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SEX, INFECTION, AND TRUST: CONDOM USE AMONG GAY MEN AND
THEIR PERCEPTIONS OF HIV

BY

MICHAEL JEFFREY STALEY
BACHELOR OF ARTS, CARROLL COLLEGE, 2006

THESIS

Submitted to the University of New Hampshire
in Partial Fulfillment of
the Requirements for the Degree of

Master of Arts

in

Sociology
September, 2011

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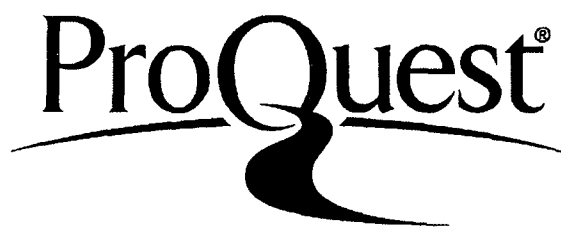
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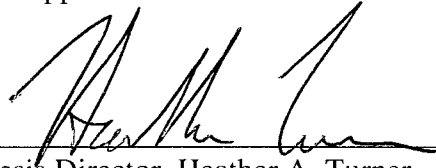
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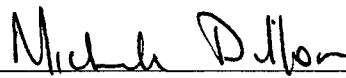


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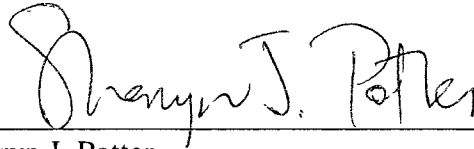
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Date

“Sexuality is something that we ourselves create—it is our own creation, and much more than the discovery of our secret side of desire. We have to understand that with our desires, through our desires, go new forms of relationships, new forms of love, new forms of creation. Sex is not a fatality: it’s a possibility for creative life.”
—Michel Foucault (1984/1994:163)

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ABSTRACT

SEX, INFECTION, AND TRUST: CONDOM USE AMONG GAY MEN AND THEIR PERCEPTIONS OF HIV

by

Michael Jeffrey Staley
University of New Hampshire, September 2011

Unprotected anal intercourse among gay men remains high, despite the well-known fact that HIV/AIDS still disproportionately affects men who have sex with men (MSM). This qualitative, exploratory study seeks to understand the meanings and motivations of gay men's condom use and non-use. I observed three organizations that center on gay identities in the spring and fall of 2010 and in the spring of 2011. Additionally, using a semi-structured format, I interviewed 19 gay or bisexual men between the ages of 19 and 39. Condom non-use was high; 16 men reported not using a condom in their sexually active lifetime. Three different types of condom users were identified: the intentional user, the stepwise user, and the occasional user. Using a condom during anal intercourse, which public health institutions promote, was often contradictory to the meaning gay men held about the physical act.

CHAPTER I

INTRODUCTION

Public health practitioners view the condom as a highly effective solution to ending a 30 year-old epidemic, HIV and AIDS. Yet, many men who have sex with men may view the condom differently, as an instrument that symbolizes mistrust and emotionally disconnected sex. This view complicates HIV prevention because it pits risk reduction methods against gay men's desire to engage in meaningful, emotionally connected sexual relationships.

Since 2006, estimated rates of HIV infection among gay men have increased (Centers for Disease Control and Prevention 2009). Condomless sex among men who have sex with men may be to blame, but the reasons and motivations behind men not using condoms are not well understood, especially considering that between 1996 and 2006, infection rates among men who have sex with men remained relatively stable (Centers for Disease Control and Prevention 2010a). Researchers have demonstrated that the increase in infection, in part, may be related to an increase in unprotected anal intercourse (UAI) (Jacobs et al. 2010).

The male condom has proven to reduce the risk of HIV/AIDS infection by as much as 98 percent (Centers for Disease Control and Prevention; Varghese et al. 2002). Despite this well-known, effective risk reduction method, some gay men still engage in UAI. A 2002 study of gay men in Louisiana found that 47 percent of gay men engaged in UAI at least once in the twelve months preceding the study (Dean and Hayes 2004).

Among gay men over the age of 40, 49.6 percent of the men engaged in UAI over the course of their lifetime (Jacobs et al. 2010). And in another population, rates of UAI were as high as 83.9 percent, of which many of the men reported knowingly engaging in unprotected intercourse with an HIV-positive partner (Halkitis and Parsons 2003). Knowing that gay men engage in UAI is valuable for explaining an increase in HIV infection rates and is an impetus for renewing efforts to promote risk reduction. However, there is no clear distinction between condom users and condom non-users; that is, some gay men use condoms some of the time and in different circumstances (Halperin 2007). That is, little is understood about the patterns of condom use among men who have sex with men—why they choose to use them with some partners and not with others.

Many pro-condom public health campaigns have emerged since the onset of AIDS in the early 1980s. And, in the height of AIDS incidence (the early 1990s), it seemed that many of these campaigns were effective in reducing infection rates, as incidence rates subsided in nearly all high risk populations in the mid and late 1990s (Centers for Disease Control and Prevention 2009). The use of condoms among gay men became known as the “condom code”—which made condom use more a rule, rather than an exception during sexual intercourse (Warner 1997). Because many gay men lost entire social networks during that period (Kadushin 1996), the visible effects of HIV/AIDS may have encouraged condom use and safer sex practices among gay men. Highly active anti-retroviral therapy (HAART) began to effectively treat the disease in the late 1990s with fewer side effects, increasing life expectancy of HIV-infected individuals to ages comparable with non-HIV-infected people (Fan, Conner, and Villarreal 2007; Lai and

Hardy 2004). HIV/AIDS transitioned from being a terminal infection to a chronic disease with the introduction of HAART; thus, the epidemic has largely become invisible.

Many studies address the American HIV epidemic quantitatively (Lauby and Milnamow 2009; Lavoie et al. 2008; McIntosh and Thomas 2004; Remien et al. 2009; Saewyc et al. 2006; Scheer et al. 2008; Sifakis et al. 2007; Whittier, Lawrence, and Seeley 2005), and several studies use similar epidemiological research methods to assess condom use (Blackwell 2009; Camara et al. 2010; Centers for Disease Control and Prevention 2006b; Centers for Disease Control and Prevention 2009; Dodge, Reece, and Herbenick 2009; Eaton et al. 2009; Greenberg et al. 2009; Halkitis and Parsons 2003; Jacobs et al. 2010; LeBlanc 2007; Mansergh et al. 2002; Scheer et al. 2008; Van et al. 2007; Varghese et al. 2002; Wilson et al. 2010; Zablotska et al. 2009). These studies have clearly established that gay men are engaging in risky sex, but are unable to fully explain why they are doing so. Qualitative studies, which may better help explain the motivations behind risky sex acts, have only been conducted in sub-populations of gay men. For example, Dean (2009) describes sex acts between men who purposely seek other willing men out to have sex without the use of a condom, a behavior colloquially known as “barebacking” (cf. p. 13 ff). Thus, researchers often struggle to identify the reasons and motivations that explain certain risk behaviors, namely, condomless anal sex between two men.

Several concepts have been hypothesized to be determinants of risky behavior, that is, to explain why gay men are having sex without condoms, including complacency, fatalism, condom fatigue (Centers for Disease Control and Prevention 2010b), risk-thrill

(Halperin 2007), and misinformed serosorting¹ (Eaton et al. 2009), but no research has directly addressed these as underlying processes—though some have hypothesized on the issue (see Halperin 2007). These concepts will be explained in detail in the next chapter.

A qualitative approach provides a nuanced view of why gay men choose to or choose not to use condoms during sexual intercourse. Furthermore, this method may help researchers to understand perceptions gay men have regarding condoms, condom use, and gay men's perceived susceptibility to HIV. This information could prove to be important in the future of HIV/AIDS prevention campaigns, and adds to the body of knowledge concerning gay sexuality and HIV/AIDS.

This exploratory, qualitative study aims to determine the reason(s) and meanings gay men attach to their sexual behavior and condom use, and how they reconcile their own risky behavior with the reality of the HIV/AIDS epidemic. Motivations surrounding sexual behavior, sexual risk and perception of HIV, condom use, and attitudes toward HIV/AIDS are of specific interest.

The first chapter explains the current landscape of HIV and condom use in the United States, particularly among gay men. The discussion places the current problem—why some gay men may not be using condoms during anal intercourse—within current public health efforts to promote condom use and reduce HIV incidence. Also included in chapter one is a discussion on the discourse of sex by those who promote safer sex, and the ineffectiveness of public health efforts as social controls, perhaps because they attempt to undo sexual liberation, a battle fought by gay men and women in the 1960s and 1970s. The aim of this discussion is not to resolve the contradiction between HIV

¹ Serosorting refers to a process by which gay men seek out sex partners of the same HIV status.

prevention and sexual liberation, but to uncover the meanings and motivations behind condomless sex. As such, I hope this research will address how the quest for sexual liberation and disease prevention efforts represent conflicting goals that may detract from future safe sex promotion.

In the second chapter, I describe the research methodology used in the current project. I used semi-structured interviews with open-ended questions to gather information regarding sexual decision-making, perceptions of HIV, and condom use from 19 gay or bisexual men between the ages of 19 and 39. Additionally, I observed and collected data from three community groups that were centered on themes that aimed to provide support and open environments for individuals who identify as lesbian, gay, bisexual, transgendered, queer or questioning (LGBTQ). Limitations inherent to the methodology are discussed at the close of the second chapter.

Findings from the observational and in-depth interviews are presented in third chapter, and in the fourth and final chapter, I discuss the application and implications of this study for gay men and for HIV prevention researchers and practitioners.

CHAPTER II

HIV/AIDS, SEX AND CONDOMS AMONG GAY MEN IN AMERICA

Since the beginning of the epidemic, HIV incidence among men who have sex with men (MSM) has generally risen, while HIV incidence among other transmission categories (e.g., heterosexual contact, puerperal transmission, intravenous drug use) has steadily declined since the mid-1990s (Centers for Disease Control and Prevention 2009). The CDC estimates that, in 2009, just over 56 percent of newly diagnosed cases of HIV infection were due to male-to-male sexual transmission (Centers for Disease Control and Prevention 2011). Indeed, since the beginning of the epidemic in 1981, gay men have disproportionately been affected by HIV infection and prevalence (Bloom et al. 2010; Centers for Disease Control and Prevention 2006a; Centers for Disease Control and Prevention 2009; Centers for Disease Control and Prevention 2010b; Cochrane 2004). A brief explanation on the calculation and reporting of HIV rates is included on page 93.

MSM are disproportionately affected by HIV² largely due to increased risk associated with anal sex. Of all sex acts, anal penetration provides one of the most efficient means of transmission for HIV, usually because of the trauma it causes to the thin tissues of the anus and rectum. Anal sex is common among gay men. Using a Louisiana sample, the CDC reports that about 89% of gay men had anal intercourse over the course of a year (2002). Anal intercourse without the use of a male condom, as I

² MSM are 44 times more likely than non-MSM to become infected with HIV (Centers for Disease Control and Prevention 2010b).

discuss below, greatly increases the risk of transmission of HIV (Centers for Disease Control and Prevention, n.d.a; Davis and Weller 1999; Varghese et al. 2002).

Race and age cohort are important factors to consider when analyzing HIV incidence. Among white men, those aged 30-39 experienced the highest rates of infection, followed closely by those aged 40-44. Among black men, those aged 18-29 experienced the highest rates of infection. These trends have been fairly static since the late 1980s. However, men older than 50 emerged in 2005 as a cohort with rapidly growing HIV incidence.³

A Brief History of HIV/AIDS and Gay Men

The history and present status of HIV/AIDS is and was greatly affected by the gay community and activists since the beginning of the disease in 1981. Many historical narratives provide a picture of the gay community struggling with the devastation of the disease while taking the socio-political reins of the disease (Padgug and Oppenheimer 1992; Riggle and Tadlock 1999; Shilts 1988). In order to understand the modern HIV/AIDS epidemic, researchers must also understand its socio-historical evolution.

AIDS first emerged in the early 1980s in gay men. The scientific community first called the disease “gay cancer” and later “Gay Related Immunodeficiency Disease” (GRID) and was later changed to Acquired Immunodeficiency Syndrome (AIDS) (Padgug and Oppenheimer 1992; Shilts 1988). Thus, since its discovery, AIDS has been associated with gay men and the even more taboo act of gay sex.

³ Note that both incidence *and* prevalence for MSM aged 50 and older is increasing. The CDC credits the rapidly growing prevalence rate to the effectiveness of highly active anti-retroviral treatment (HAART). Jacobs (2010) points out that increased prevalence increases the risk of transmission in age cohorts; the greater the proportion of HIV-positive men there are to HIV-negative men, the greater the probability that an HIV-negative man will engage in some sort of risk behavior with an HIV-positive man.

The Stonewall Riots of 1969 are generally viewed as the beginning of the gay civil rights movement. This fledgling movement came on the back of the sexual liberation movement, which emerged in the late 1960s as well. Gay men formed lobbies that advocated for their sexual freedom (Button, Rienzo, and Wald 1997). Characterized by the Mattachine Society, the Stonewall Riots in New York City, and the liberationist speeches of Harvey Milk, the movement that emerged before HIV/AIDS was founded on radically different principles than the modern gay rights movement, which seeks marriage equality, non-discrimination laws, and legal and social sanctions that promote an environment in which same-sex couples can acquire and raise children (Button, Rienzo, and Wald 1997; Carrington 1999).

HIV/AIDS changed the focus of the gay rights movement from items like marriage equality and sexual freedom to access to health care, the promotion of AIDS research, and one of the largest safer sex educational campaigns to date (Button, Rienzo, and Wald 1997; Cochrane 2004; Shilts 1988). Activist organizations formed in metropolitan areas such as the Gay Men's Health Crisis (GMHC) in New York City, the San Francisco AIDS Foundation, and ACT-UP, an organization that managed to blockade the Golden Gate Bridge, and hold many other protests in front of government institutions. The gay community has remained a powerful force within the HIV/AIDS epidemic (Button, Rienzo, and Wald 1997; Riggle and Tadlock 1999; Shilts 1988).

Amid the campaign for HIV/AIDS treatment and research funding, gay men also began to educate themselves and each other about safer sex practices, namely the practice of using a condom during anal intercourse. Using condoms became a folkway (a socially held rule that is lesser than a more; for example, table manners) and even a more within

the gay community; this form of social control is often referred to as “the condom code” (Warner 1997). Organizations such as GMHC and ACT-UP took on the role of educating the public and informing the media, in addition to their political lobbying for funding (Shilts 1988). In addition, the NIH and CDC also initiated far-reaching social marketing campaigns that aimed to educate the public on HIV infection and safer sex practices, which included—and still includes—major promotion of the male latex condom (Centers for Disease Control and Prevention 2003; Centers for Disease Control and Prevention; Shilts 1988; Sutton et al. 2009).

Condoms

Aside from abstinence, condoms are the most effective means of preventing HIV transmission (Centers for Disease Control and Prevention, n.d.a). One study reports that the use of a condom reduces the risk of HIV infection twenty to one per sex act (Varghese et al. 2002), and the CDC concurs that condoms are 95% effective in preventing HIV infection (Centers for Disease Control and Prevention 2006b). In other words, the use of a condom drastically reduces the odds of seroconversion, especially for MSM who have four or more sex partners (Dean and Hayes 2004).

While condoms have proved to be a safeguard against HIV for those who practice all types of sexual acts, about 48 percent of the men who had anal sex over the course of one year did so without a condom at least once (Centers for Disease Control and Prevention 2006b; Dean and Hayes 2004), and other studies have reported even higher rates of unprotected anal intercourse (UAI) among gay men (see introduction) (Halkitis and Parsons 2003; Jacobs et al. 2010; Mansergh et al. 2002).

HIV Prevention and Condom Non-use (Unprotected Anal Intercourse)

Many theories exist to explain why gay men are engaging in high-risk sexual behavior, that is, anal sex without the use of a condom: for example, complacency (Centers for Disease Control and Prevention 2010b; Halperin 2007; Dean 2009; Eaton 2010). Yet these theories rest largely on speculation and not systematic research, or they target specific populations of men who are known to not use condoms (such as barebacking in Dean's (2009) research). Consequently, many HIV prevention campaigns have targeted audiences with these notions in mind. Six of the most widely held concepts and beliefs that explain condom non-use are described here.

Complacency and Fatalism. Some researchers (including the CDC) claim that, especially among young gay men (18-24), there is an attitude of complacency toward HIV. Gay men in younger cohorts did not experience the major loss of partners, loved ones, and friends in the 1980s and early 1990s as men in older age cohorts did (Kadushin 1996). The lack of imminent death may lead sexually active young men to believe that HIV is mostly benign, a chronic condition that is easily treatable. The use of HAART, claim public health officials and agencies (Centers for Disease Control and Prevention 2010a), may quell the fears of MSM who therefore may not use condoms or may engage in other forms of risky sexual behavior.

Serosorting. Many MSM engage in serosorting, that is, choosing sexual partners who they believe to be either HIV negative or positive. This method of partner selection has both positive and negative effects on HIV incidence. Men who are HIV positive and who are aware of their status often select sexual partners who are also positive. Likewise, HIV negative men choose partners who are perceived to be seronegative. However,

because many infected men are unaware of their HIV positive status, but falsely believe that they are HIV negative, serosorting can often lead to the spread of infection without either partner being aware of their serostatus (Eaton et al. 2009; Wilson et al. 2010; Zablotska et al. 2009).

A very small number of gay men participate in what are called “poz parties.” These events are sex parties where HIV-positive men go to have unprotected anal sex with other HIV-positive men. HIV-positive men attend these events under the presumption that the other men present are also HIV-positive men (UPI 2005). In rare instances, however, seronegative men will attend these orgies in order to become positive—these men are often referred to as “bug chasers” (Dean 2009). And in even more rare instances, HIV-positive men seek to have sex with HIV-negative men in order that the negative partner would convert; these men are known as “gift givers” (Dean 2009).

