REASONABLE TRUST: AN ANALYSIS OF SEXUAL RISK, TRUST, AND INTIMACY AMONG GAY MEN

by

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We accept this thesis as conforming to the required standard.

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This thesis explores the psychosocial dynamics of sexual risk-taking in men who have sex with men, with particular focus on the dilemmas that gay men face in establishing trust in themselves and reasonable trust and intimacy with their sexual partners. As well, the practical function of this study is to analyze past and current social marketing efforts aimed at reducing the spread of HIV/AIDS, and to offer suggestions for how to approach a strategy to reduce HIV incidence in gay men and at the same time bolster efforts to assist men who have sex with men (MSM) in adhering to safer sex guidelines.

In part, this thesis uses a sample of participants of the Vanguard Project cohort (St. Paul's Hospital, Vancouver, British Columbia), in order to explore the social meanings attributed by MSM towards sex, risk, intimacy, and attitudes toward HIV/AIDS. Through the use of first-person narratives, this thesis examines the concordance or discordance of MSM beliefs and behaviour with long-standing theoretical models of harm reduction methods concerning sexual risk.

The study reveals that, in great measure, due to past life course events, many gay men suffer from a lack of trust in themselves, which results in a tendency to make irrational or unreasonable decisions concerning their long-term sexual
health, and a lack of trust in other gay men. As well, through the misguided and often untruthful health models that advocate fewer sexual partners and rely upon the false assumption that all potential sex partners are carriers of contagion, the sense of mistrust has been reinforced. The lack of confidence in self and others further translates into a suspicion of the motives and/or efficacy of social institutions entrusted with community health development and maintenance, rendering their efforts even less effective. Moreover, traditional harm reduction messages, especially ‘fear campaigns’, often act as a deterrent, rather than as an incentive, to harm reduction. Of more appeal are supportive harm reduction messages delivered by someone whom the recipient trusts, especially when the social meanings of sex, risk, trust and intimacy are, for many gay men, less fixed and more contingent than for the population at large. This means that attempts to modify risky behaviour must acknowledge and negotiate multiple meanings, shifting values and changing social climates, as well as routine epidemiological concerns.

The research identifies four key themes within a problematic of trust, risk and intimacy, and delineates the harm reduction social complexities experienced by gay men in the study group; these recurring themes deal with family and early socialization, internalized homophobia, contingency and instability of meanings of risk, trust and sex, and the trustworthiness of the messengers of harm reduction strategies. Out of these recurring themes come a number of
recommendations for remedial programs aimed at both mid- and long-term reductions in HIV incidence. The recommendations are grounded in the recognition that homophobic and/or dysfunctional social conditions are, to a great extent, implicated in sexual risk behaviour, and therefore must be eliminated or ameliorated before meaningful harm reduction gains can be realized. The discussions with the gay men in the study reveal their need for positive role models and communal social support in their efforts to combat HIV infection, suggesting a need to rethink the meanings of what it is to be gay, a need to redevelop and revitalize what was once a vibrant and cohesive community, and bearing in mind the lessons of the past, a need to re-approach the task of stemming the tide of HIV infection in ways that are sensitive to the factors that adduce high-risk sexual behaviour.
# TABLE OF CONTENTS

ABSTRACT ........................................................................................................... ii

FIGURES ........................................................................................................ vii

TABLES ........................................................................................................ viii

ACKNOWLEDGMENTS ..................................................................................... IX

PREFACE ........................................................................................................... 1

CHAPTER 1 – THEORY .................................................................................. 17  
   RISK, TRUST AND INTIMACY AS PROBLEMATICS ................................ 21  
   RISK ........................................................................................................... 25  
   MACRO PERSPECTIVES ON TRUST ...................................................... 29  
   MICRO PERSPECTIVES ON TRUST ...................................................... 43  
   BRINGING TRUST AND RISK-TAKING TOGETHER ................................ 47

CHAPTER 2 – GAY MEN, SEXUAL FREEDOM AND HIV ......................... 52  
   HIV/AIDS STATISTICS ......................................................................... 53  
   FRAMING THE DEBATE ......................................................................... 58  
   HIV AND RISK BEHAVIOUR ................................................................. 65  
   THE SOCIAL PSYCHOLOGY OF RISK .................................................. 73  
   PERCEIVED INVULNERABILITY ............................................................. 77  
   UNDERSTANDING SO-CALLED NON-RATIONALITY ............................. 81  
   THE SOCIAL SIGNIFICATION OF SEX ................................................. 86  
   WIDER SOCIAL CONTEXTS ...................................................................... 93  
   THE THEORY OF COGNITIVE DISSONANCE ....................................... 105  
   ALTERNATIVES TO DISSONANCE THEORY ......................................... 109  
   OTHER THEORIES .................................................................................. 112  
   GAY MEN AND RISK BEHAVIOUR ....................................................... 115  
   GAY COMMUNITY ATTACHMENT ......................................................... 118  
   UNPROTECTED VERSUS UNSAFE ANAL INTERCOURSE ....................... 126  
   ADOLESCENT SEXUAL BEHAVIOR ...................................................... 128  
   CONCLUSION ........................................................................................... 131

