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Sexual decision-making among homosexual men in the San Francisco Bay Area

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SEXUAL DECISION-MAKING AMONG HOMOSEXUAL MEN
IN THE SAN FRANCISCO BAY AREA

A Thesis

Presented to

The Faculty of the Department of Health Sciences
San José State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Public Health

by

Matthew Edward Staley

May 2000

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ABSTRACT

SEXUAL DECISION-MAKING AMONG HOMOSEXUAL MEN IN THE SAN FRANCISCO BAY AREA

by Matthew Edward Staley

This thesis addresses the topic of "barebacking" (engaging in receptive anal sex without using condoms), between men who have sex with men (MSM) in the greater San Francisco Bay Area. This qualitative study is based on in-depth, personal interviews with 13 men who have made a conscious decision to eschew current safer-sex recommendations.

The results indicate that mainstream published reports mask deeper issues of gay male identity, culture, community, and latent and overt societal homophobia. Themes regarding non-use of condoms were identified and include: physical and psychological sensation differences; relationship stability and intimacy; intentional infection and re-infection with HIV; mistrust of the public health and medical establishment; and the impact of a divided community. The results also indicate disparities between current safer-sex educational programs and the lived reality of men who have coped with the threat of HIV/AIDS.

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CHAPTER 1

Introduction

The goal of this study was to investigate the attitudes and beliefs of men who have sex with men (MSM) in the San Francisco Bay Area regarding HIV/AIDS and latex barrier usage for receptive anal intercourse. This area of inquiry was chosen due to epidemiological data released by the Centers for Disease Control and Prevention in 1997 that showed an increase in the number of individuals placing themselves at risk for HIV infection as evidenced by increases in sexually transmitted diseases, particularly rectal gonorrhea, among MSM in San Francisco. These data suggest the possibility that new and potentially riskier sexual behaviors are occurring in the MSM population in the San Francisco Bay Area.

The specific intent of the study was to explore and elucidate relevant behavioral choices about condom use during anal intercourse, and to identify those factors that helped to motivate these choices. Recognizing that many variables influence an individual's health-related behavior decisions, this study employed an open interview format that allowed participants to explain their behaviors and their motivating factors in their own words, to provide a richer and more comprehensive understanding of the "barebacking" phenomenon. For the purposes of this study, "barebacking" is defined as a conscious decision not to use

condoms for receptive anal intercourse.

Participants in the study were self-identified men who have sex with men residing in the counties of San Francisco, Marin, Alameda, and Contra Costa who reported not utilizing condoms for at least 50% of their episodes of receptive anal intercourse. Individuals who were diverse in terms of age, race, ethnicity, and HIV serostatus were included in order to capture a mixture of relevant themes.

Statement of the Problem

The HIV/AIDS pandemic is entering its 20th year and continues to be an issue of major concern to public health professionals across the world. Millions of individuals have been infected with HIV, and hundreds of thousands have died from AIDS, the clinical syndrome caused by HIV (Katz, 1997). While all ages are susceptible to HIV, the age groups most affected in the United States have been individuals between their late teens and early 40s. This population group comprises most of the workforce and is also the group most likely to parent future generations. The loss of large numbers of this segment of the population presents enormous complications and difficulties for nations, particularly those in the developing world.

While HIV and AIDS have been primarily manifested in heterosexual women in much of the world, in the United States the epidemic has largely been focalized in the men who have sex with men population (MSM), particularly in

major metropolitan areas. San Francisco was struck particularly hard by the incidence of both HIV infection and active AIDS. Receptive anal intercourse without the use of a condom has been identified by the Centers for Disease Control and Prevention (1997) as a major route for the transmission and acquisition of HIV.

The intensive efforts of various agencies and communities have ameliorated this impact dramatically. The incidence of AIDS among MSM of all ages and races in San Francisco peaked in 1992 and then declined steadily until 1995 (Katz, 1997). The Centers for Disease Control and Prevention (CDC) reported in 1999 that the AIDS incidence rate among MSM in San Francisco has remained stable since that time.

National gonococcal infection trends.

Sexually transmitted diseases, including gonococcal infection, serve as a marker for sexual behaviors associated with an increased risk for HIV infection (CDC, 1997). Across the United States, gonococcal infection rates have steadily declined and continue to do so, with the recent exception of the infection rates among MSM. It was against this background of declining incidence and stable prevalence that a report from the CDC was released in 1997. Since 1993, the CDC has funded several public sexually transmitted disease (STD) clinics as sentinel surveillance sites to collect data regarding the incidence

of gonococcal (GC) infections. Additional focus was directed at eight sites across the nation, including San Francisco, which reported a rate of greater than 5% of these infections among MSM.

Among those eight sites an average rate of 12% (range 4.2% to 35.1%) of GC infections were reported among MSM in 1993. By 1996 this average rate had almost doubled to 23.5% (range 7.2% to 57.1%). The median age of infected MSM was 30 and remained stable from 1993 to 1996. The percentage of white individuals increased from 58.6% to 64.9% while the percentage of African American individuals decreased from 23% to 17.4%. There were no appreciable changes in the proportions among other ethnic groups. The CDC report (1997) did not identify any confounding factors that might explain the increases and concluded that there was a distinct likelihood that an increase in unprotected sexual intercourse was occurring among MSM.

The 1997 CDC report noted that it was possible that this increase in the rate of GC infections could herald a new epidemic of HIV infection among MSM due to high-risk sexual behaviors and the potential changes in the urethral epithelial tissue associated with GC infection that could facilitate HIV transmission. Wasserheit (1992), in a review of 163 studies, reported on this associated risk, and concluded that STDs of all types resulted in a three- to five-fold greater risk of HIV transmission.

West coast gonococcal infection trends.

Seattle, Portland, and San Francisco were the three sites that showed the greatest increase in GC infections among MSM between 1993 and 1996 (CDC, 1997). Increases were 125%, 124%, and 24%, respectively. While Seattle and Portland had considerably larger increases, the actual incidence of reported GC infection in San Francisco has always been higher, ranging from 35% to 55% from 1993 to 1996. These findings were alarming due to the fact that GC infections among MSM declined substantially throughout the 1980s as condom-protected intercourse became highly prevalent among MSM (CDC, 1997).

San Francisco gonococcal infection and sexual behavior trends.

In January 1999 the CDC published a report that confirmed that the increases in GC infection rates among MSM coincided with an increase in sexual intercourse without condom usage (CDC, 1999). The Stop AIDS Project in San Francisco surveyed 21,857 MSM from 1994 to 1997 regarding sexual practices and found that the percentage of men always using condoms for both insertive and receptive anal sex decreased from 69.6 to 60.8 in 1997 (CDC, 1999). The greatest decrease in condom usage for anal intercourse was among MSM aged 26-29, from 68.2% in 1994 to 58% in 1997.

The San Francisco Department of Public Health reported

that rectal GC infections, which are a reliable indicator of unprotected receptive anal intercourse (URAI), declined from an incidence of 42 per 100,000 in 1990 to 20 per 100,000 in 1993, but steadily increased from 21 per 100,000 in 1994 to 38 per 100,000 in 1997. The increase occurred among all age groups and ethnic groups, but was most concentrated among MSM aged 25-34 whose rates of rectal GC infection more than doubled from 41 per 100,000 in 1994 to 83 per 100,000 in 1997 (CDC, 1999).

The CDC noted that the incidence of HIV in this population had not increased, but also pointed out that the time to diagnosis of HIV infection ranges from 6 to 18 months, which is considerably longer than that for GC infection, ranging from 2 to 3 days (CDC, 1999). Furthermore, HIV infection can remain asymptomatic for years, and unless an individual seeks testing, the infection remains undetected and incidence rates are unaffected. GC infection, however, generally produces rapid symptoms that lead to the seeking of medical care, diagnosis, and reporting (CDC, 1999).

Implications.

The public health implications of these reported changes in GC infection and the associated sexual behaviors are alarming. MSM between the ages of 25 and 34 are placing themselves at great risk for HIV infection, which raises the possibility that a second epidemic will emerge

in time. Gail Bolan, MD, the director of the San Francisco Public Health Department's Sexually Transmitted Disease Clinics during the time of the study conducted by the CDC, confirmed this hypothesis. Dr. Bolan (personal communication, October 4, 1999), who is now the Chief of the STD Control Branch of California Department of Health Services, pointed out that California does not collect sexual orientation data from patients and that self-reported sexual behavior is often inaccurate. Although Dr. Bolan is cautious to claim with absolute certainty that unprotected anal intercourse is the only behavior that would result in rectal GC infection, she does say that the only conceivable alternatives are, at best, unlikely. For example, she recognized that it was possible that sexual devices, such as dildos, could transmit the GC bacteria, but noted that there were no studies that had examined the effectiveness of this route of transmission. She remains skeptical about the likelihood of alternative routes given the delicate and fastidious nature of the bacteria. Dr. Bolan confirmed that unprotected anal intercourse is the most effective mode of sexual HIV transmission.

Public reaction.

The release of the CDC's 1999 findings sparked a flurry of articles in the popular press, including the San Francisco Chronicle and magazines targeting homosexual men (Gendin, 1999; Harpaz, 1999; Russell, 1999; Scarce, 1999).

However, the popular media was not reporting on a new behavior, but simply one that became more prominent and lent itself to sensationalistic reporting styles. While many men who have sex with men embraced condoms for anal intercourse, the behavior was never an all-inclusive practice. The academic press has reported on men who have chosen not to utilize condoms for episodes of anal intercourse since 1994. Researchers including Hospers, Molenaar, and Kok (1994); Remafedi (1994); and Ridge, Plummer, and Minichiello (1994) worked independently and in different geographical locations. What is perhaps new is the increasing prevalence of the behavior as indicated by the rising rates of rectal GC infection.

Impact of anti-retroviral therapies.

Given the overall relatively low HIV prevalence in San Francisco among men who have sex with men, approximately 20% in 1999, as opposed to up to 70% in 1992 (San Francisco Department of Public Health, 1999), the risk of contracting HIV regardless of engaging in anal intercourse without condoms is significantly lower than it has been in years based on the epidemiological data collected and reported by the San Francisco Department of Public Health. However, widespread use of effective anti-viral medications that can control HIV infection and AIDS symptoms and lead to a longer life span will also result in an increased pool of infected men capable of transmitting the infection. Dan

Wohlfeiler, former education director of the San Francisco STOP AIDS Project, argues that an uninfected man engaging in unprotected anal sex increases his chances of encountering an infected person and becoming infected himself due to the potentially subtle nature of HIV infection in sexual partners who are taking anti-viral treatment regimens (personal communication, October 21, 1999).

HIV infection risk-modeling.

Recently released data from the San Francisco Department of Public Health provided mathematical models that, for the first time, delineated the actual risk involved in specific sexual behaviors. The findings of epidemiologist Susan Buchbinder were included in this report (San Francisco Department of Public Health, 1999). Buchbinder's models showed the risk of HIV acquisition for an HIV-negative man who engaged in unprotected anal intercourse with an HIV-positive man to be 1 in 120. However, Buchbinder's research found that condom utilization for anal sex might not be as effective in preventing transmission of HIV as once thought. She reported that men who had receptive anal intercourse with an HIV-infected partner, and consistently used condoms, were only one-third less likely to contract HIV than those men who did not use condoms consistently for receptive anal intercourse with an HIV-positive partner. Buchbinder

cautioned that her statistical models do not have sufficient power to allow firm conclusions about the safety and efficacy of condom usage. She also pointed to an inherent limitation of statistical studies, which is that they can only estimate the average risk to a group of individuals as opposed to the actual risk for any one individual person. While this type of modeling cannot determine individual risk, it does suggest that there is a risk involved in the type of sexual behavior that was studied in this project. The model also highlights the fact that current prevention messages, which promote the utilization of condoms for anal intercourse, may be encouraging behavior that is not as effective as it was once believed to be.

Research reactions.

Numerous theories have been proposed to explain the reasons for the increasing occurrence of unprotected sex in MSM (Bosga, et al., 1995; Dilley, McFarland, Sullivan, & Discepola, 1998; Hays, Paul, et al., 1997; Hays, Kegeles, & Coates, 1997; Hospers, et al., 1994; Kalichman, Kelly, Morgan, & Rompa, 1997; Kalichman, 1998; Kalichman, Nachison, Cherry, & Williams, 1998; Katz, 1997; Kelly, Hoffman, Rompa, & Gray, 1998; Remafedi, 1994; Robins, Dew, Kingsley, & Becker, 1997). However, most of the relevant studies in recent years have almost exclusively employed quantitative research designs. Few qualitative studies

have explored the motivations, attitudes, or beliefs regarding the need for consistent condom usage for receptive anal intercourse among MSM, the population identified by the epidemiological data as being most at risk for HIV infection. Qualitative research can provide an important context for understanding why those behaviors occur. As noted by Donovan, Mearns, McEwan and Sugden in 1994

Quantitative research removes individuals from their social context. Qualitative research is required to locate individuals within their social milieu and to better understand them as individuals interacting with others and involved in an ongoing decision-making process about sexual pleasure and risk. (p. 605)

Clearly, any sexual behavior that places an individual at risk for HIV infection, whether with one other person or a group of people, is a social behavior. Research that honors and explores this social basis is essential to an understanding of the phenomenon of unprotected anal intercourse in MSM.

Overall Research Question

This research was designed to address the following research question: What are the attitudes and beliefs of men who have sex with men regarding condom usage for receptive anal intercourse?

Objectives

This research was designed to meet the following objectives:

1. To understand the attitudes and beliefs of men who have sex with men regarding condom usage for receptive anal intercourse.
2. To identify the choices made by the research participants regarding condom usage for receptive anal intercourse.
3. To function as a preliminary qualitative needs assessment for the identified population.
4. To add to the emerging literature on the health behavior attitudes and beliefs of men who have sex with men regarding condom usage for receptive anal intercourse.

Methodology

This research followed a qualitative design, which utilized an open-ended long-interview format. For DePoy and Gitlin (1998), one of the purposes of qualitative research is to "uncover the meaning of how humans experience phenomena through the description of those experiences as they are lived by the individual" (p. 82). This design was chosen due to the researcher's belief that MSM constitute a definite culture and experience attribution characteristics that are distinct from other segments of the population and his belief that an understanding of these values would be essential to developing effective intervention techniques. It is the researcher's conviction that the experiences, motivations, needs, and emotional contexts of all behavior are best understood when the population of interest is

queried directly in an open-ended format that allows for the fullest possible expression of perceptions, concerns, and beliefs. Given the enormous complexity of human behavior, a qualitative approach was thought to provide a broader, more comprehensive picture of the context for risk-taking behaviors.

Participants were recruited in a number of ways following a convenience sampling model. A World Wide Web page was created that gave essential information regarding the study, including contact information. A text copy of the page can be found in Appendix A. This approach was chosen in recognition of the enormous popularity of the Internet among men who have sex with men in the San Francisco Bay Area. Study recruitment advertisements were placed in three free weekly newspapers, the San Francisco Bay Guardian, the Bay Area Reporter, and the San Francisco Bay Times, which are distributed in MSM venues throughout San Francisco, San Jose, and the East Bay. These venues include bars, coffeehouses, and commercial establishments designed for sexual contact. Text copies of the advertisements are located in Appendix B. Participants were also encouraged to recruit friends and others who met the inclusion criteria, a process known as snowball sampling (DePoy & Gitlin, 1998).

This research project was submitted to the Institutional Review Board (IRB) of San Jose State

University, and approval was received from that body prior to the collection of any data. Informed consent was obtained from each participant prior to the collection of any data. Further details regarding IRB approval and informed consent can be found in Chapter 3.

To elicit information in a natural context that would most closely resemble conversation, data collection was performed with minimally structured individual interviews. In order to protect confidentiality, or anonymity, participants were asked to provide an identifier of their choice for the purposes of the interview, transcription process, analysis, and writing of the report. Participants were also asked to indicate their age, county of residence, HIV serostatus, relationship status, and frequency of receptive anal intercourse without condoms. A general question was posed that queried research participants regarding their attitudes about using condoms for receptive anal intercourse. If non-usage of condoms was sporadic, additional questions focused on why they had chosen not to use condoms and under what circumstances condoms were, or were not, used. Further questioning was based on the particular responses of the individual participant. Although an interview protocol was used, no script was utilized and different subjects were asked different probing questions depending on the nature of their responses.

Interviews were conducted in locations chosen by the research participants. The comfort, privacy, and confidentiality of the participant was of paramount importance. The only requirement regarding the interview environment imposed by the researcher was that there be a minimum of background noise as the interviews were recorded on audiotape. In order to meet this requirement, interviews were conducted in the participants' or the researcher's home.

The interviews ranged in length from 1 hour to 2 hours and 15 minutes. Interviews continued until no new information was elicited, or until participants indicated that they wished to terminate the interview. All participants were offered an incentive of \$25 for completing the interview. Participants were asked if they would be willing to serve as participant reviewers to ensure the validity of the study findings, with the understanding that their mailing or electronic-mail address would remain strictly confidential. Participants were also informed that serving as a participant reviewer was not required. Regardless of their willingness to serve as reviewers, all participants were given the opportunity to identify an address that project results could be mailed, if they so desired. The information above was included in the consent form that all participants signed. The consent also served to assure participants that participation was

voluntary and that a decision not to participate would not prejudice their relationship with San Jose State University.

All interviews were audiotaped. The taped interviews were later transcribed and then examined for common themes and ideas expressed by the participants. Themes were not quantified; rather they were identified and examined to determine if there were issues raised which could be used to inform the development of future research studies.

Definitions

The following definitions were used in this study.

Men who have sex with men.

Conceptual: Biological males who self-identify as gay (exclusively engage in sexual intercourse with biological males), bisexual (engage in sexual intercourse with both biological males and females), and straight (exclusively engage in sexual intercourse with biological females) but who in fact also engage in sexual intercourse with biological males.

Operational: Biological males who report that they exclusively engage in sexual intercourse with biological males, or who self-identify as gay.

Receptive anal intercourse.

Conceptual: Any sexual activity in which a penis is received into the anus and rectum.

Operational: Any sexual activity in which a penis is

received into the anus and rectum of a biological male as reported by participants.

Unprotected receptive anal intercourse.

Conceptual: Any sexual activity in which a penis is received into the anus and rectum without utilization of a barrier, with or without ejaculation.

Operational: Receptive anal intercourse without utilization of a barrier as reported by participants.

Safer sex.

Conceptual: Sexual activity that reduces the opportunity for the transmission of the Human Immunodeficiency Virus.

Operational: Sexual activity in which blood or semen exchange is avoided as reported by participants.

Barrier.

Conceptual: Any device designed for use during sexual contact that prohibits exchange of blood, semen, or vaginal secretions.

Operational: A male or female condom designed to prevent exchange of seminal fluid.

HIV serostatus.

Conceptual: The presence (positive) or absence (negative) of antibodies produced by the human immune system in response to infection with the Human Immunodeficiency Virus as detected by a Food and Drug Administration licensed diagnostic test system.

Operational: The presence (positive) or absence (negative) of antibodies produced by the human immune system in response to infection with the Human Immunodeficiency Virus as reported by participants.

Normative behavior.

Conceptual: A standard, model, or pattern of behavior regarded as typical by the study participants.

Operational: Recurrent descriptions or themes related to sexual behavior as reported by the study participants.

Primary partner.

Conceptual: An individual with whom a person shares emotional bonds and a physical expression of those emotional ties.

Operational: An individual, identified by a participant, to whom the participant is emotionally attached, engages in sexual intercourse with, and with whom he shares a physical residence.

Female condom.

Conceptual: A polyurethane device resembling a male condom which is designed to be inserted into the vagina prior to the initiation of sexual intercourse.

Operational: The same device as described above that is inserted into the rectum of a biological male prior to the initiation of anal intercourse.

Limitations

There were limitations to this study due to the design, which included self-report, and sampling technique. These limitations were acknowledged before data collection.

The small sample size limits the external validity of the results. However, given the lack of recent attempts to engage MSM directly in a dialogue concerning sexual behaviors, and the attendant attitudes and beliefs associated with those behaviors, this small-scale study was an essential first step. Data may not be generalizable to the entire MSM population, but themes and concepts that emerged may prove to be transferable to those groups of MSM who have similar demographic characteristics and who have made sexual choices similar to those participants queried for this study.

The sampling technique employed may have created selection bias because those individuals willing to discuss their sexual behavior and sexual motivations openly may have personal characteristics or possibly even social or political agendas not typical or representative of the MSM population in the San Francisco Bay Area. However, this factor does not invalidate the insight or perspective in their accounts or the utility of those accounts to illuminate their lived experiences.

Significance

This study presents data that can be used to inform

further research aimed at designing a new approach to HIV prevention for men who have sex with men in the San Francisco Bay Area. Implementation of a new prevention program based on the needs, concerns, attitudes, and beliefs of this population could forestall a return of an AIDS epidemic similar to the one that struck San Francisco in the 1980s. As it has been estimated that the monetary cost to treat an AIDS patient is between \$100,000 and \$200,000 per year in 1997 dollars (Katz, 1997), the savings to the ever-shrinking health care infrastructure of the country are enormous. Beyond fiscal rewards, the psychological damage done to the MSM community by the AIDS epidemic may never be completely understood, or will we as a society ever know what those men whose lives were lost in their most productive years might have contributed if they had lived. Human costs, while hard to quantify, may well be more important for the long-term health of a community and culture than monetary ones.

The design and process of the research had a significance of its own. The participants were directly engaged in a dialog about their health perceptions and needs in a manner that gave participants a sense of ownership and investment in the research, gave them the opportunity to express themselves in their own words, and created a richer and more complete picture of the phenomenon than is possible using rigidly formulated

questionnaires and scaled formats. This study contributes to the knowledge base by offering qualitative data to complement the existing quantitative data.

Perhaps the participants who so generously gave of their time to be a part of this study learned something about their own thoughts, feelings, and motivations while recognizing a connection with others in their community with whom they might never have direct contact. This new knowledge and the process of participating in its generation may prove to be of benefit to the participants.

CHAPTER 2

Literature Review

Different researchers and authors frequently use differing terminology to describe similar phenomena. In an attempt to make the many salient issues regarding non-usage of condoms for receptive anal intercourse comprehensible, this Chapter utilizes a framework developed by the California STD/HIV Prevention Training Center (CAPTC) (n.d.). According to Alice Gandelman, Director of the CAPTC (personal communication, November 25, 1999), several CAPTC staff members developed this framework with input from behavioral science consultants from the University of California, San Francisco. The intention was to create a user-friendly model that incorporated behavioral science theories into STD/HIV prevention work. The model attempts to provide unifying concepts across multiple theories for the purpose of training STD and HIV prevention staff in the use of behavioral theory for the development of behavioral interventions. Appendix C can be consulted for definitions and examples of what are referred to as "domains," formalized in the framework as areas, placeholders, or categories. The five identified domains include risk appraisal, self perceptions, emotion/arousal, relationships and social influence, and structural/environmental factors.

Risk Appraisal

The domain of risk appraisal includes those factors

that pertain only to an individual's perception of his or her risk for acquiring a certain condition as influenced by his or her perceived susceptibility and the perceived severity of the condition. Within this domain, several specific risk factors have been identified in the HIV-related literature. Two authors (Katz, 1997; Robins, et al., 1997) noted the belief that one's own youth, or the youth of a sexual partner, had a protective effect against HIV. An even more widely represented aspect of this domain was the belief that being in a boyfriend relationship with a partner of any age would provide protection against HIV infection (Bosga, et al., 1995; Hays, Paul, et al., 1997; Hays, Kegeles, et al., 1997; Hospers, et al., 1994; Kalichman, et al., 1997; Katz, 1997; Remafedi, 1994). The most revealing studies about unprotected sex within relationships were those of Bosga et al. (1995) and Kalichman et al. (1997). Bosga et al., found that of 165 men reporting unprotected anal intercourse (UAI), 120 had done so with their boyfriend and of those 78 were unaware of their partner's HIV serostatus. The work of Kalichman et al. found that of those men reporting UAI, 52% were in a relationship. These studies have indicated that MSM tend to use condoms with non-main partners and tend to be less likely to do so with their main partners due to often inaccurate perceptions of the partner's risk for HIV infection, or their partner's HIV serostatus.

Several authors who were studying young men's conception of the inevitability of acquiring HIV (Dilley, et al., 1998; Hospers, et al., 1994; Kalichman, et al., 1997; Katz, 1997) revealed a different aspect of risk appraisal. Their research suggested that when men view infection as inevitable or as a part of the gay male experience they are not motivated to practice self-protective sexual behaviors such as using condoms for receptive anal intercourse.