Medical researchers have also made attempts to link a new strain of HIV—sometimes called the HIV superstrain—to HIV-positive men who have sex with multiple other seropositive men. Though few in number, some HIV positive men are superinfected: that is, they are infected with multiple strains or mutations of HIV, which complicates treatment and reduces its efficacy (Eaton et al. 2009).

Complacency can stem from feelings of invincibility (e.g., perceiving HIV to be a chronic, completely treatable infection), but also from fatalism—the notion that acquiring of HIV is inevitable. In essence, infection for those with a fatalistic attitude toward HIV is part of being gay and engaging in gay sex.

Complacent young men sometimes become “bug chasers” to “get it [infection] over with.” Little empirical research exists on how individuals take on the “bug chaser” mentality; current literature focuses on bug chasers as an existing subculture (Dean 2009; Grov and Parsons 2006; Halkitis and Parsons 2003; Ridge 2004; Tewksbury 2006).

Condom Fatigue. Early in the AIDS epidemic, public health officials used social marketing campaigns to encourage condom use, especially among high-risk populations, such as gay men and intravenous drug users (Button 1997; Shilts 1987). This commonly became known as the “condom code” in the height of the AIDS epidemic (Warner 1997). As the effects of the disease and threats of infection lingered, gay men became inundated with safer sex messages. The persistent pro-condom campaigns of the early 1990s may have become stagnant and ineffective especially to older gay men who have been continually exposed to these social marketing campaigns over the past 30 years. While many HIV/AIDS entities cite condom fatigue as a reason why older gay men engage in high-risk sexual behavior, research rarely supports the notion of condom fatigue (Adam et al. 2005; Murray and Adam 2001).

Condom fatigue can take on another form: the HIV vacation. Recent research demonstrates that gay men, regardless of HIV status, on vacation are more likely to engage in sexual activity and less likely to use a condom (Whittier, Lawrence, and Seeley 2005). Furthermore, many HIV-positive gay men report wanting and sometimes actively taking vacations from anti-retroviral treatment regimens (Whittier, Lawrence, and Seeley 2005). Stopping anti-retroviral treatment is damaging because the infected individual’s viral loads may increase (and consequently reduce the number of CD4 cells, also known as “T cells”), as well as allow the virus to morph into another form resistant to the

positive person's treatment regimen, making the infection more difficult to manage (Fan et al. 2007).

Risk Thrill. For some gay men, not knowing their HIV status enhances the sexual experience because they neither know if they are going to become infected or if they are infecting someone else. Risk thrill can be summed up in the term "Russian Roulette"—a potentially suicidal game that involves one bullet in a six-chambered revolver (Shields, Hunsaker, and Stewart 2008). The risk thrill a gay man experiences when having sex without condoms is not dissimilar from other kinds of risky behaviors that thrill the deviant participant. Ridge (2004) documents this kind of increased risk, adding that men who had sex without condoms in his Australian sample thought it added a "thrill" to their sexual encounters, as well as increased intimacy.

Barebacking. Purposely having anal sex without a condom is colloquially known "barebacking." This act is different from "bug chasing" and "gift giving"; neither partner desires to become HIV positive or infect someone with the virus. For men who bareback, serosorting is essential for HIV prevention and most will not engage in this risky behavior unless they are certain that their partner is of the same serostatus (Moskowitz and Roloff 2007). Dean (2009) describes the barebacking subculture in detail using his content analysis of websites for men who wish to engage in the activity. He claims that most men who engage in this kind of sex do so because they desire skin-to-skin contact, view the rectum as a "womb," and have fetishes for semen.

Additionally, some men engage in barebacking do so indiscriminately, either because they view condoms as inconvenient to use, or because having sex without a condom is more pleasurable. Those who search out partners for sex without the use of a

condom, being mindful that their potential sex partner's HIV status is the same as their own, are "barebackers." Those who have sex without a condom, but who do not seek out their partners based on whether he will require them to use a condom during intercourse simply engage in condomless sex. While the activity of condomless sex appears to be the same between those who bareback and those who are bug chasers, the motivations are distinct.

HIV/AIDS and the Re-Pathologization of Gay Men

Divorcing our understanding of why gay men use condoms or do not use condoms from the long socio-political history that produced the current social climate regarding gay sex and sexuality would be erroneous. Michel Foucault (1978) traces the archaeological roots of our modern understanding of sex and sexuality, and ultimately explains how the human body, sex and sexuality have become objects of control through discourse—the way sex and sexuality are talked about or not talked about, who is talking about it, and where it is being professed are all important to consider. The beginning of the "truth of sex,"⁴ says Foucault, was not a product of the Victorian era, but one with antiquarian roots (1978: 3-8). Thus, to consider homosexuality from the advent of the sexual liberation movement, circa 1968 (see Button, et al. 1997), would miss the process by which homosexuality became pathologized—that is, how homosexuality became an illness. This discourse, and moreover, confession of the "truth of sex" is important to understanding modern social constructions of sex and sexuality, especially non-heterosexual forms of sexuality (1978: 19, 20, 24).

⁴ "Truth," in Foucauldian terms is socially constructed—that is, that truth is defined by institutions in society.

As the world moved beyond preserving itself from death—when war, plague and famine subsided in Western society—governments, religions, and institutions became preoccupied with producing capital. The strength of any nation-state is its ability to produce and producing requires a productive population. As Foucault claims, governments began to conceptualize human beings not as “people” but as “a population” (1978: 25). Governments and institutions started to track the ability of its people to be contributors for capital gains, and at the root of this economic equation was sex. After all, it is by sex, which, by the 19th Century was discursively confined to a man and a woman under the contractual auspices of marriage, new producers are born. And inversely, those conditions that inhibited production also became pathologies that had to be counted and carefully monitored, and treated if possible—impotence, birth control, and no less, homosexuality were among the counted (1978: 25-27). Homosexuality, being gay, therefore was first deemed “unnatural” by religious figures, and later, *scientia sexualis*, or the science of sex, categorized homosexuality (along with all other desires that went against procreative sex) as pathological (1978: 54-55). Indeed, even public health, according to Foucault, was created to “ensure the physical vigor and moral cleanliness of the social body; it promised to eliminate defective individuals, degenerate, and bastardized populations” (1978: 54).

For Foucault, power emanates through discourse, but also in silence (1978: 26, 73). Power is everywhere and it cannot be escaped (1978: 100, 101). In a later interview Foucault explains that we are not “trapped” by power and by the discourse around us—we are as much freed by the power that circulates because we have the ability to change it (though not to escape it) (Foucault 1984/1994: 167). Foucault viewed pleasure as a key

way in which individuals could change power—to use power to disentangle what power had formerly condemned them (Foucault 1981/1994: 137). Foucault does not claim that sex has the ability to free us from the relations of power in society, but that we, as a society, ought to adopt an “ethics of pleasure, of intensification of pleasure” (Foucault 1982/1994a: 131). Thus, to inhibit pleasure, or the ability of a person to experience pleasure, is to block a way of transforming or creating positive power, power that frees, rather than represses the individual.

Homosexuality, says Foucault, was not considered to be a danger before the 18th century; as long as men went about their business (i.e., duty) to reproduce, no one cared what he did in his leisure time (1982/1994a: 127). The problem ensued when homosexuals started forming relationships; “that individuals are beginning to love one another—there’s the problem” (1981/1994: 136). Foucault elaborates that it is the creation of a homosexual identity (a task which he later describes as the task that gay men and women must foremost undertake) that has the ability to change power in such a way that it would no longer subjugate sexual choice and desire. Thus, the reason why homosexuality became controversial in the latter half of the 20th century was because gay men and women were forming alliances and creating their own identity, which sharply cut across the procreative requirements for sex laid out by centuries-long edicts and laws created by religions and governments.

Being gay certainly has intrinsic ties to sexual desires and acts with someone of the same sex (e.g., men desiring and engaging in sexual encounters with other men). But, it is the science of sex that turned sexual act and sexual choice into an all-inclusive identity:

The nineteenth-century homosexual became a personage, a past, a case history, and a childhood, in addition to being a type of a life, a life form, and a morphology, with an indiscreet anatomy and possibly mysterious physiology. Nothing that went into his total composition was unaffected by his sexuality (1978: 43).

Society prescribed that someone who had sexual desires and acted upon them was wholly gay—a homosexual—and those sexual acts marked the totality of his life (e.g., his work, his leisure, his family life, etc.). But, when gay men embraced the notion that their sexuality defined who they were and created their own, new reality and identity (or, rather, began living openly the identity they had been living for decades, even centuries, before), these relationships were and are problematic in a heteronormative society (Foucault 1981/1994: 136-137).

Foucault's thesis on power-sex-pleasure (how the body, sex and sexuality became the objects of regulation in order to maintain a producing society) rested on the presumption that human beings no longer had to occupy themselves with fending off death, hunger, and disease (1978: 137-138). The epidemic, at least for gay men in the 1980s and early 1990s, was not over, however. Judith Butler (1993) claims that AIDS presented a situation that Foucault could not have predicted when he published *The History of Sexuality* in 1978. She claims that Foucault's thesis was short-sided by the epidemic; Foucault reasoned that technology would save us (in this case, gay men) from the perils of disease, because, at the time of her writing, HIV/AIDS was terminal and the medical had very little to offer to delay the sure death that followed an HIV diagnosis (Butler 1993: 97-98). Thus, gay men were reduced to a former challenge of warding off disease and death, while heterosexuals, for the most part, were not. This fight against AIDS re-pathologized gay men.

Foucault argues that power in society is exercised in a much more subversive manner—men no longer lose their heads on “scaffolding” (1978: 138). Foucault explains: “[one] might say that the ancient right to *take* life or *let* live was replaced by a power to *foster* life or *disallow* it to the point of death” (1978:138). In other words, governments no longer execute individuals who pose threats to their “regimes of truth” (Foucault 1984: 72-73). Rather, governments use other means of control to “disallow” them to live (1978:138). For example, the United States government defined marriage as a “legal union between one man and one woman” (*Defense of Marriage Act* 2006). Building on Foucault’s premise and Butler’s argument, the United States also “disallows” some HIV positive people to live by providing an inadequate supply of anti-retroviral medications that would dramatically extend their life expectancy.

In some ways, gay men and women changed society around them during the sexual liberation movement of the late 1960s and 1970s. For example, homosexuality was no longer considered a disorder after the American Psychological Association, under pressure from Alfred Kinsey, voted to eliminate it as such in 1974; it was consequently removed from the *Diagnostic and Statistical Manual of Mental Disorders- III* in 1980 (Spitzer 1981). HIV/AIDS, however, changed the trend of normalizing homosexuality, and conversely *re-pathologized* homosexuality. In fact, in the early 1990s, Butler points out, homosexuality was said to *cause* AIDS (Butler 1993: 54); thus, homosexuality, which caused AIDS, ultimately caused death—and provided the government with a sufficient reason to codify homosexuality all over again. The result was a massive affront on gay sexuality in the name of public health (Button 1997; Shilts 1987)—a war against

disease that “disallowed” gay men to perform the very act by which their identity was formed: sex.

David Halperin (2007) assesses the modern problems of the HIV epidemic through a Foucauldian lens similar to Butler’s analysis in the early 1990s. Halperin argues that HIV has allowed the government, primarily the Centers for Disease Control and Prevention, to subjectify gay men. In other words, HIV prevention among gay men has become a fixation among the public health sector—saving gay men from their own sexual devices is the new goal and project.

The male condom, therefore, is the current device, implemented and promoted by public health officials, not only for controlling the sexual *acts* of gay men, but even the sexual desires of gay men—sex without a condom is deemed risky behavior. Targeting “populations” of gay men and enforcing the “condom code” is a transformed “regime of truth”—one that limits the pleasures of gay men. Thus, the condom, when considered in a broad socio-historical context, is a way of pathologizing a sex act between two men that constitutes an entire identity, an identity once cast upon the gay man by society, no less.

Halkitis, Gomez and Wolitski (2005) describe sex behaviors, meanings and motivations of HIV-positive gay men. They argue that the majority of public health literature and HIV prevention materials have “neglected the very essence of sex, treating it as a cognitive and rational construction, controlled solely by one’s mind and not one’s heart” (2005). To view gay sex as an act that a man commits unidimensionally (e.g., for physical pleasure) misses that gay sex, as it is for heterosexuals, is an act that is bound to human emotion and is demonstrative of trust and caring.

Thus, HIV prevention materials, from a Foucauldian perspective, may unintentionally make the “truth” of gay sex: the way it is spoken of and confessed, a clinical, mostly pathological act and a discourse on risky behavior, meanwhile losing the perspective that, for the men who engage in it, sex is not simply a physical act of pleasure. HIV prevention may have subjugated the very population it intends to serve by harboring such a narrow view of what sex means. Halperin states, “the American medical establishment in the United States never told [gay men] it was safe to have sex, let alone that sex was good . . . [they] never even told [gay men] it was safe to kiss” (Halperin 2007). The only public voice of gay sex in the Western world was one of safe sex—to use a condom during anal intercourse—there has never been discourse on gay sex as an act beyond it’s clinical implications and consequences.

Foucault was himself a gay man who was known to frequent bathhouses and sadomasochistic (S/M) clubs for gay men in San Francisco. On the topic of AIDS, Foucault said very little; when confronted about the epidemic, he very much saw it in the light of discourse giving power: “This danger lurking everywhere has created new complicities. Before no one ever said a word: now we talk to one another. We all know why we’re [at the bathhouse]” (Ryan 1993). Ironically, Foucault died of AIDS related complications in June, 1994 (Ryan 1993). In 1982, Foucault told an interviewer, “I would like and I hope I’ll die of an overdose of pleasure of any kind” (1982/1994a: 129). One could certainly argue that he did perhaps die because of intense pleasure.

Exploring Why Gay Men Do Not Use Condoms Through Qualitative Methods

HIV/AIDS is one of the most monitored epidemics nationally and globally. Quantifying infections remains a chief task for public health agencies and governments.

Identifying trends in infections—who is being infected, where and how (i.e., method of transmission)—is important for prevention and education efforts and treatment availability. Several recent studies examine the epidemic, giving particular attention to patterns of behavior and infection in subpopulations, and attempt to assist in predicting future incidence (Centers for Disease Control and Prevention 2009; Centers for Disease Control and Prevention 2003; Dean and Hayes 2004; 2009; Smith, White, and Moracco 2009).

However, researchers have no systematic research that explains why gay men choose to use a condom during sexual activity or why they do not. On many fronts, HIV education and prevention campaigns lack research on their target audience and do not have evaluative measures to test their efficacy. In other words, many education and prevention campaigns may be failing to address their target audience. Until the reasons why gay men choose to not use condoms and engage in sexual risk have been identified and monitored, the public health establishment is ill-equipped to change condom use patterns, attitudes toward sexual risk, HIV-testing practices, and ultimately reduce the number of new HIV infections.

HIV prevention research has not sufficiently explained why gay men do not use condoms and has failed to learn from those who do (e.g., Dean 2009; Halkitis and Parsons 2003). Quantitative research, the preferred method of inquiry in HIV/AIDS research, may not be able to capture shifts in gay culture and sexual behavior because it examines specific factors (variables), meanwhile missing new trends in behavior, prevention, and infection. The problem remains that researchers may not always know which variables to test, or even what those variables might be. Therefore, qualitative

research may be a proficient method to identify those factors that will impact the future of HIV/AIDS prevention and education. This research seeks to identify reasons why gay men choose to or not to use condoms during sexual activity, and assess attitudes toward safer sex.

Survey research is well equipped to capture information about sexual practices and general sexual behavior, and such is the practice in HIV/AIDS research. However, undesirable behaviors such as “bareback” sex—anal sex without the use of a condom—anonymous sexual encounters (some research refers to this behavior as “casual sexual encounters”), multiple sexual partners, and other high-risk behaviors can be underreported or falsely reported because of the respondent’s perception of what those terms mean. Answers to these questions may be biased because of social desirability as well. Qualitative methods that include both observational and in-depth interview components have the ability to navigate these issues; the researcher has the ability to more clearly understand the nuances of the behavior in question. In other words, when participants respond to the question, “Have you ever had sex without a condom?” they may reply, “Yes, but it was only because there was no condom available.” A questionnaire or survey may report this sexual encounter and individual as someone who engages in barebacking, which is not accurate. Likewise, a prevention campaign would look much different for this individual than it would for a gay man who intentionally seeks out sexual encounters in which condoms are not used. Qualitative methods, particularly in-depth interviews, allow the researcher to probe deeper into the participant’s responses, allowing for clarification and further development of ideas (Strauss and Corbin 1998; Emerson et al. 2005).

Additionally, subtle cultural shifts can be hard to detect using even the best survey methodology, especially amid campaigns to promote certain behaviors such as safer sex because these campaigns promote certain social expectations and desirability. These shifts may not be easily quantified, especially if they are not reported. Qualitative methods have the ability to potentially capture these details by allowing individuals and groups to use their own words to describe situations, actions and concepts, rather than using the researcher's words (Strauss and Corbin 1998).

Alienation and Condom Use and the Expansion of Serosorting

Several theories exist to explain the sexual behavior of gay men and the lack of condom use (Adam et al. 2005; Centers for Disease Control and Prevention 2006b; Centers for Disease Control and Prevention 2010a; Dean and Hayes 2004; Mansergh et al. 2002; Varghese et al. 2002; Whittier, Lawrence, and Seeley 2005). However, most of these theories come from quantitative research and often the qualitative underpinnings or explanations of these findings are absent (e.g., Halkitis and Parsons 2003).

For this project, I explored some untested ideas regarding high-risk sexual behavior among gay men, while also being aware of emergent themes, patterns, and concepts identified in HIV prevention literature. In addition to examining these common presumptions of sexual practices, I also propose three new theoretical explanations. First, as a group in society that is oppressed for their sexual identity and whose sex acts are considered taboo, it is possible that the group is experiencing alienation. That is, the gay community is disenfranchised or perceives to be disenfranchised from mainstream society. Gay men may see condom use and safer sex as part of the mainstream culture

from which they are excluded and may choose not to use them because they view them as part of an institution that rejects them.