CHAPTER 3 – SOCIAL MARKETING: THEORY AND PRACTICE ............. 135  
   NONSTAGE AND STAGE THEORIES – STATE OF CHANGE .................. 143  
   FEAR CAMPAIGNS .................................................................................. 149  
   INEFFECTIVE USE OF FEAR APPEALS .............................................. 160  
   THE PERSUASIVE HEALTH MESSAGE (PHM) ...................................... 161  
   DO THESE (OR ANY) CAMPAIGNS WORK? ........................................... 189  
   CONCLUSION ........................................................................................... 192

CHAPTER 4: ENACTING RISK AND TRUST .......................................... 196  
   INTRODUCTION ....................................................................................... 196  
   THE STUDY GROUP METHODOLOGY .................................................. 202  
   RISK BEHAVIOUR, AND COMING OUT IN THE SAMPLE GROUP .......... 206  
   HEALTH BELIEFS AND RISK BEHAVIOUR .......................................... 214
# Table of Contents

- **Comparing Knowledge and Attitude** .................................................. 220
- **Practicing Trust** .............................................................................. 228
- **How Do People Trust?** ................................................................. 232
- **Conclusion** .................................................................................. 236

## Chapter 5 – Assessing Sexual Risk and Rational Choice ............................. 241
- **The Purpose of the Case Studies** ...................................................... 241
- **Case Study – Christian** ................................................................. 244
- **Case Study – Patrick** .................................................................... 257
- **Case Study – Martin** ..................................................................... 267
- **Case Study – Josh** ......................................................................... 281
- **Case Study – Alan** ........................................................................ 292
- **Conclusion** .................................................................................. 309

## Chapter 6 – Problematising Sexual Risk and Trust ................................ 324
- **Theme One – Family and Early Socialization** .................................. 330
- **Theme Two – Internalized Homophobia** ......................................... 337
- **Theme Three – Contingency and Instability in a Sexually Vectored Gay World** ........................................................................ 344
- **Theme Four – The Messenger** ....................................................... 359
- **Conclusion** .................................................................................. 365

## Chapter 7 – Conclusion ........................................................................ 373
- **Summing Up** ................................................................................ 373
- **HIV Optimism** ................................................................................ 383
- **Safe Sex Fatigue** ........................................................................... 384
- **HIV Prevention Intervention** ......................................................... 385
- **Social Support** ............................................................................. 388
- **Internalized Homophobia** ............................................................. 394
- **Social Meanings** ........................................................................... 400
- **Trusting Others** ............................................................................ 404
- **Social Policy Changes** .................................................................. 409
- **Personal Empowerment** ............................................................... 414
- **Social Marketing** .......................................................................... 421
- **Limitations of the Study** ............................................................... 427

## Appendix 1 ...................................................................................... 430
- **Glossary** ...................................................................................... 430

## Appendix 2 ...................................................................................... 433
- **Sample Criteria** ............................................................................ 434
- **Correspondence** .......................................................................... 436
- **Informed Consent Form** ............................................................... 440

## Appendix 3 ...................................................................................... 442
- **Vanguard Questionnaire - Baseline** ............................................. 443
- **Vanguard Questionnaire - Follow-Up Fourth Wave** ....................... 456

## Appendix 4 ...................................................................................... 475
- **Interview Schedule** ...................................................................... 476

## Bibliography .................................................................................... 480
FIGURE

1-1: From intention to risk management 26
2-1: AIDS, Males, 1977, Canada 56
2-2: Year 2000: Median age of first diagnosis 57
2-3: Theory of Planned Behaviour 73
2-4: A dynamic model of sexual interaction 97
2-5: Attitudes to condoms by gay community attachment 119
2-6: Gay community attachment by age 123
3-1: AIDS: The Climax of Death 152
3-2: Winners Always Use Condoms 155
3-3: Don’t Die of Embarrassment 158
3-4: Safer Sex: Keep It Up! 164
3-5: Your Sex Partner for Life 167
3-6: Anytime you sleep with someone . . . 170
3-7: Good Boys 174
3-8: I Love Condoms 175
3-9: Always 178
3-10: Party 180
3-11: Welcome to Condom Country 182
3-12: Framework for developing culturally specific PHM 187
<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-1: AIDS incidence over time, Males, All ages</td>
<td>54</td>
</tr>
<tr>
<td>2-2: Year 1994: Median age of first diagnosis</td>
<td>56</td>
</tr>
<tr>
<td>2-3: Risk Model (McLure &amp; Grubb)</td>
<td>68</td>
</tr>
<tr>
<td>2-4: Behaviour (Vanguard Project)</td>
<td>71</td>
</tr>
<tr>
<td>2-5: Reason for not using a condom</td>
<td>82</td>
</tr>
<tr>
<td>4-1: Sex education by age, source and first impression</td>
<td>219</td>
</tr>
<tr>
<td>4-2: Attitudes toward HIV therapies and potential infection</td>
<td>222</td>
</tr>
<tr>
<td>7-1: Hierarchy of sexual stigmatization</td>
<td>401</td>
</tr>
</tbody>
</table>
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they know who they are, and it is because of them I was able to include the crucial first-person accounts, extracting the richness of their experience and insight.
When I began conducting interviews and developing the fieldwork aspects of this dissertation in the fall of 1999, my standpoint was informed by my conviction that there appeared to be an obvious correlation between self-esteem and condom use, especially amongst gay men and men who have sex with men (MSM) regardless of how they self identify sexually. This belief was born out of numerous studies (see Odets, 1994; Pajares, 2000; Gonsiorek & Weinrich, 1991; Gagnon, J.H, 1988; Strathdee S.A. et al; 1998) that indicate that gay men more frequently suffer from low self-esteem than straight men, are more frequently underemployed, and are almost always marginalized both as adolescents and as adults. Coupled with the general absence of an appreciable decrease in new HIV infections\(^1\), the studies suggest that self-esteem and unprotected anal intercourse (UAI) may somehow be linked. After all, is it not logical to assume that the preservation of life is one of the strongest human endeavors and that high-risk sexual behaviour is counterproductive to that enterprise?