The most recent development in the domain of risk appraisal involves the perceptions of men who have sex with men regarding the use of combination antiviral drug regimens and post-exposure prophylaxis (Kalichman, 1998; Kalichman, Nachisom, et al., 1998; Kelly, et al., 1998). Post-exposure prophylaxis (PEP) refers to the administration of anti-viral medications to HIV-negative persons, or those of unknown status, no later than 72 hours following a potential exposure to HIV, whereas combination therapies are given to men who are in the more advanced stages of HIV infection. These treatments usually involve three or more medications. The advent of these treatments, which are believed by some MSM to represent a cure for HIV or at least the effective management and control of the infection, has potentially prompted a resurgence of unprotected anal intercourse. While many MSM continue to recognize their susceptibility to HIV, their perceptions of

severity may have changed due to anti-retroviral therapies.

While it is possible that MSM are accurately modifying their perceptions of susceptibility to HIV infection due to the advent of PEP, this is still a controversial issue (Kalichman, 1998). Those studies that have shown PEP to be effective were focused on health care workers who experienced a percutaneous exposure to HIV (CDC, 1995; Puro, Ippolito, & Guzzanti, 1992; Tokars, Marcus, & Culver, 1993). Kalichman (1998) cautions that while further studies are underway to determine the efficacy and safety of this approach in MSM exposed to HIV through sexual contact, conclusions regarding the appropriateness and effectiveness of PEP for MSM should be avoided.

Self Perceptions

The domain of self perceptions includes factors that may contribute to an individual's appraisal of risk and includes internal thought processes, attitudes, beliefs, and the acquisition of requisite skills needed to enact a behavior. This domain was less widely represented among the HIV-related literature, but four authors (Hays, Paul, et al., 1997; Hays, Kegeles, et al., 1997; Remafedi, 1994; Robins, et al., 1997) noted that men engaging in UAI were more likely to express low self-efficacy when talking to their partners about the use of condoms. This belief may also be expressed within the domain of relationship/social issues. It is important to remember that the domains are

not designed, or intended, to be mutually exclusive.

Emotion/Arousal

While emotion and arousal are present throughout all the domain areas, the authors of the Domains Framework felt that it was important to isolate these issues. They felt that most formal behavioral science theories imply that behavior change is a rational and cognitive process. However, that may not always be true when addressing issues related to STD and/or HIV acquisition.

This domain is well represented in the HIV-related literature and the issues raised are diverse. Diaz (1996, 1998) detailed a number of negative emotional states, including experiences with internalized homophobia and racism that he associated with a lack of sexual protective behaviors. Other authors also noted an association between feelings of depression, emotional need, loneliness, low self-control, and sexual objectification (Dilley, et al., 1998; Hays, Paul, et al., 1997; Hospers, et al., 1994; Kalichman, et al., 1997; Martin & Knox, 1997; Remafedi, 1994; Robins, et al., 1997, Strathdee, et al., 1998). Other identified issues of emotion and arousal were the lack of sensation and intimacy associated with condom usage (Diaz, 1996; Hays, Paul, et al.; Hays, Kegeles, et al., 1997; Hospers, et al., 1994), the taboo appeal of not using condoms after being told for years to do so (Hospers, et al., 1994), and a relationship between prior sexual abuse

and lack of condom usage (Strathdee, et al., 1998). Most recently, Herscher (1999) quoted an HIV-positive gay male writer as saying, "The sex drive is the most powerful drive there is" (p. A1). Clearly, the interplay of emotions and arousal states impacts an individual's sexual behaviors, especially as those factors are experienced in relation to other people in complex relational situations. As noted earlier for the domains of risk appraisal and self-perceptions, the emotion and arousal domain is integrated and expressed throughout all of the others.

Relationship/Social Issues

The domain of relationship/social issues captures the interactions between two or more people, including power dynamics, cultural norms surrounding social behavior, gender roles, and sexual scripts. These issues may occur within formal relationships as well as in the broader social setting. Factors associated with relationship/social issues were widely reported. The single most prevalent factor was the level of attachment to the gay community as expressed by membership in gay organizations and other social networks involving peers and friends (Dilley, et al., 1998; Hays, Kegeles, et al., 1997; Hospers, et al., 1994; Martin & Knox, 1997; Strathdee, et al., 1998). There was a strong positive association between high levels of community attachment and safe sexual encounters. Only Katz (1997) reported on a negative peer

norm that discouraged using condoms. Rotheram-Borus, et al. (1994), in a study of gay and bisexual youth in New York City, found a strong association between lack of condom usage among those males who bartered sex for money and/or drugs. This non-usage of condoms was particularly pronounced when the young men engaged in sexual intercourse with females.

Structural/Environmental

The domain of structural and environmental factors includes those factors that are, or are perceived to be, beyond the control of the individual, which can influence risk-taking behavior. The two most pronounced structural/environmental issues identified by researchers were low socioeconomic status and low educational level. Six of the studies reviewed found an association between these two factors and unprotected sexual encounters (Kalichman, et al., 1998; Robins, et al., 1997; Rotheram-Borus, et al., 1994; Ruiz, Facer, & Sun, 1998; Strathdee, et al., 1998; Van de Ven, Noble, Kippax, Baxter, & Cooper, 1997). Ridge et al. (1994) detailed a completely different type of association within this domain in their study of gay youth in Sydney, Australia. They found that those men who met their sexual partners in gay commercial venues, such as saunas, bars, coffeehouses, and restaurants, were more than twice as likely not to use condoms during anal intercourse than those men who met sexual partners through

established social networks of friends.

Alcohol and Drug Use/Abuse

Although the California STD/HIV Prevention Training Center (n.d.) includes alcohol and drug use issues within the emotion/arousal domain, for the purposes of this review substance use will be treated separately due to the omnipresence and complexity of the issue. Many authors (Diaz, 1998; Hays, Paul, et al., 1997; Hospers, et al., 1994; Kalichman, 1998; Kalichman, et al., 1997; Katz, 1997; Remafedi, 1994; Robins, et al., 1997; Rotheram-Borus, et al., 1994; Ruiz, et al., 1998; Strathdee, et al., 1998) found an association between substance use before, and/or during, sexual encounters, and a decreased usage of condoms. However, only Diaz made an attempt to correlate this substance-use behavior with any other identified factor. All of the participants in Diaz's study who reported alcohol and/or drug use did so during periods of negative emotional states, such as loneliness or depression, or when experiencing the isolating effects of internalized homophobia or racism (Diaz, 1998).

Summary of the Existing Literature

There has been a great deal of research focused on MSM and many different approaches to understanding the phenomenon of unsafe sex have been attempted. The result has been, unfortunately, somewhat confusing. It would appear from the research cited that the MSM population at

risk for HIV infection is depressed, drug and alcohol abusing, of minimal educational achievement, and poverty stricken. This may be quite an inaccurate portrait of many MSM in the San Francisco Bay Area who are engaging in UAI.

Limitations of the Existing Literature

Part of the problem lies within the nature and restrictions of research and publication. Of the 12 studies for which both a study conduct and publication date were available, the average time from study completion to publication was 2.75 years. It would indeed be ideal if characteristics of populations did not change in that amount of time, but it is likely that they do. Another problem with existing research is that the vast majority of it is integrative in research design, with considerable quantitative components. While this is not necessarily a negative factor, it can be since quantitative research tends to use close-ended type questioning, frequently in the form of surveys, which limits responses to those the researcher identifies a priori as important. This reductionist approach relies on defined and distinct variables that often fail to take into account the social context and complexity of human behavior. Donovan, et al. expressed a similar concern in 1994:

Quantitative research removes individuals from their social context. Qualitative research is required to locate individuals within their social milieu and to better understand them as individuals interacting with others and involved in an ongoing decision-making

process about sexual pleasure and risk. (p. 605)

The only qualitative studies located in the review are those of Diaz (1996, 1998), Hospers et al. (1994), and Dilley et al. (1998). This does not reflect researcher preference, but rather the characteristics of the literature located through the PsycINFO and MEDLINE databases. The Hospers data are aging rapidly and were collected in Amsterdam, which limits the applicability to the United States. Diaz did perform his studies in San Francisco, and his work is relatively recent. However, Diaz's work in 1996 was specifically focused on gay Latino men and his 1998 work involved men who had been in study groups for at least five years. These factors limited the applicability of the data collected to other groups. Diaz consistently returns to the themes of racism, homophobia, and poverty to explain his subjects' drug and alcohol abuse and unsafe sexual encounters. While not rejecting the potential importance of these issues, Diaz presents very little, if any, confirming data within his work to support these contentions. However, Diaz's work is important in that it focuses on Latino MSM, a population that is poorly represented or not represented at all in the other studies presented in this review.

What Diaz (1998) does include, which is of great importance, is a warning against viewing unprotected sexual behavior as a pathology. Diaz makes this comment in

reference to the term "relapse," which is commonly used in the literature to describe unsafe sexual encounters. This is a loaded term, replete with the assumptions of drug and alcohol rehabilitation. It implies that men who have unprotected sexual encounters "know better" and have "just slipped up" due to any one of the numerous factors previously mentioned. Diaz attributes these behaviors not to pathology, but to oppression, which has a victimizing effect. Nevertheless, it seems possible that for many MSM in the San Francisco Bay Area, unprotected intercourse is neither pathology nor the result of oppression. In fact, it seems likely that the behavior represents an active, conscious decision to engage in sex in a certain way. In addition, the literature, and the CAPTC domains framework, focuses on risk behaviors that contribute to the potential acquisition of HIV. While this correlation allowed the CAPTC framework to be utilized as an organizational tool for a literature review, neither the framework nor the literature cited allows for an understanding of the motivations underlying an HIV-positive individual's decision not to utilize condoms for receptive anal intercourse.

New Perspectives

There has been strong commentary in the popular press regarding the emergence of MSM who have chosen not to utilize condoms for receptive anal intercourse. While

these works have not been subject to peer review, they present an opportunity for the researcher to gain knowledge of the most current perceptions and ideas being circulated in the MSM community. While these sources were not viewed as definitive, they do provide a "finger on the pulse" of current thought, perspective, and reaction.

An emergent view of the phenomenon comes largely from the work of Scarce, published early in 1999. This San Francisco-based free-lance journalist explored the world of "barebacking," the gay vernacular term for anal sex without a condom, and wrote about his discoveries. Scarce confirmed some of the issues raised by academic researchers, including the sense of the inevitability of acquiring HIV, the idea that gayness is equated with HIV/AIDS, and a certain element of survivor's guilt among those who have lost many friends and lovers to AIDS but who have remained uninfected themselves. These issues are probably present in the MSM community, but Scarce uncovered some other important issues, unmentioned in the academic research, that deserve investigation. Scarce described the importance some men place on "skin-to-skin" contact and semen exchange as a form of emotional bonding that transcends the physical. Scarce suggested that some men are suffering from "condom fatigue" and want to experience sensations denied to them by the "safe-sex establishment," but were available to their older peers until the

recognition of the sexual modes of HIV transmission.

Herscher (1999) took the concept of fatigue beyond the use of condoms and related it to AIDS and HIV in general. She noted that while the feeling may be formalized as "burnout, denial or false hopes, ... many gay men are tired of AIDS taking center stage in their lives" (p. A1).

For some men, seroconversion is reportedly viewed not as a devastatingly negative event, but rather as a positive life transformation, a coming into full belonging in the gay male culture. Others take the symbolism even further and equate HIV infection with conception. This relation, while admittedly not a common one, does speak of a deep understanding of the mechanisms of viral infection. For some gay men, infection with HIV from another man through anal intercourse may be a means of keeping a special partner in his life forever (Russell, 1999). Herscher (1999) noted another aspect of the importance of semen exchange in men's feeling of masculinity, love, and power. In speaking of his partner's unwillingness to utilize a condom for anal sex, one gay man reported to Herscher that condoms made his partner "feel less of a man," and that exchanging sperm was the "ultimate" sexual experience, potentially equated with concepts of procreation and pregnancy for the insertive partner as well as for the receptive.

There are perhaps elements of a generational conflict

present as well. The younger generation is sometimes called "murderers" by older gay men for their unprotected sexual behaviors, whereas the younger generation responds with charges of "condom Nazi" and "self-homophobia." Some members of the younger generation of MSM reported perceive the current prevention messages as shame-based and out of touch with the reality of the new generation (Scarce, 1999). Perhaps Tony Valenzuela, an advocate of bareback sex, who is HIV-positive himself, best expresses the new generation's potential view of HIV/AIDS. Valenzuela said, "I entered my sexual identity, coming of age in AIDS, and forming a relationship to HIV that is unlikely to be shared by the architects of HIV prevention" (Gendin, 1999, p. 2). Valenzeula recognized a key difference between his generation and the older one. "I come from a generation that has normalized the epidemic. It's not my experience to lose half of my friends and feel the debilitating effects of the virus" (Harpaz, 1999, p. A6).

The popular press works cited above generated discussion at a professional conference. Eric Rofes, a long-standing AIDS activist, was a featured presenter on the topic of "risky sex" at AIDS Impact 1999, an international conference addressing the psychosocial aspects of AIDS, in Ottawa, Canada, in July 1999. Rofes's presentation was largely based on the as yet unpublished work of Michael Scare. Rofes noted that given the lack of

published data, his presentation could only be heard as his impressions. Rofes did make an important distinction between unprotected anal intercourse, which the literature shows not to be a new phenomenon, and "barebacking" which he formalizes as anal sex without condoms that incorporates an element of ritualized, symbolic transgression into the sexual arousal mix. The appeal of transgression implies there is a construct against which gay men can rebel, or perhaps even a message that is seen as denying of sexuality and therefore an enemy to be resisted and thwarted. Rofes speculated that this transgression is directed towards prevention efforts that have pathologized anal sex without condoms and have left gay men feeling as though they have been manipulated during a crisis situation that may have passed. An unidentified audience member who participated in the question-and-answer session noted that homosexuality has always been, and perhaps always will be, transgressive. His question was, therefore, what norm is being transgressed against by this behavior? There was no clear answer to this question.

During Rofes's presentation, it was noted that the behavior known as "barebacking" is not necessarily new. This impression was substantiated by a participant from the United Kingdom who noted that both a recognition and discussion of the occurrence of receptive anal sex without condoms has occurred in Europe for years and that the

American impression that unprotected anal intercourse is an American phenomenon is false.

Rofes also pointed out that unprotected anal intercourse is occurring among a broad spectrum of gay men, not just among the younger generation who did not experience the devastation of the early years of the AIDS epidemic. This observation begs the question of whether multiple motivations lead different men to engage in similar behaviors.

The works of Scarce, Rofes, Harpaz, and Gendin have not been subjected to peer review. However, these works are timely, and Scarce and Gendin's works are based on observations of and membership in the high-risk community on which they are commenting. Both academic and popular views have valuable information to impart and have proven useful and necessary in the formulation of sensitizing and open-ended questions for a qualitative approach to this research.

CHAPTER 3

Methodology

The purpose of this study was to investigate the attitudes and beliefs of men who have sex with men (MSM) in the San Francisco Bay Area regarding HIV/AIDS and latex barrier usage for receptive anal intercourse. The specific goal of the study was to explore and elucidate the motivations for this behavior and to identify those factors that helped to motivate these choices.

Overall Research Question

This research was designed to address the following research question: What are the attitudes and beliefs of men who have sex with men regarding condom usage for receptive anal intercourse?

Objectives

This research was designed to meet the following objectives:

1. To develop an understanding of the attitudes and beliefs of men who have sex with men regarding condom usage for receptive anal intercourse.
2. To identify the motivations assigned by the identified population to condom usage for receptive anal intercourse.
3. To function as preliminary qualitative needs assessment for the identified population.
4. To add to the emerging literature on the health

behavior attitudes and beliefs of men who have sex with men regarding condom usage for receptive anal intercourse.

Research Design

This research followed a qualitative design. For DePoy and Gitlin (1998), one of the purposes of qualitative research is to "uncover the meaning of how humans experience phenomena through the description of those experiences as they are lived by the individual" (p. 82). This design was chosen due to the researcher's belief that MSM experience attribution characteristics that are distinct from other segments of the population and the belief that an understanding of these experiences would be essential to developing effective intervention techniques. It is the researcher's conviction that the experiences, motivations, needs, and emotional contexts of all behavior are best understood when the population of interest is queried directly in an open-ended format, which allows for the fullest possible expression of perceptions, concerns, and beliefs. Given the enormous complexity of human behavior, a qualitative approach was thought to provide a broader, comprehensive picture of the context for risk-taking behaviors.

Conceptual Framework

According to Depoy and Gitlin (1998), "individuals create their own subjective realities and thus the knower and knowledge are interrelated and interdependent" (p. 27).

This research sought to examine the motivations and beliefs that underlie MSM's choice to engage in receptive anal intercourse without using condoms. As this behavior directly contradicts the current scientific knowledge base regarding prevention of infection with a potential fatal virus, the decision was made to employ a qualitative conceptual framework.

One of the underlying assumptions of the qualitative research framework is that individual knowledge can only be understood through the knowing of the individual life experience that serves to motivate actions (Depoy & Gitlin, 1998). In approaching this research, it was postulated that some MSM were choosing to engage in sexual activities, such as receptive anal intercourse without a latex barrier, for reasons other than a lack of knowledge regarding scientifically recommended methods for preventing HIV transmission. Knowledge assessment lends itself to quantitative inquiry, but the meanings of specific actions assigned by the individual do not.

The formulation of a quantitative research project designed to discover motivational factors would require the researcher to employ a strategy of reduction, or the breaking down of motivations into discrete components that could then be measured. This approach would also assume that the motivational factors were already known. However, it is the researcher's belief that the complexities of

human behavior and the motivations that underlie behavior defy such an approach. Individuals' unique experiences of the world may encourage them to engage in identical behaviors, but the individuals may have very different reasons, or rationalizations, for doing so. Those individuals who engage in behavior as a consequence of their experience of their lived reality are those who are in the best position to articulate those realities and motivations.

In addition, receptive anal intercourse is an inherently social activity in that at least two different people, with potentially different life experiences and realities, come together and interact, however briefly. Within the context of this interaction, new layers of meaning may be assigned and experienced by the participants. Ideas, or constructs of reality, that are created in isolation may shift within the social, interactive context inherent in sexual activity, thus creating alternative experiences and attributions associated with the behavior. As only the participant directly experiences this interactive reality, a researcher seeking to know and potentially understand the experience as lived by the participant, must directly query the participant. This approach allows participants to transmit their knowledge and experience directly, in their own words, in a way that enriches the data collected and the

potential meanings to be gleaned from those data.

Incorporated into the conceptual framework of the qualitative method is the concept of the life history and the ways in which individuals' experiences of living can impact their personal reality, and consequently, their behavioral actions and choices (DePoy & Gitlin, 1998). The qualitative method allowed for participants to reflect upon life experiences that may have contributed to their choosing to behave in certain ways. These life experiences may influence individual choices regarding sexual behaviors, risk or sensation-seeking, risk appraisal, or denial more than any form of intellectual knowledge, particularly within the interactive and socially intimate situational context of sexual intercourse. The individual who has participated and experienced the phenomena of his/her own life is therefore the one who is best able to articulate and describe that experience.

Qualitative researchers Rubin and Rubin (1995) identified a number of key attributes inherent in the qualitative interview process. These attributes are that qualitative interviews are flexible, iterative and continuous in design. Additionally, Rubin and Rubin identified depth, detail, vividness, and nuance as attributes to be sought in the process of conducting qualitative interviews. The researcher took steps to incorporate all of these components.

Flexibility in qualitative interviewing effectively rules out the utilization of a fixed set of questions. Instead, the responses of participants are carefully listened to, which may prompt further questioning based on the participant's own life experience and interpretation of events and motivations. The researcher sought flexibility in the interview process by not utilizing a script beyond the collection of demographic information. Each interview was unique and was built upon the responses of the participant.

The iterative process encourages the researcher to be attentive to recurrent themes and concerns expressed by different participants as well as recurrent themes within the interview of an individual. The researcher focused on emerging areas of concern, but did not remain limited in questioning if new themes emerged. Through this iterative process, the researcher can reach the point referred to by Glaser and Strauss (1967) as theoretical saturation. Theoretical saturation occurs when no new ideas or themes are recovered from interviews. The researcher continued recruitment efforts and interviews until theoretical saturation was achieved.

New ideas and themes were probed continuously in an attempt to uncover new areas of experience and meaning. Employing a continuous design also meant that new informants might be identified during the interview process

who may not have been identified during the initial process of creating a sampling frame and inclusion/exclusion criteria.

The depth of the information collected was also of concern, and attempts by the researcher to attain this quality informed the interview process. Depth refers to the degree of thought that is included in both the question and the answer that it elicits. For example, if a participant engages in receptive anal intercourse both with and without utilization of a latex barrier, the researcher considered it important to inquire about situational contexts that might exist in one situation and not the other. This style of questioning revealed differences in attributed meaning and opened new areas for inquiry.

The researcher considered it important to gain as much information about the specifics of each discussed sexual encounter as possible. Important details included the physical characteristics of the sexual partner, the location in which he was met, the location in which the men engaged in sexual activity, the emotional state of the participant at the time the sexual encounter occurred, impressions regarding power dynamics in the encounter, the influence of alcohol or other drugs at the time, and other factors that became apparent during the course of the interview and that varied depending on the respondent.

Vivid responses were those that conveyed emotional

meaning. By encouraging participants to re-live the experience they were relating, vivid responses were obtained. Participants were on occasion able to recall such vivid features of an encounter as actual pieces of conversation; nonverbal communication which occurred prior to, during, and after sexual activity; physical sensations; and cues to their partner's emotional state. These vivid details allowed the researcher some degree of insight into the interpersonal dynamics of the encounter as experienced and related by the participant.

Nuance refers to multiple layers of meaning ascribed by the participant to a certain situation. Some participants provided more nuanced answers in response to further questioning when their initial answer indicated a certain degree of ambivalence about an encounter, such as when they described a sexual encounter as "no big deal," or "it wasn't really that important." Contradictory statements or implications can sometimes be an indication of ambivalence. For example, if a participant described a strong emotional attachment to his sexual partner during a vivid recollection, and then later discounted the encounter, further questioning by the researcher might reveal emotional contexts of disappointment or rejection.

Sampling Frame and Participants

Potential participants in this research were biological males who engage in receptive anal intercourse

with other biological males without the utilization of a latex barrier for at least 50% of the episodes in which they engage in receptive anal intercourse. Participants were required to be residents of the counties of San Francisco, San Mateo, Santa Clara, Marin, Contra Costa, or Alameda. This limitation was imposed to minimize the expenses associated with travel. The study did not control for the geographical or physical locations in which receptive anal intercourse was engaged in.

The preliminary design considerations of the study imposed an age limitation upon study participants that required them to be between the ages of 25 and 34 at the time of enrollment. This age range restriction was chosen due to the epidemiological data cited in Chapter 1. However, as the study progressed and as further data were collected, it became apparent that this age restriction had the potential of severely limiting the quality and richness of the data.

Epidemiological surveillance data, such as that reported in Chapter 1, are inherently limited in their ability to represent the sexual activities of all MSM. Surveillance data regarding sexually transmitted diseases (STDs) are collected from public treatment sites, laboratories, and private physicians and are intended to be broadly representative. However, within the field of STD control, it is commonly recognized that reportage is far

from complete or representative. The age group of initial interest, 25-34, is less likely to have health insurance and thereby have less access to private physicians than are older age groups. The impact of this access lies in the fact that private physicians are less likely to perform diagnostic testing on patients to ascertain the existence of a STD than are public facilities. If no specimen is collected for testing, it is impossible for a laboratory to report an infection to surveillance agencies. Private physicians are more likely to treat apparent infections based upon typically clear physical symptoms without reporting presumptive infections to governmental agencies that collect and disseminate epidemiological findings (G. Bolan, personal communication, October 20, 1999).

In addition, the researcher's preliminary research indicated a wide variation in age among men who are engaging in receptive anal intercourse without the utilization of latex barriers. This research was conducted through reviews of popular press articles (Gendin, 1999; Scarce, 1999), investigation of Internet-based sites which are created and maintained for men who wish to meet other men interested in engaging in unprotected anal intercourse, as well as the conference presentation of Rofes (1999). All of these sources indicated that the behavior of interest is more widespread than epidemiological data alone would indicate.