Second, I reason that ideas centering on serosorting may not be extensive enough. Gay men may have a false understanding that HIV-positive men only associate with other HIV-positive men and do not actively seek sex partners on websites that facilitate anonymous sexual encounters. Therefore, men who presume to be HIV-negative have a false trust that all of their partners are also HIV negative (Eaton et al. 2009; Snowden, Raymond, and McFarland 2009; Wilson et al. 2010; Zablotska et al. 2009).

Finally, in accord with Foucault's explanations on the exclusion of homosexuality from modern discourse on sex—that gay sex falls outside of the realm of acceptability—and that those individuals who are gay are sexually pathological, I hypothesize that HIV/AIDS will serve to re-pathologize homosexuality. And while gay sex is in and of itself seen as a form of illness, gay men may view the condom as a barrier to fully expressing trust and commitment through the sexual act. That is, the condom sterilizes and strips of meaning a physically intimate conjugation of two men, and therefore, they forego condom use: not because they are complacent about contracting HIV, but because they desire to express intimacy with their partner.

CHAPTER III

METHODS: TALKING ABOUT SEX, HIV, AND RISK

This qualitative study used multi-method qualitative research to better understand why gay men are choosing to have unprotected anal intercourse and their perception of their risk of acquiring HIV. Qualitative method was most appropriate for this study because it allows the researcher to gain a deeper more nuanced understanding of condom use and non-use than does survey methodology or other instruments that do not allow the researcher to interact with the research participant.

This study contains an observational portion. I attended meetings of three groups (and also interviewed some of the men in these groups) and took detailed field notes, which will were coded in a similar fashion as the interviews (see below). The observational portion of this study contextualizes the interviews and provides additional data that aided in understanding general attitudes and perceptions of condoms, sex, and HIV susceptibility. That is, it provided a window into participants' everyday conversation and practices that the interviews alone could not provide. Additionally, it allowed the researcher to place these interviews within a social framework that included socio-political positions, socioeconomic status, education, race, and especially peer interaction.

Setting

This research took place in an area adjacent to a metropolitan area. The primary areas where individuals resided at the time of observation or interviews were adjacent to this large metropolitan area and many individuals from these areas commuted for their

work to the metropolitan area. According to Census Bureau estimates, the median age of the area in which the study was conducted was 36. The area was predominantly white (95 percent) and the median family income is substantially higher than the national average—just over \$70,000 annually compared to \$51,000 nationally. Nearly 90 percent of residents had a high school diploma compared to the national average of 84 percent. Generally, the area in which the observation and sample were acquired is economically affluent, white, and educated (U.S. Census Bureau 2010).

Observational Data

I observed three organizations that had a core identity that centered on LGBT people and/or issues. More details about each group are given in the descriptive findings in the results chapter of this manuscript. I selected these groups for substantive and accessibility reasons (outlined below). All of these settings are naturalistic; this selection was an advantage over research that is conducted in clinical or artificial settings because it reduces the social desirability of pro-condom use responses and recounting low-risk sex, which tends to be viewed in a more positive light by public health researchers and practitioners.

The Wednesday Hill Gay Men's Chorus. The members of the first group, the Wednesday Hill Gay Men's Chorus (WHGMC),⁵ were gay men who ranged in age from 20 to men over the age of 65, although most of the men are in their 40s and 50s. Most men in the group were not married and were not in committed relationships, although several were. In some instances, both partners participated in the chorus. This group was small enough to be personable—everyone was familiar with everyone else. Additionally,

⁵ Proper names of places, cities, groups, and individuals were replaced with pseudonyms to protect the identity of the participants.

this group was well connected to the gay community throughout the area in which it resided, which, I predicted, would enable the participant referral method of sample recruitment to work well; unfortunately, that was not the case. None of the chorus' referrals contacted me for an interview.

During the first two interactions with the chorus, several members asked me privately why I selected the chorus for observation and what I expected to glean from my research. They seemed concerned that I was somehow going to exploit the group or felt that my presence was intrusive. However, I assured them that my notes were confidential and that individuals in the group could choose not to answer my questions. None of the members left the rehearsals or the organization because of my presence there.

At a practical level, the group met weekly and had mandatory attendance rules. Thus, there were almost always enough men present so that the group's dynamic was not changed by who was there and who was not. Finally, the group's meeting location was within driving distance, allowing me ease of access to attend rehearsals, board meetings, social activities, and performances.

Campus Out. The second group, Campus Out, was a group of undergraduate college students. This group, in contrast to the WHGMC, consisted of men and women mostly between the ages of 18 and 23. The group, usually between 15 and 40 in number, was comprised of approximately two-thirds men who identified as gay, bisexual or queer, and the other third were women who identified as lesbian, bisexual, queer or questioning. A few individuals identified as transgender and straight and some students chose not to reveal their sexual orientation. My observations were of the entire group, not just the gay men who attended the meetings. I chose this group because it is located at a campus that

is easily accessible, and because it allowed me to access younger individuals for interviews that did the WHGMC. Much like the chorus, however, none of these participants' referrals resulted in an interview. Finally, I assimilated quickly into this group because I appear young and most of them seemed to engage me as though I were a peer. None of them questioned my presence; my purpose for attending was mentioned only in passing during my first visit, and there was never mention of it again.

LGBT Campus Advocates. The third group, LGBT Campus Advocates, met less frequently than did Campus Out; the membership consisted of men and women between the ages of 23 to their late 40s. The group catered to and was created for graduate students': some faculty from the local university attended social gatherings, but not the movie, activism, or discussion nights. This group was also much smaller than Campus Out; typically less than 12 people attended meetings or gatherings, unless it was a large event, such as at the showing of a popular film about LGBT seniors, where the number tripled. The additional members at those events were interested allies who identified as straight or whose sexual identity was unknown to the researcher. This group was key to identifying potential interviewees; 13 of the 19 interviewees' participation in the study were due to direct or indirect referrals from members of LGBT Campus Advocates.

Because I attended this group as a participant long before I began conducting this research, the participants felt at ease around me and talking to me about my research. None of them expressed concern about my research or that they were subjects of my research. Of note, however, I did not interview many of the gay men in this group because I had friendships with them that were established before I started this study. I did, however, ask them to pass along recruitment and contact information to individuals

with whom I had no previous relationship who might be interested in participating as an interviewee. And, as noted above, these contacts were critical in acquiring the majority of the interview sample.

Requirements for Participation

Nineteen men were interviewed for this study. In order to participate, the individual had to be male and identify as gay or bisexual. Participants were recruited using direct recruitment from one of the three groups discussed previously, and via participant referral. Individuals were screened for eligibility in the study. Respondents had to be 18 years of age or over and have had oral or anal intercourse with two or more partners in the past year prior to the interview. If the respondent met eligibility requirements and agreed to be interviewed, I scheduled an interview within two weeks after my initial contact.

Interviews

I used a semi-structured format for the interviews. I used a guide, which is included in Appendix A, but quite often varied from the guide as the questions were open-ended and the participant's response often warranted a follow up question or point of clarification.

Participant Referral. Many participants were recruited by referrals from other participants—a technique often referred to as “snowball sampling.” This technique is ideal for targeting individuals who identify as a sexual minority and is used in many studies for LGBT men and women (see Carrington 1999; Stein 2001). Additionally, this technique is often used to build samples from populations that are difficult to access (e.g., homeless persons, drug addicts, etc.) (Lee 1993). At the conclusion of an interview or via

a contact I already knew within the local gay community, I asked individuals to pass my business card and information about the study to other men who might want to participate. These men contacted me directly to indicate their interest in participating in the study. After establishing their eligibility, I scheduled an interview time.

By attempting to recruit potential interviewees from these three different groups, each composed of a different age cohort, I expected to attract a diverse sample of interviewees. However, two of the three groups resulted in only a handful of interviews (WHGMC and Campus Out). Thus, the resulting sample, which was acquired almost entirely through connections in or through LGBT Campus Advocates, was rather homogenous in terms of age; most of the participants ranged between 23 and 29. Importantly, however, not all of these participants were students; some of them had graduated from the nearby university and were beginning careers locally, while others were undergraduates who did not attend Campus Out's meetings. Therefore, the sample included men who were not only graduate students, but who were at various stages in their careers, life, and their sexual experiences.

Conducting the Interviews

Location. Interviews took place in private settings, such as reserved rooms in public libraries, university offices, at my home or at the participant's home. One interview took place in my car because the restaurant selected for the interview had removed its private booths. Each interview was scheduled for approximately one hour, but because of the relatively unstructured nature of the interviews, the interviews lasted between 40 minutes and over three hours. Most of the interviews lasted a little over an hour.

Participant Rapport. I expected that I would have to pressure some of the

respondents to answer sensitive and intimate questions. However, quite the opposite was true: typically, the respondent responded in a narrative that sometimes resulted in them disclosing more information than I had intended. While I did not discuss my sexuality openly with the respondents, most of them assumed that I was gay or bisexual because I often referred to sex acts using in-group language. For example, rather than asking if they were typically the receptive or the insertive partner during anal sex (the clinical terms) I asked if they were the top (insertive) or the bottom (receptive). Additionally, the individual that referred them to me may have indicated that I was trustworthy. With the exception of one individual, who openly admitted that he was uncomfortable talking about his sex acts, all of the men appeared to be comfortable and I was able to get honest responses from them. Many of them preceded the telling of sensitive information by saying, “Well, since this is a safe place . . .” or “I’m trusting you with a lot of information here.” Therefore, I believe that my ability to easily achieve rapport with the interviewees reduced the social desirability of their responses. Finally, by not attaching the respondent’s name to even the consent form or in the recording, I believe that many of them felt that they could be honest about their sexual behavior because there were few, if any, links that could directly implicate them in any activity. Anonymity in the interviewing process was essential to getting honest and open information.

Special Considerations for Human Subjects. My study required that men discuss sensitive and private personal information regarding their sexual behavior and practices. Additionally, there existed the potential that I would discover information that could personally and/or publicly harm an individual, such as a sexual or relational affair, HIV status, or unsafe sexual behaviors. And even though none of the 19 men reported being

HIV positive, the sensitive nature of the details I requested made it essential that I kept the identities of those I observed and interviewed confidential. While the geographic location of the study could be important to the findings, this information is withheld to assure confidentiality of the participants.

There also existed the possibility that individuals would view me as an outlet—in effect, treat my interview with them as a therapeutic opportunity. Recognizing that I was not qualified, nor was it my role as a researcher, I referred men to LGBT friendly resources that are equipped to handle such situations when the situation warranted it. Only one man took a list of resource information and he did so for the HIV testing information that it included (this resource sheet is not included here because it includes place-names that could identify the area from which the sample was acquired).

Outside of issues surrounding confidentiality, the amount of harm posed to participants in the research was very low. In three of the interviews, the men became emotional when they were recounting events with former partners and lovers. In one instance, the interview stopped for a few minutes while the respondent composed himself. In another instance, I received an email message from a participant indicating that my interview made him reflect critically on his sexual decision making and that he felt greatly benefited by his participation in the study. Additionally, there were no immediate rewards or incentives for participating in any part of this research; participants were free to opt-out at any time and had the option of not answering any or all of the questions.

The University of New Hampshire's Institutional Review Board (IRB) approved this research. This approval extended to the research design of the study, the recruitment

of participants, the interview guide, the transcription process, and protection of identity in the writing of this manuscript. Protocols and directives given by the IRB were implemented throughout the study. Interviewees were given a consent form; the consent form did not require a signature in order to maintain confidentiality of the subject (see Appendix B). At the conclusion of this research endeavor, the original recordings were destroyed and identifying information was removed from the transcripts. The transcripts are stored in a secure location.

Recording and Transcribing the Interviews. Seventeen of the 19 interviews were digitally recorded. One individual requested that he not be recorded and in another instance, the recorder malfunctioned. I transcribed the interviews, while most of the transcripts match the recordings verbatim, some areas were not transcribed, such as when the interview digressed or when the interviewee was listing details from his childhood. Finally, I checked sections of transcripts while listening to the recordings to ensure accuracy. Sections that were inaudible or undecipherable were noted in the transcripts; however, very few of these errors exist because the recordings were of high quality and there was very little background noise interference.

Data Analysis

I coded the interview transcripts and observational field notes by identifying themes and sub-themes. I used Microsoft Word and its highlighting feature as well as Apple Pages and the highlighting feature in that word processor.

I coded the data using both open and focused coding techniques. To reduce bias, I conducted the open coding first. This allowed me to identify patterns of behavior relating to sexual decision-making, condom use, and perceptions of HIV susceptibility. I divided

by those individuals who used condoms, those who did not, and those who sometimes used condoms; sixteen of them fell into the third category. I then identified the reasons, motivations and/or circumstances (e.g., the condom broke, or “the guy seemed safe”) behind why the interviewee did or did not use a condom.

Secondly, I coded for concepts that were identified in other studies and HIV prevention materials by using a focused coding technique. After the open coding process was complete, I began with clean copies of each of the transcripts and field notes and coded for instances of complacency, fatalism, condom fatigue, and so forth. Definitions for these terms are explained in the review of literature in this manuscript. In both open and focused coding, data analysis was complete when no new data emerged from the transcripts (Emerson, Fretz, and Shaw 1995). In other words, the coding was complete when no new data were apparent in the coding process.

A sociology graduate student checked the coding independently, a process referred to as intercoder reliability. This step exists to reduce bias and maximize validity and reliability in the study by minimizing my bias. Since I designed the survey instrument, conducted the data collection, and did the primary analysis of the data, themes could have been heavily influenced by my interpretation. When coding agreement fell below 70 percent, it was to be dropped. No themes were excluded because of coding disagreement.

Generalizability. The intent of this research is not to be able to produce findings that can be generalized nationally or even regionally, but to produce testable hypotheses, address previous theories and hypotheses and to identify patterns of behavior relating to condom use. The current study seeks to explore trends and patterns within a relatively small group of gay men. The broader “gay community” is comprised of many cultures

that vary by region, age, country, etc. This study addresses only one type of gay culture that, nonetheless, shares many similarities to the larger gay culture in the U.S. and in Western culture generally (see Harris 1997; Carrington 1999). That is not to say that these regional cultures are vastly different from one-another; in fact, most places have more similarities than they do differences.

The research methods described here aim to identify meanings behind why gay men choose to or choose not to use condoms when engaging in anal intercourse. This exploratory study is specifically concerned with the motivations of gay men toward condom use, how those motivations translate into behaviors, and how their perception of risk for contracting HIV changes those motivations and/or behaviors.

Sample

The Wednesday Hill Gay Men's Chorus (WHGMC). At the beginning of my observation of the chorus, which lasted approximately five months, 34 men were singing with the group. By the time the chorus gave their season concert, 22 men remained in the group. The men range in age from 18 to their early 70s, though most men in the chorus are in their late 30s to their early 50s. From casual conversation during breaks and socials after rehearsal, I learned that most of the men are in professional occupations or retail. While most of the men do not have college degrees, about a third do, and about five of them have graduate or professional degrees. The vast majority of the group is working and middle-class. With two exceptions, all of the members identify as homosexual. One of the active singers is a heterosexual man and one of the non-singing board members is a heterosexual woman. The WHGMC rehearses weekly on Tuesday evenings in the basement of a Unitarian Universalist Church (UUC).

CampusOut. This university-based social and support group consists of LGBTQ+ undergraduate students ranging from 18 to 25. Barring special events, such as the group's annual drag ball—a dance in which men wear women's make-up and clothing, which attracts 300+ people—approximately 15 to 40 students attend the regular meetings. The meetings take place in a room in the student union at the center of the university. Typically, a member of the university's diversity office also attends these meetings, but rarely, if ever, engages the students. The majority of the students come from the state in which the University is located, and with the exception of two or three regular attendees, group members are from one of the six states that make up New England. Most of the members are white, which reflects the general racial composition of the campus. The group consists of about two-thirds men. Two to five were "allies"—individuals who identify as heterosexual, and the rest of the participants identify as gay, lesbian, bisexual, transgendered, questioning, or queer.

LGBT Campus Advocates. Consisting mostly of graduate students, this group met less frequently than the undergraduate group and was substantially smaller. Some faculty also attended this group during social gatherings. Ages ranged from 23 to 51, but typically the 4 to 10 individuals who could be considered "regulars"—those who consistently attend the group's functions and events—are between 23 and 32 years old. Most of the students in the group are in doctoral level degree programs, and some have been attending the University for five or more years. Unlike the undergraduate group, students in LGBT Campus Advocates hail from all over the United States; in fact, only one regular attendee grew up in New England. All of the "regulars" identify as gay, lesbian, or transgender. One woman who occasional attends identifies as bisexual, and

another man identifies as heterosexual. The group meets in an academic space in one of the campus buildings.

Interviewees

Nineteen gay or bisexual men participated in face-to-face interviews. These men ranged from 19 years of age to 39 years of age, with most of them being between the ages of 23 and 29. All of the men resided within a 40-mile radius of one another in coastal New England. Ten of the men came from homes in which their parents divorced, and the remaining men's parents were still together—one of the respondent's was raised primarily by his paternal grandparents. Ten of the men grew up in homes where they sometimes or often attended church; of those who reported a religious upbringing, half of them were Roman Catholic, the five attended Christian Protestant or Evangelical churches. Only one of the ten religious individuals claimed that they practiced any form of religion currently. Josh, a 23 year-old who meditates and leads meditations frequently; he no longer worships in the same Christian tradition that his mother did during his childhood. Twelve of the men were enrolled, graduated from, or affiliated with the university in which Campus Out and LGBT Campus Advocates is located, but not all of these men attended one or the other group.

Fifteen of the men identified as gay and four identified as bisexual. Seven men reported having vaginal intercourse with a woman at some point in their sexually active lifetime. The men reported having between one⁶ and 11 anal or oral sex partners in the

⁶ In order to participate in the study, participants were required to have two or more sex partners in the previous 12 months. One individual claimed that he met the requirements, but in the interview, retracted his claim and reported only one sex partner during that period. Because, however, he had more than two sex partners in his lifetime, I chose to leave him in the sample.

previous 12 months; individuals reported the number of lifetime sex partners to be between 2 and approximately 150. Two individuals had never had anal sex at the time of their interview and two could not estimate the number of partners from whom they received or had given oral sex. Seven of the men had between 14 and 25 anal sex partners.