I enlisted the cooperation of the Vanguard Project, a prospective open cohort study involving gay and bisexual men between 15 and 30 years old (at baseline),

\(^1\) In particular demographic sectors, significant real increases in infection rates have been observed, particularly in Black and Latino communities.
who have not previously tested positive for the HIV antibodies. Subjects are recruited through physicians’ clinics and community outreach in Vancouver, BC. Participants are tested annually for HIV antibodies and asked to complete a self-administered questionnaire pertaining to sociodemographic characteristics, sexual behaviours and substance use. For my purposes, potential participants in the project were screened to meet the following criteria; 1) they had to have engaged in UAI in the 12 months prior to completing their last questionnaire and 2) they had to meet certain general conditions of self-esteem, and drug or alcohol use. (The complete list and relative weighting can be found in Appendix 2.) The eligible subjects were then sent an invitation to participate in this project, and the participants were randomly selected from the response cards that they sent back.

In the past three years, having interviewed a number of these Vanguard participants, conducted 10 group discussion sessions with a sub-set of the Vanguardians who were also individually interviewed, and analyzed reams of quantitative data on self-esteem, sexual behaviour and demographic information, I no longer hold so tenaciously to the belief that self-esteem and the more comprehensive measure of self-efficacy are highly correlated with not using condoms for anal intercourse. In fact, the qualitative discourses and quantitative data suggest that self-esteem is, at best a minor consideration, and in fact men who have sex with men (MSM) (whether they self identify as gay or not) with
either consistently low self-esteem or consistently high self-esteem behave almost exactly alike with respect to sexual risk-taking (Vanguard data, unpublished). Additionally, only a minor fluctuation was observed in those people with nomadic self-esteem. Nomadic self-esteem is characterized by fluctuations depending on the time and circumstances. For example, in a cruising situation in a bar, having been rejected a number of times when approaching someone with whom to have safer sex, a man with situationally low self-esteem could accept the risk of UAI out of desperation and frustration. It is important to understand why the starting point for this analysis was initially grounded in empirical and epidemiological factors. Simply put, this has been the modality for HIV prevention strategy development for almost two decades and has been the prevailing paradigm.

I originally adopted a traditional health belief model, since it appeared to me that the most effective mechanism for slowing down or halting the spread of HIV in male homosexual and bisexual communities in North America would be the widespread adoption of new-style interventions to alter sexual behaviors that place people at risk of infection. Since the start of the epidemic more than 20 years ago, public understanding of HIV has expanded, and research has identified a number of relatively effective medical and social interventions for HIV and AIDS (HAART – Highly Active Antiretroviral Therapy, prophylaxis, better nutrition, and stable housing to list a few). However prevention efforts have, in
the main, not begun the move from purely educational (or knowledge-based) messages to behavioral and psychosocial-based interventions that motivate and sustain behavior change (Cain, 1997). Focusing on individuals, groups or communities, such interventions attempt to change individual attitudes, beliefs, skills, and risk behaviors associated with HIV transmission as well as community and social conditions that encourage or at least do not discourage risk behavior. Agencies that deliver interventions have been slow to abandon, or at any rate modify their own traditional health behavior and harm-reduction beliefs, and consequently have neglected new forms of intervention along the lines of risk self-appraisal and harm-reduction skills.

With the release of the "men's survey" (Myers et al., 1993), it became apparent that the efforts of safe sex educators was meeting with only moderate success. This study indicated that only 68.9 percent of the 818 gay and bisexual men surveyed nationally reported using condoms all the time for insertive anal intercourse and 71.7 percent reported using them for receptive anal intercourse. Most alarming was that 12.2 percent and 11.5 percent of the men respectively indicated that they never use condoms for anal intercourse.

The report itself, through its numerous tables and figures provided a tremendous amount of data with respect to 'what' was happening in the field of HIV prevention, but did not delve to any great degree into 'why', after more than a
decade of concentrated HIV education, so many gay and bisexual men were continuing to take risks through their sexual behaviors. These findings were alarming not only because of the data presented, but also because they called into question the efficacy and methodologies that had been used, and were still being used, by AIDS service organizations (ASOs) to stem the tide of new infections.

Could it be that the messages were too harsh, too dogmatic, directed at the wrong populations? Or were they as effective as one could hope for, and the cold reality was that there would always be a certain percentage of the population that would not heed the warnings? The latter supposition was too depressing to consider, since in a sexually vectored society, a mere 1% of new infections per year could amount to a more than a 50% population infection rate in less than a decade.2

In Vancouver, new approaches were hastily tried – community forums on sex and AIDS were planned and executed, increased presence of safe-sex educator volunteers in the most likely environments for unprotected sex was initiated (the bathhouses, parks and Wreck Beach – a nude beach with a ‘gay’ sector), and pamphlet and condom distribution programs were developed for all of the gay bars in the city. In short, almost all of AIDS Vancouver’s resources were redirected towards HIV education and condom distribution.