Human Immunodeficiency Virus (HIV) serostatus, relationship status, race and ethnicity were not used as inclusion/exclusion criteria in an attempt to remain within the philosophy of qualitative research. This philosophy lays emphasis upon the importance of the representative, or rich nature of the data collected. This approach was felt to be particularly important in that it allowed the researcher to capture the full range of themes expressed by participants. The researcher felt that a diversity of themes would enhance the research process and improve the quality of the data collected.

Sampling

This study employed non-probability convenience sampling methods. These methods involve the establishment of inclusion and exclusion criteria and the enrollment of volunteer participants until the desired richness of data is collected (DePoy & Gitlin, 1998). Snowball sampling was also employed. This method involves asking participants to identify friends or acquaintances who fit the inclusion criteria and who might be willing to participate (DePoy & Gitlin, 1998).

To recruit participants, the researcher employed several activities. A World Wide Web page was created and posted on the Internet that gave details regarding the research project and provided contact information. Postings were placed on electronic bulletin boards that are

designed for MSM, which directed them to the Web page (see Appendix A). Advertisements were also placed in newspapers marketed to MSM and distributed free of charge throughout the greater San Francisco Bay Area. Specifically, these publications were the Bay Area Reporter, the San Francisco Bay Times, and the San Francisco Bay Guardian. These advertisements contained inclusion criteria and contact information. Text copies of the advertisements are included in Appendix B.

Confidentiality

To ensure the confidentiality of participants, a cellular phone number and an electronic mail account were established solely for the purpose of the research project. Only the researcher had knowledge of the passwords required for access to either the voice mail or e-mail accounts.

Although some participants chose to use their own names during interviews, this information and any other potentially identifying information continues to be kept confidential. All research materials, including consent forms and audiotapes, are kept in a locked cabinet. A code name was assigned to each participant and was used on all research notes. A list with the code names is kept in a separate file away from the lists of real names and all other identifying information. All potentially identifying information will be destroyed when the final thesis is filed.

Informed Consent

This research project was submitted to the Institutional Review Board of San Jose State University and approval to conduct the study was received from that body prior to the collection of any data (see Appendix D). Informed consent was obtained from each participant prior to the collection of any data.

Each participant was given a two-page consent form printed on San Jose State University letterhead which detailed his rights, contact information in the event of complaints, and an assurance of confidentiality (see Appendix E). The contents of the consent form, including permission to be audiotaped, were reviewed verbally by the researcher prior to data collection. The researcher signed and dated two copies of this consent form in the presence of the participant prior to asking the participant to do the same.

The consent form assured participants that no foreseeable risks or benefits were associated with participation in this research. Participants were informed that if the research results should be published, individual participants would not be identifiable and that any potentially identifying information would be kept secure in a locked cabinet. Participants were furnished with contact information for the researcher, the Department of Health Sciences, and the Graduate Studies Office at San

Jose State University. Participants were also informed that their decision regarding participation would not prejudice their relationship with San Jose State University. Finally, participants were informed of their right to withdraw at any time and to receive a copy of the completed research.

One of the challenges of this research was developing a means to allow the participant to remain anonymous if he chose, while still collecting the required signed consent form. In order to accomplish this, the participant was provided with two envelopes and instructed to place the signed consent forms into the envelopes and seal them. Each envelope was coded with the date and time of the interview. The researcher retained one envelope and the participant retained the other. Participants were informed that the envelopes containing the signed consent forms would remain sealed unless a human subjects complaint was filed.

Assumptions

The assumptions underlying this research included:

1. Individual qualitative interviews would be the best method for collecting the required data for this study.
2. Lack of knowledge regarding the modes of transmission of HIV was not a factor that contributed to the sexual behavior being studied.

3. A minimum of 10 participants could be recruited by utilizing the chosen sampling methods.

4. Participants would be willing to discuss intimate sexual behaviors and their personal motivations for engaging in such behaviors in an open and honest manner with the researcher.

5. Common themes would emerge from the data.

6. The current literature regarding the motivations for engaging in receptive anal intercourse among the study population could benefit from new data collected in a qualitative manner.

7. The researcher would be able to maintain an analytical perspective and rigor during the collection and analysis of the data, despite his being an openly gay man, by taking measures to minimize bias.

Data Collection Methods

Data were collected through personal and private interviews. Once participants agreed to participate in the study, a time, date, and place for the interview was agreed upon. Interviews were scheduled at the convenience of the participant. The researcher identified himself as a gay male to establish a level of comfort for participants. The researcher felt that being openly gay was a way to establish empathy and a common understanding of terminology. This allowed the interviews to proceed in a familiar style, requiring a minimum of conversational

repartee prior to discussing intimate topics with participants. Gathering the type of data described above required a certain level of comfort between the researcher and the participant. Being in a home setting helped to create this comfort. Participants were also encouraged to partake of food and beverages, and if necessary, tobacco if they so chose, to increase their comfort level.

Interviews developed as a conversation that encouraged participation and honest recollection. If participants seemed distressed at any time, they were encouraged to take a break from the interview. If a particular subject was upsetting and a break was or was not desired, a change in the line of questioning often proved to be appropriate. Any indication of judgment on the part of the researcher was carefully avoided, even if the answers resonated with the researcher.

Given the type of information being collected, the researcher anticipated the possibility of psychological trauma due to recollection of potentially difficult experiences. Due to this consideration, the researcher developed a list of resources that participants could access for low-cost or free counseling, if they felt this was necessary or desired. The Pacific Center and the Wright Institute, both located in Berkeley, were listed for East Bay residents, and the Castro Health Clinic and the Haight-Ashbury Free Clinic were listed for residents of San

Francisco. Jewish Family Services was listed for residents of San Mateo and Santa Clara Counties. Jewish Family Services provides services to members of all faiths despite its religious affiliation. No participants indicated any level of distress or trauma, with one exception. This individual did not need a referral because he was already under the care of a mental health provider.

Upon completion of the consent form, the audiotape recorder being employed was activated. Participants were asked to choose an identifier by which they would be referred to for the duration of the interview. Participants were free to use their own name, or an alias if they so chose, but the accuracy of the name given was not queried. Basic demographic information was collected from each participant. This information included age, self-identified race/ethnicity, sexual orientation, HIV serostatus, county of residence, and the manner in which they had been recruited for participation. Participants were also asked to identify, to the best of their knowledge, the sexual routes of HIV transmission. The researcher has worked in the field of HIV prevention for eight years and was conversant with the sexual routes of HIV transmission prior to asking participants to provide this information.

Following the collection of this preliminary information, participants were asked to estimate the

percentage of sexual encounters involving receptive anal intercourse in which condoms were not used. If participants indicated that latex barriers were occasionally, but not routinely, used, an additional question was posed which inquired into the situational contexts in which latex barriers were employed. A general question was posed inquiring why the participant had chosen to engage in receptive anal intercourse without utilization of a latex barrier. From this point in the interview, questioning would vary according to the responses of the participant. This approach is consistent with the established methods of qualitative interview techniques.

While a conversational style was employed, certain common attributes of conversation had to be modified. Most commonly this meant that participant queries of the researcher had to be minimized, although not avoided. For example, some participants wanted to know the researcher's preferences regarding sexual activities relating to the usage, or non-usage, of latex barriers for anal intercourse. These inquiries were responded to by querying the participant as to why this information was important to him and reminding the participant that the focus of the conversation was on him.

Interviews lasted from 1 hour to 2 hours and 15 minutes. The length of any interview was not predetermined but was based on diminishing returns. Once

little new information was being collected, the researcher moved to terminate the interview. The researcher was careful not to disrupt the participant's conversation by waiting for a natural pause and asking if there was any further information that the participant wished to share. The researcher closed each interview by asking if there were any further questions that could be answered regarding the process of data analysis, confidentiality, or other concerns the participant might have. If there were no further questions, participants were thanked for their time, given the \$25 incentive, and asked to serve as a participant reviewer of the data analysis section of the project report.

Equipment

As noted earlier, all interviews with participants were audiotaped. Participants gave their consent for this procedure both verbally before the interviews commenced and also by signing the consent form.

All interviews were taped using a hand-held audio recording device manufactured by Sony Corporation of Taiwan. No external microphone was used as the researcher felt that the presence of such a device might discourage the disclosure of personal information. Standard size audiocassettes, 90 minutes in length, were used for recording. TDK Electronics Corporation of Port Washington, New York manufactured the audiocassettes. New batteries

were installed prior to each interview to ensure that loss of power would not negatively impact the natural flow of the interview.

Efforts to Minimize Bias

The researcher employed several means to increase the fittingness, credibility, confirmability, and generalizability of the data. Fittingness was sought within the process of participant recruitment. The methods employed to achieve credibility included bracketing, member checks, peer debriefings, and prolonged engagement. Confirmability was accomplished through the use of an independent rater, while the presentation of the data allowed for transferability. These methods are detailed by Beck (1992, 1993), DePoy and Gitlin (1998), and Lincoln and Guba (1985).

Fittingness.

Participants were selected, in part, to ensure that the data collected would be fitting for an analysis of the phenomenon of unprotected receptive anal intercourse among MSM. Only respondents who indicated that they engaged in receptive anal intercourse without condoms for the majority of their sexual encounters were included. Also, only those respondents who indicated that they were comfortable discussing intimate topics with the researcher were interviewed. Therefore, participants had both direct experience of the phenomenon and displayed an ability to

discuss it.

Credibility.

Credibility of the data was sought through several complementary means. The researcher employed a method of prolonged engagement with the participant population. The researcher actively sought and read materials describing the phenomenon under study prior to initiating interviews. The interviews themselves also allowed for prolonged engagement due to their length.

The researcher engaged in a process of bracketing to investigate his own opinions and perceptions that might have influenced the collection and analysis of the data. These perceptions and opinions were recorded both verbally and in writing. These journals were then referred to throughout the interviewing and analysis processes.

Peer debriefings were also utilized. In this process, the researcher engaged public health professionals and other colleagues in conversations about the research process to investigate any potential bias and to gain suggestions for modifying the research process.

Member, or participant, checks were also used to increase the credibility of the data. This process involved inviting participants to review the project as it developed through the analysis stage to ensure that ideas, feelings, and experiences were accurately represented by the researcher. All participants were queried regarding

their willingness to serve as participant checks. Five of the participants agreed to serve as participant checks, and they provided contact information in the form of mailing or electronic mail addresses to which the researcher could send the preliminary analyses. They reviewed the preliminary drafts of the fourth, fifth, and sixth chapters, and provided commentary on them. This process served to increase the credibility of the study by seeking direct participant commentary that ensured the researcher accurately represented the experiences of the participants.

Participant checks were also built into the interview structure. Whenever a participant made vague or unclear responses, the researcher initiated further questioning to clarify the meaning being ascribed by the individual participant.

Participants were also asked to comment on concerns related by other participants. This method elicited further commentary from participants in later interviews, as well as providing a measure of the credibility of the themes that emerged within the interview process.

Confirmability.

The confirmability of the data coding process was sought through the use of an independent rater. This individual had no prior contact with the data prior to performing this function. The independent rater was a sociologist who had experience working with qualitative

data and with the coding process. The rater was provided with a minimum of 10% of the representative text that the researcher proposed as illustrative of the research results. The independent rater was also provided with a listing of the coding categories identified by the researcher. The rater was then asked to assign the text to code categories based on her reading of the text. Initial agreement reached only 72% and was judged to be too low. Consultation between the researcher and the independent rater revealed that the sub-theme category of ejaculation was better presented as a theme of its own due to the perceived mixture of physical and psychological motivators. Two themes, drug use and abuse, and mistrust were felt inadequate to support or reflect participant motivations for engaging in unprotected, receptive anal intercourse. These two categories were deleted. A second evaluation of the representative text resulted in an agreement of 92%, which was determined to be acceptable.

Transferability.

Transferability was sought through the use of rich textual data taken from the transcribed interviews with participants. By incorporating large slices of data, the researcher provided sufficient data for potential appliers to determine the transferability of the data and the findings of the research analysis.

Data Analysis

As noted previously, all interviews were recorded on audiotape. These interviews were later transcribed verbatim for analysis and coding. Transcription also involved the notation of significant pauses in the conversation, laughter, and nervous responses.

However, even within the context of the interview, analysis occurred through careful attention by the researcher to the content of the responses made by the participants. This continuous analysis process informed the questioning process as it unfolded within the context of the interview itself. In addition, immediately following the interview, the researcher verbally recorded his observations of the ease with which the interview progressed, the ease with which the participant was able to relate experiences, and any changes in these characteristics as they occurred during the interview process.

The data were reviewed and coded for recurring themes and content. Coffey and Atkinson refer to coding as "a first step toward organizing the data into meaningful categories" (1996, p. 36). The general scheme used in the initial coding steps was to look for responses that indicated concerns and motivations that were expressed by multiple participants. This scheme resulted in 10 general categories into which responses could be coded. Once the

data were organized into major categories, additional analysis was performed on each category to delineate the meanings and experiences into sub-theme categories. These sub-theme categories provided for the richest level of understanding of the responses.

A spreadsheet matrix was created which had each of the 10 major coding categories as well as identified sub-categories within each code. Representative quotes by participants were included within the spreadsheet so that original data were not completely separated from the coding categories. The matrix allowed for a process of examining common themes, patterns of responses, and other regularities of the data. This method also allowed the researcher to identify paradoxes easily, differences in meaning assigned to similar experiences, and contrasts between the experience of participants. The identification of these patterns and contrasts allowed for some generalizations to be made about the experiences of participants and the meaning they attributed to those experiences.

As themes began to emerge, participant reviewers were contacted and asked to comment on the researcher's interpretation of the responses. In addition, the data were reexamined continuously with the completed transcription and coding of each interview to allow for an ongoing process of cross-comparison which served to

identify emergent themes. This process of continuous contact with the data and reanalysis in light of new responses helped to inform the elucidation of meaning. The specifics of participant responses, and the elucidated themes, is the subject matter of Chapter 4, which details the results of the study.

CHAPTER 4

Results

This chapter describes the recruitment experience, participant characteristics, and the analysis of the interviews with participants. The themes that emerged from data collected from participants include physical sensation, ejaculation, psychological sensation, relationship stability and intimacy, partners, intentional infection, re-infection, treatment, prevention messages, community, and choices. Within some of these thematic categories, sub-themes are also presented and explicated.

Recruitment

Newspaper and Internet-based methods of recruitment for the study's interviews began on December 22, 1999. A total of 13 participants were recruited for interviews by December 30, 1999. Data collection was completed by January 4, 2000. Additional interviews beyond the 13 scheduled were not pursued due to the constraints of time and funding, as well as the appearance of consistent themes in the completed interviews.

Both newspaper and Internet-based methods of recruitment yielded approximately equal numbers of participants, with six participants responding to the Internet-based advertisement and the remaining seven responding to the newspaper advertisements. There was, however, a difference in the number of responses to

individual newspapers. Six of the seven newspaper respondents answered advertisements from the Bay Area Reporter, one from the San Francisco Bay Guardian, and none from the San Francisco Bay Times. In addition to the one participant answering an advertisement for participation from the Guardian advertisement, the researcher received two phone calls from women who identified with the term barebacker that was used in the advertisement. These callers were not asked to participate, as they clearly did not fit within the sampling frame criteria.

There was a marked increase in the number of responses to both the print and Internet advertisements following the Christmas and New Year's holidays, with up to five inquiries being received in one day. However, the response during the holidays was still sufficient to recruit the number of participants needed, with some responding prior to the holidays to schedule interviews for a later time.

Participants

The names of all participants have been changed in the transcript to protect the anonymity of participants. All 13 participants were biological males. All participants answered a core set of demographic questions that included age, ethnicity, HIV serostatus, and relationship status. The demographic characteristics of the participants are summarized in Table 1. Participants are listed in the order in which interviews were completed.

Table 1

Participant Characteristics

Name	Age	HIV Serostatus	Primary Partner	Race/Ethnicity
Chad	40	Negative	Yes	White
Bob	38	Positive	No	White
Lawrence	46	Unknown	No	White
Darrel	36	Positive	No	White
Charles	26	Positive	No	White
David	34	Negative	No	White
Albert	48	Unknown	No	White
Rich	36	Positive	No	White
Mark	36	Negative	Yes	Native American
Evan	41	Positive	No	Asian
Sean	35	Negative	No	White
Peter	30	Negative	No	White
James	48	Positive	No	Jewish

The majority of participants self-identified their race/ethnicity as white, and the majority did not report being in a primary relationship with another man. There were comparable numbers of participants who indicated positive and negative HIV serostatus. The average age of the participants was 38, with a minimum age of 26 and a maximum age of 48.

The majority of the participants resided in the City

and County of San Francisco. Of the three who did not, Chad resided in Alameda County, Albert resided in Marin County, and Rich resided in Contra Costa County. All three of these counties have borders that are contiguous with the City and County of San Francisco.

All participants self-identified as gay except Albert, who identified as bisexual. He further indicated that he had not been sexually involved with a woman for a number of years.

All participants reported that they were not exclusively receptive partners when engaging in anal intercourse. However, their commentary related to the usage, or non-usage, of condoms was restricted to episodes of receptive anal intercourse.

Knowledge of the modes of HIV transmission was also assessed through the use of an open-ended question that asked participants to relate to the researcher their understanding of the transmission routes of HIV. All participants demonstrated high levels of knowledge regarding the modes of HIV transmission and specifically recognized that receptive anal intercourse without a latex barrier device was an especially risky activity.

All participants demonstrated a willingness to discuss their sexual choices and their motivations for these choices in a frank and open manner with the researcher. Through the course of these interviews, numerous consistent

themes emerged that are presented below.

Physical Sensation

The theme of physical sensation was further segmented into the sub-themes of feeling, the spontaneity of the sexual experience, and the use of Reality brand condoms to increase the levels of both feeling and spontaneity. Each of these sub-themes is presented below.

Feeling.

All participants cited the difference in physical feeling as a motivating factor for their decision not to use latex condoms for receptive anal intercourse. In Albert's words

The feeling of a dick going inside me without a condom just feels better. I feel different, I feel more real, it turns me on more. I get harder. This is more like it should be, natural fucking. Condoms keep people from getting hard. They are problematic.

Evan also noted a problem with his sexual partner's ability to maintain an erection while wearing a condom. "The other person does not lose their hard-on [when not wearing a condom]."

Bob elaborated more on the difference for him as the receiving partner as well as his sensation of the difference after many years of using a condom for receptive anal intercourse.

Sex is a lot better without a condom. The second guy I had sex with in San Francisco after I moved here was HIV positive, and I knew that. We began to have sex and, we started fucking. He wasn't wearing a rubber, and I thought this is the hottest thing in the world.

It was just like the first time I had ever had sex. I thought it was incredible.

Darrel also indicated that there was a considerable difference for him as well. "It causes a lot of drag when I am receiving. It makes a big difference. Much more energetic sex, much more passionate sex. It lasts longer."

Lawrence elaborated further on the difference in physical sensation, and also indicated that there was a distinct danger of pain associated with using a condom when he was the receptive partner.

It is much easier to induce gentleness. I don't like to be hard fucked. That is not an act of friendship. I like it to include playfulness and gentleness. Condoms tend to carry the risk of somebody doing harm. I am more likely to bleed after being fucked with a condom.

Sean was very clear that for him having to use a condom was enough of a burden that he would rather forgo sexual contact altogether than have to use a condom.

It is more trouble than it is worth. You might as well not do it. It is just uncomfortable. It doesn't work right, there is always a problem, and it doesn't feel good. The other person doesn't feel as good and they are not into it as they are if they are not using it. I would rather just not do it.

The lack of physical sensation and the perceptions of physical awkwardness were clearly important concerns for the participants and played a role in their decision not to use condoms for receptive anal intercourse.

Spontaneity.

Another component associated with physical sensation

and feeling that was uniformly reported by participants and intertwined within the other physical motivations was the experience of the spontaneity within the sexual encounter. According to Darrel, "There is a lot to be said for spontaneity and the whole excitement of it." Chad echoed this sentiment. "I think a lot of it was being caught up in the moment, not wanting to destroy something that felt good. I enjoyed it."

There was a definite sense from all participants, phrased in different ways, that a positive sexual encounter was not planned and choreographed. All 13 men used the actual word spontaneity, which indicates the sensation's central importance.

Reality brand condoms.

Two participants, Lawrence and Darrel, spoke of their use of the Reality brand condom, which was originally designed and marketed for females. It is constructed of polyurethane instead of latex and is intended to be inserted into the vagina prior to the initiation of sexual intercourse. These two participants have appropriated this device for engaging in anal intercourse and reported that its use results in more physical feeling and more spontaneity in the sexual encounter. Lawrence said, "The Reality condom does feel good though. If someone has already inserted it, it does not interrupt the experience." Darrel elaborated further on his experience of the Reality

condom and indicated that it can be incorporated into the sexual encounter itself.

With a female condom you don't have that constraint and it's a little more natural. Granted, the female condom is thicker in its material, but what it does is that it creates like a vacuum inside the rear. Yeah, and it like vacuum seals to the walls of the anal [sic] and it's a lot more natural feeling. I mean you don't necessarily feel the thickness of the condom there, and it is a lot more lubricated because you have lubricant on both sides of the condom, the inside and the outside. It is a little less coarse and plastic feeling. Upon insertion they feel different, but when you are being fucked there really isn't that much difference, you can't tell that they are there. They are a lot less constraining than the latex condoms. They are a bit thicker, but it doesn't constrain the penis. Basically, you still have the sensation of the anal [sic], but not as much of the constraint around the penis. You are feeling more of the anal [sic] than the condom. It is a turn-on for me. It doesn't feel rough with an inserted female condom as opposed to the latex condom. The latex one can be like having something inserted without lube. Dry and uncomfortable. There is something about sticking your finger up there. I mean lubricating and loosening, that whole process. It is a part of the experience.

For these two participants, the use of the Reality brand condom has provided a way to experience much of the same physical sensation they associate with not using a condom while still providing some feeling of safety from infection. No other participants reported using this device despite the fact that all participants had heard of it or knew people who used it.

While the Reality condom is a barrier device, it is discussed here because it represents an innovative solution to the issues of decreased feeling and spontaneity reported

by many participants. The implications of the incorporation of this device by two participants will be further explored in Chapters 5 and 6.

Psychological Factors

In addition to the physical difference reported when engaging in anal intercourse without a latex barrier, many participants also reported a number of psychological differences that motivated their decision not to use latex condoms. This thematic category was segmented into sub-themes that include life satisfaction, fatigue, physical attraction, nostalgia, the lure of the forbidden, and attraction to a risky situation.

Life satisfaction.

Several participants reported that the quality of life, rather than its duration, was more important to them. Charles, who is HIV-positive, noted

If I live I live, if I die I die, as long as I am happy while I live. It's the quality. As long as I am happy, that is all that really matters, and I am not hurting anybody.

Darrel, who is also HIV-positive, directly correlated the quality of his life experience to his infection.

I've got HIV. Sooner or later something is going to come along to kill me. That's just the way life goes. Everybody dies. I'm out to make my life happy and fun and have a good time while I'm doing it, and I try not to hurt anybody while I'm doing it.

Rich, another HIV-positive participant, indicated a similar motivation.

I am one to believe that when my number is up it's up. You can do whatever you can to prevent dying, but there are so many things you can die from. It is just when you're number is up, it's up. I'm not actively trying to hurt myself, but I am certainly going to enjoy myself. You could walk out and get hit by a bus tomorrow.

Not only HIV-positive participants emphasized the importance of quality of life, however. Sean, who is HIV-negative, also stated that the experience of living life was the most important factor.

You start thinking I want to live my life more to the fullest. I mean, we are all going to die anyway. Would you rather die living your life partially, or having really lived? When you're younger it is really important. As you get older, you don't worry as much. I don't.

These participants explained that death is an integral part of the experience of living and that living life in the manner that felt most natural and psychologically fulfilling to them was more important than any potential risks associated with the decision not to require condoms for receptive anal intercourse.

Safer sex fatigue.

Several participants, across all ages, noted a psychological sense of fatigue with safer sex messages and the entire issue of HIV infection. These participants were HIV- positive, negative, and of unknown status. Lawrence said, "HIV has been here for so long that it is really becoming kind of a boring subject." For Chad, the fatigue he reported had a more direct impact on his sense of the

pleasure of having sex with another man.

Using a condom is an intrusion into my life and into my desire to be intimate. It is a reminder and an intrusion. I am tired of being reminded of it. Why can't two people just fuck and not have to worry about this thing every time they get naked?

Albert elaborated further on what the psychological experience of fear was like for him.

You get so scared for a while, so fearful, and then after a while you get tired of going crazy calling the hotline for every bruise and cold. You realize you have to live your life, and I think that is what is happening. People want to live their lives without fear. Either societal fear or even the politically correct "use condoms every time" kind of thing.

