases among those aged 50+ years rose from under 20,000 in 1995 to almost 130,000 in 2005, with persons aged 50+ years comprising approximately one third of all AIDS cases in San Francisco, Los Angeles, and New York. But within the gay male Baby Boom subcohort are two further subcohorts of men living with HIV, distinguished by age and historical era in which HIV infection occurred (here, pre- or post-ART in 1996). Some of these were infected and diagnosed before 1996, only benefiting from ART after years of ill health and of witnessing large numbers of friends and/or partners dying, with no medical cure and little palliation for HIV/AIDS in sight. Others were infected and/or diagnosed in later life, after ART was made available.

Members of these further subcohorts of HIV-positive older gay men have very different personal histories whose effects on social support, mental

health, and everyday life remain unknown. Compared with the late diagnosed, the long-term infected have longer and arguably more complex histories of multiple HIV-related conditions, social stigmatization, and health-related interruption to professional career at ages traditionally devoted to securing financial status and thus bringing severe financial repercussions. The medical, social, and professional careers of late infected men and their clinical and mental health statuses, however, may differ from those of the first group in key ways, given that HIV infection and/or diagnosis occurred later in life and thus at a later point in their physical, social, psychological, and career development. For example, in addition to the negative impact of age on HIV/AIDS, late diagnosis—significantly higher for older MSM—is associated with poor clinical outcomes. These include short-term mortality, where older adults diagnosed late had 2.4 times the risk of dying within 1 year of diagnosis than did younger adults (Smith, Delpuch, Brown, & Rice, 2010—see also Martin et al., 2008).

Missing Links: The Need for Further Study

Reaching its peak during these gay male Baby Boomers’ adulthood and early middle age and centered in a number of large cities with organized, flourishing gay communities, the HIV/AIDS epidemic cast a long shadow, shaping these men’s personal and collective health, social resources, and, often, politics and careers. Yet, profound gaps in our knowledge and understanding of the consequences of this disaster for these men endure, as the three key mechanisms (interdependence, agency, and timing) by which life course theory argues environment shapes lives remain underused in relevant research. These gaps are particularly wide given the preponderance of clinical and psychological research. Long-term effects of HIV/AIDS on these men that have been empirically documented are the psychological impacts of multiple losses (Ingram, Jones, & Smith, 2001; Nord, 1998) and these losses’ short- and long-term effects on social networks, relations, and support. But, as with much research in this area, the more intricate phenomenon of *interdependence*, so central to life course research, is often overshadowed by a concern with social networks or support as dependent or independent variables rather than areas of investigation in their own right (see e.g., Burgoyne & Renwick, 2004; Crystal et al., 2003). Inadequately understood effects of HIV/AIDS on

gay male Baby Boomers that unfold within interdependent networks include intergenerational relations (Gorman & Nelson, 2004) and sexual and romantic relationships (Elford, Bolding, Maguire, & Sherr, 2001; Lear, 1997). Equally important, underinvestigated areas of interdependence are the experiences of gay men caring for those with HIV/AIDS and impacts of HIV/AIDS on wider circles of family and friends (see Brown & Powell-Cope, 1993; Gregory & Longman, 1992; Mitchell & Knowlton, 2009). These already complex areas are further complicated by the fact that, although in the typical absence of children and extended heterosexual families gay men usually rely on “friends-as-family” (Weston, 1991) for informal support, high mortality rates from AIDS caused the loss of gay men who could have otherwise provided care and support (Hash, 2006, p. 124). Particularly lacking is research into the consequences and management of AIDS deaths among MSM within the African American community, which suffered so disproportionately from these deaths (but see e.g., Cohen, 1999; Johnson-Moore & Phillips, 1994).

Research also generally elides the second mechanism identified by life course theory, *agency*, in failing to examine how gay male Baby Boomers rebuilt their social networks, relations, and identities, both throughout the epidemic and in later years. There is little recognition in the literature on aging and HIV/AIDS of the agentic-political actions of many of these men and their contemporaries in response to the epidemic’s political mismanagement. Despite a substantial literature on AIDS activism (Brown, 1997; Epstein, 1989; Gamson, 1989; Gould, 2009), social attitudes and political beliefs and activities among gay male Baby Boomers in particular remain underresearched. It is likely, however, that these were shaped by memories of the stigmatization of HIV/AIDS, the suffering of gay communities, and HIV/AIDS activism of the 1980s–1990s. Such research is essential for understanding the full impact and long-term effects of this disaster on the lives of gay male Baby Boomers. It can also further understanding of how communities more generally rebuild themselves in the aftermath of disaster—a potentially fruitful area given both the aging of society and the increasing likelihood of disruption to social networks (on which those in later life rely) posed by environmental changes and global conflicts.

Finally, although some scholars have noted that “the 50s generation may have suffered the

most egregious losses from AIDS” (Cohler, 2007, p. 103), most research into aging and HIV/AIDS fails to pay adequate attention to issues of *timing*, displaying little recognition that these men are Baby Boomers in the first place. Little research situates the experiences and circumstances of gay men aging with HIV within such sociohistorical processes as the rise of open, organized urban gay communities (for a rare exception, see Gorman & Nelson, 2004). Moreover, few studies consider that gay men who experienced these multiple losses did so in their early adult through middle years and that these losses thus intersected with age and life course factors to shape later life. An obvious example is the massive number of premature deaths within a relatively young cohort, disrupting not only individual and collective health but also normative expectations and life plans held by a range of actors linked through family, families of choice, and romantic and friendship ties. Another example is professional careers (Weiner, 1991), as many of these men invested time and money in AIDS-related caring, organizing, and activism at the epidemic’s height—again, at ages (25–45) traditionally key to professional advancement. Finally, that gay male Baby Boomers aging with HIV fall into two further subcohorts based upon the historical era in which they were infected further demonstrates the lasting—and highly complex—role of timing in human development, as medical developments shape how HIV infection plays out in later life.

In conclusion, uncovering the internal heterogeneity of the Baby Boom generation requires the application of life course theory’s conceptual repertoire and theoretical sensitivities to the experiences, circumstances, and careers of this subcohort. Such research could illuminate the domains listed at this paper’s outset—the impact of HIV/AIDS on politics, professional careers, financial and health status in later life, social, neighborhood, and community ties (particularly in regards to care giving and social support), and health and health care practices—and the complex interrelationships between them. Researching similarities and differences within this subcohort of gay men would shed important light on the long-term effects of illness in political context, and personal, social, and community disruption on aging and the life course. In addition to identifying the implications for policy and service development, such study could, we suggest, further our understanding of life course theory in the light of an ongoing illness scenario rarely seen in modern times and of the interlocking

multiplicity of factors that continue to shape the lives of the Baby Boom generation.

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