However, a few people felt that ‘more of the same’ was not the answer. There

5
had to be some underlying reasons that explained why MSM were continuing to have unprotected anal intercourse, despite the massive public education campaigns — social marketing interventions geared to behaviour change. Some people were of the opinion that gay men (especially those whose lives had not been touched directly by infection, or indirectly by the illness or loss of friends) were ‘naturally’ promiscuous or intrinsically shy about discussing condom use ‘in the heat of the moment’. Others believed that there was insufficient personal motivation to adopt safe sex practices on a consistent basis — that either many gay men believed that HIV and AIDS were the inevitable outcome of a sexually vectored lifestyle, or that a denial factor was at play — a belief that ‘it won’t happen to me’.

In fact, response categories provided in almost all survey questionnaires allowing participants to explain why they did not use condoms (for example, in the Myers et al. study) were all pragmatic and situational categories such as “He was my regular partner,” “The sex was so exciting,” “It makes me lose my hard-on,” “I am HIV negative,” “I pulled out before cumming,” “I was using alcohol,” “We did not have a condom.” It appears that the researchers gave no consideration at that time to any deeper meanings of sex, intimacy, trust, the significance of fluid exchange and other psychosocial variables that might have an impact on the decision not to use condoms for anal sex. And why should there be such

\[ 0.01 + (0.01 + 0.01) + (0.01 + 0.01 + 0.01) + (0.01 + 0.01 + 0.01 + 0.01) \ldots \text{ten iterations} = 0.55 \]
considerations? At the time, it was believed that condom usage was a mechanical issue that required a mechanical response. It was assumed that using condoms should be viewed in the same light as wearing seatbelts in an automobile – an automatic response to a potential risk.

In July 2000, health officials in San Francisco made the shocking pronouncement that after an impressive decline and then a subsequent leveling-off of reported cases of HIV infection in the city, the number of men testing positive for the virus had significantly increased. Nine hundred new infections were recorded in 1999 – a rate almost double that of the previous year. Gay men accounted for 575 of the new cases. (Barillas & Garbo, 2000; Coates, Katz, Goldstein et al, 2000)

While the absolute numbers for Canada are proportionately lower, it is known that reported cases rose more or less steadily from 1986 through 1992, remained stable from 1992 – 1995, and then experienced a dramatic decrease from 1995 (1165 cases) to 1997 (373 cases). Preliminary data for 1999 (Health Canada, 1999) suggests that an estimated 4,190 Canadians (all categories) became newly infected with HIV in 1999, compared with almost the same estimate in 1996. However the distribution among exposure categories changed significantly. From 1996 to 1999 there was a 30% increase in new infections per year among
MSM (from 1240 to 1610), and a 27% decline in the number of new infections among injection drug users (IDUs).³

The San Francisco data triggered alarm bells all over the continent. Could San Francisco’s experience be indicative of new HIV infection rates elsewhere? Or was this merely an anomaly? Coincidentally, that same month there were also reports from the XIII International AIDS Conference (held in Durbin, South Africa) about the high rates of HIV infection among gay men in the United States. Community workers, health professionals, and clinicians blamed the increase of new HIV cases on a relaxation in many gay and MSM communities’ adherences to safer sex guidelines.

However, that interpretation fails to consider other factors. For example, how many respondents dispense with the use of condoms within the confines of a monogamous relationship? And on a broader scale, might the new data represent a failure of the ‘use a condom every time’ prevention message to motivate gay men in an era of treatment advances and lower AIDS mortality?

Steven Goldstone, M.D. states:

Clearly, we would never tell an HIV-negative monogamous heterosexual couple to always use condoms. We need to adapt to safer sex teaching for gay men to accommodate the large numbers of monogamous gay men . . . that said we must also realize, as evidenced by a recent Australian

³ There has also been a rise in heterosexual infection (from 700 in 1996 to 880 in 1999)
study, that a significant number of men who consider their relationships monogamous are still getting infected with HIV. That's why education efforts are so important. (Quoted in Barillas & Garbo, 2000)

Dramatic improvements brought about by the new anti-retroviral drug 'cocktails' have simultaneously breathed new life and a concomitant easing of safe sex practices into the MSM community. The question becomes how are we to establish HIV prevention in an era when there is a palpable weariness with AIDS, and complacency that the epidemic is practically over?

Therefore, I begin this work with the hypothesis that the great majority of gay men who fail to maintain traditional safe sex behaviors likely do so despite knowing the potential risk. Additionally, I hypothesize that those men who deliberately choose to have sex in a manner which they know could be infectious may feel the need to justify their decisions to themselves at the same time they make them, through a process known as 'internal dialogue'. In this regard, the study also examines the belief held by cognitive therapists that internal dialogue contributes causally to symptomatic behaviors, and that it is therefore a useful locus of intervention for changing the behaviors. (Gold, 2000) These self-justifications are a variant of what is referred to as individuals' 'internal dialogue' or 'self-talk'. This is not to suggest that the gay men, in the throes of sex, talk to themselves in sentences and paragraphs; but there may very well be a mental conceptualization of these dialogical processes, perhaps merely limited to a series of perceptual images.
If self-justification does indeed contribute causally to the occurrence of high-risk sex, we need to know if and how AIDS education might counter it. Almost always, AIDS education is delivered at a time and place other than during sexual contact. So the beliefs that are accessible at the time education is being received -- the beliefs with which it comes into contact -- are 'cold light of day' beliefs (Gold, 2000). To the degree that rationalizations arise out of reasoning that is rejected in the cold light of day, potential high-risk takers may be unaffected by any educational information. If gay men do not hold a resilient 'cold light of day' belief that they may become infected with HIV as a result of their behaviors, telling them that infection is possible will end up a rejected message, and ultimately prove of little personal concern.