Bob had opinions similar to those expressed by Albert and related the sense of fatigue not only to himself but also to the gay male community as a whole.

Life sucks sometimes and sex is one of the last great pleasures you have, and I think that is where the energy comes from. I think it comes from a seed, and that seed comes from having a need that is not being met, and I think that people responded to that, and they are still responding to that. I think what it all comes down to is it is really hard, and that is probably why this barebacking thing has taken off the way that it has is because we as a community since 1977 have had to put up with this. We must wear a condom every time. It is getting old. If it were so easy to do, we wouldn't have teenage pregnancy. It is not easy, and I think that is one of the things I came to San Francisco to escape.

Attraction.

Lawrence indicated another psychological state that was implied by other participants but not stated as clearly. The physical desirability of a partner as perceived by participants was a motivating factor for

engaging in receptive anal sex without a condom.

If I am wildly attracted to a guy, I am much more likely to forgo even those peripheral but actively implemented concerns such as how many people has he been with already, or is he loaded, or does he smell clean. If he is very toasty, I will set all that aside. It has nothing to do with some high born religious experience. The religious experience is being with a high-born, super alpha male. They are the silverbacks of our society. It is the hierarchy. We are primates first, and that is exactly what the bareback thing is about. The whole word protected is a non-sequiter with sex. If I am going to be protected, I might as well not have sex. We do it to get off, no more and no less than the wonderful fun a pre-adolescent teen has with another guy behind the barn in the countryside. If we are going to reduce it to a science, why bother? I can jack off and have as good a time alone as I am going to with somebody who reduces it to a clinically spic-and-span experience. When there is a man of champagne quality, there is no way I would not give my life for that moment. That moment can wash away all the traumas of a previous life.

Nostalgia.

For some participants who experienced their sexual coming out as gay men prior to the advent of safer sex behavior, there was a psychological sense of nostalgia associated with a return to having sex without condoms. All participants, with the exception of Mark who was in a primary relationship when the HIV and AIDS crisis began, had at some point in their sexual lives utilized condoms. For those who reported a feeling of nostalgia, not using condoms was a return to their past sexual expression and this was true for both HIV-positive and HIV-negative men. As David, who started having sex when he was 14, said, "It felt more natural, like what I had grown up with." Bob

also related something similar.

To be able to share a partner's cum inside me again, the way that I had for so many years before I knew I was positive, was incredible. I was sexually active in Chicago as a teenager, and in New York as an adult, and this was in the late 1970s, early 1980s and, you know, it was anything goes back then. I remember that as part of my sexual coming out. It's part of the nostalgia, and I think all those factors combine. It was so very intimate and such a great throw back.

For James, it was not only a remembrance of things past, but also a practice that he associated with sexual identity and membership in the gay community.

I moved to San Francisco in 1973 when I was 21 and went through 10 years of just incredible, free-wheeling sexuality, and to me that was a very important part of what being gay was about to me. It is not just that I want to have sex with men, it is that I like that whole easy sexuality that existed between gay men in the 1970s when it was just good, clean fun. I really enjoyed the scene in bathhouses where you did not have to go through the mating and dating ritual stuff that you have to in other circumstances like in bars or whatever. It is just a complete sort of visceral attraction that is immediately consummated. To have to go through all these considerations, how far am I willing to go, what am I willing to do, where are the condoms, all this stuff, it absolutely shatters the mood. Too clinical. It is not just that all that stuff was fun, it was a real feeling of bonding, and almost like a feeling, even with no words, of connecting with not only that person but with all the gay people in the world because it was possible to do that. Knowing that this was a part of our culture, this is our tribe. The whole act of putting on a condom completely breaks that.

The lure of the forbidden.

Several participants identified that part of their attraction to anal sex without a condom was because it was the act that had been forbidden to them. Bob related how

his feelings about having receptive anal sex without a condom for the first time after using condoms for years. "It was so naughty, that was a part of it. It was so naughty to do that!" Lawrence elaborated further on what the experience of the forbidden was like to him and related it to societal pressures and norms.

I think internalized homophobia is in most everyone who is gay in the Western, Judeo-Christian-Moslem world. It is probably even in Japan now too. It has been stigmatized and that, ironically, is part of what makes it so hot. It is what makes sex with Catholic priests so hot and what makes sex so good in Salt Lake City.

Attraction to risk.

Peter implied in this statements that it is not just that anal sex without a condom is forbidden but also that it is the inherent risk that he finds attractive to a certain extent. However, he is clear to note a distinction between what is purely fantasy and that which he is willing to make reality.

I started reading a lot about barebacking. Started fantasizing. But I try to limit my partners to negative guys, and I tried to not take any loads [have men ejaculate inside of him]. I think everybody has their fantasies, and there are things that they fantasize about that they will eventually go on to experience. Then there are the fantasies that are probably things they won't. So there are things I have thought, hey, I've beaten off to it, it turns me on, and I'm going to go out and do it. Conversion, either forced or willing, a lot of it is awfully exciting, but when confronted with it in person, I have always gone, oh no no. Bad idea! I do not glamorize AIDS. I don't think I have a death wish. I don't drive my car recklessly, but there is something about some of the conversion stuff and that ultimate risk that there is something erotic about. Because it

is risky I guess.

Despite the erotic attraction, Peter indicated that he has not chosen to have anal sex without a condom with a man he knows to be HIV-positive even though he reported that he certainly has had multiple opportunities to do so.

Ejaculation

The theme of ejaculation was originally included as a sub-theme of physical sensation. However, upon further review with the assessment of the independent rater, ejaculation was classified as a separate theme which is a synthesis of both physical and psychological/emotional sensation.

Participants made a clear distinction between having receptive anal sex without a condom and having their partner ejaculate inside of them. Not all participants wanted their partners to ejaculate inside, but among those who did prefer this, there were clearly physical sensation rewards associated with their partner doing so. Evan stated it very succinctly. " I like guys to cum [ejaculate] inside me." Rich elaborated more on the physical benefit of his partner ejaculating inside of him.

When somebody is shooting [ejaculating internally] it's like such a turn-on. I generally will cum [ejaculate] at the same time. It's that intense for me. I don't know how you describe it. It is the part that turns me on the most. I don't have to see it. I'll feel it come out later. That is the good part of it too, the knowing.

Peter also indicated that having a partner ejaculate inside of him was an important physical excitement of the sexual act.

I really don't know what, something about a man being inside, and I feel the same way when I am the top. I can't tell you exactly why, but the idea of someone shooting inside of me or shooting inside of a guy gets me excited. There is definitely a big draw to it. It is absolutely more intense and is something I think about an awful lot now.

Bob could not describe what the actual sensation for him was when his partner ejaculated inside of him, but he did state that it was an important component of the physical, sexual act. "It's just part of it. You're not supposed to waste it. It's there."

David related that the physical sensation for his partner was an important component in his attraction to the act of having a man ejaculate inside of him.

There is a sense that as a bottom I identify with taking a guy's fluid as something that is highly erotic and taking a part of him. It is sort of an acknowledgment of the partner and that is a psychological component along with the pure physical. There is a dimension of being willing to do it for a guy, and when I have sex with a guy and he shoots inside me, there is a definite... [pause]. I watch what is happening on his face, and there is a sense of giving him that kind of pleasure, and I like that. It is a powerful thing. It is risky and I know it, but there is a definite up side to it in connection with the guy, and what kind of pleasure you are giving him. Providing that intensity of pleasure is important and is a calculated decision and in some cases is as important as needing to protect myself.

Not all participants reported an attraction to having their partner ejaculate inside of them. For those who did,

the intensity of the attraction was strong and important. In David's case, it was clearly important enough to risk infection with HIV to experience receiving and providing the physical pleasure associated with internal ejaculation.

Relationship Stability and Intimacy

The two participants who indicated that they each were involved in a primary relationship with a man who shared a residence with them expressed motivations and psychological sensations related to the stability and intimacy of their relationships that they associated with not using condoms for receptive anal sex. In speaking of a prior relationship with a man whom he believed to be HIV-negative, although he later discovered that he was in fact HIV-positive, Chad said

At that time, I knew that HIV and AIDS were real possibilities. But looking back on my frame of mind at that time, I don't think I consciously thought, worried, or cared. I wasn't really looking for HIV. I was still terrified of the possibility, but I was more terrified of being alone. I think at that point demanding the use of condoms, or suggesting it, or making it a condition of the relationship, was more fearful to me than becoming infected.

Despite the risk in which Chad placed himself, he remained negative, although he did not know this for several years due to his fear of being tested.

Mark was in a relatively new relationship with a man for less than a year when he completed his interview. He indicated that it was important to the stability of his relationship not to demand the use of condoms for a number

of reasons.

It is kind of a blind faith. I get tested every six months. We have discussed condoms before and tried them one time, but my partner had an allergic reaction to the latex so that is out of the question. As far as I know, he does not have sex with other people. It is a question I always ask him because he is in and out of people's houses as a plumber, and he has told me that while working in New York he would have sex with customers. He said he doesn't fool around with anybody, but again, it is just his word. I know that we should use condoms. I guess I have just taken a leap of faith because I know the dangers that I am taking are extremely high risk. I guess it is kinda [sic] like being blind and just trying to be in love and trying to work on that. We have discussed it, and we are not seeing anybody outside of the relationship, and we got tested, and it is like okay. We will leave it at that right now. But there is always that lingering, is he being faithful? He only ejaculates inside of me when we are into that little honeymoon stage with lots of "I love you," stuff like that. It is not really planned to be that way, it just happens.

Chad is no longer in the relationship he commented on earlier. He has been involved with a man for over seven years whom he knows to be HIV-positive. Chad was HIV-negative at the time of his initial contact with the researcher. Condoms are no longer used, although they were for the first six years of the relationship.

It was more of a gradual shift from always using a condom to maybe a brief insertion to a full-fledged fucking without a condom. I'm sure there were times after sex when it was said that was silly. We really should not be doing that. From my point of view, without a condom there was something present emotionally that I did not always feel when we had to stop and put on that condom. Being receptive, there was, and is, a certain connection, intimately, physically, even emotionally that I just don't experience when there is a condom involved. It is difficult to put into words. It is not just a physical difference. There is something unspoken and felt, not physically, that exists when it is flesh to

flesh. Maybe passion is a better word. Maybe just total acceptance of that person on both parts. Having sex without a condom when both partners know the status of the other is maybe a statement that I accept the risks, I accept the possibility of the risk, but there is something more important happening here even when that risk is present. The intimacy, the connection is more important. The love that is involved. Without ejaculation does not take away from that feeling, it is not about the exchange of semen. I have always been the type of person who would rather see a person cum anyway, so feeling that ejaculation inside of me is really not the issue. I think it is more the act of accepting that person and feeling that intimacy and saying no to something that would take away from a feeling that I want to experience with everything that comes with it. That feeling is more important than the risk.

Chad elaborated further on the psychological impact that condom utilization had for him within the context of the relationship.

Using a condom makes me think about the possibility of HIV at a moment when I probably should be thinking about it more than at any other moment, but I do not want to. It is almost like putting a condom on is making some sort of statement about me as a person, that this thing called HIV is with me, or it is not just me and my partner, there is some element to having sex that I didn't want to think about. Sex became less intimate and more threatening. Because it was an interruption of a moment and a feeling of intimacy. Being able to have sex and to not think about whether there are condoms in the headboard, all the things I have thought about it in the past. I don't want to say a resignation to it, but that is maybe partly what it is. It may be that I want to enjoy sex for sex and come what may. Maybe it is as simple as I want to live now, and I want to experience. When there is a condom involved you are not really having sex. It is more than a latex barrier. It is somewhat of an emotional barrier, an intimacy barrier, keeping something between you and your partner. There is something there that I don't want to be there. It is more than just a barrier to disease. Recently, it has been a barrier to being totally involved, or totally with someone, or totally getting into a moment. Allowing sex to be what I

always imagined it should be. Which is not having to worry about putting on a condom and not having these other fears, intrusions, interruptions. All pretty negative things.

Chad contacted the researcher several weeks after the initial interview to report that he had just tested positive for HIV. When asked how he felt about that event, Chad had the following to say.

I was looking for intimacy and it was worth the risk. I can say without hesitation that it was worth it. I would not do it differently if I could. I wouldn't. Something has changed within me, and I don't know if I can even describe what that is, but I am a very different person than I was. And that is not just since I found out I was positive. I think my perceptions of sex with a man, my perceptions of intimacy with a man, have evolved into maybe what I idealistically thought it should be when I first had feelings for men. And for me, condoms cannot be there for me to experience that.

Partners

In order for participants, other than the two who are in primary relationships, to engage in receptive, or insertive, anal sex without condoms, they have to find partners. Availability and the selection process were two distinct aspects regarding the seeking of partners that were related by participants.

Availability.

Participants reported having no difficulty in locating partners willing to engage in receptive or insertive anal sex without using condoms. Peter reported quite the opposite experience. "In the beginning, I was very surprised at how easy it was." Bob also noted that by

utilizing the Internet, he found it very easy as well. "I put an ad on [an Internet bulletin board for men seeking men for sex] advertising raw [without condoms] fuck buddy and I had 36 responses in three days." Sean shared his experiences when meeting men in person. "In San Francisco there is this whole other mind frame. Eighty percent of the men I meet don't use condoms and would be thrilled or delighted that I didn't want to use them."

Selection.

All of those participants who were HIV-negative specifically stated that they sought out other partners who verbally reported their HIV-negative status. HIV-positive participants also sought out partners whose serostatus matched their own. For example, Bob reported a clear choice and preference.

At this point I pretty specifically seek out other HIV positive partners primarily because I don't want to go back into that box again and wear a condom. I think that positive people should stay together and that negative people should stay together. It is almost a rule for me that I rarely deviate from.

Darrel, who is HIV-positive, also stated that he seeks out other positive men for sex. "Being with another positive person is a lot more freedom, no restraints, no worries. That makes it more sensual and fun."

Rich reported that he would occasionally have sex with negative men, but only if they are aware of his status and are aware of the potential risks involved. However, he

said that he would usually only engage in unprotected sex with negative men if he is the receptive partner.

I won't top somebody who is negative. That is the one thing I won't do. It is not an absolute, but I am not real comfortable with it though. If I do, and it is without a condom, I won't cum in them. That I won't do at all. It makes me feel uncomfortable to feel that I might infect someone. There is an actual mental block. I have a hard time staying hard. There is a natural physical/mental block. I just can't do it.

Bob relates his reluctance to engage in unprotected sex with negative partners to two events in his past. The first occasion was in relation to his partner, who was negative, when he was living in South Carolina.

I had felt like a pariah for so many years with [his partner] being negative. I had issues about having sex with him for most of our relationship. I will never clear from my mind the images of his face the first time I came straddling his chest. It shot up near his face. He flinched like Godzilla was coming after his throat and that never left me. In that relationship, it never, ever left me. I was poison.

That negative experience repeated itself to some extent later in Bob's life after he had moved to California.

I had somebody that I met at an AIDS Ride function, and I was wearing my Positive Peddlers T-shirt. It was how much clearer could I be that I was positive. He was very interested in going home with me, and I kind of assumed he was positive until we started having sex. We started to fuck and I said, "You're positive right?" He said, "No" and I said, "Okay, you recognize the shirt," and he said, "Oh yeah, I'm okay." I said, "Okay," you know, and then we were kinda laying there afterwards and he got kinda quiet. I said, "So I got to ask you this, are you gonna think about this tonight and wonder if you did the right thing, or do you do this all the time?" He said, "Well yeah, I probably will." Then I said, "Don't use me that way. I'm not going to be the source of your drama on this, so if you want to have sex with me

again it will be with a condom or not at all." With this guy, something clicked in my head, and I just thought I am not okay with this anymore, I'm not going to be a part of that anymore.

Darrel reported a similar negative experience with an HIV-negative man that convinced him that the pain he felt after having unprotected sex with a HIV-negative person was not worth the experience.

There was one time when I did have sex with somebody unprotected when I was the top and we had talked about bringing rubbers and lube beforehand. But when it got down to it, it was so hot and heavy that I didn't put one on. And he asked me afterwards if I was positive and I told him yeah. He was negative and it was a real nasty scene, but it ate such a big hole in me to think that I had done something like that, that I had endangered somebody's life. It just... [pause]. I did nothing but sit in my house for an entire weekend and cry. I have always tried to make it a practice to have sex with a condom when I am with a negative person. It was such, that is part of the dangers, I don't ever want to feel that guilty again. That hurt big time, right down to the core of my being, that disrupted my entire life and I couldn't imagine ever doing that again.

Intentional Infection

There has been a fair amount of coverage in the popular press, as referred to in Chapter 2, regarding intentional infection with HIV. The vernacular term commonly used for those seeking HIV-infection is "bug chaser," while the term for those who seek to infect others with HIV is "gift giver." Participants were asked to report their perceptions regarding this phenomenon and the reporting of it in the press. All participants had very strong reactions. Peter said, "Most of it is talk and most

of it is fantasy." Sean also did not report believing that it was really as clear-cut as some of the reporting would make it seem.

Guys say that, but I don't think they really want to. They think that they do. They want to be a part of that community and have this hard core sex. They just say whatever at that age and then they end up HIV+. Young guys really into sex move to San Francisco and the sex clubs and parties. Those guys are not gonna put a rubber on.

James was even more outspoken about his lack of belief in this behavior.

I don't even think that bug chasers and gift givers really exist. I think the whole thing is a fantasy. Even those people who say they are bug chasers, you can't be a real one, or at least not a good one, for very long. If you really want to get infected, you can get infected! I don't know anybody who is positive who makes a fetish out of infecting someone else.

Darrel did not deny that such practices existed, but he was quite clear about where he stood on the issue.

Positive people who want to infect have a big problem, a psychological problem. Why the hell would anyone want to go out and infect as many people as they could? I don't get that. It is like committing murder. And where is the fantasy in becoming HIV positive? I guess some people are so warped and sick and twisted enough to maybe think that way. Maybe that is beautiful to them. Maybe they lost someone to HIV or found out one of their friends is positive and they want to be just like them, a weird type of thing like that. I don't know, it is kind of disturbing. Can somebody's life be that sad that they want to go out and contract HIV?

Bob acknowledged that such behaviors probably did exist, but he nonetheless had strong opinions about it.

Oh, that's too sick for me to even contemplate. I know it is out there, I read about it, I hope that is

some demented queen's ramblings on the Internet, but I am afraid that it's not. I mean there are people out there who for whatever reasons need to do that, but I just think that is too twisted for me to even think about for long. They should walk a mile in our shoes when they think about that. I mean testing positive was certainly a watershed experience in my life and my life is a whole lot different than it would be otherwise, and it is a whole lot better than it would have been otherwise, I think. But the crystal ball doesn't go backwards any better than it goes forwards, but I really think it grounded me into a better person, but I sure as hell wouldn't recommend it as a life-style choice. Therapy is cheaper in the long run than testing positive. But I understand that, I do understand, I guess to some degree why somebody would feel left out because so much of the focus in our community is about HIV. For some people who have self-esteem issues, or whatever, they might feel like, hey I can be part of the club too. And I laugh and make sort of tongue-in-cheek comments about membership has its privileges, but as a rule it's just what it is. I would hope to see that our generation is the last one to go through this, 'cause I don't think, just as it is not natural to have sex with a condom, it is not natural to be 38 years old and wondering if you are going to be 50.

None of the participants identified with a position of actively seeking infection or actively seeking to infect others. David, however, expressed the possibility that he would intentionally seek infection in the future.

Anybody who is in the position that I am has probably entertained some scenario about deliberate infection. I see these things on-line, these conversion parties, I have chosen not to do that. I would have to be in a much more cynical mindset than I am right now to do that. It is conceivable that at some point in the future I might choose to do that.

Re-infection

Re-infection refers to the hypothesis that a person currently infected with HIV could become infected again through unsafe sexual contact with another strain of HIV.

The potential for re-infection has been promoted as a reason for HIV-positive men to continue to refrain from engaging in sexual activities, such as receptive anal intercourse, that are known to present the potential for HIV transmission.

No HIV-positive participant reported thinking that the medical literature was convincing in regards to the possibility of re-infection with a drug-resistant strain of the virus. None of the HIV-positive participants reported believing that such a biological event actually happened, and as Evan said, "Even if it does happen, it is more important to do what I want to do." Bob based his lack of belief in the re-infection process on personal experience.

I've had some of the most infected cum [semen] in the world inside me for five years now, and I have two regular sex partners, a couple that I play with, a couple of times a month, two, three times a month. They both fuck me, and they both cum [ejaculate] inside me and this has been going on for several years now and both of them are multi-drug resistant which I didn't know when it started happening and maybe if I did know that I might have thought twice about it. But then I thought what's done is done, I'm not gonna freak about it now and the fact is that I have no detectable virus below 50 and its been consistent for five years since I started protease. I'm on the same regimen that I started on five years ago so my blood work is very stable and I feel like if this re-infection were true that I might have seen something happen.

Treatment

The existence of treatment that can control HIV-infection and the clinical manifestations of AIDS has been postulated as a potential motivating factor for men to

resume engaging in anal intercourse without condoms. Several studies designed to investigate this potential influence were cited in Chapter 2.

All participants were familiar with the currently available anti-retroviral therapies used to treat HIV and AIDS. All HIV-positive participants, with the exception of Charles, were currently taking a treatment regimen. All HIV-negative participants indicated that they either knew people who were taking medications or that they had read about them in the press. However, all participants' stated opinions about the treatment regimens and the role those treatments played in their decisions regarding sexual behavior and health were varied.

Chad, who was not taking medications at the time of the interview, did report that the effect of the medications that he had observed in his partner influenced his thinking about HIV infection.

I think it has to be a part of how I feel about the disease. I'm sure it does. Based on the experience I have of my partner who has known that he is positive for seven years and has experienced no physical signs of the disease and knowing that the treatments are not a guarantee of anything other than controlling the disease, I think it is part of how I view the danger, the possibility of living your life with HIV. It is almost as if it is two different diseases when comparing the past with the present. It makes the disease seem less dangerous. Being able to live a quote normal life with the drugs today is greater than that possibility would have been ten years ago. I think the disease is the same as it always has been in terms of physical consequences, but I think how you can live is very different. Somehow, that connects in such a way that the danger is reduced.

David's comments were more skeptical about the ease of taking the medications.

I can't imagine that the medications are that easy. I am sure there is nausea and sickness. I believe that is true. The temptation is to think that protease inhibitors are just like popping Advil, but I'm sure it is not.

Mark also voiced an opinion about the efficacy of the medications. "In a way, I think they are so toxic that it might promote your symptoms a little more rapidly."

Charles, the only HIV-positive participant who was not taking the medications, stated that he was certain they were harmful. That conviction was his reason for not taking them.

All the people that I know that have survived haven't taken them. People that I know that are taking these drugs have either died or have deformities that are worse than the disease itself. Wasting syndrome is not caused by AIDS, it is caused by AIDS drugs. Most of the deaths are not because of HIV. They are because of the drugs. All of that. I don't know a single person who has died of HIV. I know plenty of people who have died because of having adverse reactions to drugs.

Prevention Messages

The influence of environmental factors upon behavior should not be underestimated. Individuals make behavioral choices with input from, and in response to, factors encountered within their daily lives. One factor with which all participants reported a familiarity was HIV-prevention messages disseminated throughout the gay community.

Many participants reported a general dissatisfaction, and even anger, with the HIV-prevention messages they have seen in their community. Their statements indicated dissatisfaction and anger, which prompted them to spurn the behaviors promoted by the prevention community by engaging in exactly the behavior (unprotected anal intercourse) that the prevention agencies consistently tell them not to engage in.

Chad indicated that he remembered his experience of seeing these public messages and the effect they had on him psychologically and emotionally.

I remember the "always use a condom" message. Assume that everyone is positive. Don't get fucked, nobody will fuck me, or make sure that they use a condom. This affected my self-esteem and my guilt level. I would feel guilty about having sex without a condom. I knew that there were many people at the bathhouses not using condoms, I saw that, and knew that the times a condom was used were minimal. Thinking that, it would reinforce the idea that everyone is positive. I figured that if people were not using condoms they must be positive.

If I go to the bathroom why do I have to be bombarded with yet another warning? If I enter these doors [to a bathhouse] I should be doing so with enough knowledge to make up my own mind. I was angry. It made me question my sexual desire. The posters had that effect. And it was not a positive effect. They reinforced my guilt and my denial of my sexuality. How could you have not already known the facts? If you did not already know the facts it was your failing. If you chose to be in situations in which you did not know your partner's status you had the responsibility to go in armed with the information to make your decisions regarding behavior and those decisions were ultimately mine to make. It was appropriate to provide the information, but the decision was mine.