Three of the 19 interviewees were recruited from the WHGMC; an additional three were recruited from Campus Out. None of the remaining sample participated in the study as a result of referrals from these men; the remaining 13 were recruited from LGBT advocates or contacted me via a referral from a member of LGBT Campus Advocates. Because the majority of participants were the result of referrals from LGBT Campus Advocates, they were all relatively the same age (23 to 29), but came from a variety of life circumstances. Some were beginning their careers; others were well established in their careers and partnered. Still, some others were undergraduates who did not participate in Campus Out; thus, the participant referral technique I implemented resulted in a sample that could not have been achieved by recruiting participants from the groups alone.

CHAPTER IV

RESULTS: PERCEPTIONS, CONDOMS, LOVEMAKING, AND PEER NETWORKS

In this chapter, the six main findings of this research are presented. First, I explain how gay men talked about sex in group settings, then turn to how gay men perceive sex and HIV. Next, the patterns of condom use and non-use are described, following an explanation of how gay men viewed the male condom. I end with findings regarding the influence of peer groups on individual's condom use patterns.

A Note on the Coding Process and the Presented Findings. The open coding process, rather than the focused coding process, yielded results that better explained the reasons and motivations behind gay men's condom use. The focused coding process did not result in conclusive findings; only complacency was identified in some of the responses, but was later contradicted by the same respondent. For example, some of the respondents indicated that HIV infected people are not to blame for their infection, but later said they would blame themselves if they became seropositive. These contradictions were better explained by the open coding process. That is, the themes I identified in the open coding of the transcripts held more validity than did the concepts identified in other research. I expected, however, that this would not be true; that, because I build the interview guide from my observational data and using concepts previously identified in HIV literature, the focused coding would yield more accurate results.

Gay Men's Discourse on Sex, Condoms, and HIV in Group Settings

WHGMC. Sexuality defines the chorus—the word “gay” is in the group’s name, and ultimately, it is homosexuality that remains the common thread for the members. Likewise, the rehearsals were filled with sexually charged comments, corrections, and gestures; even the music that the chorus rehearsed had sexual overtones. One song was entitled “Tom, Dick, or Harry,” while lyrics in other songs were adapted from “bless this bride” to “bless this guy.” Songs that are not overtly sexual were often made to be sexual. The song “I’ve Got a Ticket to the Kingdom” is about an individual who is acknowledging his newfound salvation via the death and resurrection of Christ. The words “Go tell Mary and go tell John,” were sexualized when the men failed to enunciate the word “go”—they sang, “ho.” Additionally, the men often gestured at one another when the word “Mary” came up; Mary is often a name gay men use to refer to one another.

Silas, 31, mentions that the highly sexual atmosphere of the chorus is just “gay nature.” He continued,

People feel comfortable enough . . . but it’s not unique to the group . . . we feel open so we can express ourselves and joke about our [sexuality].

Sam made similar comments as well, referring to the chorus as a place that is outside of the “straight world.” Sexual attraction is what the men of the choir have in common, so the regular discourse about sex is understandable.

Some sexual remarks were homosexual, however, and would not be understood in most social situations outside of groups of gay men. Referring to the song “I’ve Got a Ticket to the Kingdom,” Silas remarks:

“I’ve got tickets to my kingdom.” There is loud laughter. Julian says, “I’ll take a quarter’s worth.” Ethan continues, “You need a ticket.” There’s more laughter. Jordan holds his hand as though he’s holding an erection and says, “You have to be this tall to ride.”

Silas’ comment and the following comments of the other men referred to Silas having anal intercourse with them. In this context, Silas’ comment about being “naughty” outside the usual confines of heteronormativity were logical when the chorus is understood as Sam described it, a place that outside of the “straight world.” This comment further explains this point: “Then, one of the men makes a joke about fluffers—usually women who perform oral sex on straight men to arouse them in gay pornography. Jeremy adds: ‘Oh, we know there are a lot of fluffers in here!’” Outside of the group, these jokes would likely be received as doubly offensive because of their homoerotic nature coupled with their overtly sexual theme.

The men in the chorus talk about sex, make sexual gestures, and even sing about sex. After spending less than an hour with them, it becomes understandable that *everything is about sex*. But, after spending nearly 70 hours with the chorus, no one mentioned HIV or condoms. One of the members, I later found out, is HIV positive, but only two or three members of the chorus knew that there was an HIV positive individual in the chorus, and other than the infected individual, only one board member knew the identity of the infected person.

Generally, the men in the chorus only referred to sex jokingly or via innuendo. They never discussed sex seriously. When I asked Zach, an interviewee who was not a member in the chorus, why gay men do not talk about HIV or STIs, he said that it is “just too serious.” The atmosphere of the chorus was generally upbeat and happy—when the men were joking, it could have resembled a comedy club; speaking of such grave or

clinical issues like condoms or HIV no doubt would have changed the atmosphere. Or, perhaps, because many of the men lived through an era in which many gay men died from HIV/AIDS, it was a topic too personal to discuss in such a non-personal setting.

Campus Out and LGBT Campus Advocates. While these two organizations met separately, their discussion, or rather, their lack of discussion, about sex or safer sex was similar. In my limited time with the university-based groups—I observed Campus Out for a mere 15 hours and LGBT Campus Advocates for approximately 12, 3 of which they spent watching a film—safer sex was only mentioned once when the leader of Campus Out announced that there were free condoms available at the student health center. There was no discussion about the condoms or safer sex following his announcement. When I asked the leader of Campus Out why the group never talked about safer sex practices, he claimed that they “save the topic” for when a safer sex practitioner comes from the campus health services. In other words, they devote one meeting to the topic each year, but do not talk about sex, safer sex, or HIV and STIs otherwise.

The LGBT Campus Advocates never mentioned sex, safer sex, or HIV (other than when I was asked about my research). In fact, the topic of sex, other than claiming an actor in a film was sexually attractive, never entered the conversation.

One large difference between the two campus-based groups and the chorus is that the campus-based groups consisted of both men and women who sexually identified in many different ways. In the chorus, the membership was all men and all, save for one, openly identify as gay. The mixed atmosphere of the campus-based groups could have impeded conversations or interactions regarding sex because sex acts are different for the men and women in the group. Consequently, the risk associated with sex is different for

the gay men in the group and the lesbians in the group. Lesbian sex acts and sex acts of gay men put them at polar opposites for HIV susceptibility—lesbians have relatively little risk of acquiring HIV via sex acts (Centers for Disease Control and Prevention, n.d.b).

Summary of Group Observation. My observation of the three groups previously discussed allowed me to understand the gay culture from which the interview participants came; it provided a context by which I could understand how men met each other, generally, to have sex or to date. And while HIV and condom use were never a mainstay in the conversation of any of the three groups I observed, it did afford me an opportunity to hear how gay men talk about sex in general. In other words, the themes that emerged here are what was *not* part of the everyday conversations, namely, condoms and HIV, even though gay men frequently and openly discussed sex, either via innuendo or in satirical banter.

Because I observed the gay men's chorus before beginning interviewing men, I was able to learn how to ask important questions regarding sexual behavior and decision-making, including in-group terms for different types of sex acts. In other words, my pre-interview observation helped shape questions I used in the semi-structured, in-depth interviews. Furthermore, by observing these groups, I had a window into the gay culture in the area of New England in which I recruited interviewees.

Through my observation, I learned of community resources, such as AIDS activism organizations which helped me determine the level and types of resources, such as free condoms and HIV testing, that were available to the men in the sample. If the sample for this study was recruited from a rural area, men may not have been tested for HIV because the nearest center that offered anonymous or confidential testing was too far

away. Men in areas that have no clinic face going to their doctor (who may not know that they are having sex with men) to get an HIV test or may forego the test all-together. Because there are ample resources available to gay men in the area in which I conducted the research, this was not a reason for not being tested; indeed, all 19 of the men reported that they knew of at least one clinic that offered confidential and/or anonymous HIV testing on a regular basis.

Most importantly, interacting with the men in these groups help me to make connections with gay men who knew other gay men, which led to the recruitment of many of the 19 men who participated. The interview phase of this study would not have been as effective if I had not spent time interacting with and observing local gay men. However, these interactions did not glean results that directly answered the current research question. Therefore, the remainder of the findings (detailed below) were derived from the interview portion of the study, unless indicated otherwise.

The next two sections describe how gay men perceive sex, that is, if they view it as an emotional experience, a purely physically pleasurable activity, or a combination of both; the latter section describes how gay men perceive HIV susceptibility and their notions of what HIV means for an infected person in the United States.

“Getting Your Rocks Off”: How Gay Men View Sex

In a heteronormative sense, sex is typically viewed as vaginal intercourse. For gay men, however, the term “sex,” and the behavior to which it calls upon, is more ambiguous. When referring to sex throughout the interviews, I often had to clarify the sex act to which I was referring. With many of the men, we had to pause to reconcile my clinical definition of sex—vaginal, anal, or oral penetration—with their own definitions

of sex: “[Sex is] just ejaculating together.” Another 21 year-old gay man referred to sex as skin-on-skin contact, “when you’re naked and in bed with someone and you’re enjoying each other, that’s sex.” Therefore, outside of procreative sex, the act is a bit more ambiguous. Sex, for the purposes of the present study, refers to anal and/or oral penetration. Seven of the men also reported having vaginal intercourse at some time since they first became sexually active. Because my primary focus is on condom use in gay men, I do not discuss vaginal sex here, though there is some risk of contracting HIV for the male partner in unprotected vaginal intercourse (Centers for Disease Control and Prevention n.d.b).

While most of the men thought anal sex was the most advanced form of intercourse—as a 23 year-old gay male put it, the “culmination of sex”—not all participants preferred to engage in anal sex. The same 23 year-old, Zach says of anal sex, “anal sex is such a job, it’s such a chore . . . I think the idea that you’re having anal sex is sexier than it actually is . . . I don’t really like anal sex very much.” Two of the men reported having anal sex because the act felt obligatory. Both later became involved in long-term relationships in which they only engage in oral sex.

Most of the men downplayed the significance of oral sex; many of them claimed that they did not count oral intercourse as sex at all. Two of them could not estimate the number of oral sex partners they had in their lifetime. One man called oral sex “a gay handshake.” Even the men who reserved having anal sex for only romantic partners (i.e., they did not engage in anal intercourse on “one night stands” or with men with whom they were not in a romantic relationship) downplayed the significance of oral sex. Oral sex seemed to be viewed as an activity that required lower levels of commitment. One

man in a long-term partnership claimed that oral sex—the only form of sex in which he and his partner engaged—was just for “getting your rocks off”—the act was not the same as “lovemaking,” the label most men gave to anal sex between two committed individuals that was viewed as an emotional expression of love and caring.

Oral sex is typically viewed as a low-risk source of transmission for HIV (Centers for Disease Control and Prevention 2010b); all of the men in the present study perceived oral sex as such. Erving, a 29 year-old man referred to oral sex in this vein: “I think [all my past experiences were] *just* oral” [emphasis mine]. All but two individuals used the phrase “just oral” when referring to oral sex. Only one man, Josh, a 23 year-old bisexual man, had engaged in anal sex with a partner without having oral sex first. Engaging in oral sex, therefore, is common among these gay men; most of them view it as a form of foreplay that leads to anal sex, or a fast way to have an orgasm. Low levels of personal commitment associated with oral sex seemed to be the main factor behind the respondents’ willingness to engage in oral sex over anal sex rather than the low risk of contracting HIV through penis-to-mouth intercourse.

Sex, no matter how the respondent defined the act, was generally viewed as a carnal, primal, physical activity. Two of the men referred to it as “animalistic.” That is, most men say that sex, most of the time, does not require or presume an emotional commitment from either partner—sex is simply a physical act, “[the intimate definition of sex] is a Disneyland fairy tale. . . . sex is just a carnal thing, even if you, like, really care about that person.” Some of the men claimed that sex can be associated with emotional attachment for the other partner—an expression of love between the two—but

even as such, some sex acts between two people, even if they are in a committed relationship, were sex for the sake of physical pleasure.

Many early gay rights activists rejected the notion of family values in exchange for sexual liberation—that sex ought to be had freely, regardless of sexual identity and marital constraints (Button, Rienzo, and Wald 1997). Many modern gay rights activists, however, push the fight for sexual liberation to the shadows and construct modern LGBT people to be just like everyone else (Carrington 1999; Stacey and Biblarz 2001). Despite the trend that gay men and women seem to be adopting more traditional models of family life, the way respondents in this study defined sex more closely reflects the point-of-view of the sexual liberation crusaders of the Harvey Milk era (Button et al 1997; Carrington 1999). Thus, sex, for most individuals in this study, does not require the context of a committed relationship. Fourteen of the men accumulated the majority of their sex partners outside of a romantic situation. The other five, however, tended to have the opposite view of sex, that it required emotional commitment; these men had far fewer sex partners (or none at all—they had not engaged in anal sex) compared to men who were approximately the same age in the study. It must be stated, however, that nearly all of the fourteen men who viewed sex in a carnal way also claimed that, even though it was more rare, sex could involve a deep intimate connection with a romantic partner. In sum, for the fourteen men who have had sex outside of a relationship, sex had a dual meaning, the latter of which was rare (the deep, emotionally connected sex referred to as “lovemaking”), and that such a connection was not required for sex to occur.

Finally, being the receptive partner in anal sex, that is, the “bottom,” for some of the men changed the meaning of sex because it is more invasive than being the insertive

partner. Additionally, as Underwood (2003) references, the act of being penetrated could be viewed as being effeminized. Some men in the study who reported that they preferred to be the insertive partner for anal sex would not engage in receptive anal sex with partners outside of the context of a committed relationship. And, in the context of their committed relationships, they were “bottoms” only because they wanted to reciprocate for their partners, not because they experienced pleasure from being penetrated.

Gay Men's Perceptions of HIV in 2011

Interviewer: So what about HIV and AIDS? When you hear that, what comes to mind?

Travis: Death.

Most of the gay men in this study took HIV seriously—a life threatening disease or one that will significantly and negatively impact one's ability to have a normal life. Travis' short but effective answer to my question demonstrates his serious view of HIV/AIDS.

While most individuals thought HIV to be a grave infection, all of them perceived their susceptibility of contracting HIV to be low, extremely low, or thought that they had no risk at all. And based on the CDC's evaluation of risk, most of these men's perceptions were accurate: I asked the men what they perceived their risk to be at the present time; and none of the men in my sample were engaged in what infectious disease experts deem highly risky behavior (e.g., frequent and multiple sex partners; frequent, anonymous unprotected anal sex; using drugs and engaging in sex; etc.) But *all* of the men were at *some* risk of contracting HIV via sexual transmission in this study. Therefore, it is important to understand how an individual's perception of HIV and of contracting HIV contributes to their sexual decision making and condom use.

Like Travis' narrative describes above, the gay men in the present study took HIV seriously. When the interview shifted from the individual's sexual history to a discussion centered on HIV, the conversation became more solemn and deliberate; there were fewer jocular mannerisms, the interviewee often leaned forward, and, if the interviewee had used jokes or sarcasm to convey his points earlier in the interview, those linguistic elements ceased. Among the younger men in the sample, the descriptions of what an HIV positive person might look like were often worse than the descriptions of an HIV positive person by an individual was 25 or older. Patrick, 23, when imagining what an HIV positive person might look like, explains "Very gaunt sickly people in the late stages of the disease." Leo, 25, has a less drastic impression of HIV; when asked how he felt about an HIV positive person, he remarked:

Sort of a feeling of great sadness comes over me, because, you know it's permanent. And even though it's getting more and more manageable, you know, with scientific advances that are coming right along, to me it's sort of like a switch, like you don't have it, and then you have it, and that's it.

The men in the sample in their 30s were more likely to know someone who was HIV positive, which may contributed to their descriptions of HIV as being less harsh. Ken, 31, describes HIV this way:

. . . to me it's a virus like any other kind of virus like anybody gets. It's just passed on through the fun stuff . . . To me, it just seems to be a fact of . . . life, you know. So it's kind of like . . . Crohn's Disease or cancer. It's a part of them and a part of their experience. And, you know, they are dealing with it.

Nick, also 31, speaks of HIV infected people similarly:

Those people aren't different . . . they're the same people . . . [It] doesn't come across as being this big thing that's going to kill everyone. I've known people that have been positive for a long time . . . they're regular people with a virus. It's not like all of a sudden they become positive and everything stops.

HIV was viewed by many of the respondents relative to other diseases and negative life events. Josh contracted human papillomavirus (HPV), an event he explains by saying: “[When I found out I had HPV] I spent days thinking, ‘Oh my god, my sex life is over. It’s over. This is terrible.’ With HIV, with the threat of it . . . I wasn’t worked up so much” Many of the men in the sample did not take HIV lightly, but viewed it as a condition that could be managed by taking the appropriate medications. Josh’s comparison of HIV to HPV, a virus by which many sexually active individuals become infected and never experience any symptoms or negative health consequences, indicated that he perceived all STIs that are life-long, incurable conditions as major ordeals in which the infected person had to consider. In other words, any incurable disease is viewed as a major drawback that the infected person has to learn to cope with. Three other men in the sample expressed similar sentiments about HIV and other STIs or chronic health problems. Therefore, for many of the men who described HIV in this way, it is not that they are complacent about HIV, but that they liken it to other infectious, permanent diseases, even if the other diseases pose less drastic health consequences. Viewing HIV in a relativist fashion, for the men who described it in these terms, did not *reduce* the severity of HIV to other STIs; rather, it *elevated* other incurable STIs to the level of severity of HIV.