Effective communication and education therefore, must be understood in light of how sexual risk is perceived, internalized and operationalized by gay men. What pressures come to bear when education and information collide with intimacy and arousal? What has and has not worked in the past? What has been the relationship between life course events and personal or social change? What has been the role of trust as well as the role of stigma, agency, and peer or community pressure through social marketing programs? Difficulties arise with this approach, however, since it is highly likely that even with all of this information, most gay men will not react uniformly given that they are not, in themselves a homogeneous group, nor do they ascribe the same meanings to sex, love,
intimacy, risk, trust, social pressure, or social marketing messages. In fact, one of the major premises of this examination is that there is no more homogeneity amongst gay men than there is amongst heterosexual men.

At one point in the history of AIDS education, the prevailing paradigm was ‘empowerment’ — that is, teaching and sanctioning gay and bisexual men, through the use of purported community norms, to ‘just say no’ — ‘no’ to unprotected sex, ‘no’ to multiple casual partners, ‘no’ to sexual encounters — without first negotiating the limits and boundaries that one would accept. However, I hypothesize that negotiation of sexual safety within relationships is not only a matter of individuals bargaining for their own preferences (from perhaps different positions of power); rather, these preferences may be at least partly formed in response to the qualities they perceive in their partners, and in their relationships with them. I suspect that these exchanges may inform future practices, and therefore result as much if not more so, from sexual and emotional experience, as they do from elements that are a consequence of ‘cold light of day’ knowledge.

Psychologists and sociologists have considered whether optimistic biases about risk reduce the adoption of precautions. Weinstein and Lyon (1999) argue that acknowledgment of personal susceptibility promotes a form of precaution

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4 Similar to Nancy Regan’s concept with respect to drug use in the United States.
implementation ("I'd better not do that"). On the other hand, Taylor and Gollwitzer (1995) suggest that while people may engage in risk avoidance strategies in the abstract, when concrete circumstances requiring new precautionary behavior present themselves, it is more usual that an optimistic risk assessment bias emerges ("It won't happen to me"). "It will not happen to me" risk denial perceptions are a major finding emanating from epidemiological research (Vanguard, 2000). In this study, I examine the acceptability of risk by considering how individuals weigh relative risks with their own health and their 'love relationships'.

Unprotected sex may be 'reasoned action' (Ajzen and Fishbein 1980, Ajzen 1988, Conner and Sparks 1996) in the context of certain relationships, and may be a concomitant acknowledgement of the place of emotions in sexual behavior, (Rhodes and Cusick, 2000); hence, the title of the thesis – "Reasonable Trust". Reasonability, in the context of this thesis refers to 'agreeable to reason or judgment', or in other words, it is based on some belief, action or thought, whether that belief is true or not. People may believe, for example, that they are an expert in a particular sport, while the reality may be that, compared to others, they are not. This unfounded belief may then lead them to take risks that are beyond their real capabilities. While in the purely technical sense, "reasonable" and "rational" have been linked with the notion of pure reason, or impartial, highly logical abstract thought, in current parlance it has taken on a more contingent property –
that of 'simple common sense, equitability and fairness'. (Webster, 1989: 1197)
Also underscored is the notion that relationship quality is as likely to influence
sexual behavior as sexual behavior is to influence relationship quality (Rhodes and
Quirk, 1998; Rhodes and Cusick, 2000). Thus there is a symbiotic interaction
between the significance of condom use and relationships. This is especially
salient when one considers that emotions may be held to be a major feature of
reasonable risk and relationship decision-making. If we recognize that sexual
activity interacts with desire and perceptions of relationship quality, we can see
that decision-making about sexual behavior may not simply be inherent in the
individual as an expression of his or her self-interests. In this rationality of desire
among couples, the mere pleasure of sex and the communication of relationship
quality may be accorded greater common sense importance than potential health
dangers. This, in turn, has important repercussions for the sense of balance that
is struck between relationship quality and virological safety. In fact, non-condom
sex is most prevalent within the context of 'primary' or 'intimate' relationships.
This has been found to be the case among sex workers, gay men, heterosexual
men and women, and injection drug users (Day 1990, Stall et al. 1990, Davies et
relationship quality and viral safety is a particularly important aspect of explicit or
implicit negotiation in primary relationships.
If health risks are perceived to be of subordinate concern to both sexual satisfaction and relationship quality, and appear to be incompatible with these cherished aspects of sexual behavior, then HIV prevention, which accentuates individual physical health over emotional relationships and gratification, may provoke 'resentment and resistance' in those whom they target (Lucey, 1998). As we shall see, safer sex and fears of transmission may be perceived as a barrier to emotional intimacy. Additionally while HIV-positive gay men appear to be more anxious to protect their partners, especially those who are HIV negative, this protectionism can, in turn, serve as a barrier to the development of emotional relationships. Concurrently, sex with casual partners (which thus avoids emotional entanglements) is on the rise (Piaseczna et al, 2001). This in turn leads to another conundrum: what is the degree of responsibility of someone who is HIV-positive to inform and or protect this casual partner, when that partner has no emotional connection or exclusive attachment to him? We will discover that in the interviewed members of the Vanguard cohort, this is a major issue.