You cannot legislate how someone is going to have sex. If I have decided to not use a condom, whether I

go to a bathhouse, a sex party or my bedroom, it is not going to change. If I go into a situation where there are other men who have the same ideas that I have it is ultimately our choice on how we behave. I don't think sexual behavior should be condemned.

Chad's experiences of prevention messages were clearly negative. Bob also indicated that the prevention messages were detrimental to his ideas of sexuality.

I'd just been brainwashed by those people into thinking that it was wicked to not have a condom between you and your partner when you have sex. I think what it had more to do with than anything was that we are going to make every sexual act that you do either less sensual or even outright icky.

Well and one of the observations that I made is that we are talking about whose responsibility it is, who's more responsible, who's less responsible. Our society places the blame and the burden on a heterosexual woman to not get pregnant. And yet, this same sort of mechanism, this same sort of passing of seed of a different type from positive to negative, the burden is placed on the carrier of the seed instead of the recipient. Why is it now more my responsibility to prevent you from getting infected? I just thought that's just part of our culture, that our culture is so homo-biased that it is evil to have sex anyway and therefore you have to repress your sex and this is why you to repress your sex because you're going to cause this epidemic to spread, and I think that is a bogus response.

Albert also stated that prevention messages were designed to serve the interests of certain gay men as opposed to the larger population.

It is wise for people in public positions to denounce bareback sex. I have enough of education stuff. I don't think I need anymore of that. I think it is trying to put forth the good boy image, we are all angels here, and it is not true and I don't really want to be a part of that whole thing. I don't think it is true that you have to use a condom every time and I used to know a fair amount of people who were involved in safe sex networks and a couple of people who were like facilitators for groups in the city and

I found them the most irritating people in the whole fucking world. I couldn't believe it! One guy kept trying to tell me how condoms could be turned into a better sexual experience. I know you can turn anything into a fetish, but that one was not going to work for me and I knew that in the 80s.

Lots of gays want to gain acceptance. I understand that, but I am sick of the whole thing, too. In some ways we are all alike on some levels, but we have to be ourselves too. There is a variety in sexuality. Even gay marriage which I think of as part of a different culture. Some people have long term relationships and that is great but not everyone does and doesn't have to.

The sanitizing the whole thing is part of it. There is a need to get money. The liberal establishment puts a lot of money into this thing and they are scared too, and they want to know that gays are doing the right thing. I don't want someone telling me that there is a certain way. This is how it is going to be done and that's the way you do it. And that is the message that I hear. There is a stigma associated with not using condoms, right now. I think that is going to be there. I think people are afraid of gay sex anyway, even the more liberal are still afraid of sodomy. But get over it.

James indicated that prevention messages and HIV in general had become the sole issue of importance to the gay community and that many other important issues had been left behind, including reasons why bareback sex might in fact be a positive activity for some people.

Health and sex is all about AIDS these days and all the other stuff, social connections, conversation, intimacy, community, and recreation are all considered secondary. There are important psychological benefits from having the kind of sex I want to have. I really think I have been able to keep my outlook on life really upbeat largely because I am still have the kind of sex I want to have. There is something to be said for that whole mind body connection. I think there is a tremendous psychological harm to the whole gay community with the advent of the kind of HIV prevention that was basically laid on us. The whole use a condom thing would have been fine as an emergency measure, but what it has become is gay men

have to use a condom every time for the rest of their lives is pretty much the message now. I sure would not want to be a young gay man coming out now and realizing, oh God this is what it has got to be! For those of us who did get to experience what gay sex really should be about, it is very disconcerting. Worse than disconcerting, why not just say give up? Frankly, I really think that the use a condom every time message is homophobic in its underlying intention. If you consider what would have happened if AIDS had primarily struck the heterosexual world, there is no way that heterosexuals would ever have accepted the prevention message of use a condom every time for the rest of your lives as any kind of a solution. They would have absolutely demanded that there be an all out government funded effort to find a vaccine and a real cure. At root it is trivializing gay men's sexuality to kind of assume that everybody will just roll over and accept that they have to use a condom all the time.

James also commented on his perception that the current prevention messages were created and promoted by individuals who had hidden agendas aside from the protection of the health of gay men.

Those who really started the organizations which push the "safe sex" agenda are those who were too ugly or uninteresting in the 1970s to be a part of the sexual culture, not because they did not want to. It is all about having sex. But if you tout that as a good thing, you are not about to get the support of the corporations, the straight foundations or the government.

James expressed concern about the potentially incorrect semantics of the current prevention messages and the harm that these messages may ultimately cause.

The other thing that really bugs me about this is the words safe and unsafe. There is no such thing as safe sex, much less that condom use equals safe sex. The real fact of the matter is that condom use is not safe. It may be safer in some situations, but it is certainly not safe. Condoms can break. And in fact if you really want to look at degrees of safety, it is

a hell of a lot safer for two negative men to have unprotected sex than it is for a positive man to put on a condom and rough fuck a negative guy. I think there are a lot of negative people who take the message of condom usage equaling safe sex and they do make sure that a condom is being used, but they don't do any other kind of screening of whether the person is positive or negative. And they really don't make sure that a person is using a condom correctly, and may be putting themselves at more risk than if the prevention approach was I'm going to only have sex with only guys who are negative, and granted, you never know for sure, but you never know that a condom isn't going to break either. It is not about what is safer or not. It is about how one is going to be perceived. If somebody were negative and converted because a condom was being used but it broke, the powers that be would be like you poor thing you did the best that you could, and these things happen it is really too bad. But if that same person had done everything they could to make sure that the person they were having sex was also negative and was having unprotected sex and turned out they were wrong, then that person has been totally irresponsible. But the result is the same. They have both done something to try to lessen their risk, but condom use has become like a religious proscription and to not use them is a heresy. And just like any religious type thing it is all based on assumptions and beliefs that nobody ever questions. Once you question you realize there is not a black and white about this.

Finally, Lawrence stated that the current HIV-prevention messages were damaging the cohesiveness of the gay community.

Current HIV prevention messages establish an us and them mentality between the younger and older generations with the implication that my generation is the carrier of all the ills, a Pandora's box if you will, and young men open it at their risk.

Lawrence's comment foreshadows another thematic concern expressed by participants, which had to do with their feelings, impressions, and experiences as related to the gay community.

Community

The importance of the influence of community upon behavior should not be underestimated. Individual behavioral choices are made within the context of a larger organizational or societal structure, or in response to a lack of structure. For many participants, a lack of nonsexual-based venues for participating in the gay community and the presence of structures that seemed to promote sexual activity reinforced their decision not to utilize condoms for anal intercourse.

Several concerns were expressed by participants regarding the gay community in the San Francisco Bay Area. In general, participants indicated that they were not entirely happy with what they had experienced, with the exception of Peter, who did not express many complaints, and Albert, who conveyed no connection to the gay community and therefore did not feel that he could form an opinion. The concerns expressed included comments about a lack of a cohesive gay community, contrasts between their experiences of the gay community in San Francisco with their experiences in other parts of the United States, deep divisions among gay men, and a perceived lack of a positive vision for the future.

Lack of community.

Charles stated that the massive amounts of money being spent on HIV prevention and research could be redirected.

The gay community? There is not really a gay community. It [research money] could go for strengthening that through bringing in support services. Bringing in disenfranchised gays. Right now basically the gay community consists of bars and gift shops. If you don't want to go someplace and spend money you really don't have a place in the gay community. Drop in centers, places where people can get together without doing commerce. We don't have churches, except for MCC, but we don't have those societies that a church provides. It provides more, take away the religion and the dogma. It is a very strong society. They have a purpose. We don't have things like that. Unless you want to join a church, we don't have those types of societies. We don't have those types of communities. The money could go for that.

David noted that there were community resources available, but that there was room for improvement and that the lack of connection played a role in his decision to practice anal sex without condoms.

Some of it does exist although in limited quantities. There is a gay running group so if you want to do that you can do that. Or there is this organization called Max for professional men, but for the most part it doesn't look that different than the Midnight Sun [a Castro district bar largely patronized by young and handsome gay men] for the most part. In DC we had a 20s group with a structured discussion to make it comfortable for people to interact without getting into an overly cruisy mode. It was a way of providing connection. There are all sorts of other ways you could do that in other ways in smaller measures but it's not happening often enough. It can be hard to find out about them and it is not clear to me how many people look. It is really about finding ways to get people to talk to each other, to build social networks and have fun.

Sometimes I think that if you don't like the way things are go and change it, but then I think I am 34 and my job is hard enough. There are some things I have thought about doing such as a cross-generational dialogue to bring older and younger men together. I think one of the things that is missing here is mentorship. People come here and just sort of fall into the city very passively. There are so many

elitist and exclusionary people in the city. I love being in the city. I don't think I would be as happy in San Jose. If I were ever to leave here it would be because of the lack of deep connections and friendships. My decision to bareback was not all about that, but the propensity has increased and all these factors play into that.

Mark also indicated that there was a lack of community in San Francisco or that at least the community that existed did not welcome him or make him feel comfortable, despite the availability of resources.

I actually feel that there are a lot of resources out there, but it is very cliquish. It is just a matter of where you are connected or whom you are connected with. Personally I feel that they are as supportive as they can be, but I feel you have to be in a certain group or certain crowd. Even going out to some of the clubs it is like that. If you are not 6 foot tall, blond and blue-eyed, you really don't fit in. If you go to the Mission and you are not dark-haired with olive skin you don't really fit in either. I have been here for almost 4 years and the friends that I have, the majority of them are straight. The gay friends that I do have, they are very... [pause]. It took a long time to establish a friendship because they were like tacky or wanted to have bad attitudes, but once you get to know them they are different.

Sean also noted that the gay community was fragmented and not cohesive unless you belonged to a select group of people within the larger gay community.

First thing to come to mind is leather or bear scene. They are the only people who seem to have a community. Everyone else is just kind of on their own. Just with their lovers or professions and do what they want without concern for how it affects other homosexuals. Although they will be emotional and love Auntie Mame, but I don't think they are supportive of anyone outside of their own little circle. I think that is terrible. It has not always been that way, but it has become much easier to be gay now because of the work other people have done and they are resting on other people's laurels. Enjoying all the freedoms without

giving back.

San Francisco in comparison.

All of the participants had migrated to San Francisco from other parts of the country. Several of the participants drew comparisons between their experience of gay communities in other cities to the community in San Francisco. Charles remembered what gay life was like in Iowa.

Iowa was different because there was fewer people. The more people you have the more confusion. I like leather, there are thousands of people who like leather, so we can all be a part of the leather community. In Iowa, there might be two other people into leather. If I am a bull dyke, there might be two other bull dykes and there is not enough to split off and have your own private communities. You want to be around gay people, you have to interact with them all. So people are forced to interact with people that were different from them, and forced to have friendships with people who were different, with different viewpoints, different life experiences. There was a community there, but it was a small group of people. The more people you have the more diverse it becomes and people can start going off into their little groups. It is hard to figure out how to bring them back together.

Sean grew up in Los Angeles and stated that the emphasis of the community there was distinctly different than it is in San Francisco.

Los Angeles is more of a dating than a sex-based city like San Francisco is. You don't want to get a bad reputation down there. Up here you can get more of a bad reputation by being prudish. So San Francisco is more focused on sex than Los Angeles. If you were a whore, it was bad, but here it might play to your advantage. Having your picture in the Bay Area Reporter is not a negative thing, it might be a status thing. Being with a porno star was a status symbol in LA, but only if you could afford them because they

were good to have sex with, but you certainly were not going to invite them to your parties.

David came from Washington DC and noted that gay men there were "more into dating, not as promiscuous, more intelligent although more uptight." Mark's experience of growing up on an Indian reservation in South Dakota was also distinctly different. He indicated that gay men and lesbians were integrated into the community as a whole and were not stigmatized. He recalls, "I was never called a faggot until I moved to San Francisco."

Gay men divided against themselves.

Some participants indicated that the greatest problem with the gay community in the San Francisco Bay Area centered on gay men themselves and the intercommunity divisions that exist. Sean clearly stated that this was the case.

It is really ridiculous for gay people to look down on other gay people for what they are doing. I can't believe that other gay people hate guys because they are queens or drag queens or whatever they are into. It is like prejudice within prejudice. They become their own worst enemy. They don't know how good they have it. Back in the old days everybody banded together and needed each other. Even in 1983 it was still like that in LA.

Charles reported experiences similar to those expressed by Sean; in fact, Charles's comments about the divisions between gays were even stronger.

I think it is self-righteous queers that are shutting down the sex clubs, shutting down the bars, that are complaining about people smoking in bars, that are complaining about people having sex in the bars, and

complaining about people cruising the alley and walking down the street and dressing strangely. Straights are not fucking us up. It is the gays. It is the gays in government, the gays on city planning commissions that are fucking us up, because straights don't care. Self-righteous, homophobic queers who are afraid of anything that makes them look like they're not straight.

They think they are going to gain acceptance. Look just like everybody else, act like everybody else, and drink just like everybody else, and have sex just like everybody else, then they will think we are just like them. You are not like them, people are still gonna beat you up, you can be completely indistinguishable except for the fact that you have another man for a lover and they are still gonna beat you up and kill you. And they don't give a damn. It is not gonna help more people come out. It is not gonna do anything better. It is not gonna secure your rights. Securing your rights is making sure that what you want to do is protected, not changing your lifestyle to fit in with them.

James also indicated that the gay community has lost something over time in its seeming need to fit in with the larger culture surrounding it.

Gay life in SF is extremely varied probably more so than in any other city because there are so many of us. From an overall cultural thing it is pretty good. In the 70s it was really innovative and creative, exciting. I think that gay life now is sort of repeating the same old stuff. It is not setting trends, it is not at the forefront of things, and if anything, people are sort of glorifying in how normal it is. I think that is kind of too bad. I think I liked it better when it was a little edgier.

Future vision of life within the gay community.

As indicated, many participants indicated the greatest issue was the quality of the life they led, not the number of years they lived. Two participants expanded on this theme by relating what their visions of the future held for them as gay men in the community in the San Francisco Bay

Area. Lawrence, who at 46 was at the upper end of the age scale for participants, had this to say.

Most sex for me has an escape element to it. It is an escape from the isolation of being a homosexual male among males, a breed known more for exploration and pioneering than settling and nurture. I think it is questionable that there would ever be lots of takers for gay marriage unless it was for the benefits.

Some doors are closed to me sexually. In San Francisco the truth of the matter is that it is much more a liability to be older than it is be young and positive. Because if you are either very young, very hung, or very beautiful, or very rich, or extremely, extremely amusing, witty beyond belief, one of those or any mix of those, people could completely care less about your status. They won't even ask. He's hot, it is not an issue. If you are less than beautiful or you are older, or if you are not super-hung, or if you are not super rich, or if you cannot entertain with a combination of Jim Carey and Bill Murray all at the same table, then you are lessened. It is a hierarchy in that sense. I would not say that carnality is not available, but carnality and warmth is less available. What we are left with is a very nervous group of men. Men feel a lack of connection and a lack of satisfaction with life here in the city. Some young men have told me that they can't imagine wanting to be 45.

David, 34, indicated that his lack of belief in the likelihood of developing a long-term relationship in San Francisco impacted his sexual decision-making process.

I get a little frustrated with all this talk about sort of saving yourself for an ideal relationship. I don't know if in my case that is really gonna happen. It might, in which case I would be totally monogamous. I find that I get sort of jaded and sometimes I do develop a well fuck it attitude. So what! If I have sex and I turn positive then I'll deal with it. I won't be much worse off than I am right now.

David indicated that he did not believe in the likelihood of a relationship developing, but stated that he still felt the need for contact with other men. He stated that in

order to have that connection, he had to play according to the social environment rules that he perceived to be prevalent.

If I want to hook up with guys and connect with guys, what is the way that I am gonna do it? It is probably, ultimately, once I get frustrated enough, to pander to the level that I see. It is either to live up here in my little glass tower and turn into a spinster or sort of get into the scene and the rest of it. In San Francisco the number of men who are willing to have unsafe sex is pretty astronomical, and so the gut sense is that I am just getting pulled into it. Willingly. It is not an unpleasant experience.

David elaborated further on how he perceived the social environment, and on how that environment affected his emotional states.

What is most important in SF is if you have a hot body and a big dick. You can work at 7-11 or have a doctoral degree. You can be the sweetest, most thoughtful guy or a prick. Everyone wants to know what I look like, do I have a bubble butt, what size is my waist. Body fascism is very strong in this city. Conforming to a particular body type is pretty strong. This reinforces your sense of disconnection. All of this stuff around disconnection and the difficulty in meeting people directly influences my own behavior. Frankly, all this stuff that happens makes me cynical and it fucks with my self-esteem.

Ultimately, David stated that his perceptions of the social climate for gay men in San Francisco led him to question how his future life would look.

What does the average gay man think about his life at 60? I have no fucking clue! Am I going to be wearing a cashmere sweater, sitting out on the front porch and hosting people with my partner or am I going to be in some old folk's home with people I don't know because my parents have died. I only have one sister and I really have no living relatives and I may not have a partner. Well, that sounds like a fucking miserable existence. Or is it that I am going to keep working

pretty hard up until I am 65 and I am sort of tired and not any better socially connected than I am right now, so what exactly does the future look like?

David indicated that his negative perceptions of the community in which he lives, and a lack of a clear and positive vision for the future, have interacted in such a way as to influence his behavior. The excerpts above are taken from a much longer transcript located in Appendix F. A review of the extended quotation will serve to place the excerpted comments into a more holistic perspective.

Choices

A universal theme expressed by all participants was that of personal choice. Participants were clear about their having chosen to engage in receptive anal sex without using condoms. As David said, "I don't forget to use a condom. I know that we are not going to use condoms." Evan stated it even more simply. "It is my choice. Everyone makes their own choices." Chad also felt that choices were the central issue for him as well.

It comes down to a personal choice. A person is making this choice based on hopefully knowledge and his own experiences. I think we live in a world where there is enough information available to you that if you choose to bareback you are accepting any and all risks. I think it is inappropriate to try and control behavior, but I don't think it is inappropriate to get as much information to people as possible.

David also supported the right of individual free choice, but he also added, "people have a moral responsibility to know their status and not intentionally put people at

risk."

Peter questioned the integrity of those in the community who seem to be opposed to an individual's right to make a free choice.

When I see the fanatical types they are often hypocrites and they may have done it once or twice, or fallen off the wagon and now all the sudden are absolutely against it. I think life is full of risk. I think people decide whether they are going to drink and drive, whether they are going to do drugs, whether they are going to ride motorcycles without a helmet or at all, go skydiving. And I think, not to say that I think any one of those risks are any more serious than any other, but I just don't believe in having a sanitized life without the freedom to do whatever you want to do. When it is time to pay the consequences, then that is a different story. And this is one of the risks I choose to take.

It used to be that it was dogma that you practice safe sex. You use condoms. And I never encountered anybody who didn't. As time went by, there were the little slip-ups, I was too drunk, I was too fucked up, or at least that is what they said. For me, and a lot of guys I am with, it is a conscious choice. They have decided that that is what they are going to do.

James echoed Peter's sentiments and said that "taking informed risks is an essential part of one's life and can actually enhance one's life."

Every participant had unique and insightful things to say regarding receptive anal sex without a condom and the myriad issues surrounding the experience. The information presented here is only a sampling of the richness of the responses. While there were clearly a variety of themes identified and presented, the overall implication for the researcher was that multiple factors interacted to influence the behavioral choices of participants.

Participants uniformly indicated more than one motivation for their behavior. The goal of Chapters 5 and 6 will be to synthesize the many themes expressed and to present recommendations for the practice of community health education with the community in which the participants live.

CHAPTER 5

Discussion

The excerpts from participant interviews presented in the previous chapter are revealing of the motivations and feelings of the participants regarding their decision not to utilize a latex barrier device for receptive anal intercourse. Numerous thematic concerns were represented and the intention of this chapter is to discuss the meanings and implications of those themes. The researcher has chosen not to attempt to substantiate or argue the truth of participants' perceptions. The participants openly related their lived experiences, and their words provide insight, clues, and important information. The researcher's position is that each individual's life experience is important to the development of an understanding of a phenomenon.

This chapter will open with a discussion of the recruitment process and participant characteristics. The discussion of the study results will move through three frameworks in an attempt to organize and synthesize the responses of participants. Instead of discussing each identified theme independently, the domains framework developed by the California STD/HIV Prevention Training Center (n.d.), which was introduced in Chapter 2 and further explicated in Appendix C, will be reintroduced to organize the discussion. The flexibility of this theory-

based framework allows for an organized array of participant themes. Its broad comprehensiveness eliminates the need to introduce numerous individual theories that may include only a limited number of constructs relevant to the themes expressed by participants. Further discussion of alternative frameworks is discussed later in this chapter and in Chapter 6. The close of this chapter will attempt to highlight meta-themes and to create a synthesis of the issues, motivations, and concerns expressed by the participants.

Recruitment

The ease with which participants were recruited and the number of individuals who contacted the researcher and expressed interest in participation suggest several issues of importance. It would appear that the behavior known as barebacking is not rare and that individuals engaging in this form of sexual behavior are comfortable enough with their choice of sexual expression to speak about the behavior with a researcher whom they do not know personally. When the time frame of the recruitment is considered, this perception is further substantiated. The bulk of the recruitment effort occurred during the popular December and January holiday season. That there were sufficient numbers of willing participants despite this holiday season is indicative of the potentially large numbers of men who have sex with men (MSM) who identify

with the term barebacking. Furthermore, once the holidays had concluded, the number of respondents increased beyond the already high levels experienced during the holiday season. At its peak, as many as 10 inquiries regarding the study were received daily.

It also became apparent that many individuals who have chosen not to use condoms for receptive anal intercourse are willing to speak about their motivations and experiences. Several respondents reported that they were pleased to see that someone was investigating the phenomenon in an unbiased manner. They also indicated that no one had ever taken the time to ask them about their motivations before condemning their behavioral choices. The unbiased nature of the research was emphasized to all potential participants during the initial contact. The researcher unequivocally stated to potential participants that he made no judgments regarding the behavior and was solely interested in recording the lived experiences of participants. Participants' comments, and the volume of the response, would indicate that barebackers wish to speak about their experiences and that men who have chosen this form of sexual expression should be given an opportunity to engage in a frank and open dialogue in an effort to demystify the behavior and to elucidate the motivations which underlie it.

The success and failure of the different recruitment

methods employed provides guidance to future researchers who may wish to sample this population. The success of the Internet-based recruitment suggests that barebackers are conversant with the use of the Internet, have private access to the Internet, and spend enough time utilizing the Internet that they are likely to see recruitment messages posted on-line. This method of recruitment also has the advantage of being of very minimal cost to any individual or organization that maintains an Internet connection for other purposes, such as organizational World Wide Web sites or personal e-mail accounts. However, as noted earlier, relying exclusively on an Internet-based approach does introduce the possibility, if not the likelihood, that a sampling bias towards those of higher socioeconomic and educational status will be introduced.

Print recruitment proved to be as effective as Internet-based efforts, but the choice of publications proved critical to a degree that was surprising to the researcher. As was indicated in Chapter 4, the print advertisement in the Bay Area Reporter (BAR) was clearly the most productive. The BAR is specifically targeted to gay men and is widely distributed free of charge in locations they frequent. Therefore, it was not surprising that this publication yielded a high number of responses. What was surprising was the lack of responses from the other two publications selected: the Bay Times and the San

Francisco Bay Guardian (SFBG). Both of these publications are frequently found in the same locations as the BAR and both have an apparently large gay readership, based on the distribution locations. Despite this, the San Francisco Bay Times advertisement yielded no participants and no inquiries. The SFBG has by far the largest circulation of all three papers, estimated to be 450,000 copies weekly by the editorial office of the publication, and yet, the advertisement yielded only one participant.

It was interesting to note that the two female respondents called in response to the advertisement printed in the SFBG. Upon researcher inquiry, it was found that both of these women came from the eastern United States and both reported that the term barebacker was used in that location to refer to women who do not use condoms for sexual intercourse with their male partners. The researcher had made the assumption, due to a familiarity with the implications of the term in the press in the San Francisco Bay Area, that readers would understand the term to mean men who have receptive anal sex with other men without utilization of a condom. The researcher was not aware that this assumption had been made until receiving these two phone calls. This incorrect assumption would be important for future researchers to bear in mind when composing print advertisements for placement in publications with a mixed readership.