Two factors appeared to importantly influence how respondents perceived HIV: their age and if they knew an individual(s) living with HIV. Eight out of the 11 men age 25 and under described HIV and AIDS or a person who had the disease in exaggerated terms; they saw the disease and its toll on a person’s well-being as more significant than those who were over 25. Only one of the interviewees over the age of 25 described HIV

or AIDS in such terms. Age may be a spurious factor, however, because HIV prevalence becomes higher as men age (that is, HIV prevalence in an age cohort increases over time), and because older men may have larger social networks, which increases the likelihood of knowing and HIV positive individual. Eight of the 19 interviewees knew someone who was living with HIV/AIDS; only one of them knew a person who died of AIDS related complications (but was not closely associated with him). Knowing someone with HIV not only impacted condom use patterns (cf. Travis, p. 61, 71), but also impacted the respondent's view of HIV and an HIV infected person. Individuals who knew an infected person described them as "just like everyone else" rather than "gaunt." Leo, 25, describes his HIV positive friend, "You wouldn't know, you would have no idea unless you were friends with him He seems happy and healthy." The respondent's age and their association or lack of association with an HIV positive individual influenced how he viewed HIV as a disease, not necessarily an HIV infected *person*.

Additionally, the men in the study often removed agency or blame from the infected individual for contracting HIV, claiming that the person seroconverted by no fault of their own. Jason, a 23 year-old gay man, explains "when I was younger, I thought that having HIV/AIDS meant that you had sex with a lot of people and didn't even care. And now I know that that's not even close to being true." Zach, also 23, claims that HIV positive people are "really unlucky," indicating that getting HIV is somehow a virus an individual gets by chance. In the past thirty years, people living with HIV (PLWHIV) and HIV/AIDS activists have attempted to remove stigma from HIV and AIDS in such a fashion that it also removes the role of agency (Bloom et al. 2010; Quam 1990)—the responses reflect that those efforts have been successful among these gay men.

Gay Men's Perceptions of Their Susceptibility to HIV Infection

All of the respondents indicated that they viewed the likelihood of contracting HIV as low. Furthermore, all of the men felt that they were mitigating their risk in some way, either by what they thought was regular or sufficient condom use, partner selection (serosorting), or abstaining from sex or certain types of sex (e.g., refraining from anal intercourse, or from being the receptive partner in anal sex). The question, "What would your life be like if you were HIV positive?" revealed a variety of answers ranging from "my life would be over" to "I'd just deal with it." Adam, 29, remarked:

I imagine that finding out that you're HIV positive is a life-shattering event. I would think that you would go through a pretty quick withdrawal process from a sex life . . . you have to be able to enjoy life and sex is a part of that, and I don't know how to make that work. I think that would probably change everything.

Bill, 27, claimed "the idea of being in your 20s and having this disease that you're going to carry for the rest of your life is terrifying to me." Contrarily, Nick, 31, said, "I don't know that there would be a lot different [from my life now]." Responses regarding how life would change varied; those who knew an HIV positive person tended to offer responses that were more like Nick's, while those who did not gave answers more like Bill's. Knowing an HIV positive individual did not make the interviewee complacent about the disease, but gave them a more realistic impression of what being HIV positive means in an everyday context.

The question also brought to light prejudices and deeper considerations about HIV. Zach previously said, in short, that HIV positive people are not responsible for their infection, but when asked how he would feel if he were HIV positive, he quickly responded, "I would be so upset with myself . . . I let myself get AIDS [sic]. I mean I

think there's a way to prevent it." The conversation continued:

Interviewer: But you just said that this guy over here was unlucky. But for you it's not about luck?

Zach: Yeah. Yeah. This is . . . no. . . . Um . . . I think there's a way to prevent it, I do. I have to think there's a way to prevent it, or I'm screwed, you know what I mean?

By asking individuals to talk about their susceptibility of contracting HIV, a great deal more was learned about what they *actually* thought of HIV/AIDS. Like Zach, many of the men said that they would feel responsible for becoming infected, that it could have been prevented. Thus, their apparent removal of agency for HIV positive people did not apply to their own situations; some of the respondents *did* actually understand HIV to be a disease for which an individual was responsible in contracting—a contradiction of standards that exposed some of these gay men's beliefs and attitudes about HIV and AIDS that were otherwise not forthcoming.

Place—where the respondent currently resides, dates, and chooses partners for sex—also mattered when the respondent evaluated their risk contracting HIV. Most of the respondents viewed the New England area in which they live and date as “safe.” Patrick explains how he perceives where he lives to be almost risk free in terms of contracting HIV:

[In] Washington, D.C., there's a much larger population of HIV positive people. So, where 40% [sic] of the people have HIV, it goes beyond the point of that transmission thing where, suddenly, seeing a student here, if you spot someone bleeding on the [university] campus, then your first thought is that you need to put on a layer of protection because that blood could be potentially infected—that's not something that crosses your mind. But in Washington, D.C., that's something that's a legitimate thought. I mean, you need to make sure that you have something so that the blood doesn't come in contact. It's statistically likely [there], here it's not statistically likely.

Isaac also sees the area where he lives in New England to be low risk:

Interviewer: What do you think your personal odds are of contracting HIV?

Isaac: I'd still say, on a scale of 1 to 5, where 5 [means 100% chance of infection], I'd say like between a 1 and 2. I mean, considering this . . . atmosphere . . . I think this place is pretty safe.

Some of the men expressed that if they lived in metropolitan areas in which they perceived there to be a higher prevalence of HIV, they would be more careful about using condoms. Jason explains: “[Being in] New York City makes me want to use [condoms] like 57 times more. I mean, I want to put them on my face and hands; I don’t know where [they have] been.” The respondents view the suburban and somewhat rural area in which they live and work as a low-risk area. Estimates from the CDC, however, report that there was modest increases in the number of infections from 2006 to 2009 in the area where the participants resided (Centers for Disease Control and Prevention 2009); thus, the level of risk in the region is actually higher than the men perceived it to be, leading them to make decisions regarding their sexual safety that were not accurately informed.

The Ambiguity of Confronting Sex Partners About Their HIV Status

Asking about a prospective partner’s HIV status is the easiest and most forward to way to serosort. While only three of the men engaged in oral or anal sexual intercourse with an HIV positive man, all but two indicated that they would engage in sexual activity if their partner were positive. And when the tables were turned—that is, the respondents were asked what they would do if they were HIV positive, many respondents claimed that they felt they would have the duty to warn their partners: “I would have to be a lot more abrupt with what I say [with sex partners]. I would probably have to tell people all the time. I would want to, I think” (Jason, 23). Isaac, 25, echoed these sentiments, “You

would have to tell everybody.” This willingness, even expressed wantonness to tell potential sex partners about their supposed HIV status, also demonstrated that the respondents expected their partner to disclose their HIV status if they were positive—and that if their partner did not disclose that he was HIV positive, he was assumed to be HIV negative.

By not openly disclosing HIV status, a positive individual could assume that his partner was HIV positive as well. HIV positive individuals, especially those who are on HAART, sometimes experience forms of human wasting, usually marked by a form of lipodistrophy (e.g., sunken-in cheeks, smaller buttocks, a protruding abdomen, and other abnormal body shapes). Some positive men serosort by looking for these characteristics in other gay men as an indication that they are also positive. And positive men who do not show any form of wasting may look for men who do as a physical indication that they are HIV positive. Therefore, a positive individual can mistakenly assume that an HIV negative man is actually positive, expose him to HIV, and consequently, unintentionally infect him.

For those that made no verbal effort to inquire about their partner’s STI and HIV status in this study, silence meant that they were negative and disease free, often referred to as “clean.” Only about half of the men regularly engaged their sex partners in a conversation about HIV status and STIs before engaging in anal intercourse; less than five asked about their partner’s HIV status before receiving or giving oral sex. Adam describes the scenario:

Interviewer: Did you ask them about their HIV status?

Adam: No.

I: Did they ever ask you, or did it ever somehow come up?

A: I don’t know that it really did, no. No.

Six men asked the man in which they were about to engage in anal or oral sexual intercourse with if they were “clean.” Sex partners can inadvertently interpret the term “clean” differently. For example, if the respondent used the term, I asked him to clarify what he meant by “clean,” a question for which the answers were quite inconsistent. None of the respondents mentioned HIV status in their list of what would constitute being not “clean.” By asking a sex partner if he was “clean,” the respondent intended to inquire about HIV status and STIs, when many of the same men who asked the question interpreted the term “clean” themselves to refer to STIs and not HIV status.⁷ Thus, the words “clean” and “HIV negative” were not synonymous; these terms were ambiguous and the potential for misinterpretation among these men was high.

Some respondents enlisted the help of Internet dating services to find sex partners, as well as romantic partners. Many of these websites allowed users to indicate whether they are HIV positive, HIV negative, and some allow the user to indicate that they do not know their status in their profiles. Those searching for romantic partners or for sexual intercourse without commitment (i.e., a “hook up”) can search for partners by their self-reported HIV status; in other words, an individual can filter out HIV positive individuals. All except two interviewees—Bill, an intentional condom user (cf. Bill, pp. 60-61) who is “terrified” by the idea of becoming positive and Erving, a stepwise user (cf. Erving, pp. 67-68) who strongly disliked using a condom—would not date or engage in sexual behavior with an HIV positive man. Fifteen of the other men who engaged in anal sex

⁷ I asked the interviewee, “When you are seeking sex partners, do you ask what their HIV status is?” If they responded affirmatively, I then asked them how they ask such a question.

claimed that they would continue to be sexually active with a positive person if they were romantically attached, and two regularly engaged in sex with an HIV positive person with the use of a condom. Neither of the two respondents who had not had anal sex explicitly said that they would engage in anal sex with an HIV positive person, even with a condom. Thus, most men are willing to participate in a sexually involved romantic relationship with an HIV positive individual provided they could mitigate the risk by using protection—for them, the romantic value of a relationship outweighs the risks of contracting HIV.

After the termination of a six-month romantic relationship with an HIV positive man, Josh had unprotected anal intercourse with an anonymous partner whose HIV status was unknown; he elucidates why heightened risk in the context of a relationship is reconcilable:

. . . if I get positive from [my ex-boyfriend], I will have gotten positive from someone who I was very careful with . . . [who] I loved, who loved me, and who was very careful with me. Accidents happen. Condoms aren't 100% effective. If I get positive from [my ex-boyfriend], then I'll move on . . . I'll be okay, eventually. You know, I'm sure I'll go through a process or whatever. But I will have gotten it from someone I loved and shared something with. If I get it from this mindless fuck in a back alley of some dirty section of [a city] by some guy who I don't know . . . what will that have done to the times that [my ex-boyfriend] was so careful with me. What would that have done to the representation . . . the memory of [my ex-boyfriend's] kindness and his willingness and his protection of *me*. *I would have thrown that away.*

Thus, for Josh, who viewed the odds of contracting HIV as “real,” the way he contracted the disease mattered. But, his perceptions of living with the disease were not misinformed; he did not take having the disease lightly—but, that getting it accidentally from someone he loved and cared for was worth the risk.

Some men did not talk to their partners about their HIV status or if they had

some other kind of STI. Of those who did, many used words that could easily be misinterpreted and lead to serodiscordant sex, exposing and possibly infecting one of the partners.

Condoms: Patterns of Use and Non Use

Of the 17 men who engaged in anal intercourse, 16 engaged in anal intercourse without the use of a condom at least once, and the majority of the 16 did so at a much higher frequency and with multiple sex partners. Unprotected anal intercourse was commonplace, and yet, all of the men in this study considered themselves to be “condom users.” Of the 16, only one of them used the recommended testing protocol⁸ before stopping the use of condoms. Four of the remaining 15 individuals reported that they were tested for HIV once before engaging in UAI with their partner, but never confirmed the initial negative test result at the recommended three and sixth month intervals. Whether or not an individual knew about the proper procedures for being tested for HIV (so that he could discontinue condom use) varied, but most were unaware, suggesting that, if at any juncture in HIV/AIDS education, the latency period of infection and prolonged condom use are areas that deserve more attention.

For gay men whose initial test results yield false negatives (i.e., the individual is actually HIV positive, but the test result indicates that the individual is HIV negative), unprotected anal sex can be more dangerous than having unprotected anal intercourse

⁸ The CDC and other HIV/AIDS experts typically recommend that individuals who desire to engage in UAI be tested in time intervals: initial testing, a three month, and then a six month follow up confirmation of the initial negative test result, and for individuals who may have been exposed to the virus, another nine and then twelve month confirmation of a negative test result (Atkins 1998).

with a knowingly infected and medicated individual who has an undetectable viral load.⁹ If an HIV positive individual engages in UAI under the assumption that he is HIV negative and does not retest (he continues to have sex assuming that he is HIV negative), the viral load can increase exponentially and increase the likelihood of infecting a sex partner many times over (Camara et al. 2010; Centers for Disease Control and Prevention 2010a; Wohl et al. 2009).

This study demonstrates that gay men engage in unprotected anal sex regularly, contrary to the once supported ironclad “condom code,” that gay men always engaged in safer sex by using a condom. Still, all 17 men who had anal intercourse had used a condom at least some of the time.

Thus, the discussion shifts here to understanding patterns of condom use rather than a black and white definition of condom use and non-use. Many researchers and HIV prevention practitioners disagree with this type of research and categorization of risk management, arguing that HIV is black and white—either an individual is infected or they are not—but condom use is not black and white. Condom use, as Halperin (2007) points out, is variable, and simply because an individual does not use a condom every time he engages in anal sex does not mean that he will become HIV positive. The fact that all 16 of the individuals who had sex without a condom in the present study reported to be HIV negative at the time of the this study demonstrates this case in point. Indeed, many men who have sex with men engage in anal intercourse, some unprotected, and never become infected with HIV.

⁹ A viral load refers to amount of HIV in an individual’s blood. HIV positive individuals with undetectable viral loads are at a dramatically reduced risk of passing on the virus (Fan, Conner, and Villarreal 2007).

Three Types of Condom Users: Intentional, Stepwise, and Occasional

Three distinct patterns of condom use emerged from the interviews. None of the 19 interviewees reported using condoms during oral sex on a regular basis—only one respondent claimed that he had ever used a condom for oral sex, which was at his partner’s request. Therefore, condom use here is discussed in terms of anal sex exclusively. Two of the men in the sample had never engaged in anal sex; therefore only 17 of the men are included in the discussion on patterns of condom use. Additionally, some of the men reported periods of time in which their condom use changed. The numbers in the groups below do not add to 17; some men had as many as three different phases since they first became sexually active. The resulting three types of condom users, to whom I respectively describe as “the intentional user,” the “stepwise user,” and the “occasional user.”

The Intentional User. Some gay men take very seriously the “condom code,” and practice, or at a very minimum, fully intend to engage in only safer sex. Seven of the interviewees described their condom use as “intentional.” Intentional users generally had accurate views of HIV transmission (though one, Bill, had a heightened awareness, even a fear of contracting HIV and STIs). Furthermore, of those men in the study who explained different phases or patterns of condom use in their lifetime, only one of them was an intentional user before he loosened his requirements for wearing a condom. The rest of the men adopted an increasingly strict adherence to using condoms; that is, they may have had a period in which they did not require a condom, but due to a life event of some kind, began to be more consistent in their condom use or requiring their partner to wear protection during intercourse.

Only one individual, Bill, 27, claims to have used a condom every time he engaged in anal intercourse since he first became sexually active. Bill was extremely concerned about contracting HIV or any STI, which prevented him, he says, from having a greater number of sexual partners: “I’m worried about diseases. STDs. . . . I screen very heavily with people I get involved with. I don’t want to catch what anyone else has. And I want to keep track of one relationship.” By screening, Bill is referring to a process that he describes as meeting an individual multiple times (in group or one-on-one settings), inquiring about their sexual history and health status, and inquiring with others about the individual’s reputation. Bill had only four sex partners total, a relatively low number compared to the other men, with three of whom he had anal sex, both penetrative and receptive.

Travis, a 19 year-old gay man, who, for a five year period demonstrated occasional condom use (only when his partners requested it), became an intentional user when he learned of one of his friends becoming HIV positive. Generally problematic, however, is that other men in the study who knew of friends or acquaintances—even sex partners—who were HIV positive or became HIV positive while they have known them, did not always change their condom use or make sexual decisions that lessened their risk of contracting HIV. The men who knew someone who was HIV positive had a better understanding of what everyday life is like for someone who is HIV positive. But, of the 9 men who knew someone who was HIV positive, only two of them, Travis and Josh, changed their condom using behavior. This suggests that simply knowing an individual who is HIV positive may not be an indicator of consistent condom use. Additionally, the strength of the relationship of the interviewee to the infected person may be a factor in

determining how the impact on the interviewee's condom use. Travis claims that the individual that seroconverted was a close friend, whereas the other 7 men described their relationship to an infected person as an acquaintance or a friend they see from time-to-time.

Some intentional condom user types claimed to use condoms all of the time, but when probed, revealed that there had been instances in which they or their partners did not wear protection while engaging in anal sex. Two of the men in this study fit this categorization, Derek, 23, and Isaac, 25, both bisexual men. Isaac describes an instance in which he continued to have sex after he realized his partner's condom broke:

Interviewer: Have you always used a condom?

Isaac: Yep.

Interviewer: So every time you've engaged in anal sex, there's been a condom?

Isaac: [pause] Once not, and once I had a condom break.

Both of these men claim that, in the instances in which they did not use a condom, they were intoxicated. As many researchers have documented, alcohol and substance use decreases the likelihood of condom use and increases risk behaviors generally (Gidycz et al. 2007; Larimer and Lydum 1999). The findings from this research affirm that, in instances where the interviewee was intoxicated, he was more likely to engage in anal sex without a condom.

Sexually active condom users have little control over faulty condoms; and indeed condoms do break. Both Derek and Isaac had instances, as did many others in this study, when a condom broke during anal intercourse. However, in every instance of a broken condom, the user continued to have sex, and either left the broken condom on the penis or removed the condom entirely and inserted the penis with no protection. Isaac explains

that a condom broke when he was the receptive partner: “I mean, he still came [ejaculated] in the condom, but there was cum [semen] down the side of the condom when he pulled out.”