A further working hypothesis is that sexual safety is inversely related to relationship quality. This notion has been supported by Wellings et al. (1994) who also suggests that relationships which falter at the 'condom barrier' do so for a wide variety of reasons, not the least of which is an unfounded perception that the inevitability of infection is always present, and thus part of everyone's sexual
script – an acceptable or sometimes unacceptable risk, however disagreeable it may be.

Thus far, we have been referring to anal intercourse without a condom as “unprotected anal intercourse” or “UAI”. However, from this point forward, it becomes important to distinguish between sexual behaviours that are unplanned (condom-less sex because no condoms were available, or drug / alcohol induced laxness, for example) and those that are planned, whether articulated or not. In the former instance, UAI is an appropriate, value-neutral description of the event. In the latter case, it is not.

In the latter situation the notion of ‘unprotected’ becomes awkward. One naturally assumes latex (or polypropylene) condoms constitute ‘protection’, but are condoms the only form of protection worthy of consideration? As will be demonstrated, the idea of protection extends far beyond the perfunctory use of condoms, into the realms of the social and psychological (conscious and subconscious thought). Therefore, from this point on, I intend to make a purposeful distinction between “UAI” and “barebacking”. “UAI” will represent condom-less anal intercourse that is neither planned nor generally acceptable in the ‘cold light of day’, while the term ‘barebacking’ will signify anal intercourse that is deliberately devoid of condoms. The distinction is not merely terminological, as I shall show. There are significantly different implications and
repercussions socially and personally, depending on what type of condom-less sex is at issue.
CHAPTER 1 – THEORIZING SAFE-SEX RESEARCH

The plan of this thesis is that I initially examine what constitutes risk for HIV infection, the notion of the sociology of decision-making and risk-taking in its individualistic and wider social contexts, and the various theories with respect to rationalization of risk and the relationship between beliefs and behavior. In that light, it is important to discuss briefly why theoretical considerations of trust, risk and intimacy are salient in this thesis.

Theory has a number of purposes in assisting us to comprehend communication processes. In the behavioral sciences, one of the most fundamental roles is that of description. Theories expose the complex world in which we live, and in so doing, help it to become understandable. John Dewey, an early 20th-century philosopher, commented on the role of theory by posing the following question:

Does it end in conclusions which, when they are referred back to ordinary life experiences, render them more significant, more luminous to us, and make our dealings with them more fruitful? Or does it terminate in rendering the things of ordinary experience more opaque than they were before? (Dewey, 1929: 3)

The second function of behavioral theory concerns the prediction of outcomes. Predictive theories elaborate on descriptive theories to their subsequent logical point by stating: ‘if X occurs, then Y is more (or less) likely to occur’. This is a higher level of theory in that the procedure of presupposing and distinguishing
relationships among antecedents and consequences accords an even greater degree of comprehensibility to the world around us.

The third function of theory is explanation. Although theories that predict relationships among variables generate hypotheses and fuel much research, these theories do not necessarily explain why: i.e.: 'if X occurs, then Y is more (or less) likely to occur because . . . ' Theories that are explanatory in nature create even greater understanding. They are often crucial in attaining the ability to prescribe effective interventions.

The final goal of theory involves prescription. Prescriptive theories build on prediction and explanation. Stated in the abstract: 'X may be made more (or less) likely to occur by doing A, B, and/or C, which in turn will make Y more (or less) likely to occur'. (Maibach et al (1995:2). This type of theoretical construction endows theory with its highest level of understanding. It is the difference between understanding that condoms are made from latex (or other material), that condoms prohibit the transmission of sexually transmitted diseases or unwanted pregnancies, and understanding that a condom, when properly used will preserve life, protect others from infection, and slow the attrition rate of gay men.

Behavioral decision-making (BDM) is largely concerned with the cognitive processes by which humans perceive, structure, and evaluate alternative courses of action. It goes far beyond the relatively simplistic cost-benefit
components included in the Health Belief Model, The Theory of Reasoned Action and Protection Motivation Theory. BDM research includes the study of risk perception, problem structuring, consequence (outcome) valuation, probability judgment, and heuristics and biases. (Holtgrave et al, 1995:24)

In other words, the BDM model more closely approximates the objectives of analyzing trust, risk and intimacy as a complex series of cognitive and emotive issues that, while interlinked, have their own unique, and sometimes so-called irrational elements.

Second, I interrogate historical safer sex social marketing models, focusing on the most popular, KAB (knowledge, attitude, and behavior), through an analysis of a number of theory-driven strategies for behavior change, especially campaigns that rely on appeals to fear in order to promote better health practices. These campaigns will be examined using a number of examples of HIV prevention messages from around the world. Their shortcomings, as well as their strengths, will be scrutinized in light of Canadian and American data on infection rates over the past number of years.

Third, I investigate issues of life course and self-esteem, human agency and strategic adaptation, and how these relate to both individual statuses and identity perceptions, using case studies of some Vanguard participants. Stigmatization and its effects on life course will also figure prominently in my analysis of sexual behavior, risk and safety, with a focus on the rules that couples (casual or regular) make regarding sexual behavior that differentiate amongst sexual activities,
partners and contexts. In this analysis, three organizing principles emerge — sexual behavior is a social construction; freedom of action is constrained by social material conditions; and social structure and organization influence risk behavior.