In terms of resource allocation and recruitment effectiveness, it is also important to note that the advertisement in the SFBG cost \$168 for a two-week print run, while the far more productive advertisement in the BAR ran for three weeks at a cost of \$48. For researchers who are operating within a limited budget, effective resource allocation is critical. It may be possible to purchase an advertisement for only one-week to determine the effectiveness of the venue. This approach would have been possible with the SFBG, but not with the San Francisco Bay Times, which only sells three-week advertisements. More importantly, it is critical to utilize more than one recruitment venue to obtain as representative a sampling as possible. However, the effectiveness of the venues should still be considered carefully to ensure as diverse a sampling as possible regardless of expense.

Participants

The most important, although not unexpected aspect of participant characteristics recorded by the researcher was the high level of knowledge regarding HIV transmission demonstrated by all participants. All participants were familiar with the sexual routes of transmission and recognized receptive anal intercourse as being the most likely and efficient mode of infection. This level of knowledge would indicate that public health education efforts have been effective in communicating knowledge,

even if those efforts have not been effective in maintaining behavior change over time. Three participants also indicated that they either work for or volunteer with AIDS service organizations, which increased their knowledge regarding the modes of transmission. Clearly, knowledge of transmission modes has not resulted in behavior change or maintenance for these participants, which would indicate that, at least in their cases, the other factors and motivations which enter into the process of decision-making carry more importance in terms of influencing behavior than does knowledge.

It was interesting to note that there was an even distribution of participants among those who were HIV-positive and those who were HIV-negative. The decision among participants to engage in unprotected receptive anal intercourse did not appear to be a decision that was based strictly on the serostatus of the individual in question. As was true for knowledge, serostatus alone cannot be seen as a sole motivational factor for participant behavior. However, this research did not employ a randomized sampling mechanism, and the total number of participants was small. Therefore, it is not possible to draw universal conclusions regarding the impact of HIV serostatus on behavioral choices. Future research efforts that employ a random sampling method and which draw upon a larger participant pool could further explore this connection.

The behavior under consideration was reported by men of a wide range of ages, with an average age of 38. The epidemiological data would suggest that the likelihood of unprotected receptive anal intercourse would be higher among younger men, but this research was unable to support that assumption. A future research endeavor that employed a random sampling method and a larger sample size would be better able to determine the age distribution of men who are not using condoms for receptive anal sex. As indicated in Chapter 1, it is possible that reported incidence rates of rectal gonorrhea, and by inference unprotected receptive anal intercourse, could appear to be higher in the younger age group. If so, this could be due to the greater likelihood that younger men would access public clinics, which would be more likely to report the infections than many private physicians. Given the age range, future research efforts should consider greater segmentation of participants based on age, but these same efforts should not neglect to include men who are outside of the age ranges that demonstrate the highest reported rates of infections indicative of certain behaviors.

The sample clearly over-represented participants who identified as white. This was an unfortunate occurrence, but also not an uncommon one when sampling the gay male population. There were no indicators in any of the recruitment messages that would have served to discourage

men who identified as other than white from responding. Nevertheless, it is possible that the recruitment venues selected are not accessed by sufficient numbers of non-white men or that non-white men are less likely to identify themselves as MSM, even if their actual sexual behavior does include sex with the same gender. It is also possible that frank discussions of sexual behavior may not be a part of the cultural frame of some non-white MSM. Facilitating recruitment of non-white participants, utilizing culturally appropriate venues and outreach methods, would seem critical to future researcher efforts.

The majority of the sample identified as gay or homosexual, although the recruitment messages did not use either of these terms. While it is true that the selection of the BAR as a print venue could serve to introduce this bias, the researcher felt that the inclusion of Internet-based recruitment and the other two print venues might serve to recruit men who identified their sexuality as other than gay or homosexual. However, only one participant, Albert, did so by identifying as bisexual. It would seem likely that at least some men who do not identify as gay engage in unprotected anal intercourse without condoms. For example, Sean reported that he had receptive anal sex without a condom on several occasions with a man who identified as heterosexual. Sampling men who have sex with men, but who do not identify as gay or

bisexual, could prove to be even more difficult than sampling men who identify as non-white due to a felt need or desire to maintain secrecy regarding their sexual contacts with other men.

The relationship status of participants revealed the possibility of sampling bias introduced through the semantics of the recruitment effort. Two participants, Chad and Mark, each identified themselves as being in a primary relationship with another man, while all other participants denied any such involvement or, as in the case of Lawrence, characterized the relationship as "casual." It is unclear to the researcher if men who have sex with men are more inclined to forgo the usage of condoms with casual partners than with partners in ongoing relationships, or if men who are engaged in ongoing relationships and do not utilize condoms with their primary partner do not identify with the term barebacker. The term may include an implication of casual sexual encounters to many readers because of the manner in which the term has been used in the popular press articles cited in Chapter 2. These articles uniformly focus on sexual activity at sex parties. It might prove to be important in future research efforts to make an explicit effort to indicate in recruitment messages that men engaged in a primary relationship are also eligible, or even encouraged, to inquire.

Framework for the Discussion

While identified themes were explicated and demonstrated with representative text in Chapter 4, this discussion of the results has been built around the domains framework developed by the California STD/HIV Prevention Training Center (n.d.). This framework has been chosen because it allows for a requisite flexibility and comprehensiveness in discussing the identified themes and because it has been conceptualized as a framework that incorporates elements of multiple formal behavioral theories. This approach proved more useful than organizing the discussion around one of many available individual theories, none of which would completely capture the diversity of concerns and motivations that were expressed by participants. While certain thematic issues expressed by participants are placed within different domains for the purposes of discussion, it is not the researcher's intention to imply that these concerns could not also be placed within another domain. The domains were not designed to be mutually exclusive, and human behavioral motivations rarely can be classified along discrete and clearly delineated boundaries. The categories are simply used as a basis for framing discussion.

Even though the domains framework proved most useful for organizing this discussion, there were certain thematic concerns that the researcher felt were not completely

captured by the domains. These concerns will be explored at the close of the chapter along with an exploration of other models that may be more directly applicable.

Risk Appraisal

The first domain to be considered for discussing the results is risk appraisal. As the name implies, this domain refers to individuals' assessments of their risks for acquiring a particular condition, in this case HIV infection. This domain is focused on the actions and motivations of the individual and does not actively incorporate the influence of other people or environmental factors (California STD/HIV Prevention Training Center, n.d.).

Internal ejaculation among HIV-negative participants.

Those participants who self-reported as HIV-negative uniformly did not seek to experience internal ejaculation unless their sexual partner self-reported his HIV status as negative as well. Participants reported that ejaculation into the rectum presented the greatest likelihood of infection with HIV, and in this sense, they correctly appraised their risk for acquisition of HIV. However, for those participants who reported that the experience of internal ejaculation was important, as it was for David, the risk was worth taking. David was clear about the possibility of there being a risk since he could not be certain that sexual partners would accurately self-report

their HIV status. David took a calculated risk based on his perceived hierarchy of potential cost versus potential benefit.

However, it is important to note Chad's experience of internal ejaculation. Chad, who was HIV-negative at the time of the interview, reported having receptive anal sex without a condom with his primary partner, who was HIV-positive. Chad made it very clear that internal ejaculation was not a part of the sexual encounter with his partner, and yet he later contacted the researcher to relate that he had converted to HIV-positive status. If Chad's recollection was accurate, Chad was exposed to HIV and acquired it from his partner without experiencing internal ejaculation. It may well be impossible to prove empirically, but this experience would serve to contradict the reported belief of many HIV-negative participants that if the insertive partner does not ejaculate, the risk of HIV-infection is reduced.

Partner selection among HIV-negative participants.

That HIV-negative men actively sought other HIV-negative men was not a surprising finding. It appears that these men were not actively seeking infection with HIV, but were instead looking for a sexual experience that was positive for them in other ways. However, these participants seem to be arriving at this method of partner selection through their assessment of risk for infection

with HIV. They do not have any misconceptions about how HIV is transmitted, but in a manner similar to that in which HIV-negative participants determined which sexual partners they would allow to ejaculate inside of them, HIV-negative participants also engaged in a process of weighing potential costs against the potential rewards of condom-free receptive anal intercourse. Since they knew that the risk for HIV infection was greater when engaging in this specific sexual activity with a man known to be HIV-positive, they chose to act in a manner in concordance with their risk assessment process, but that still allowed them the sexual experience they were seeking.

Internal ejaculation and re-infection among HIV-positive men.

The themes of internal ejaculation and re-infection are inextricably linked for HIV-positive participants and are distinctly related to their appraisal of the risk inherent in the chosen behavior. HIV-positive participants are no longer in a position to be concerned with appraising their risk for acquiring HIV since they already have it. However, HIV-positive participants uniformly reported being familiar with the hypothesized phenomenon of re-infection.

None of the HIV-positive participants indicated a belief in the process of re-infection, in which, it is hypothesized, an HIV-positive individual would acquire another strain of the virus, which might be more virulent

or resistant to treatment. All participants reported that they had never seen substantiated proof that such an event occurred, or (as in the case of Bob) personal experience contradicted the concept. The researcher conducted a search of the Medline database and failed to discover a single study that discussed the concept, much less established it as fact. Of course, when the ethical implications of conducting a study that would establish this concept as fact are considered, it is not surprising that there is a lack of data. Yet, if there is in fact no substantiated proof that re-infection does occur, the challenge becomes how to account for the fact that every HIV-positive participant had heard of this argument as a reason not to have anal intercourse without a condom. Participants indicated that this was an argument that they had heard put forth by prevention service organizations, and they indicated that this was yet another attempt to appeal to the fear and hatred of men having sex with men, despite there being no proof available to support the claim.

The researcher queried Gail Bolan, M.D., Chief of the STD Control Branch for the State of California, regarding this issue (personal communication, January 3, 2000). Dr. Bolan disputed the term re-infection by pointing out that in medical terms this would require that an infected person be completely cleared of HIV infection and then be infected

again by a partner. Re-infection in this manner is not uncommon with other sexually transmitted diseases. However, Dr. Bolan was also clear about the fact that clearance of HIV from an infected person had never been established, so in strict medical terms, re-infection could not be substantiated. The correct medical term for the event which participants referred to as "re-infection" would be "super-infection." Dr. Bolan's sense was that, regardless of the terms used, this was an unlikely event, although as already asserted by the researcher, a study that could establish or effectively deny the event would be subject to ethical dilemmas too serious to be overcome. In sum, it then remains a hypothetical situation.

Participants who were already HIV-positive, therefore, may have appraised their risk for super-infection as nonexistent and proceeded to engage in the sexual behavior that was most fulfilling for them. Given the lack of proof regarding what is termed re-infection, it seems irresponsible for individuals, much less agencies whose mandate it is to provide accurate prevention education, to promulgate messages that were perceived by participants as stating an unverified and potentially unverifiable fact. If the message is disseminated at all, it should always be with the proviso that the phenomenon is only postulated and not proven. Provoking fear and the repression of sexual behavior is, at best, a suspect activity unless there are

accurate and rational reasons for doing so. Those reasons are currently lacking in regard to the issue of re-infection or super-infection.

Treatment.

As was noted in Chapter 2, the potential impact of effective HIV treatment regimens has been postulated and investigated as a motivational factor for men to engage in unprotected sexual encounters due to a lessening of the perceived risk attributable to the advent of these medications. A leader in this research has been S. C. Kalichman and numerous colleagues (Kalichman, 1998; Kalichman, et al., 1997, 1998). However, participants in this study, with the potential exception of Chad, did not indicate agreement with Kalichman's assertion that the advent of treatment has lessened their perception of the severity of HIV infection. All HIV-negative participants still stated that the physical consequences of HIV could be severe. These participants also reported that the medications themselves would not be easy to take and that the medications would undoubtedly have numerous side effects. These participants may well have differed from the participants in other studies in that they all either have friends who take the medication regimens who have detailed the consequences of the medications, have seen certain effects first-hand in the community, or may have read information regarding the side effects. None of the

participants reported believing that the medication regimens were a cure for HIV infection or AIDS.

Data indicate that Chad's perceptions of HIV were slightly different than those of other participants. This difference appears attributable to Chad's experience of seeing former friends die despite treatment. Chad compared these past experiences with what he describes as the normal life of his current partner. Chad in part attributes his partner's healthy life to the HIV treatment regimens. However, Chad stated that he understood that the treatment regimens were not a cure, but instead functioned only to control the disease and perhaps to prevent the appearance of physical manifestations. It was not the danger of acquiring HIV that changed for Chad. He indicated instead that he no longer perceived that being HIV-infected was a definitive death sentence.

The comments of Mark and Charles challenge the assumption that the advent of treatment for HIV has resulted in a perception of decreased susceptibility to HIV, or a lessening of the severity of the disease. Mark indicated that he was suspicious that the medications might be worse than the illness itself, while Charles was very clear that they were. It seems that both of these participants based their opinions on personal observations of people who were taking the medications. Charles reported much stronger opinions than Mark in regard to the

negative effects of the treatment regimens and stated that an HIV-infected person was more likely to die from the side effects of the treatment regimens than from infection with HIV.

Despite the different reactions expressed by participants, the clear implication was that the new and continuously evolving HIV-treatment regimens did not function to lessen participants' appraisal of their risk for HIV infection. All participants still reported that infection was possible, and they did not indicate that taking the medications was easy, or even safe and efficacious. These responses indicated to the researcher that for this group of participants, despite the findings of other researchers, HIV-treatment regimens had no impact on the risk appraisal process.

The risk appraisal domain, as formalized by the CAPTC, includes other potential factors that can impact an individual's perceptions of their risk for a condition. These factors can include stereotyped beliefs about who is at risk, fatalism, and misconceptions about how infections are transmitted, as well as perceptions of personal susceptibility to, and the severity of, a given condition. Many comments by participants focused on susceptibility to HIV infection and their perceptions of the severity of the infection.

Self Perceptions

The domain of self perceptions refers to the thought processes of the individual as related to risk behavior, the individual's sense of the value or efficacy of safer behaviors, and the individual's self-efficacy related to enacting those behaviors (California STD/HIV Prevention Training Center, n.d.). In a manner similar to the risk appraisal domain, self perceptions is primarily concerned with the individual and not the influence or presence of factors outside of the individual.

Life satisfaction and fatigue.

The sub-themes of life satisfaction and fatigue that were identified in Chapter 4 are related to and best discussed within the domain of self perceptions. Participants seem to have engaged in an internal dialogue in which they weighed the outcomes they expected to arise from their behavioral choices and then chose the behavior that they determined had the most favorable outcome according to their own desires.

The theme of the quality of life being more important than the quantity of life was one that was expressed by a number of participants. This could be classified as fatalism since participants returned to the idea that life is a finite quantity that is to be enjoyed while it can.

From the researcher's perspective, to label the participants' ideas "fatalistic" would be to impute a

pathological sense of hopelessness, which was not necessarily expressed in the interviews. Living a life that is inherently satisfying in the moment may, for some people, create a happier and psychologically healthier existence than a life in which the fear of infection overrules all other desires. Despite having full knowledge of the risks associated with unprotected receptive anal intercourse, the data revealed that participants felt that an enjoyable sex life was essential to a satisfying life experience.

An obsessive concern with either death or safety from death can itself become pathological by limiting a person's ability to engage in life fully. These issues of individual discretion and tolerance of risk will ultimately determine which risks are acceptable and necessary in order to live a meaningful life.

Several participants also reported a sense of fatigue with the entire AIDS epidemic and the standards of behavior that have been imposed upon men who have sex with men. The commonly held understanding of the modes of HIV transmission has led to admonitions to gay men not to engage in anal intercourse, receptive or insertive, without utilizing a latex barrier; to limit their number of sexual partners; and not to exchange semen. In a way that is similar to the expression of life-satisfaction concerns, it is conceivable that the psychological fatigue expressed by

participants could be linked to fatalism or a sense of the inevitability of contracting HIV. However, it also seems that fatigue and the normalization of a continuing phenomenon can ultimately be adaptive, allowing individuals to conquer their fear of that which has become more familiar and to return to a lifestyle that they perceive as normal and satisfying. Long-term exposure to most any phenomenon likely creates a sense of normalcy, particularly among those exposed most intensely and over the longest period. For men who have lived with the threat of HIV and AIDS for close to 20 years, the threat may have become normalized. Continued appeals to fear of infection may have lost the original power of urgency and may now be instead disorienting, alienating, and ultimately irritating reminders of an issue that for many is old news. For younger men who came of age sexually after HIV and AIDS were widely recognized, appeals to fear of infection may also be irrelevant. This group of gay men did not experience the initial fear and are perhaps unlikely to respond to attempts to recreate it.

It seems clear that for participants in this study, the expected outcome of living a satisfactory life was more relevant than potential exposure to HIV. It may not be important to determine whether the behavioral motivation for older men who have sex with men is due to a normalization of HIV infection, or if the motivation of the

younger generation is due to their never having known a world without HIV. Respecting and honoring the perspectives and life-choices of individuals is of the utmost importance.

Partner selection among HIV-positive men, intentional infection, and choice.

These three thematic categories have been included together as they are emblematic of a core construct within the self perceptions domain, which is an individual's standard of behavior and his identity. Every individual maintains an internalized standard of appropriate behavior in the larger world and a sense of himself/herself. This does not imply that these standards are always in accordance with the standards that society or other groups seek to impose upon its members. In many instances, these standards may be in conflict. Within this domain, the center of gravity is the individual.

The responses of HIV-positive men regarding their process of partner selection, while not necessarily surprising, show the sense of responsibility present. All of the HIV-positive participants indicated that they made every effort to be certain that their sexual partners were aware of their HIV status prior to the initiation of sexual intercourse. They reported being strongly opposed to placing another person at risk for HIV-infection.

Although these men chose not to use a condom, their

behavior could still be described as responsible in that they did not intend to infect others. They are not engaging in unprotected sex out of a sense of bitterness or anger, and they are not knowingly endangering other people. They are instead negotiating in good faith with other potential adult partners to find the type of sexual expression that feels the most physically and psychologically fulfilling to them. The choices and actions of this study's participants offer insight into a responsible reframing of health education prevention messages. From this new paradigm, men who have sex with men might be encouraged, to the best of their ability, to determine the status of their partners through honest dialogue and then to proceed to engage in a consensual sexual encounter in which both parties feel comfortable. This approach would always be subject to a certain element of risk in that men might lie about, or honestly not know, their status. However, any sexual encounter between two or more people who do not know each other well, and sometimes even between those who do, contains a certain element of risk. The complete elimination of risk from everyone's daily life seems to be impossible. The participants in this study offer elements of a model for identifying and negotiating the rules they bring to their sexual encounters, and their selection of sexual partners.

The reaction of HIV-positive participants to the topic

of intentional infection with HIV appeared to be related to their sense of responsibility. Their responses were very clear and represented some of the most harshly judgmental responses recorded. Not one participant gave any indication that intentional infection was a motive for his behavior. None of the participants identified with this practice. Since participants either did not report believing that anyone intentionally sought infection, or that a very limited number of individuals did so, the researcher believes that this behavior is rare. And yet, if it is rare, the researcher is left with the challenge of accounting for the numerous reports regarding the behavior in the popular, mainstream press. This issue will be revisited later during the examination of meta-thematic concerns.

All participants, both HIV-positive and HIV-negative, indicated that they had made a conscious choice to behave sexually in a certain way that was in concert with their own standards and identities. They strongly stated that their choices should be respected, not stigmatized or pathologized. Participants did not deny that many factors may have influenced their decision not to use condoms for receptive anal sex, but they also felt that it was within their right of free choice to engage in this activity with other consenting adults who were fully informed of the potential risks involved. Participants indicated their

desire to have their choices respected. However, they also indicated that they did not necessarily feel that their choices were the best for all men who have sex with men. The general consensus was that as long as sexual activity was consensual and informed the choice to use condoms or not lies within the realm of individual choice.

Emotion and Arousal

It would seem obvious that issues of emotion and arousal would play a role in an individual's decision to engage in any sexual behavior. These issues were clearly present, in one form or another, for all of the participants in this study. The California STD/HIV Prevention Training Center (n.d.) notes that emotional issues such as positive and negative moods, shame, guilt, and sexual arousal can influence an individual's risk behavior choices. While participants did not necessarily use the same terms to describe the motivations for their behavior, they did indicate emotional and arousal states that include those coded as attraction, nostalgia, the lure of the forbidden, and the attraction to risk.

Attraction.

Lawrence's eloquent description of the motivational power of attraction is perhaps best described as anthropological in its implications. He is describing a need to bond with those men whom he perceives to be at the apex of the male hierarchy. Lawrence clearly states that

this connection with a man whom he perceives to be a "super alpha male," terminology usually applied to the study of other primate and canine species, is an experience that is "religious" in nature. Lawrence reported that this connection is worth the risk he takes, and he indicated that he is fully cognizant of the potential physical consequences.

This point of view may be difficult for some to understand. It would seem that Lawrence has made an informed choice to experience a sense of fulfillment that for him transcends the inherent physical risk. To act in a manner that would deny or denigrate an act that is clearly of paramount importance to an individual would seem to be an attempt to force the values and assumptions of one person onto another. Such an action serves to deny an individual the freedom to act in accordance with his/her own self-identity and standards. When the actions engaged in involve consenting and informed adults, the power of desire can be seen as healthy and connective.

Nostalgia.

While responses coded as nostalgia do indicate a fond remembrance of times and practices past, there is also an important sense of identity inherent in the remembrances. The emotion of nostalgia intersects both the domains of self perceptions, as related to self-identity, and emotion and arousal. The physical act of condom-free sex was for

many participants their first experience of gay sexuality. For men whose sexual identity was formed in a time when condoms were not promoted for receptive anal intercourse, the current socially promoted act of using a condom may be experienced as a denial of sexual identity. Denial of one's identity can lead to negative emotional states such as depression or anger.

The participants' accounts raise the question of what is of greater potential harm to health and well-being. Is there more harm inherent in risking exposure to HIV or potential exposure to a new strain of the virus, or does the greater harm lie in enacting a behavior which some feel denies identity, connection, and membership in a social group or peer network? For some men the greater harm may indeed lie in exposure to HIV. However, for others such as James, it would appear that greater damage would come from the loss of identity inherent for him in forsaking a sexual activity that has signaled membership within, and bonding to, the larger community of gay men. To ignore this felt need, or to impugn the behavior as suicidal or fatalistic, is to deny an individual the means of achieving a healthy connection with a larger community. This assertion is not intended to imply that all gay men should forsake condoms in an attempt to bond with a larger community. However, the careful and thoughtful accounts of men such as James and David argue that gay men should be free to make those

choices which are most emotionally satisfying to them.

The lure of the forbidden and attraction to risk.

It is not clear to the researcher what the inherent attraction to risky activities is, or how emotional satisfaction is derived from engaging in them. It also did not appear that the participants who mentioned this aspect could fully articulate the source of the attraction. However, an examination of human activities would support the notion that it is a relatively common attraction for human beings. Many sporting activities including skydiving, race-car driving, mountain climbing, and extreme skiing contain an inherent and undeniable element of the ultimate risk of loss of life. In addition, the threat posed by these activities is considerably more immediate than the risk posed by HIV infection. However, these and other risk-taking sports are socially sanctioned as manly and heroic. What is mystifying is why it is that dangerous activities labeled sport are glorified and celebrated with lucrative contracts and televised displays, while an intimate condom-free connection between two men is condemned as risky and reprehensible.

It is certainly possible that the motivation is distaste for the idea of sexual activity between two men, and the presence of a potential health risk provides a convenient justification for reviling the activity. If this is true, then perhaps the attraction to the risk, or

that which is forbidden, lies in an unconscious or subconscious rejection of those who would deny men the physical and emotional expression of sexual arousal and attraction. This rejection of societal pressures to conform may be essential to the identity-building process engaged in by some men who have sex with men.

Peter's comments highlight the fact that the risk of HIV-infection is erotic and enticing for him. However, the actual act of knowingly placing himself at the highest possible risk for HIV-infection by engaging in receptive anal intercourse with an HIV-positive man remains strictly a fantasy. Fantasy seems likely to be an inherent component of erotic attraction. An acknowledgment of the fantasy attraction of the risk of exposure to HIV-infection and an open dialog around that topic with an emphasis on distinguishing between fantasy and reality might prove productive in lessening unintentional exposure to HIV.