Intentional users typically experienced regret after not using a condom. Both users in this category explained that they felt “bad” after realizing that they had not used a condom: “I felt really bad about it . . . Because . . . because before that I have always used condoms.” Intentional users described their failure, even though it was in isolated incidences, as a personal let down. In a sense, they regretted not using a condom not because they put themselves at risk of contracting HIV or an STI, but because they had always adhered to the “condom code” prior to the incidence of condomless sex. Thus, their lack of condom use was a violation of their personal standards.

Intentional users in this study seem to have internalized condom use as a behavior that they ought to do—that is, wearing a condom is the right thing to do. Thus, describing or attempting to explain sexual encounters in which a condom was not used is difficult because the interviewee did not have an explanation, but felt regret afterward. These two men engaged in sex in an intentionally safe way, however, and even though the condom broke and ultimately the sex act became unsafe, these men did not intend to have unsafe sex, thus, they are still intentional users.

Many gay men who are in long-term committed relationships decide to stop using condoms. Researchers and HIV experts agree that, as long as both partners in a relationship test consistently HIV negative and that have sex with only each other (i.e., monogamy), then there is extremely low risk in contracting HIV or any other STI (Centers for Disease Control and Prevention 2010b). “Consistently testing negative”

refers to testing HIV negative at time intervals—three months after the initial testing, followed by a six month test, and for those who may have been exposed to the virus at some point, testing again at nine and twelve months. After an individual has tested negative for a six or twelve-month period of time, respectively, then experts agree that the individual is HIV negative (Atkins 1998). Of course, prolonged condom use for even six months or longer can be difficult to sustain (Dean 2009; Halperin 2007). Intentional users typically exhibit this ideal type of condom use to maximize the efficacy of condoms in preventing HIV. One of the intentional users in this study never had the opportunity to fail at intentional condom use—that is, he never had a relationship that lasted for six months, so the recommended HIV testing protocol did not apply to his relational status. Therefore, in his situation, he may actually demonstrate condom use patterns more like stepwise users (described below), rather than intentional users.

After being in a monogamous relationship, Ken, 31, and his partner wanted to discontinue condom use. Ken describes how he came to his decision:

[We had been in a relationship for] six or seven months and we had been tested continually through that time because we wanted to be sure. And so, when we were both certain, we were like “okay” let’s do this since we’re being monogamous. So, it wasn’t a problem.

Only two intentional users—Bill, who has used condoms consistently throughout his sexually active lifetime, and Travis who became an intentional user after one of his friends seroconverted—said that they would follow the recommended guidelines for stopping condom use when they desired to not use condoms with a sex partner. Intentional users, who like Ken, are generally educated on the latency periods of the disease, how HIV is transmitted, and how to adequately prevent contracting it, are at extremely low risk of contracting HIV

sexually. Unlike Bill, however, Ken did not express a conscious worry of contracting HIV; that is, his motivation for using condoms was to prevent HIV, but he felt as though he could safely stop using condoms when other conditions were met, namely, being engaged in a monogamous sexual relationship for an extended period of time with an HIV negative partner.

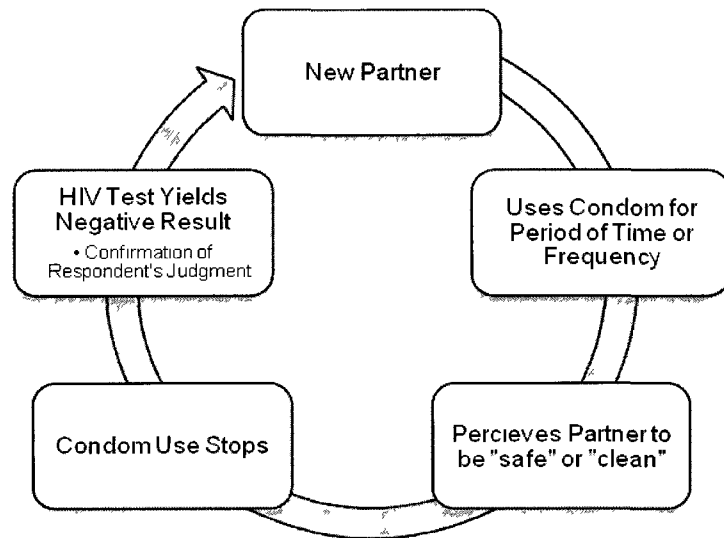
Intentional condom users had highly internalized views that condoms were a condition of having sex, and discontinuing condom use, though a possibility, could only be done after both partners were indisputably HIV negative. Public health messages that promote safer sex have been successful with some men, as these findings demonstrate. Some of these men claim to have learned about safer sex from high school sex education classes, campus educators, or from community health organizations. In two instances, the interviewee says that he witnessed a friend's seroconversion or met someone who was HIV positive, and that experience brought to mind the former lessons of sexual safety.

The Stepwise User. “[With] total strangers, I was somewhat decent about using protection. But with people I had been with once or twice before, you know, you use protection the first time, and then after that, it doesn't count, you know” (Adam, 29). Perception of safety is key to understanding decision-making behavior surrounding stepwise condom use. Ten of the 19 interviewees described condom use patterns that I describe as stepwise condom use. Stepwise condom users use condoms during anal intercourse for a certain number of sexual encounters or a certain period of time with the same partner and then stop using them after they perceive their partner to be “safe” or “clean”—that is, that they perceive their partner to be HIV negative and to not have any

STIs. After a stepwise condom user perceives his risk of contracting HIV or other STIs to be low, he discontinues wearing a condom or requiring his partner to wear a condom.

Stepwise condom use behavior is illustrated in Figure 1.

Figure 1. Stepwise Condom Use Behavior



Stepwise condom use can be viewed as a form of serosorting. In many instances, the men discussed their HIV status, testing habits, and previous sexual encounters with each other, and if they perceived their partner to be low risk, they discontinued using condoms; low risk typically meant that the interviewee perceived his partner to have relatively few sex partners, to have used condoms in the past, to have never gotten an STI (i.e., is “clean”), and that he tested HIV negative at some point. Leo, a 25 year-old gay man with multiple sex partners describes the pattern of his condom use:

Interviewer: Did you typically use condoms; did you typically not?

Leo: I would sort of say it's a mixed bag. Maybe half and half. From the first time, I would be pretty insistent about it, and then as I got more comfortable with someone, I would sort of be more lenient about not using one . . . I think it was more about my level of trust for the person. So, the level of risk that I thought I had.

I: About how many times did you have to have sex with somebody before you would have a certain amount of knowledge or trust or what have you?

L: I can't be sure. Maybe two or three times.

I: In the times that you did use a condom, what sorts of things did they tell [you] or did you perceive that you viewed them as trustworthy or disease free?

L: Well, you know, it was asking them when they had been tested and if they had anything [STIs] before, and then it's, um, sort of my own interpretation of how slutty I think they are, or how risky I think they've been.

And in another instance:

Leo: He knew that I had just gotten tested, um, I made him wear a condom for a while, even though, you know, but before he got tested, we were both having sex without it. He knew that I had been tested from the get go, so he was more okay with me not using one. But I still wanted him to have one on, and then, you know, it eventually just sort of [stopped] . . . I talked to him about his sexual history, and he's only been with like, a handful of partners, not many at all, so I felt like the risk of it all was pretty low and he just came out [of the closet] not too long ago. He's been with a lot more women, I think, probably, you know equal amount of men and women. So, um, with girls I feel there's less of a chance of a guy getting [HIV or an STI] from a girl and I factored all of that into it. And then it's a very brief like, "oh don't worry about [putting on a condom], it's fine," but we never discussed it at length.

Stepwise condom users, like Leo, think that they are mitigating their risk of contracting HIV or other STIs by using their own judgment and perception to rule out sex partners they view as promiscuous (i.e., "skanky") or who might possibly be infected with HIV or an STI. While Leo and several others were diligent to ask about sexual history of their partners, not all of the other stepwise users were. Erving, 29, who reported disliking condoms in general, describes a typical sex encounter:

Erving: [We started having sex] like typical gay guys [do], probably like two dates after meeting each other. Yeah, it was probably within a week, we were having sex.

Interviewer: Did you use a condom then?

E: The first time, yes.

I: But after that, you didn't?

E: Yeah, we didn't.

I: Why? What made you stop?

E: I don't know. I think maybe that we probably thought we were comfortable with each other and um . . . In hindsight, it's stupid. I think what happened was the first time he put a condom on me and I think it was like, the world's tightest condom. I couldn't even get it up. It was like an instant . . .

I: Buzz kill?

E: He . . . Yeah, it was really like the world's tightest condom! He actually ripped it off, actually, and then we started to have sex. And then, um, I don't think a condom was used again.

As it did with Erving, sometimes the lack of functionality of a condom interfered or was the reason why the respondent discontinued condom use (e.g. "I think it was like, the world's tightest condom. I couldn't even get it up."). For stepwise users, initial condom use is a way to judge the level of risk of their partners, as well as to portray himself as a "safe partner." That is, if the partner wears a condom, the respondent assumed that he had worn a condom in all previous circumstances and that he was "safe." Their assessment of safety is a way to discontinue condom use quite early in a sexual relationship and mitigate their risk, perceived or actual, during sexual encounters.

Frequent unprotected anal intercourse with multiple partners is the most risky type of sex. Therefore, stepwise condom use *does* have the potential to reduce the possibility of infection of HIV or other STIs; of those I identified as stepwise users in this study who were tested for HIV at the time of this study, none were HIV positive. Still, stepwise condom use behavior leaves the sexually active individual at a substantial risk of contracting HIV and STIs because the participants rely on their own perceptions of what an infected person might look like or how many sex partners are required for an individual to become HIV positive.

Josh, a 23 year-old bisexual man, explained his stepwise condom use behavior with multiple sex partners. Relatively recently in his sexual history, a man who Josh was in a

relationship with learned that he was HIV positive. Josh's partner suspected that he might be HIV positive when they met (which he did not disclose to Josh), so he insisted on using condoms during anal sex, even though Josh wanted to stop using protection. Unaware of his partner's HIV status, Josh recalled an incident in which he continued to have sex with his partner even though he knew the condom had broke and he subsequently removed it entirely before ejaculating in his partner. After his partner was confirmed as being HIV positive, the two men continued to have anal and oral sex, but mitigated the risk by using condoms all of the time; Josh explains the progression to consistent condom use:

So, I found out [that he was positive]. It did change things. From that point forward, I no longer swallowed, he . . . it's so weird, because my perception of safety . . . I compromise it all the time. I don't think I do it intelligently. But, in the heat of the moment, 'why the hell not?', kind of thing.

Josh described this situation as one that "change[d] things" which he later explained, in terms of his perception of susceptibility of contracting HIV, made it a very real possibility, more than a "slight possibility."

Like Josh, many of the occasional condom users and stepwise users changed the their behavior after finding out that a friend or acquaintance had become HIV positive or they had personally gotten an STI. Erving describes a recent encounter with a benign STI:

Erving: Well, to get to it, I think that, the past year or two, [Erving's boyfriend] and I really calmed down with the playing [with outside partners], realizing that we don't want to go through any heartache or . . . riskiness.

Interviewer: Riskiness, in terms of what?

E: Getting something . . . Um. Getting something. And going through that, horrible whatever. We actually played around with someone, a while ago, um, like a week or so later, [Erving's boyfriend] had some kind of crabs,

and I think that was kind of an eye opener. Um. Even though it was just crabs, you can get it from just touching each other. But I think it was a little bit of an eye opener. I mean, there was someone with crabs in our house and they gave it to him.

This incident did not change Erving's condom using habits, but it did change what sex acts he was willing to do with partners who were not his boyfriend; after the incident he described, he said that most of his activity with other men was limited to oral sex ("just oral sex").

Stepwise condom use behavior was exhibited by ten of the men in the present study. Stepwise users, for the most part, got tested regularly for HIV, and to a lesser extent all STIs (i.e., "the full work up"). In fact, 17 of the 19 individuals were tested within the 12 months prior to their interview. As Halperin (2007) suggests, however, an individual will test HIV negative, until they do not (excluding false positive test results, which are extremely rare). In other words, this type of risk management prevents a sexually active person from becoming HIV infected until it fails; it is not an efficacious form of HIV prevention. Thus, it seems that, for the men who engage in stepwise condom use behavior, testing negative for HIV and other STIs *reinforces* their perceived ability to distinguish a "safe" partner from one who is not—from a partner who is HIV positive and one who is HIV negative. In short, an HIV negative test result promotes the somewhat risky sex behavior by affirming the stepwise user's ability to discern between a safe person and an unsafe one. Don, a 39 year-old gay man and stepwise condom user describes going to get tested: "It's not a big deal anymore. Really. Um. It was . . . I just go in and do both the HIV and STD screening. It's really . . . I've done it so many times that I, I don't get nervous about it. It's not stressful waiting there. It is what it is." Other stepwise condom users expressed similar experiences of going to get tested. Other types

of condom users typically expressed anxiety over getting tested for HIV.

The Occasional User. Four men's condom use patterns were somewhat erratic at one point in their sexual history and one, though sexually active, has never used a condom. There is little reason or logic behind the decision to use a condom or to not use a condom for the occasional user type. Of note, at the time of the respective interviews, all four men's current condom use behavior could no longer be categorized as "occasional." In many instances, occasional users deferred to their partners condom use preference; in other situations, the occasional users chose not to use condoms because there were none immediately available, and still in others, condoms were readily at hand, but the individual did not have an explanation for not using a condom:

Josh: I had a fuck in the street . . . it was literally an alley about two weeks after [a break up]. . . . [We] just fucked in this corner. And that's what it was, nothing more than that. You know, I mean.

I: Did you wear protection that time?

J: No. No! Oral and anal and no protection. And the condoms were in my bag.

I. How come you didn't use them?

J: I couldn't tell you. I couldn't tell you. It had nothing to do with my level of sobriety.

I: Did you think about using them?

J. Yeah . . . All I know is that . . . that like, we're making out and then all of a sudden I'm liking leaning up against this all and he's like playing from behind. That's one thing, and then he was in me. And . . . at that point, huh . . . [he pauses to compose himself] . . . I . . . shoulda coulda woulda. . . . I mean, feasibly, he could have gotten off inside of me. I didn't see any result [any semen]. And then I topped [penetrated him]; I didn't get off [ejaculate]. I didn't talk to him again.

Travis, who became an ironclad user when he found out his friend was HIV positive, recounts his sexual encounters as an occasional condom user:

Interviewer. When you did use a condom in that situation, were you usually the person who had the condom or were they?

Travis: I always have one [now] Sometimes I had one [then], but sometimes Whether I used it or not is a different story.

Occasional condom use can often occur because one or both (or more) of the partners are intoxicated or under the influence of some kind of drug. As Josh mentions above, it had nothing to do with his “sobriety level,” but some of the other occasional users summed their occasional condom use up to being “drunk.” Russ, a 23 year-old bisexual man, now a stepwise user, says that the only “sober sex” he has ever had is with his current boyfriend. He says that he regularly engaged in sexual intercourse with another man without the use of a condom while meeting other men and women for sex during the same time period; he claims that his long term sex partner was also engaging in sex with other men without the use of a condom during this period of time. Russ describes his condom use while intoxicated:

Interviewer: You hooked up with the same guy in college a couple of times, did you use condoms then?

Russ: I don’t think so. Probably not.

I: What about, in other hook ups, when you said you were really drunk?

R: Both of those times I did [use condoms].

This sporadic type of condom use is the most difficult for HIV prevention practitioners to target because, aside from the fact that occasional users are often aware of the dangers of UAI (e.g., Josh’s sexual encounter, described above), there is little or no logic or misunderstanding to dispel for this type of user. In this sample, most men realized that they were putting themselves at an elevated risk of becoming infected with HIV or another STI and changed their pattern of condom use to one that they perceived as safer: three out of these four men are currently stepwise users, and one, Travis, is now an intentional user.

Occasional users are different from intentional users because their lack of condom

use is not isolated to one or two incidences, but characterized by intermittent condom use. A condom, for an occasional user, is not a requirement for the sexual act. In several sexual encounters that Travis, Adam, and Erving described, respectively, they only wore a condom or were penetrated by their partner using a condom when the partner requested it or provided the protection. However, an occasional users are not individuals who “bareback”—while the requirement to wear a condom was inconsistent among these users, none of them sought out sex without the use of the a condom. That is, they neither intended to have safe sex, or unsafe sex. Barebacking requires that the individuals in the sex act require that condoms *not* be used. Thus, among occasional users in this study, none of them were anti-condom.

Only one interviewee (Zach) claimed to have never used a condom in his sexually active lifetime of six or more years. He perceived his risk of contracting HIV to be extremely low because he engaged in sex with only one partner total. And, by present standards for evaluating HIV susceptibility, this man’s perceptions were realistic. I characterize this man as an occasional user primarily because the reasons he never used a condom were circumstantial—that he was in a committed relationship with another man from a young age. Should Zach have had more sex partners for whom he did not use a condom, he conceded that it is likely they would use condoms, placing him in either the stepwise category or the intentional user type.

Again, Zach’s behavior is not barebacking. While many of the men in the present study preferred anal sex without a condom, none of them deliberately sought out sex partners with the intent of having unprotected intercourse. Condom non-use, whatever the

motivation, however, does put sexually active gay men at a higher risk than abstinent or condom-using counterparts.

Transitioning Patterns of Condom Use. Many men who reported having anal sex demonstrated different patterns of condom use at different periods in their sexually active lifetime. Five of the 17 men transitioned at some point from one type of condom use behavior to another, and some of them transitioned to a different type of behavior more than once. The type of condom use pattern in which I categorized an individual stemmed from the *modal* sort of condom use pattern that an individual described during a sexually active period in their lifetime. Respondents may have had isolated incidents that were atypical and could not be characterized by their condom-use type.