One of the most understandable impediments to modern-day harm reduction planning is the fact that many gay men in particular are fed up with HIV/AIDS education, being told what to do, and being told that there is still a crisis of immense proportions plaguing the community. (Rofes in Barillas & Garbo, 2000) Again through the medium of case studies, I examine the psychosocial affects of both creating and living in a culture of crisis, the difficulty of maintaining that crisis mentality over a prolonged period of time, and what happens when people do not acknowledge this crisis mentality. Significant in this analysis is the notion of trust and intimacy, as opposed to distrust and detachment. Also, the binarism of 'good fag, bad fag' is examined in light of community norms and standards, media portrayals of HIV/AIDS, and the values and meanings of gay sex.

Finally, there is a need to merge the discourses on trust, risk, and sex. I therefore examine the production of trust theoretically and practically, distinguishing between the different processes of granting and receiving trust, and examine how trust or distrust manifests itself in decision-making with respect to risk-taking. It is at this juncture that we are likely to find the manner in which life-course events and health-belief models have a particular bearing on trust levels, and in so doing,
on risk-taking. I then examine whether so-called ‘wholesome health beliefs’ are a significant motivation for behavioral change, given that behavioral change itself is frequently thwarted by the allure of pleasure and personal gratification. Finally, I consider the degree to which risk-taking is a part of a lifestyle, how much risk is 'deprogrammable', and how much may be virtually entrenched or 'hard-wired' into our psyches.

In establishing the confluence of trust, risk and intimacy, my analysis will clarify why I believe the entire array of social marketing efforts to reduce HIV infection needs to be re-thought, and why I believe that risk taking is so complex an issue that no single model can have utility for anything more than narrow market segments. I locate this analysis not in the existing paradigm of rational choice and moral panic, but in a new problematic of reasonable trust and sexual risk. This paradigmatic shift will become more evident as the chapters unfold.

Risk, Trust and Intimacy as Problematics

As defined, in this analysis it is apt to regard risk, trust and intimacy as problematics. Louis Althusser (1970), in For Marx explains the concept as one in which a “word or concept cannot be considered in isolation; it only exists in the theoretical or ideological framework in which it is used” (1970: 253). While the above ‘problematics’ are not of world-view proportion, that is, not essentialized from discourse or action, they rest on what Dorothy Smith suggests are a
“possible set of questions that have yet to be posed, or of puzzles that are not yet formulated as such, but are “latent” in the actuality of our experienced worlds.” (Smith 1987:110) The integration of these multiple problematics: social marketing in general and in particular the KAB – knowledge, attitude, behaviour model; notions of trust and how trust evolves into risk analysis and decision-making; and intimacy (physical and emotional) as both a human ‘necessity’ and a ‘common sense’ social behaviour, forms the bulk of this dissertation.

As Smith proposes, and as this thesis investigates, “The term ‘problematic’ enters an actual aspect of the organization of the everyday world (as it is ongoingly produced by actual individuals) into a systematic inquiry. It responds to our practical ignorance of the determinations of our local worlds so long as we look for them within their limits. In this sense the puzzle or puzzles are really there.” (110)

Ultimately, the purpose of this study is to examine the dynamics of why numerous men who have sex with men continue to do so without the consistent use of condoms, contrary to all so-called accepted logic surrounding contagion and prevention. To do this, we need to understand the meanings gay men and MSM ascribe to risk, particularly the risk of contracting HIV; to examine the relationship between the pleasure of sex and the rationality of desire; the importance of relationship quality as it pertains to trust in oneself and one’s
partner; the linkages between beliefs and behaviours; and what, if any, social marketing interventions may hold some promise with regard to changing the behaviour patterns and sexual scripts of people who choose to have unprotected anal intercourse.

It then makes sense to view these issues in the context of problematics, especially in light of their interdependent nature, and to organize the everyday world of sex and sexual expression into 'systematic inquiries'.

The general hypothesis that I am pursuing in this investigation is that the crucial dynamic in deciding to bareback is based in trust, which is born of a multiplicity of factors. There is no unicausal source of 'deviance' or risk, and therefore there can be no metanarratives that will ameliorate risk, or cause trust to be withheld or granted. The social marketing models that purport to inform, educate and condition MSM to reduce sexual risk-taking fail to consider the diversity of meanings surrounding a wide variety of social and personal constructs that impact safer sex decision-making, the motivations and cognitive rationales employed by MSM to either justify or excuse the use of condoms for anal intercourse, and the community and personal histories of 'unprotected' sexual behaviour that has infiltrated the beliefs and actions of MSM. Additionally, I demonstrate that the generally applied theoretical models for safer sex interventions fail to take in to consideration the many anomalous situations and psychosocial variables surrounding people's decisions to engage in high-risk
sexual behaviours, with the result that such models are relevant for specified and limited populations, but ineffective or occasionally counter-productive for others. In order to unpack, or at least to evaluate the 'problematics' of risk, trust and intimacy as they apply to the everyday lives of sexually active gay men, I follow a number of methodological pathways: to be sure, considerable reliance is placed on theoretical models of risk behaviour, rationality, sexual behaviour, social marketing, trust and trust-making. However, a theoretical understanding alone of these problematics would leave us fairly much in the same quandary as we started - puzzles with no solutions, or, few clues towards solving those puzzles. In that respect, I also examine how these notions play out through the use of interviews and group discussions. Using the words of the interviewees and group participants I weave a (somewhat meandering) path through the intersection of the 'problematics', not so much as to provide, at that point, concrete operationalizable actions for the future, but more to demonstrate the confluence of these issues, the contingencies surrounding their individualized and collective meanings, and thus the potential for social change, given an appropriate alignment of strategies, target markets, messages, community support and a host of other socially implicated structural and behavioural issues.
Risk