Relationship Issues and Social Influence

This domain is the one that most directly addresses the influences of interpersonal relationships on an individual's behavioral decisions. Relationships can include sexual relationships, family relationships, or any other interaction between two people. Social influence is broader in scope and can include group or societal norms (California STD/HIV Prevention Training Center, n.d.). The only theme that will be included in the discussion of this

domain is that of relationship stability and intimacy. This is not an indication that the researcher does not recognize the influence larger social groups have upon participant behavior, but rather reflects the belief that those influences are better captured through the use of a different model which will be introduced below. However, this domain does provide a useful framework for considering the comments expressed by the two participants who identified themselves as being involved in primary relationships, especially as related to the development of their relationships.

The value that the two participants in primary relationships placed upon the intimacy they experienced during receptive anal sex without condoms, and the stability that they perceived this added to their relationships, was quite clear. These two participants did not feel that being in a relationship lowered their risk for HIV-infection. In fact, they demonstrated high levels of awareness related to the risks they were taking, but still felt that the present relationship was of greater positive value than the possible future negative consequences of HIV infection. Chad continued to report feeling that he had made the right decision even after converting from HIV-negative to HIV-positive. These reports indicate a component of the previously discussed domain of emotion and arousal, but the emotions expressed

were clearly related to the relationships these two participants were engaged in.

While it may be unfortunate that Chad seroconverted, the researcher chose to take Chad's positive statements as true. It could be argued that Chad was in denial, or was making the best of the bad situation in which he found himself. However, to assert this point of view would have the potential of indicating that a relationship between two men cannot have a value greater than a threat to physical well being. This assertion suggests homophobic intent and implication. For Chad, and for other men who are in similar situations, the intimacy and psychological connection that is associated with receptive anal intercourse without a condom may indeed be more important than the potential risk of infection. Similarly, Mark's desire to work on his relationship and be in love with his partner may well have a value greater than the risk in which he knowingly places himself by allowing him the potential for emotional and psychological satisfaction. Both of these individuals have chosen to engage in condom-free receptive anal intercourse with a full awareness of the risks involved. Given the great potential for psychological and emotional health that may come from positive interpersonal and romantic relationships, these two men may well have made the choice that is the healthiest for them.

Social Ecology Model

There are five domains within the framework developed by the California STD/HIV Prevention Training Center (n.d.), and thus far, four of them have been used to frame this discussion. Rather than using the remaining domain, structural and environmental factors, the discussion will now use the Social Ecology Model, as described by Sallis and Owen in 1997, to examine and discuss the influence of the larger social factors indicated by the participants.

The introduction of the Social Ecology Model is not a major departure from the established structure of the discussion since the developers of the domains framework did include social factors. However, the domains framework places larger social factors within the same domain as relationship issues (California STD/HIV Prevention Training Center, n.d.). The researcher felt that these two factors were inherently different and deserving of separate treatment. Relationship issues imply an interaction between two people who are often, albeit not always, involved in an intimate relationship. Social influences were perceived by the researcher to be broader and to encompass more than just the interaction between two individuals. Community level factors, public health infrastructure, and prevention messages are the thematic concerns that will now be addressed.

According to Stokols (1992), ecology, a term derived

from the biological sciences, refers to the interrelations between organisms and their environments. Applying ecology to public health allows for a focus on the nature of people's transactions with their physical and sociocultural surroundings. This focus results in models, or frameworks, as opposed to a set of distinct variables. Sallis and Owen (1997) proposed a working definition of these models.

Ecological models of health behavior posit that behaviors are influenced by intrapersonal, social and cultural, and physical environment variables; posit that these variables are likely to interact; and describe multiple levels of social and cultural and physical environment variables as relevant for understanding and changing health behaviors. (p. 404)

Moos (1976) delineated four specific environmental factors that are relevant to health behavior studies. Physical settings include features such as geography and weather. Organizational factors include the size and function of organizations in the environment. Human aggregate factors are the sociodemographic or sociocultural characteristics of people in an environment, and social climate factors are the perceived aspects of the social environment such as social settings and the clarity of expectations. These factors were strongly present in the responses given by participants as they discussed their decision to engage in anal intercourse without using a condom or other barrier device.

Availability of partners.

A pronounced aspect of the social climate in which

participants live and find sexual partners is the extreme ease with which participants reported finding sexual partners who did not require the use of condoms for anal intercourse. These reports indicate that the behavior is far from rare, and perhaps it is becoming a preferred method of engaging in anal sex among men who have sex with men in the San Francisco Bay Area. Participants did note that there was a certain degree of selection bias occurring because they were so forward about their desire that they indicated believing that men who are not interested in this form of sexual behavior would not contact them. However, as noted by Rich, it has become easier over the last five years to find partners who want to have sex without condoms in San Francisco and in the East Bay counties.

The commonness of the behavior reported by participants was certainly substantiated by the ease the researcher experienced in recruitment despite it being a major holiday season. However, it is also likely that many men who in fact engage in the behavior would not be interested in participating in a research project. The presence of a large proportion of men who no longer require the use of condoms for anal intercourse suggests that prevention messages currently targeting the men who have sex with men population can no longer assume a changed and shared norm. As noted by Sallis and Owen (1997), ecological factors do interact in this example. The social

climate in which men who have sex with men locate partners and negotiate sexual encounters may be changing while the assumptions of prevention-service providers are lagging behind.

Prevention messages.

The social environment in which participants live is replete with HIV-prevention messages, and all participants mentioned them. These prevention messages are a product of the organizational aspect of the environment in which the men live. However, these organizational characteristics are not in concordance with participants' lives as reflected by the uniformly negative perceptions of HIV-prevention messages reported by participants. A colleague of the researcher stated that some people would never like any prevention message (personal communication, Dan Wohlfeiler, December 3, 1999). This may be true to some extent, but to issue a blanket dismissal of these concerns seems facile at best.

Prevention messages that are viewed as detrimental to self-esteem and sexual identity can be damaging to a community as a whole. The many participant comments indicating that sexual behavior and identity are being condemned, or that prevention messages have been imposed upon the gay community, lead to a feeling that covert homophobia is at work. This is particularly distressing when it is taken into account that many prevention messages

and services are organized and promulgated by gay men. It seems possible that for some gay men HIV and AIDS have signaled that the path to acceptance is to deny difference and to try to make themselves appear as much like the heterosexual majority as possible; to promote a "good boy" image; and to deny gay male considerations of sexual desire, pleasure, impulse, and identification. It would be truly tragic if the physical and emotional ravages of HIV and AIDS were to be compounded by prevention messages that are perceived as negative and homophobic in intent.

Participants reported perceiving a lack of creativity and responsiveness to the broader concerns of the MSM community in the current prevention messages. As noted earlier, the "always use a condom" message is perceived by participants as tired and trite. Recognition of the new realities and issues that are arising and developing messages to address them could result in more effective prevention efforts. According to some participants, many prevention agencies have lost touch with at least a certain segment of the community that they theoretically serve. There may be a need to recognize that condom usage is not as foolproof as it was once believed to be (San Francisco Department of Public Health, 1998). This recognition could lead to a creative effort to discover alternative methods of risk-reduction or harm-reduction.

It is curious to note that a participant who has lived

through the entire HIV and AIDS epidemic in San Francisco, along with some other participants, reported believing that homophobic prevention messages were being promoted by individuals who are hypocritical and bitter. Participants also reported that the messages serve a larger and more insidious purpose of repressing gay men's sexual expression. It becomes a moot point if this is accurate, if that could ever be established or disproved, as people's perceptions of reality will be more likely to guide their actions. The idea that American society is sex-and pleasure-phobic certainly does seem to be substantiated by messages that promote the use of devices that inherently decrease the physical pleasure and community identification associated with sex, reported by several participants.

If the organizational aspects of the environment in which participants live is discordant with the social climate, it seems likely that participants would be forced to make a choice regarding which aspect of the environment to follow. It is clear that they have chosen to follow their own perceptions of the social climate and ignore, and in some cases stigmatize the organizational characteristics. It may well prove to be impossible to know if prevention messages are homophobic or pleasure-phobic, or if participants perceive the messages this way in reaction to the discord between their personal desires and the organizational structure in which they live.

Perhaps it is not as important to make this distinction as it is to recognize that the disconnect exists and then work to address it so that the environmental factors are more compatible and effective than they currently appear to be.

HIV-treatment advertising.

In counterpoint to the strong attention paid to the prevention messages that are replete in the participants' social environment was the seeming lack of attention paid to the large scale advertising campaigns of pharmaceutical companies promoting products used to treat HIV infection. When participants were asked about these advertisements, they reported paying minimal attention to them. This lack of conscious attention or response is indicative of the fact that not all aspects of an individual's environment are actively incorporated into perceptions of the world.

However, a lack of conscious recognition of the impact of factors present in the environment does not mean that there is no impact at all. There has been a great deal of research done on the influence marketing and advertising has in creating opinions and attitudes. McGuire (1985) and Ray (1982) both noted that the first step to establishing receptivity to persuasive communication is exposure to the message and ensuring that the intended audience is effectively exposed. These steps, and the subtle but powerful changes in attitudes that can result, have been most thoroughly explored in relation to the impact of

advertising on adolescent smoking (Pierce, Choi, Gilpin, Farkas, & Berry, 1998).

The pharmaceutical companies seem to be creating multiple opportunities for effective exposure to their marketing messages. Even a brief amount of time spent in San Francisco's Castro neighborhood, as well as many other locations around the Bay Area, will reveal many billboards and bus shelter advertisements for HIV medications. A perusal of the publications in which the recruitment advertisements appeared, as well as other publications targeting the gay community, will reveal full- or multiple-page advertisements for these medications as well. The graphics that are included could be misleading as they invariably depict physically healthy men. These models, whose true HIV status is not clear, are often portrayed engaging in activities ranging from playing with a dog, biking, and even rock-climbing. The implication is that these medications return a person to a completely normal and active life. They may even suggest that the treatments can make life more active and adventurous than it ever was. There are also implications of financial security and physical attractiveness inherent in most of the advertisements.

Postman, Nystrom, and Strate (1987) noted in their analysis of alcohol advertisements that images designed to link their products with success, social acceptance,

sexuality, friendship, youth, attractiveness, and physical vigor were common. It is distressing that this same tactic is currently being employed by pharmaceutical companies to market their products as well.

While the participants in this study did not report associating treatment with a cure or any other positive outcome, it is certainly conceivable to the researcher that individuals who do not have personal experience with the medications could be led to believe that the medications are capable of more than they actually are. Those implications could lead some people into making less than fully informed choices that could have seriously detrimental consequences.

While several studies (Kalichman, 1998; Kalichman & Nachison, et al., 1998; Kelly, et al., 1998) reported an association between anti-retroviral treatments and unsafe sexual behavior, they did not directly examine the impact of pharmaceutical marketing strategies. Studies designed to investigate the potential impact of these relatively new advertisements, which have been in circulation since approximately 1996 (personal communication, Dan Wohlfeiler, March 17, 2000), are urgently needed. Fischer, Schwartz, and Richards (1991) definitively reported that children demonstrated an equal ability to recognize Joe Camel and Mickey Mouse. While the products and age groups clearly differ, the ability of selective images to impact audiences

has been clearly established. Responsible and accurate advertising, if the advertising of anti-retroviral and other prescription medications is to be allowed at all, should be more vigorously enforced than it appears to be currently.

Community.

The participants in this study reported strong opinions and indicated deeply felt concerns about the social health of the gay community itself. These concerns are clearly related to the participants' perceptions of the social climate in which they live, and these perceptions will undoubtedly impact behavioral choices. The concerns they shared regarding the influence of consumerism, disenfranchisement, emphasis on physical appearance, and deep divisions do not reflect a picture of a healthy community for men who have sex with men in the San Francisco Bay Area. Even more startling is the complete lack of a focused effort to confront, acknowledge, and change these issues within one of the country's most open and progressive environments.

It is shortsighted to think that gay men function in isolation from the communities in which they live. Social climate factors will influence gay men's perceptions of themselves and their behavioral choices. However, participants reported that none of the prevention efforts considered or addressed these issues. It should be

impossible for anyone to expect that men will choose to act in a manner that could increase their life span if grounded images of longevity and stability are not articulated, celebrated, or even presented to the extent that the pleasures of the moment are.

It would seem intuitively sensible to think that men's self-perceptions regarding their value in the community would impact their self-esteem and consequently their behavioral choices. However, most everything from advertising for medical providers, drug and alcohol recovery services, social events, clothing, and even HIV prevention messages incorporate images of an idealized state of maleness that few men will ever achieve. There is not a broad-based representation of the diversity of the men who have sex with men population in most any venue. There is rarely a celebration of long-term relationships or of the elders of the community. While these circumstances persist, men who do not fit the idealized vision they are confronted with daily will suffer blows to their self-esteem or to their desire for a life that spans into the senior years. Those who cannot or will not see the impact that this lack of representation has are not only deluding themselves but are also fostering a de-stabilized climate. Some participants in this study, especially Charles, David, Lawrence, and Mark, cited these influences as factors that contributed to their decision not to utilize condoms for

receptive anal intercourse. These social representation issues were not sole motivating factors, but they did clearly play a role in the decision-making process.

It is probably true that American society as a whole is obsessed with wealth, youth, and physical beauty; however, it is also equally likely that gay male society is even more so. This opinion is beginning to be substantiated by others such as Tim Vollmer, a San Francisco Bay Area medical anthropologist (2000). However, within mainstream American culture that glamorizes many of these same factors, there are also mitigating factors such as those pointed out by David. These include grandparents and parents who provide an image of the future, albeit not always a positive one, that for many men who have sex with men is singularly lacking. If there is no expectation that living a long life will prove rewarding, it is doubtful that individuals will seek to do so.

Social Cognitive Theory

A universally reported theme not yet commented upon or discussed is that of positive physical sensation, or pleasure, in the sexual act. The domains framework does not specifically address physical pleasure, although the expected outcomes factor noted by the California STD/HIV Prevention Training Center (n.d.) within the self perceptions domain might be stretched to accommodate it. The Social Ecology Model provides an even less supportive

frame for physical sensation. Social Cognitive Theory, however, does provide a distinctive and strong framework for the discussion of these factors.

Social Cognitive Theory is easily the oldest construct utilized in the field of community health education. Baronowski, Perry, and Parcel (1997) provide an overview of the theory and its development that stretches back to 1941. The theory has become incredibly complex in its development over time. For the purposes of this discussion, only the concept of reinforcement, which was delineated by Bandura in 1986, will be considered.

Reinforcement refers to responses to behavior that increase or decrease the likelihood that the behavior will reoccur. The physical pleasure participants reported experiencing, the pleasure they perceived they were providing to their partners, and the increased level of intimacy they experienced in primary relationships when engaging in receptive anal sex without condoms are components of reinforcement. Adherence to perceived cultural and social expectations based on participants' ecological experience of gay culture in the San Francisco Bay Area also provides indirect reinforcement of their sexual behavior choices.

Physical sensation and pleasure.

The uniform reportage of an increase in physical feeling when engaging in anal intercourse without a condom

was certainly not surprising. It would make intuitive sense that any barrier placed over the penis would decrease sensation. Although this sensation difference might not be as obvious for the receptive partner, participants clearly indicated that there was a difference. Of course, if an individual's partner is unable to achieve or maintain an erection there would obviously be a difference in, or sheer lack of, sensation for the receptive partner. Darrel and Charles also commented on the sensation of "drag" when receiving a condom-covered penis into the rectum. They attributed this to a more rapid drying of the lubricant such that intercourse becomes uncomfortable. This sensation seemed similar to Lawrence's concern about physical damage occurring when using a condom. Physical feeling is often one of the primary influencing factors in decisions regarding condom use. With the exception of the two participants who reported being in a primary relationship, sex was uniformly reported to be "recreational" or "for fun." A key component of the recreational aspect of sex for participants was that it felt good and, therefore, devices that decrease the pleasurable feeling are not likely to be used consistently, if at all.

While participants did not report that they could feel ejaculation occurring, they did report that it increased the pleasure of the sexual encounter for them if the

partner's ejaculation inside the rectum was a preferred part of the sexual encounter. It seems that the element of physical pleasure that was most important for participants was the pleasure that the insertive partner received from reaching climax while still physically inside the receptive partner. For Rich, providing this level of pleasure to a partner was intense enough to allow him to reach climax as well.

Participants were reinforced in their behavioral choice by the pleasure they associated with not using a standard latex condom. Sex felt better, was more fun, and more satisfying for their partners; thus they were positively reinforced to engage in the behavior again. This immediate positive reinforcement was more likely to prompt behavior than the potential negative effects of HIV infection. However, two participants discovered a way to experience this positive reinforcement while still allowing for protection from HIV or other sexually transmitted diseases through the innovative incorporation of the Reality brand condom into their sexual lives.

The Reality brand condom was designed to be inserted in the vagina prior to the initiation of heterosexual intercourse. It is constructed of polyurethane and contains an internal ring device that helps to hold it in place. Lawrence, and to a greater extent Darrel, reported discovering the use of this device through the advice of

friends or sexual partners. This device has never been approved for anal use and has not been openly marketed for that use. Gibson, McFarland, Wohlfeiler, Scheer, and Katz (1999) conducted a survey of 100 men in the San Francisco Bay Area through the STOP AIDS Project to evaluate the acceptability of the Reality condom among the men who have sex with men population. A large percentage (86%) of the men who tried the device said they would use it again, and 54% indicated they would rather use the Reality device than the standard penile condom. As the device is constructed of polyurethane, it would serve to eliminate problems associated with allergic reactions to latex and could be used to allow for greater feeling, internal ejaculation, and spontaneity. However, Gibson et al. noted certain reported problems with the device including difficulty inserting, irritation, bunching up, unpleasant texture, and noise.

In order for this device to become more acceptable for use, there would probably need to be consideration given to redesigning it, gaining approval for marketing it for male rectal use, and then actually marketing it for such use. The likelihood that these issues will be addressed is uncertain, but the researcher's opinion is that it is unlikely given that latex condoms are still not marketed for anal use even though that usage has been widely encouraged by public health practitioners. Public health

educators could advocate the rectal use of the Reality brand condom more commonly than is done currently, but the overall acceptability may remain low because of the issues noted above.

Levels of reinforcement.

It is important to note the multiple levels on which the concept of reinforcement can be seen to function. On the individual level, the immediate physical pleasure participants experience is reinforcing of the decision not to use condoms for anal intercourse. On an interpersonal level, participants reported reinforcement related to the physical pleasure they provided to their partner. Those participants involved in a primary relationship reported on the perceived importance of physical pleasure, intimacy, and romantic emotion. There is also reinforcement from the social ecological level. Participants perceive the cultural environment in which they live as being focused on physical pleasure and sexual expression. By making behavioral choices that maximize these attributes for themselves and their partners, they conform to these perceived expectations and indirectly receive reinforcement from the social and cultural environment in which they live.

Meta-themes

Underlying, to some extent, many perceptions expressed by participants was societal homophobia, which many

indicated had been internalized by some gay public health professionals. Participants reported feeling that their sexuality and desires were being trivialized, ignored, or discounted. They also stated that their choices were not being respected by the prevention industry or society at large, possibly due to underlying homophobic fears and the desire among a powerful segment of the men who have sex with men community to blend into broader American society. They additionally stated that the gay community in general was reaching a level of segmentation that rendered it a greater enemy to their free expression than the larger American society.

These perceptions were most clearly expressed during participant commentary on the high-profile reporting of men seeking intentional infection with HIV. Participants stated that the reason for the reportage was because it made for sensational headlines and stories on the front pages of mainstream papers, especially in a community where gay men have a high visibility and some degree of acceptance. High-profile reporting on a scandalous behavior could certainly be expected to sell papers in a manner similar to the tabloid press. Participants also indicated the suspicion that this type of reporting was indicative of an underlying and deep-rooted homophobia in the community despite outward appearances of acceptance. Perhaps even more disturbing to the researcher was the

assertion that it was likely to be other gay men who would create and disseminate such stories in an effort to assuage their own guilt and feelings of internalized homophobia. These assertions may well be impossible to substantiate, but as already stated, establishing the factual, empirical truth of these beliefs is not as important as the recognition of the belief since it is internal beliefs that are likely to motivate actions and perceptions.

Determining the motivations for human behavior may never be an exact science with clear cause and effect relationships as are common in physical sciences such as chemistry or physics. However, it is important for public health professionals to attempt to develop frameworks to interpret, discuss, and understand human behavior more thoroughly. This discussion of the study results has moved through three frameworks in an attempt to organize and synthesize the responses of participants. The motivations range from the strictly individual to the larger environmental ones. Participants behaved in specific manners based on their perceptions and appraisal of the risks inherent in their behavior, their perceptions of their own identity, the importance of and the inherent needs associated with interpersonal relationships, their interactions with the environment in which they live, and overarching all, the positive reinforcement they receive for behaving in certain ways. A recognition of these

multiple factors leads to a need to formulate a discussion of the steps that the profession of community health education may need to consider taking to address the motivations and perceptions expressed by the participants in this study. These implications and recommendations are the subject of Chapter 6.

CHAPTER 6

Implications and Recommendations

Research can certainly be an enjoyable experience and it may be that, in some situations, the pursuit of knowledge for the sheer sake of knowing may be reward enough. However, upon concluding this research, the researcher strongly felt that it was imperative to recommend action steps. In fact, the application of research results may ultimately be an ethical issue within the field of public health if the true intention of the profession is to improve the health of the public. Four levels of implications and recommendations will be discussed in this chapter: implications for theory, implications for policy, recommendations for research, and recommendations for community health education practice.

Implications for Theory

Theoretical frameworks serve to support the analysis and discussion of data that are collected through the research process. These frames provide important support and structure for the process of communicating research results and in the formulation of future research endeavors. However, it may never prove possible to develop a universal theory of human behavior that can accommodate the multitude of variables that contribute to human behavior. There are many models and theories in existence and in use, but no single one of these provided a tight fit

for the discussion of findings of this qualitative research study. Instead, the researcher chose to utilize components of three different theories or models that served to frame the results as they were generated.

This approach seems an important and valid one. A potential pitfall in identifying a frame prior to the collection and analysis of data lies in the possibility that the inherent richness of the data will be truncated in order to conform to the frame being employed. The opposite approach, in which data are collected and reviewed prior to the application of a frame, seems more productive and has the greater likelihood of honoring the insights contained in the data. This process requires a researcher to experience the data holistically and then choose frames, models, and theories that can be used to support that data. There certainly is room for the development of new models based on the results of research conducted with different populations, but the researcher's recommendation is that models should be expansive, not reductive. This approach allows for organization of research results from a variety of human experiences as opposed to the seemingly endless generation of frames that are little more than amalgamations and the recycling of existing models. Researchers should not hesitate to incorporate elements of multiple models into their discussion frameworks when those elements serve to frame their data more accurately.

The results of this research could serve as a first step towards the development of new models for assessing behavioral choices and risk-taking. The identified elements, which include individual, interpersonal, and group level components, indicate a need for a further examination of the decision-making processes within the context of models that recognize multiple elements.

Implications for Policy

To some extent, the practice of community health education and the research that supports this practice will continually be influenced by policy decisions. Policy decisions affect funding streams, public opinion, and the allocation of other resources related to the health of the public. Ultimately, policies that do not support the health of the entire population will serve to damage it. Issues of latent and overt homophobia are areas in which policy change and action is clearly needed.

Perhaps it is an effect of living in a relatively liberal area of the country with a highly visible gay, lesbian, bisexual, and transgender community that can lead some people to conclude that homophobia is a disappearing societal ill. However, this belief, while inherently attractive, cannot be sustained upon closer examination. It would be inconceivable that in a society truly free of homophobic tendencies, a bill such as California Proposition 22, popularly known as the Knight Initiative,

that seeks to restrict recognition of marriage to only male/female couples, could have appeared on the March 2000 ballot and be voted into law. The existence of such a measure serves to deny the possibility that there could exist an enduring and emotional bond between two individuals of the same biological sex. The researcher has also personally witnessed several instances of overt homophobia and hatred directed at a lesbian colleague. Clearly, such incidents would not occur in a society that is free of homophobia.

It is within the realm of policy decisions that true and enduring changes related to the persistence of homophobia in America can begin. Organized and sustained support from all levels of government can serve to erase fear and hatred. Policy alone will never achieve this goal, but policy does provide an important source of support and a foundation upon which other efforts can be based. The extension of domestic partner benefits, which some employers already provide, and a system of recognition for the enduring emotional bonds formed and maintained between same-sex couples, are two examples of policy changes that should be actively pursued.