Perspectives on Lovemaking and Condomless Sex

Sex, as the men in the sample explained, can be an act of pure physical pleasure, and it can also be an emotional act that demonstrates one's commitment and devotion to the other person—a form of sex some of the men referred to as “lovemaking.” All of the men acknowledged, to varying degrees, that sex is an act of physical pleasure, but not all of the men described sex as “lovemaking.” The latter form of sex occurs between two persons who are typically in a committed relationship of some kind. Four of the men in this sample said that they engaged in sex with men outside of their committed relationships (i.e., they had an open relationship with their respective partners), but the sex they had outside of the relationship was never lovemaking; lovemaking was reserved for intimate settings, not for “hook ups.”

For men who desired to engage in lovemaking, a condom posed problems because it represented the carnal form of sex, the type that does not require any form of

commitment between the participants. Additionally, condomless sex is often viewed as a symbol of trust (Dean 2009). One of the “rules” of engaging in condomless sex is that the partners remain monogamous to each other; that is, there is no extra-relational sex. Thus, when two men agree to stop using condoms, it is often a significant symbolic step of progression in a relationship. Five of the men, four stepwise condom users and one protocol user, spoke of condomless sex as a symbol that the relationship was moving forward. For them, stopping using condoms had two advantages; aside from the symbolic aspect, the stepwise users all preferred anal sex (especially when they were the insertive partner) without a condom. Not using a condom was a sign of commitment and trust in their respective relationships. Josh explained:

Josh: With a condom, it’s like “well, there’s a tube, where are we going to put it?” [laughter] That’s how it is. But without it a condom, there’s more humanity in it. I’m not sure I think of [sex] in that term every time.

Interviewer: What do you mean by humanity?

Josh: I mean, like, this is a part of this person . . . it’s not . . . it’s not . . . *it’s his penis! I can see his penis, I can feel his skin, I can feel the way it . . . the way it is!* It’s not a piece of rubber and I’m not sticking another dildo up my ass. That’s where the humanity is.

Like Josh, Leo is also a stepwise condom user who reported that condoms were barriers to intimacy. For him, the act of putting on a condom “[is] unnatural . . . in a way. You know, it’s weird that you put that thing on.” Leo went on to explain that sex with a condom is less pleasurable not just physically, but emotionally as well. Using a condom, for Leo and those who demonstrated similar patterns of condom use, unfairly eliminated the possibility of having a form of sex that was more pleasurable than protected sex.

Condoms took on dual meanings for many sexually active men in this study, particularly for stepwise condom users. Because multiple sex encounters are a part of stepwise users, stepwise users’ experiences typically stop using condoms when they have

had sex with the same partner on multiple occasions. Condoms, for these men, served as practical protection against contracting HIV and other sexually transmitted infections, but they also symbolized sex without commitment. Having sex without using a condom, then, was a sign of commitment. For stepwise condom users, however, this behavior, because it does not involve *repeated* HIV testing¹⁰ in which the result is seronegative, reduces to a form of unsafe sex that carries heightened risk of HIV transmission. To the individual who engages in this kind of serosorting and decision-making, it appears or occurs to him that he is having safer sex, when in fact he is not. And because he views himself to be at little or no risk, it is unlikely that he will sustain his HIV testing practices as he had when he was not in a committed relationship.

The Influence of Peer Networks on Condom Use

Peer groups are highly influential in individual decision-making (Durkheim 1984; Evans and Lambert 2008). Gay and bisexual men whose peer groups discussed openly their sex lives and condom use were more likely to use condoms themselves. The opposite is also true: when a participant's peer group did not discuss sex or condom use, the individual was more likely to not use condoms. Thus, for some interviewee's peer groups, condom use was the norm, for others, condom use may or may not have been the norm, but because it was not a topic of discussion, the interviewee felt no peer pressure to use a condom. Leo, always a stepwise user, describes hearing about condom use in his peer group:

Leo: I think I would be more affected if I heard someone say they didn't

¹⁰ The stepwise condom user typically tests for HIV status just before or after deciding to not use condoms during anal sex with his partner. To be certain that an individual is actually HIV negative, he must test negative over the course of six months (cf. stepwise condom users, p. 70).

use condoms. I think that would sort of justify it to me a little bit more. I feel like it's the default, the default is that they would [wear condoms] most of the time.

Interviewer: . . . you've overheard or been told that friends aren't using condoms?

L: Yeah. It only makes me . . . Reassures me somewhat . . .

I: That they didn't use condoms and they are okay?

L: Yeah. So I'm not feeling like the idiot.

If condom use was the norm within a particular group, then an individual who did not use condoms had to lie or deceive his peers so as to not violate the group's folkway of condom adherence. Adam, a once occasional condom user and now a stepwise user, describes how he deceived his peer group about his condom use to avoid being chastised:

Interviewer: So if you went back to your group of friends and . . . told them that you didn't use a condom, what happened?

Adam: I lied.

I: You lied?

A: I lied, or I would have lied . . . It was a social norm to wear a condom, yes.

In addition to discussion on condom use, discussing the reality of contracting HIV also affected the individual's and peer group's sexual behavior. When some individual heard of a friend becoming HIV positive, or met an individual who was positive, the incident often led to the group discussing HIV in the context of their own sexual behavior, and ultimately changing their condom use behavior. Perhaps one of the most striking incidents of pattern changes in condom use occurred when Travis' friend found out that he was HIV positive:

Interviewer: Does HIV ever come up in your conversations?

Travis: It did at the time. I wear a condom and don't sleep around as much.

I: Do you talk about safe sex?

T: Well [my friends and I] have the same friend in common who is HIV positive. So I think we all know we're on the same page. But [condom use is] not something that we've ever talked about.

I: And so [using condoms is] just sort of something that's an unwritten

rule?

T: Yeah.

Travis described his friend's seroconversion as an event that heightened awareness of HIV infection for him and his peer group; it made him, and those with whom he associated, talk about the possibility of contracting HIV, pregnancy, and consequences of having frequent, unprotected sex with anonymous or semi-anonymous partners.

Several of the men reported that sex was frequently discussed in their peer groups, for many in the form of innuendo, and others made jokes about it; however, except in the rare incidence like the one Travis described above, the men did not seriously discuss sex among their group of friends. Moreover, it was atypical to discuss *safer* sex and contracting HIV was discussed even less. Some reported joking about STIs; Zach claims that he and his peers often joke about Chlamydia and gonorrhea: "You know you have a rash on your dick [penis] or like you have juice coming out of you. That's funny." Typically, however, when the respondent's peer group consisted of males and females—and all 19 men reported having close male and female, gay and straight friends—the topic of pregnancy and birth control was discussed more frequently. Zach explains, "Girls only worry about having babies, not STDs."

Nearly every participant in this study engaged in unprotected anal sex at some point in his sexually active lifetime. And because peer groups have the ability to influence individual behaviors, it stands to reason that if condom use and HIV prevention were more talked about, perhaps consistent condom use would become the norm.

Finally, all 19 men claimed to have encountered some kind of HIV prevention material, such as posters promoting condom use. Fourteen of the men said that they would not read posters or electronic ads, and the other five said that, even though they

would read it, social marketing campaigns do not directly impact their condom use. Nonetheless, 17 of the men reported that, if such material were in bars or places where they go to associate with their friends, the topic of the poster (e.g., HIV prevention, condom use, pregnancy prevention, inter-personal violence) would likely be a part of their conversation. Thus, social marketing material does have the ability to indirectly benefit men who engage in sex with other men because the marketing makes HIV and condom use a point of conversation, and peer expectations (i.e., folkways) become known to everyone in the group. Leo claims: “Just talking about [HIV]. It makes you recap and think about, you know, all the times that you could have gotten something. It really makes you think of situations now. I guess just talking about HIV. People don’t talk about HIV.” By distributing propaganda that promotes risk reduction of HIV, such as pro-condom material, personal habits surrounding condom use and HIV susceptibility would likely be discussed.

This chapter described the three groups and 19 interview participants, and discussed how gay men talk about sex in group settings. I also discussed condom use and introduced three types of condom users: the intentional user, the stepwise user, and the occasional user. I reported on how gay men perceive HIV and their susceptibility to getting HIV, and their views on condom use and the meaning of using a condom. Gay men in this study perceived HIV to be a disease that would negatively impact their life and well-being, despite their understanding that individuals can live full lives with the virus. Finally, I explained the influence of peer groups safer sex habits and how they affect individual behavior; when peer groups establish condom use as the norm, individual behavior is more likely to reflect the behavior promoted and expected by his

peers. The next chapter, a discussion on gay men's condom use and the meanings behind their using or not using condoms, elaborates on these results and how they might impact HIV prevention efforts in the future.

CHAPTER V

DISCUSSION: WHY GAY MEN STOP USING CONDOMS

This final chapter includes three parts. The first objective is to provide a discussion of the most important findings from this thesis, specifically that, the findings regarding patterns of condom use (i.e., the three condom user-types) deserve further exploration in survey driven research project. Additionally, I discuss the implications of these findings, especially if substantiated in a quantitative way, and how they may impact targeted efforts on behalf of the public health sector to reduce the incidence of HIV. Finally, I detail the limitations of the study and suggestions for improving upon this exploratory study.

Of the 17 men who reported having anal intercourse with another male since they first became sexually active, all of them identified as condom users. Nonetheless, sixteen elaborated that there had been occasions, partners, or periods of time when they deliberately or accidentally did not use condoms. The findings from this study concur with recent research that demonstrates widespread condom non-use among gay men (Dean and Hayes 2004; Jacobs et al. 2010). Yet, if simply asked, “Do you use condoms when you have anal sex?” all of the men in this sample would say yes without qualification—despite that 16 of the 17 who engaged in anal intercourse did so without the use of a condom at least once. In a group of men that has institutionally pronounced the dangers of HIV well, there are sometimes specific, deliberate reasons why gay men discontinue condom use during anal sex.

As Halperin (2007) points out, not all condomless sex is unsafe sex. Indeed, nearly all of the men who were sexually active in this study took measures to assess their risk and respond as they saw appropriate. Sometimes, this response involved wearing a condom, not engaging in a specific sort of sex act, or ejaculating outside of the receptive partner's mouth or anus. Gay men who engaged in stepwise condom use, which is not discussed in other safer sex literature to date, attempted to reduce their level of risk for acquiring an STI or HIV by assessing their partners' condom use behavior. That is, if their partner used a condom, they believed him to be "clean" (HIV-negative and STI free), and then discontinued condom use because the partner was perceived to be "safe."

Stepwise condom use does not follow any institutionalized safer sex protocols, and those who engage in this type of behavior are indeed at more risk of contracting HIV than those who do follow safer sex guidelines. However, this method of risk management has been effective in sustaining a seronegative status for the ten stepwise condom users in this sample; all of them reported being HIV-negative at the time of this study. While this type of behavior is not fail proof for preventing disease transmission, this type of condom non-use is far different than the picture public health practitioners and HIV/AIDS organizations portray in social marketing campaigns: that of hasty, "in-the-moment" unprotected sex that takes place in dark corners of raves between two consenting, anonymous partners. These spontaneous sex acts do occur, but focusing solely on them neglects a calculated, intentional sexual reality that is different for many gay men. These stepwise condom users are having unprotected anal sex in the context of their romantic relationships, with partners they believe to know well and to be disease free, placing themselves at a measured risk.

Some researchers and HIV/AIDS experts caution against research that seeks to understand condom non-use among gay men, claiming that results from these studies are largely “specious” (Halperin 2007). Results from this exploratory study seem to indicate otherwise: even though not all gay men’s sexual behavior could be categorized (cf. the occasional condom user, p. 71-73), three distinct patterns did emerge from these 19 interviews, demonstrating that gay men may be choosing to have anal intercourse without wearing a condom for intentional, specific reasons. Not all unprotected anal intercourse, as I have shown here, is had under the auspices of “it feels better” or “it’s more fun.” For many gay men, sexual behavior emerges in patterned meanings and results in patterned behaviors, of which condom use is certainly one. But, as acceptance for non-heterosexual relationships becomes institutionalized and embraced by society and governments—that is, it becomes more socially acceptable to be openly gay and in sexual relationships—these patterns of meanings and behaviors are likely to change. Thus, I agree with Halperin (2007) that these findings are specious to a particular period of time in gay culture that is rapidly changing, but also that these patterns of condom use and motivations surrounding condom use and non-use are likely to be found in other groups of gay men (i.e, the results presented here are likely not unique to this sample). All social science research is constrained to the era from which it was conducted; condom use among gay men is not different, in spite of the fact that, for gay men and women, society is rationalizing and accepting sexual difference rather quickly in comparison to other human and civil rights movements (Riggle and Tadlock 1999). Thus, monitoring the sexual behaviors of sexually active gay men persistently over time is critical to developing HIV prevention campaigns that are effective.

Even though Foucault could not have envisioned what the HIV epidemic would look like in 2011, his theories regarding “the truth of sex” still hold value to understanding why gay men do not use condoms during anal sex. The findings from this research lend support to Butler (1993) and Halperin’s (2007) thesis, which build on Foucauldian conceptions of power-sex-desire, that HIV has been used by public health institutions, as well as governments and broader society, to re-pathologize gay men and to moreover ensure that society continues to view the gay sex act as “dirty” and abhorrent.

Stepwise condom users readily exemplify Foucault’s notions of “regimes of truth” aimed at controlling sex and sexuality. Recall that stepwise users use condoms during the initial sexual encounters with the same partner, and then stop using condoms once they establish that their partner is “clean” and has used condoms in sexual encounters before the present occasion. In most instances, stepwise users discontinued wearing condoms because removing the condom signified trust and commitment, in addition to intensifying the physical pleasure of intercourse.

For Foucault, the threat of HIV/AIDS and the sure death that came after infection made sex all the more pleasurable (Ryan 1993). Ryan notes that AIDS, to Foucault, brought a sense of risk thrill to the table that sex did not have prior to the beginning of the epidemic—sex became a form of “Russian Roulette” (Ryan 1993). The men in this study claimed that they were at low to non-existent risk of contracting HIV because of their ability to decipher safe partners from unsafe partners, the perceived “safe” location in which they lived, and because of their sexual behaviors. Furthermore, the act of condomless sex was never talked about in terms of heightened risk; no one, even when

prompted claimed that condomless sex was more pleasurable because of the “Russian Roulette” that Ryan speaks of when referring to Foucault’s sex life. Condomless sex, for the stepwise users in this study, was about showing affection.

Even though the gay men I interviewed described the physical act of sex to be more animalistic and instinctual than having deep emotional connections, nearly all of them claimed that sex *could* and sometimes *does* have meanings that extend beyond the physical act of penetration or being penetrated (e.g., commitment, trust, love, attachment). Foucault argues, “we should fight against the impoverishment of the relational fabric” (1982b/1994: 158). “We” refers to not just gay men, but all people, and the relational fabric to which he referred involves a multiplicity of relationships and relationship types that are possible (1982b/1994: 158-159). In tandem with Foucault’s notion that power could be used to liberate, not just enslave and regulate (see Foucault “Sex, Power, and the Politics of Identity” 1984/1994), having condomless sex, in a sense, undoes the impoverishment of relationship. In other words, the condom impoverishes gay men of a deeper intimacy. Eliminating the condom, in Foucauldian terms, develops the “ethics of pleasure” (1982a/1994:131) and ultimately intensifies the relationship one has with oneself (and for gay men, his homosexuality), and the relationship he has with his romantic partner.

The willingness of the overwhelming majority (89 percent) of gay men in this study to engage in sex with an HIV positive partner further exemplifies the point that gay men have decided to prioritize the risk of contracting HIV below their “ethics of pleasure” (1982a/1994:131). To gay men, just like to heterosexual people, relationships matter. Josh, the 23-year old who describes his relationship with an HIV positive man (cf.

Josh, p. 57), claims that if he had been infected because of the sex he had with this boyfriend, it would have been justified. Had he become infected in a random sex act, Josh claimed he would feel differently, that he would have thrown away his health and figuratively betrayed his relationship (even though it had ended) with his HIV positive boyfriend. For gay men like Josh, it's not so much that there is additional risk involved when having sex with an HIV positive partner, it's that they continue to have sex and affirm their relational ties *in spite of* HIV. Paralleling Foucault's claim that the intensification and multiplication of pleasure is a way to reroute power and reshape the "truth of sex," gay men are creating a culture in which HIV loses its power to dictate when and how they have sex: "[you] have to use power relations to refer to the situation where you're not doing what you want" (Foucault 1984/1994: 167). Condomless sex, in this case, is about power and changing profoundly changing the way in which power defines the relationships and identities of gay men.

The motivations of the stepwise user for discontinuing condom use must be understood as a compromise between mitigating risk and unleashing feelings toward a romantic partner. The stepwise user is not complacent about HIV, its effects, or his ability to contract it as some experts would suggest (Centers for Disease Control and Prevention 2010a). Rather, the stepwise condom user attempts to lessen his risk of seroconversion by using condoms to gauge his partner's "cleanliness," and then stops using condoms, in small part because it is more pleasurable. He does so in larger part because stopping condom use signifies that he is serious, committed, and has feelings of affection toward his partner.

Understanding why gay men have unprotected sex in their relationships (e.g., the stepwise user) must be done from a long trajectory of sexual history and the discourse on gay men, much in the same fashion by which Foucault (1978) traced the history of sex to its antiquarian definitions. The homosexual, once an object to be treated, censored or ignored (1978: 83-85), changed power, or at a minimum, began to shift this power in his favor by *being homosexual*, by forming relationships with men of the same sex during the sexual liberation movement of the 1960s and 1970s.

By using HIV to re-pathologize being gay and sexual acts between two men, the institutions who used power to censor, prohibit, or ignore sexuality since the beginning of the 18th century again attempted to restore their power relations with gay men. Public health offered the condom as a remedy to HIV, but the condom is a barrier, not only to seminal fluid that may transmit HIV, but also to intensified pleasure, and to forming intimate relationships. In short, the condom is a barrier to being fully gay—it stands symbolically and literally as a barrier to the full realization of full-identity. Condomless sex is an act by which gay men become fully gay and invest fully into relationship, incorporating the “ethics of pleasure” Foucault prescribed.