Policy decisions will also impact the research endeavors that are undertaken. Support for research into the changing behavior patterns of men who have sex with men appear to be lacking. There seems to be reluctance on the

part of funders to acknowledge and address these changes. It is also possible that there is a fear or reluctance on the part of researchers to propose research on this still developing topic. One participant noted that in his work with a local AIDS service organization and a major federal funder, any mention of the phenomenon of men choosing not to use condoms for anal intercourse was forbidden when applying for research funds or support. It was clear to this participant that funding for research into this behavior would not be forthcoming. Clearly, the behavior exists and may be far more prevalent than is known. Research into this behavior is urgently needed, and the political will and the policy decisions necessary to support this research are needed as well.

While this research project was not directly concerned with determining the effects of policy on behavior, future research that seeks to explore this connection would be important. Policy makers should consider the potential effects that their decisions will have on the will and ability of people to make healthy and informed choices. Policies that encourage investigation of the phenomenon of men choosing to forgo the use of condoms for receptive anal intercourse would be an important step. Policies that encourage the acknowledgment and support of gay men and women could begin a process of acceptance. Policies that encourage homophobia as an acceptable prejudice must cease.

Recommendations for Further Research

Individuals who experience fear due to prejudice are probably less likely to engage health professionals in an honest dialogue regarding their health-related behaviors and the psychological states which can influence these behaviors. Based on the information gleaned from the research described, it would seem likely that new and pressing concerns aside from HIV infection and AIDS would be revealed. Once elucidated, these concerns should be acted upon in conjunction and coordination with the community, not in isolation from it.

An important research step for the public health profession would be an exploration of the pervasiveness and potentially subtle nature of homophobia in American society. An important way that this could be accomplished is to conduct qualitative inquiries into the lived experiences of gay men in America and to honor these individuals' experiences.

Another area of important research involves investigation into alternative preventive measures, including but not limited to such options as the Reality condom. It is disappointing that after more than 20 years of the AIDS epidemic prevention messages are still centered upon the use of latex condoms. This approach to prevention may be effective, but some individuals have grown weary and even suspicious of the "always use a condom" message.

Investigation of new preventive measures could result in recommendations that are more positively received, especially if the community was involved directly in the research and development of alternative protective modalities.

Further investigations of the sexual choices of partnered men are urgently needed. These investigations must be free from the attitude expressed by a co-worker of the researcher who stated that partnered men who do not use condoms for anal sex are "stupid." The persistence of this attitude will immediately defeat any potential benefit to be derived from such an investigation.

There is also a need for a better understanding of the influence of perceived community values and norms in the lives and sexual-behavior decisions of men who have sex with men. There appears to have been a great deal of attention focused on the individual decision-making processes, but these investigations do not incorporate the important role that the social ecology of the environment in which these behaviors take place has on influencing the decision-making process.

A further way in which the issues of salience to men who have sex with men could be elucidated is by engaging them in a dialogue regarding their needs and experiences. Qualitative research is one way in which this information could be gathered. Open-format interviews with community-

recruited participants are a promising method for collecting this type of qualitative data. This type of inquiry undoubtedly requires the investment of considerably more resources than are associated with quantitative studies and research. It is far less time-intensive to distribute and tabulate surveys than it is to allow individuals the opportunity to express themselves in their own words. The analysis of qualitative data is also very time and resource-intensive. And yet, human behavior, thought, perception, and experience do not seem to lend themselves readily to a strictly rationalistic, reductive, and segmented approach. When individuals or groups feel that their stories have not been told, or have been widely misrepresented, a segmented approach may have even less utility since the creation of close-ended questions would ideally involve, at the least, the participation of the group in the preliminary study design. If this approach has not been taken, individuals who feel that they are not represented by the questions presented may not answer questions honestly, if at all.

To maximize the process and insights of future qualitative research, the researcher would strongly recommend that gay men be recruited from the community and trained to conduct the interviews. The researcher noted a marked increase in the comfort level of participants and their willingness to share experiences once they were aware

that the researcher was gay and that the researcher was not approaching the investigation with preconceived ideas or judgments regarding the behavior. The depth, richness, and honesty of the responses collected would undoubtedly be increased by the active incorporation of community members into the research design and implementation process.

The researcher also found that the scheduling of interviews had an important impact on the quality of the interviews conducted. Researchers conducting qualitative interviews should be certain to allow ample time between scheduled appointments for participants to relate the lived experiences. If interviews are scheduled too closely together, one participant is either truncated in his/her recollections, or another is kept waiting. Any of these circumstances are inherently disrespectful to the process and to participants and could damage the willingness of participants to continue with the research process.

Qualitative researchers are advised to be aware of their own limitations while conducting research of this type. Interview content can be vivid and emotional. Researchers should prepare for this possibility to the extent possible by investigating their own feelings about the behavior under study prior to the initiation of the interviews. It also proved useful to the researcher in this study to limit the number of interviews to two per day. This allowed for a period of reflection and internal

processing which served to enhance the synthesis and analysis of the data collected. Processing can be aided by the use of a journal in which experiences and perceptions are described. Peer debriefings in which friends and colleagues are engaged in conversation about the emerging data are also useful tools.

Recommendations for Community Health Education Practice

The researcher strongly believes in the importance of applying research to practice. However, the profession may need to undertake some preliminary work prior to the initiation of either research or the application of research with the men who have sex with men population.

Perhaps the first task for the community health education profession is to define what is meant by the very words "public" and "health." The researcher believes that "public" refers not to just the majority of the population. Instead, "public" conveys every single human being, of every age, race, sexual orientation, socioeconomic status, or any other variable that can be identified. The segmentation of the population into discrete units based on health risks may be beneficial in terms of epidemiological tracking, and to some extent, in the design and implementation of interventions. However, this reductive approach ignores the essential fact that every person ultimately interacts with and reacts to the larger world in which he/she lives. Even the hermit of legend who has

retreated to a mountaintop, while perhaps not interacting with society at large, has certainly reacted to it.

In approaching a definition of health, it is easy to think in terms of the absence of disease or physical impairment. The researcher's experience of the structure and emphasis of the American medical system reinforces this concept. The emphasis on disease treatment, and to some extent, prevention, only addresses the surface and most obvious concerns of the public's health. If "health" were taken to mean not only the absence of disease but also the absence of inequity, prejudice, dictatorial health messages, and the presence of structures and environments that allow people to actively pursue and attain a fulfilling life that matches their own definitions of happiness, perhaps, as a society, we would come closer to a meaningful definition of health. Inherent in this definition is the need to address hatred and prejudice directed towards those who are perceived as different from the majority of Americans.

Homophobia exists in our society and yet there has not been an organized effort instituted by the American community health education profession to combat this hatred. Health educators express concerns about violence, racism, and inequity in health care, and yet these issues as experienced by the lesbian, gay, bisexual, and transgender portion of the public have not received equal

attention. This is a grievous error that must be corrected. This comment is not meant to imply that there has not been a response or to discount the responses that do exist, but rather to indicate that there is more that needs to be done.

It is not only the lack of a response on the part of the community health education profession that has been disturbing but also some of the profession's actions. In reviewing the literature and in conducting research interviews, it has become apparent that discussions regarding men's decisions not to use condoms for receptive anal intercourse have taken a distinctive stance of describing a pathological and aberrant behavior. Studies conducted in support groups or with patients seeking other forms of counseling in response to their behavioral choices are emblematic of this theme. Of course, individuals who self-identify their behavior as problematic should be able to receive whatever forms of support and assistance they need to achieve the ability to make the behavioral decisions that they feel are necessary. But to identify these individuals as representative of gay men who have chosen not to utilize condoms for receptive anal sex does an injustice to those men who do not identify their behavioral choices as problematic. The semantics of a prevention literature that utilizes language such as "relapse" or "failure to maintain behavior" is inherently

pathologizing and can only serve to alienate an already disenfranchised population.

The focus in the community health education profession regarding men who have sex with men has primarily been on the issues of HIV and AIDS for close to 20 years to the practical exclusion of any other potential health-related concern. This focus was legitimate and critical at a time when there was no understanding of the transmission modes of HIV or that such a virus even existed. It is equally clear though that we have moved beyond that point yet the emphasis remains unchanged. Concerns expressed by participants related to a lack of community cohesion, drug and alcohol abuse, and a misrepresentation of the MSM community by a select group of individuals who may have a desire to appear as similar to the heterosexual majority as possible, are potentially being ignored. The health of the gay male community must be addressed as an organic whole.

More immediately, the prevention programs targeting men who have sex with men need to acknowledge concerns such as the lack of physical sensation and intimacy that participants noted. It is not realistic to expect that behaviors enacted in a state of emergency will be maintained as the crisis matures or as the perception of a crisis passes. It is intensely disappointing that the same intervention messages revolving around the use of condoms are still being recycled almost 20 years later.

Furthermore, there is a distinct need for an acknowledgment of the potential rewards experienced by some gay men in forming and maintaining physically and psychologically intimate relationships with other men. Inherent in this process should be the awareness that these experienced benefits may outweigh the perceived benefits of using condoms for anal intercourse as was indicated by the two participants involved in primary relationships.

Community health education professionals could take the lead in encouraging and supporting community-based activities and social opportunities that bring men together in an environment that does not necessarily endorse the perceptions noted by some participants that youth, physical endowment, and beauty are the most important attributes that a gay man can possess. However, there still must be an acknowledgment and acceptance of the potential importance ascribed by some men to sexual activity. The approach should not be an exclusive one, but rather an approach that honors multiple perspectives.

Central to the creation of any of these activities, and many other potential ones, is an understanding that the gay community is incredibly diverse and that for some unknown proportion of the community other identities may take precedence over an identification based upon sexual preference. Recognition of this factor could have a strong impact upon the ways in which the health of multiple

communities is addressed.

There seems to be a prodigious amount of work still to be performed. However, this work must be informed by the centrality of acceptance of the informed choices of individuals. If this respect were accorded, perhaps individuals would be more willing to participate in investigations and health-promotion programs in which they felt free from judgment, ridicule, and chastisement. It ultimately seems likely that only the community itself will have the power and ability to heal its own divisions and concerns, but the public health profession could facilitate this process. In order for the community to be more accepting of this assistance, it would seem of paramount importance to involve as much of the community as would be willing in the planning and development of programs and interventions. This process must not involve only those who promote the use of condoms for all sexual encounters. Those gay men who are potentially viewed as problematic or opinionated must be included as well. Perhaps this more inclusive approach would help to heal the perception that HIV prevention has become an industry, an unfeeling bureaucracy primarily concerned with self-preservation, and a Big Brother entity bent on proselytizing. Information dissemination will probably always have a place in public health programs, but perhaps where the need is greatest is for public health professionals to learn from the community

in equal exchange for teaching to the community that it professes to serve.

The researcher was motivated to undertake this project by a desire to create a research environment characterized by an equal learning exchange. The researcher never intended to create an all-inclusive or ultimate representation of any community or even of any individual. Instead, the intention was to capture the experiences of a group of men in a manner that has not been widely utilized. This process has certainly highlighted some concerns, but there are undoubtedly others yet to be illuminated. It is the researcher's hope and wish that others will be motivated and inspired to continue the work begun herein and to begin to take action based on the results of further investigation.

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APPENDIX A

Text Copy of Internet Recruitment Page

Are you doing it in the raw?

If you are barebacking, you may be a possible participant in a research program being conducted by a graduate student in Public Health at San Jose State University. The purpose of this study is to explore the attitudes and beliefs of men who have sex with men in the San Francisco Bay Area who are not using condoms for receptive anal sex at least 50% of the time.

The research is designed to allow you the opportunity to express your feelings, ideas, and concerns about these and other issues in a supportive, non-judgmental, individual interview setting. The interviews will be conducted in a location of your choice.

If you would like to participate, or if you would like to learn more about the project and what is involved in being a participant, please call the principal researcher at (510) 326-4092, or e-mail at mphtesis@aol.com.

APPENDIX B

Text Copies of Newspaper Advertisements

BAREBACKERS NEEDED!

SJSU grad student would like your participation in research based on individual interviews. 510-326-4092

Appeared in the San Francisco Bay Guardian from Wednesday December 22, 1999, to Tuesday January 4, 2000.

BAREBACKERS NEEDED

Men having receptive anal sex w/o condoms wanted for research interviews. Compensation is provided.

510-326-4092

Appeared in the Bay Area Reporter from Thursday December 23, 1999, to Wednesday January 12.

Barebackers Needed - men having receptive anal sex without condoms wanted for research interviews. Compensation provided.

510-326-4092

Appeared in the San Francisco Bay Times from Thursday

December 23, 1999, to Wednesday January 12.

APPENDIX C

Explication of Domains¹

Risk Appraisal - "This domain addresses perceptions of personal risk for STDs/HIV, a factor that is an important motivator for behavior change. A number of factors influence how a person assesses her or his risk for a particular condition. Some of the reasons for *underestimating risk* are:"

- stereotyped beliefs about who's at risk
- the illusion of invulnerability
- fatalism
- problem hierarchy
- misconceptions about how HIV (or another STD) is transmitted

Self Perceptions - "This domain encompasses the internal thought processes that influence risk behavior, interest in adopting safer behaviors, belief in the value of those behaviors, and a sense of capacity to enact them. A large component of this domain relates to beliefs and attitudes about oneself. Among these perceptions are:"

- self-efficacy
- intentions
- expected outcomes
- ambivalence
- self-standards/self-identity

Emotion and Arousal - "This domain addresses the influence of emotions (happiness, joy, fear, sadness, anxiety, etc.) and arousal of sexual and substance use behaviors. Some of the ways that emotion and arousal affect risk behaviors are:"

- positive and negative moods
- sexual arousal can influence risky behavior
- shame and guilt can provoke risky behaviors

Relationship Issues and Social Influence - "This domain addresses the interpersonal and social context of risk behaviors. STD/HIV related risk behaviors are almost always interpersonal, involving both members of a sexual or drug-use partnership. Relationships are played out within a larger context of social influence, including group norms and cultural expectations. Some of the relationship and social factors that affect risk behavior are:"

- communication and negotiation
- cultural norms and values regarding sexual communication
- cultural norms about sexuality and gender roles
- interpersonal power dynamics: coercion, sex for drugs
- relationship development
- group norms
- peer pressure
- social support

Structural and Environmental Factors - "This domain refers to aspects of public policy, social inequalities, community planning, health care, etc. that together form the context within which social and personal behaviors take place.

Larger social structures shape the everyday life of individuals, and at the same time, the everyday practices of individuals help to shape those larger structural forces. Some aspects of these larger structures are:"

- environmental barriers and facilitators
- social policies
- social inequalities
- sense of community
- social capital
- popular education

1. All excerpts taken from the participant manual for Bridging theory and practice: Applying behavioral theory to STD/HIV prevention. Available from the California STD/HIV Prevention Training Center, 1947 Center Street, Suite 201, Berkeley, CA 94704

APPENDIX D

Human Subjects Approval Letter

San José State
UNIVERSITY

Office of the Academic
Vice President
Associate Vice President
Graduate Studies and Research
One Washington Square
San Jose, CA 95192-0025
Voice: 408-924-2480
Fax: 408-924-2477
E-mail: gstudios@webos.sjsu.edu
http://www.sjsu.edu

TO: Matthew Edward Staley
440 Haddon Road, #4
Oakland, CA 94606

FROM: Nabil Ibrahim, N. Ibrahim
AVP, Graduate Studies & Research

DATE: June 18, 1999

The Human Subjects-Institutional Review Board has approved
your request to use human subjects in the study entitled:

**"An Exploration of the Attitudes and Beliefs
of Young Men who have Sex with Men"**

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Nabil Ibrahim, Ph.D., immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that all subjects need to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate, or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact me at
(408) 924-2480.

The California State University
Chancellor's Office
Bakersfield, Chico, Dominguez Hills,
Fresno, Fullerton, Hayward, Humboldt,
Long Beach, Los Angeles, Maritime Academy,
Monterey Bay, Northridge, Pomona,
Sacramento, San Bernardino, San Diego,
San Francisco, San Jose, San Luis Obispo,
San Marcos, Sonoma, Stanislaus

APPENDIX E
Consent Form

San José State
UNIVERSITY

College of Applied
Sciences and Arts
Department of Health Science
One Washington Square
San José, CA 95192-0092
Voice: 408-924-2970
Fax: 408-924-2979
<http://www.sjsu.edu/depts/ceah/docs/ha.html>

Consent to Participate in Research

Responsible Investigator: Matthew Edward Staley

Title of Research: An exploration of the attitudes and beliefs of men who have sex with men in the San Francisco Bay Area regarding HIV/AIDS and precautionary sexual behavior.

1. I have been asked to participate in a research study investigating the attitudes and beliefs of men who have sex with men in the San Francisco Bay Area regarding HIV/AIDS and precautionary sexual behavior.
2. I will be asked to participate in an individual interview. The interview will be held in a location of my choice.
3. I understand that there are no foreseeable risks or benefits from participating in this research.
4. I understand the results of this research may be published, but I will be in no way identifiable.
5. I understand that the interviews will be audiotaped and that these tapes will be kept secure in a locked cabinet.
6. If I have any questions about the research, I may contact the principal investigator listed above at (510) 326-4092. Any complaints I may have about the research may be presented to Dr. William Washington at (408) 924-2970. If I have any questions or complaints about research, subjects' rights, or research related injury, they may be presented to Nabil

The California State University
Chancellor's Office
Sacramento, Chico, Dominguez Hills,
Fresno, Fullerton, Hayward, Humboldt,
Long Beach, Los Angeles, Maritime Academy,
Merced, San Bernardino, San Diego,
San Francisco, San Jose, San Luis Obispo,
San Marcos, Sanoma, Stanislaus

Ibrahim, Ph.D., Acting Associate Vice President for Graduate Studies and Research, at (408) 924-2480.

7. I understand that no service or benefit of any kind to which I am entitled will be lost or jeopardized if I choose to not participate.
 8. I give my consent voluntarily. I understand that I may refuse to participate in the study, or any part of the study. If I choose to participate, I may withdraw and at any time without prejudice to my relationship with San Jose State University or any other participating institution.
 9. I have received a signed and dated copy of this consent form.
 10. I understand that if I so desire, a copy of the completed research report will be provided to me.
- The signature of a subject on this document indicates agreement to participate in the study.
 - The signature of a researcher on this document indicates agreement to include the above named subject in the research and attestation that the subject has been fully informed of his or her rights.

_____ Subject's Signature	_____ Date
_____ Investigator's Signature	_____ Date

APPENDIX F

Extended Quotation by David

The central question is why would someone who is intelligent, who in some circles might be seen as having a lot going for him, decide to go ahead and take risks? My ideal situation would be that I would meet a totally handsome, down to earth, very sweet man who is my age with common interests and we would live happily ever after. I have dated long enough to know that it is a pretty damn frustrating experience and in San Francisco there are a lot of weird social dynamics that make it even harder. I get a little frustrated with all this talk about sort of saving yourself for an ideal relationship. I don't know if in my case that is really gonna happen. It might, in which case I would be totally monogamous. I find that I get sort of jaded and sometimes I do develop a well fuck it attitude. So what! If I have sex, and I turn positive then I'll deal with it. I won't be much worse off than I am right now.

In San Francisco in particular, it seems like the best you can expect is a sexual playground. I know plenty of people who are in relationships who cheat on their partners. A few have tried that with me. I see a lot of people who seem incapable of having any type of emotional connection with a guy. I see a lot of guys who are so stuck on themselves and uptight that I am not sure they would ever come down to earth long enough to have a relationship. You can catalog one stereotype after another, but it all seems to boil down to what most guys are most interested in here in this city is sex. I've seen enough to know it is true. So what would you be saving yourself for in San Francisco? And that is sort of the rub in all this is maybe San Francisco is not really the best place to be if you want to have a healthy, productive relationship with a guy. There is a whole dynamic in this city about disconnection from people. People walking around pretty much as loners. Maybe there are people in this city who are having wonderful, productive relationships. Do I potentially see myself getting in one in the next two or three years? What are the odds of that? If I want to hook up with guys and connect with guys, what is the way that I am gonna do it? It is probably, ultimately, once I get frustrated enough, to pander to the level that I see. It is either to live up here in my little glass tower and turn into a spinster or sort of get into the scene and the rest of

it. In San Francisco, the number of men who are willing to have unsafe sex is pretty astronomical, and so the gut sense is that I am just getting pulled into it. Willingly. It is not an unpleasant experience. It is complicated by the fact that I am primarily a bottom and at the highest risk. To the best that I can, I choose negative partners. I suspect that there are guys who are willing to say anything to get laid at a particular time. The risk is that sooner or later I am going to hook with a guy that does that. I am not committed indefinitely to the idea of barebacking. It is something I am doing right now and I might choose to stop it in the future.

There does seem to be in all of this a sort of collective death wish. Drugs are helping with people's life spans, but I don't see people exactly trying to prolong their lives. Removing the unsafe sex portion, that does not include me. I don't do drugs at all. I am a lightweight drinker, I don't smoke, I try to work out on a regular basis. I try to pay attention to sleep. On the balance, I am guy who is trying to take care of myself. Add in what I do sexually, and I am placing myself at undue risk.

I think there is a geographical disconnection with most guys having moved a thousand miles or two from their families to be here, to come to play-land, so maybe it is a self-fulfilling prophecy. There is a definite sense that you can reinvent yourself out here and be who you want to be and it doesn't matter what you were back in Kansas or Nebraska. What is not here is some kind of deliberate community building that would serve to draw connections to people. My friends here have very small social networks. There is a sense of not really knowing or connecting with other people. If I were 22 and just moved here I might start taking crystal and going to Universe every weekend and engaging in far riskier sex than I do now and just saying fuck it. There is something in my mind that is driving why people take drugs and get really fucked up on weekends and just go to sex parties and abandon everything: total hedonism. To my mind, it is people trying to erase something out of their lives, and there is a lesser extent to which I do that as well. There is a lot of stuff that has caused me to be discouraged. I think there is a lot of that I see in myself that motivates me to take risks.

What is most important in San Francisco is if you have a hot body and a big dick. You can work at 7-11 or have a doctoral degree. You can be the sweetest,

most thoughtful guy or a prick. Everyone wants to know what I look like. Do I have a bubble butt? What size is my waist? Body fascism is very strong in this city. Conforming to a particular body type is pretty strong. This reinforces your sense of disconnection. All of this stuff around disconnection and the difficulty in meeting people, directly influences my own behavior. Frankly, all this stuff that happens makes me cynical and it fucks with my self-esteem.

I believe that a guy who would take risks and potentially get himself infected, knowingly or unknowingly, does not have very strong self-esteem. If you were to dissect my entire background you would see some reasons for that. In the world of business, I am fairly confident in myself, but it is fucking hard to have self-esteem when this is your experience in the city. There are not a whole lot of esteem enhancing experiences I have had in the Castro or in dating other guys here. Some to be fair, but more frustration than support. If I were totally secure in myself and my own esteem and how I am perceived by other guys maybe I wouldn't do this at all. But I don't know!

What does the average gay man think about his life at 60? I have no fucking clue! Am I going to be wearing a cashmere sweater, sitting out on the front porch and hosting people with my partner, or am I going to be in some old folk's home with people I don't know because my parents have died? I only have one sister, and I really have no living relatives and I may not have a partner. Well, that sounds like a fucking miserable existence. Or is it that I am going to keep working pretty hard up until I am 65, and I am sort of tired and not any better socially connected than I am right now? So what exactly does the future look like? And that is one of the things that the gay community in general has got a lot of work to do is about envisioning what the future actually looks like, which is why this cross-generational mentoring thing is important to me. I would love to find a way for young guys to get connected to a guy who is 50 or 60 and not have them molest them, but to have just a purely friendship-based thing which gives mentorship. Why should I do things in life that will only enhance my longevity if I don't know what that will look like? Without that, it is hard to make really informed choices. If the expectation that life at sixty is not worth living, than not protecting yourself seems like a reasonable way of thinking. And the gay community supports the idea that gay life at 60 is not worth

living. Everything advertising wise is geared toward a 20-year-old with a body of death. It is a youth culture really dominant in gay America. How people react to that ideal is not "That seems like a hapless young man I would like to mentor and help along in life." This is a guy I want to fuck! It is pretty fucked up. Straight people, I guess, have figured it out because you have got Grandpa and Grandma and they are either having a miserable or a happy existence or you know old people or whatever and you see the choices out in front of you and we don't. And if I thought that I would have a totally rocking future at 60 with a guy that I just grew in love with every year more and more and a social network that didn't sort of dissipate out at 40 years old I might think about my life a little differently. I don't see the rosy future. It will be what I create for myself, it will be hard, and it will be frustrating every step of the way. But because I am thinking about this in a deliberate way I may have a better chance than most for constructing something that works for me. It may mean getting the fuck out of San Francisco. Who knows!