Thus, in the long arc of our anthropological history, HIV/AIDS and the condom are prohibitionists, censors, and the ignoramus of the modern time. For those who deliberately engage in sex without the use of a condom, they are rejecting HIV and condoms as a form of social control.

Exploring the motivations for why gay men have unprotected sex is not only possible, it is critical to finding a way to reduce HIV incidence without continuing to subjectify gay men. If public health officials want gay men to wear condoms, then they

must first understand why they do not use them—and the answer to that conundrum is far more complex than an additive equation that sums to increased physical pleasure. Social marketing research has demonstrated on numerous occasions that effective behavioral interventions target specific populations and specific behaviors achieve the best results (i.e., are most efficacious in changing or promoting a behavior). Understanding *how* gay men are putting themselves at risk for HIV and other STIs is essential for creating effective HIV prevention campaigns. Prevention efforts that are built around the image of Laud Humphrey's (1975) Tea Room Trade have no effect on gay men who live their lives openly. A great deal more of gay men have come out of the closet and out of the roadside restroom than they did in the 1960s and 1970s, and HIV prevention efforts must do the same. In other words, *HIV prevention efforts must stop treating gay sex as pathological and underground to be effective.*

New forms of HIV risk may not be in anonymous sexual encounters but may be in new relationships formed from two men who are openly gay and who stop using condoms not because they want to contract HIV, but as a sign of increased trust and commitment. Condoms seem to have taken on dual purposes for the ten stepwise users in this study: condoms served to protect the sexually active individual while they assessed their safety with a new partner, but once a desired level of trust had been established, the *not* wearing a condom was a step forward in their relationship. For stepwise condom users, discontinuing use of condoms for anal sex is viewed as a sign that a relationship is serious—that the two men are committed to each other. When I asked Rand, a 24-year-old gay man, if his relationship with his newly acquired boyfriend of six weeks was serious, he replied, “I guess so. I mean, we stopped using condoms.” Another man in a

committed relationship indicated that he would become suspicious that his partner was having sex outside of their relationship if his partner insisted on using a condom after the first month or two of their relationship. Just as a wedding ring is an outward symbol of commitment to a spouse, condomless sex may be an intimate sign between two men of commitment to each other.

The time at which gay men decide to turn a casual relationship into a serious, committed one and the latency period of HIV, unfortunately, do not coincide, putting both individuals at an increased level of risk. Safer sex practitioners and HIV prevention campaigns ought to focus on reframing condoms and condom use; that is, undoing the view that not wearing a condom is a way of advancing a relationship.

Halperin (2007: 18) suggests that gay men have done a relatively good job at sustaining a “safe sex culture” over an extended period of time. While it may be a product of the young age of the men in this sample,¹¹ I agree; I found no evidence of condom fatigue or complacency among the men I interviewed. While many public health experts have exhorted the success of the condom code in gay culture generally, it can be said that sustaining safer sex practices on a personal level, that is, in individual relationships, is more difficult and gay men do not sustain condom use for the required six months of HIV testing (with negative results each time). That gay culture has promoted an atmosphere that strongly promotes condom use is a major success in the war against HIV/AIDS, but the results from this study show that the war has changed as young gay men’s sexual behavior has changed. The battle is no longer in promoting

¹¹ Gay men aged 40 are more likely than their younger peers to have witnessed or felt the devastating effects of AIDS in the 1980s and early 1990s. A discussion of how age may affect condom use, see chapter two.

condom use to the masses, but in sustaining condom use over time—at least long enough for latency periods of infection to pass—even in newly formed committed relationships, without subjugating gay men or dehumanizing gay sex as an act performed purely for physical pleasure.

Limitations and Suggestions for Further Study

The greatest limitation of the present study is that the sample from this study was quite homogenous. Save for one, all the men were Caucasian. Ages ranged from 19 to 39, which excludes older generations that are experiencing some of the greatest HIV incidence rate increases (Centers for Disease Control and Prevention 2011). Furthermore, all of the men came from economically stable backgrounds; all were employed and had homes. Gay men who are homeless, especially youth, are at higher risk of contracting HIV and other STIs than those who are not homeless (Rew et al. 2005). Men in the sample resided in the same geographic area as well. The gay culture of the area in New England where this sample was obtained is likely to be different in terms of “hook up culture” than the gay meccas of Montreal, Quebec, or Fort Lauderdale, Florida (see Kurtz and Inciardi 2003 for a description of gay culture in gay resort destinations). Several of the men in the sample made a comment that they felt risk was substantially lower in the area where they lived than in other places, which was a factor in their decision to discontinue condom use with their partner.

Another limitation was the respondent’s memory. With each interviewee, I asked them to recount sexual episodes and relationships that were sometimes years past. Many of the men vividly recalled details and their feelings while others were not able to recall specific details as easily. Drawing a more diverse sample, and a larger sample, may allow

future research to limit the conversation to a specific time period, such as two years prior to the interview to ensure that their data is valid and reliable.

Many gay men, including 13 of the 19 interviewees in this study, use the Internet as a method for finding sex and romantic partners. A great deal of knowledge could be gleaned from a content analysis of these web sites regarding the sexual identity and behavior of the participants. Because of their mostly anonymous nature, dating websites provide a medium by which gay men may seek out and engage in sexual practices that they would otherwise not. And because many gay men use the dating web sites to find sex partners, not including this step could produce an incomplete picture of dating and sexual behavior in gay culture.

Future studies that attempt to identify patterns of condom use behavior and the meanings and motivations regarding the use or non-use of condoms should focus on multiple areas that are known to be culturally different. Additionally, researchers should apply a similar research model that was used here to address sexual risk management of gay men who are aged over 40. This population is more difficult to target, but, as HIV incidence reports demonstrate, is essential to reducing incidence and prevalence of HIV in the population overall. Finally, researchers ought to recruit more minority MSM for a study like this one; the “down-low”¹² phenomenon among African-American men has the potential to produce results radically different than those presented in this volume.

Replicating this study in populations *unlike* the one used in this study will provide more

¹² The “down-low” phenomenon refers to men who have sex with men but who are not openly gay, and who are often in committed heterosexual relationships. This phenomenon was found to be more prevalent among African American males than their white counterparts, largely because researchers believe that the stigma of homosexuality among minorities is greater than among white men (Lichtenstein 2004).

nuance in behaviors of gay men for HIV prevention specialists. Thus, in a phenomenological sense, as HIV prevention researchers identify patterns of condom use among different types of gay men living in different places, public health officials will be able to create and promote more effective and specialized forms of social marketing aimed at reducing HIV incidence.

Conclusion

HIV/AIDS has reshaped and sometimes devastated populations of gay men for 30 years. After such a prolonged epidemic, now turned pandemic, researchers, health practitioners, and those who are at some level of risk of contracting HIV may pause to ask: “Is the glass half full or half empty? Has our fight been for naught?” For a period of time, an HIV diagnosis promised a prognosis of imminent death; now, infected persons are predicted to live well into their senior years and are likely to die from causes not related to HIV/AIDS. In fact, prevalence data shows that two-thirds of gay men will die HIV-negative (Centers for Disease Control and Prevention 2006a; Halperin 2007; Sullivan and Wolitski 2008: 220-247). If infection rates continued to trend as they did in the late 1980s and early 1990s, nearly all gay men would become infected with HIV at some point in their lifetime. And while HIV rates are still rising among men who have sex with men (Centers for Disease Control and Prevention 2011), the rate has been greatly curbed since the early years of the epidemic. Therefore, the glass is half full, with many great opportunities to reduce infection in our midst. Those methods are likely be social interventions—HIV has proven to be one of the most difficult viruses to contain and eradicate in modern virology.

For gay men, methods of reducing HIV incidence must not divorce the physical act of sex with the dual meaning of caring and trust and of realizing a fully gay identity. The success of future of HIV prevention lies in the balance of treating and talking about gay sexuality and gay sex as “normal”; it must not pathologize desires or reduce relationships to pure physical acts of pleasure, but approach them in a way that does not subjectify—in a way that uses power to affirm their relationships and desires.

NOTES

Explanation of Measurement of HIV/AIDS Incidence and Prevalence in the U.S.

Until 2008, HIV infections were reported in only thirty-four of the fifty states, Washington, D.C., and the five US dependent areas using a confidential, mandatory name-based tracking technique. In 2008, federal legislation required that all fifty states and five dependent areas report HIV incidence and prevalence using the name-based reporting technique. However, because there is no longitudinal data on states that did not previously report before 2009, research on trends stem from the 40 states that reported before 2009 (Centers for Disease Control and Prevention 2011; Hall et al. 2008). The data here reflect 40 states and the five dependent areas of the United States; data from the remaining ten states will not be available 2014 for the annual year 2012.

Tracking HIV incidence is difficult because many infected individuals do not know that they are infected with the virus, a period of time referred to as a latency period. HIV is relatively symptom free in its early stages—some experience Acute HIV Infection (AHI)—a period of time when the newly infected person may have flu-like symptoms; the virus is also highly transmissible during at this stage (Remien et al. 2009). Thus, an individual who was diagnosed with HIV in 2008 may have actually become infected in a year prior to 2008; actual incidence rates are adjusted to reflect these latent infections. In the meantime, the CDC uses a statistical estimation technique to determine HIV incidence and rates in the U.S and dependent areas (Hall et al. 2008).

Despite the difficulty of measuring HIV incidence, researchers agree that HIV infection rates among men who have sex with men have been steadily increasing since

2006 in the United States. The CDC predicts that there were about 42,793 adults were infected in 2009, a rate of 17.4 per 100,000. In the 40 states, District of Columbia, and dependent areas that report existing cases and new infections to the CDC, 2007 saw a marked increase in HIV infections (Centers for Disease Control and Prevention 2011). Men who have sex with men comprise the greatest number of new infections consistently throughout the history of the HIV/AIDS epidemic (Centers for Disease Control and Prevention 2010; 2009; Fan, Conner, and Villarreal 2007).

Appendix A: Interview for Thesis: Script/Questions

Hi. Thanks for meeting with me; I appreciate your time. This shouldn't take more than an hour. I'm a master's student at the University of New Hampshire. I plan on pursuing my doctorate there as well. This research will help me accomplish those goals, as well as provide information that will further our knowledge of sexual behavior and risk in gay men.

I'm seeking to know about your perceptions of HIV and some of your sexual behaviors. There are some very personal questions, as well as some that might be easier to answer. Let's start by having you tell me a little bit about yourself?

- How old are you?
- Where were you raised? (Can you describe the place you grew up in? Was it rural or in the city? Did you live with you biological parents? How many brothers and sisters did you have? Was your family religious?)
- Are you employed? Where? How long have you had that job?
- When did you realize that you were gay? When did you come out?
 - How did the people around you react to your coming out?
- When did you first become sexually active, either with a man or a woman?
 - [If woman]: When did you first engage in sexual behavior with men?
 - What did you do? Where did you meet that partner?
- How did you meet your first male sex partner?
- In your life, roughly, how many sex partners do you think you've had?
- In the past year, how many sex partners have you had?
 - Typically, what kind of sex acts do you engage in when you meet someone to have sex for the first time?
 - Has this been true for you, or has your willingness to do more (or less) changed over time? Why?
- How do you meet men to have sex with? Has this changed over time? Why?
- When you are seeking sex partners, do you ask what their HIV status is?
 - Does this affect whether or not you will hook up with them? Why?
 - Does this affect what sexual acts you will have with them? How?
- Do you know your HIV status? What is it?
- The term "sex" is a bit more ambiguous with gay people than it is with straight people. What does sex mean, physically, to you?
- Outside of the physical act of sex, what does it mean to you?
- Tell me about HIV and AIDS. How do you perceive the disease?
- Do you know anyone infected with HIV? How is their health? What do you know about their health and how their life has been affected?
- When you found out they had HIV/AIDS, how did that affect you? How did that knowledge affect your own sexual behavior?
- [seronegative subjects] Do you get tested for HIV? How often? Why do you get tested? (In other words, why is it important for you to get tested?)

- [non-testers]: Why do you choose to not get tested? Would you rather not know your status than be HIV positive? Why? How does your not knowing affect those with whom you have sex?
- What do you think the personal odds are for you of contracting HIV? What about dying from AIDS related complications?
- If your status were different, what would be different about your sex life?
- When you have sex, do you use a condom?
 - If an individual you met with to have sex asked you not to use a condom (or to use a condom), would you do it? If yes, why?
 - [Older Men] Twenty years ago, would you have answered this question differently? If yes, what has changed?
 - [Younger men] Has your condom use (or lack of condom use) been consistent since you've become sexually active with men?
- Do you think that not wearing a condom is [*or*: would be] more fun or more satisfying? Why?
- Do you think condoms inhibit sexual pleasure? How?
- Does our knowledge of safer sex—sex with a condom—change what you are willing to do sexually?
- Society is slowly becoming more accepting of gay relationships. Do you think this is true of gay sex as well?
- Do you think that, if society knew that many gay men engaged regularly in unprotected anal intercourse, their perceptions would get worse? Why?
- Do you think that condoms have any erotic value? When you see condoms, what do you think?
- How would you describe the sexuality of your social circle—friends and acquaintances? Are they mostly gay, straight or do you not know/don't discuss it?
 - Do you talk about sex?
 - [If yes]: What kind of things do you talk about?
 - Does safer sex come up in these conversations? How?
 - Does HIV/AIDS come up in your conversations? How?
 - Based on your knowledge and discussions with your friends, do you think they regularly use condoms while having sex?
 - Do you think your friends support (or would support, if they knew) your use (or lack of use) of condoms?
- How often do you encounter propaganda that promotes safer sex? In other words, do you notice a lot of advertisements in bars and clubs, magazines, or programs that you watch that encourage the use of condoms? How do you think these messages affect your sexual practices? Do they come to mind when you're looking for a sexual partner? About to have sex? After you've had sex? What about HIV adverts?
 - If there were more advertisements concerning safer sex and HIV you'd change your sexual behavior?

Appendix B: Consent Form and Description of Study



UNIVERSITY of NEW HAMPSHIRE

A Qualitative Study on the Perception of Risk of HIV, Sexual Behavior, and Condom Use in Gay Men

Michael Staley, Graduate Student in the Department of Sociology
University of New Hampshire

Consent Form - Personal Interview

Dear participant

I am conducting a research project to explore the reasons and meanings gay men associate with HIV/AIDS, sexual risk, and condom use and greatly appreciate your willingness to consider participating in this project. I plan to work with approximately 30 other men in this study.

If you agree to participate in this study, you will be asked to discuss sensitive information surrounding your sexual behavior. The interview will take approximately an hour of your time. With your consent, this interview will be recorded, and later transcribed word-for-word, omitting any identifying information. The actual recording will then be destroyed. You will not receive any compensation to participate in this project.

Although you are not anticipated to receive any direct benefits from participating in this study, I hope that your contribution to this study will be helpful by providing information on sexual behavior and risk in the gay community. You may request a personal copy of all the reports or publications from the study once it is complete.

There is no physical risk to you in this interview, however, you may note that the researcher is not a qualified therapist. For some people, recalling and discussing sexual experiences can be difficult. The researcher can refer you to appropriate resources should you need them, you are solely responsible for the cost of such resources.

Participation is strictly voluntary, refusal to participate will involve no prejudice or penalty. If you agree to participate and then change your mind, you may withdraw at any time during the study.

I seek to maintain the confidentiality of all data and records associated with your participation in this research. You should understand, however, there are rare instances when I am required to share personally identifiable information (e.g., according to policy, contract, regulation). For example, in the rare instance of a complaint about the research, officials at the University of New Hampshire, and/or regulatory and oversight government agencies may access research data. You also should understand that I am required by law to report certain information to government and/or law enforcement officials (e.g., child abuse, threatened violence against self or others, communicable diseases). Data will be kept in a locked file cabinet in my office, only my faculty

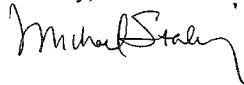
advisor and me will have access to the data. Transcriptions of your interview will be securely stored, but the recording will be destroyed.

The work will be conducted by me and reviewed by my master's thesis committee, which includes three faculty members. I am a master's student in sociology and I plan on pursuing a Ph.D. With your permission, I may want to contact you for follow-up questions in future research projects.

If you have any questions about this research project or would like more information before, during, or after the study, you may contact me at (603) 292-6440 or by email michael.staley@unh.edu. If you have questions about your rights as a research subject, you may contact Julie Simpson in the UNH Office of Sponsored Research at (603) 862-2003 or julie.simpson@unh.edu to discuss them.

Please keep a copy of this consent letter. Thank you for your consideration.

Sincerely,



Michael J. Staley
Graduate Student
University of New Hampshire

Appendix C: Internal Review Board Approval

University of New Hampshire

Research Integrity Services, Service Building
51 College Road, Durham, NH 03824-3585
Fax: 603-862-3564

16-Mar-2011

Stalcy, Michael J.
Sociology, Horton SSC
422 Pulaski Drive
Newmarket, NH 03857

IRB #: 4973

Study: A Qualitative Study on the Perception of Risk of HIV, Sexual Behavior, and Condom Use in Gay Men

Approval Expiration Date: 08-Oct-2011

Modification Approval Date: 15-Mar-2011

Modification: Addition of observations


The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has reviewed and approved your modification to this study, as indicated above. Further changes in your study must be submitted to the IRB for review and approval prior to implementation.

Approval for this protocol expires on the date indicated above. At the end of the approval period you will be asked to submit a report with regard to the involvement of human subjects in this study. If your study is still active, you may request an extension of IRB approval.

Researchers who conduct studies involving human subjects have responsibilities as outlined in the document, *Responsibilities of Directors of Research Studies Involving Human Subjects*. This document is available at <http://www.unh.edu/osr/compliance/irb.html> or from me.

If you have questions or concerns about your study or this approval, please feel free to contact me at 603-862-2003 or julie.simpson@unh.edu. Please refer to the IRB # above in all correspondence related to this study. The IRB wishes you success with your research.

For the IRB,


Julie F. Simpson
Director

cc: File
Turner, Heather

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