"Risk" as we know it is a relatively new concept in the sociological lexicon. Before the modern era, risk was a neutral term, used frequently in scientific and mathematical models to indicate probability, losses or gains. A gamble or undertaking that was related to high risk suggested that there was a strong likelihood of substantial loss or substantial reward. However, risk has been co-opted as a term generally equated with negative or undesirable outcomes, much like "danger", "jeopardy", "peril", or "hazard" (Word 2000 thesaurus). Furthermore, the notion of risk begets a moral facet, such that perpetrators of risk may be held to account in some way or another (Douglas, 1992:22-25).

Risk assessment is a technical procedure, which, like many other aspects of modern life, submits to a rational calculation of means and ends, costs and benefits. (Fox, 1991) The following figure (1-1) is based on an illustration of the process of risk assessment from the British Department of the Environment:
Figure 1-1 suggests the "simple, logical sequence of steps" (Department of the Environment, 1995:5) to be taken to identify and manage risk. This model has been widely adopted over the past 50 years (Carter, 1995). Within its parameters, all risks can be acknowledged, appraised and duly dealt with, such that all may be foreseen and offset, so that risks, accidents and insecurities are minimized or prevented altogether. However, such explanations fail to problematize risk and its assessment. A more critical approach, addressing the socially constructed and historically specific character of the conceptualisation of risk and its assessment has been proffered by the social sciences.

The work of anthropologist Mary Douglas has been instrumental in understanding the cultural end of the spectrum of social theories about risk
(Douglas, 1966). In analysing fears over pollution, she observed that it was baffling that people refused to purchase flood-plain or earthquake insurance, crossed dangerous roads, drove non-worthy vehicles, purchased accident provoking gadgets and did not listen to educative messages on risk. She suggests that the reason such behaviour seems baffling is the failure to consider culture. Employing the typology of cultures she developed (Douglas, 1996), she illustrated how the risks one focused upon as an individual have less to do with psychology (which informs rational-choice theory and the health-belief model) and more to do with the social forms in which people construct their understanding of the world and of themselves.

Further, as Rayner (1992) puts it:

If the cultural processes by which certain societies select certain kinds of dangers for attention are based on institutional procedures for allocating responsibility, for self-justification, or for calling others to account, it follows that public moral judgments will advertise certain risks powerfully, while the well-advertised risk will turn out to be connected with legitimating moral principles. (p. 92)

What is considered a risk, and the purported gravity of that risk, will be perceived differently depending on the organization or grouping to which an individual belongs (or with which s/he identifies). The free-market environment, for example, will see competition as the main risk, to be repulsed by teamwork and leadership. The bureaucrat perceives radical change as threatening, requiring group commitment as a risk reduction strategy.
Risk assessment must start with some previous information about the world, what is 'feasible' and what is 'improbable', what is 'significant' and what is 'inconsequential' or patently 'ridiculous'. Such judgments may originate with 'scientific' sources, may depend on 'common-sense', or may be the product of experiential learning; in any case, the perception of a hazard's existence and notions about the etiology of that hazard will depend on these judgments. How the judgment is constructed (i.e.: what evidence is included and what is excluded) is relative and culturally contingent.

Furthermore, psychologists generally acknowledge that to be a teenager is to be in a permanent state of crisis. Rickel and Hendren (1993: 141) indicate that the period of adolescence in the life-course is "perhaps one of the most complex periods of physical growth and development". As sex organs develop, grow and the body becomes enslaved to hormonal changes, the simultaneous acquisition of specific sex-role identities and gender scripts create a "challenging and difficult period" (Ibid.) for youth.

The mixed pressures for both abstinence and participation in sexual activity are a normal experience for adolescents; unfortunately, either choice produces a sense of guilt or of longing. One of the earliest theories to emphasize the direct influence of interpersonal and social factors was Davis' 1944 socialized anxiety perspective. He argued that each social class and each culture exercised its own
degree of social control in the form of instilled guilt over budding adolescent sexual urges. If there was too little social control or anxiety, or too much, the adolescent would be led into dysfunctional sexual behaviours. However, a suitable degree of socialized anxiety (depending on each culture's values regarding sexuality), would lead an adolescent to meet external standards for sexual behaviour. Hirschi (1969) added that adolescent sexual behaviours increased when agents of socialization (family, school, church) failed to convey sociocultural expectations for sexual behaviour.

Given the lack of sociocultural expectations for sexual behaviour for adolescents who are gay (other than complete prohibition), it becomes obvious, according to Hirschi's postulation, that gay adolescents should seek out sexual experiences more frequently and more aggressively than their heterosexual counterparts. Davis (1944) would concur, in that the social prohibitions against homosexuality, and in favour of compulsory heterosexuality, leads one into so-called dysfunctional behaviours. As we can see from the above examples, being both adolescent and gay, whether or not one has the language to self-label, is to be quite alienated from oneself, one's peers, and society.

Macro Perspectives on Trust

Since trust relationships are fundamental to the stability of social and psychosocial interactions, they deserve centrality in the analysis of barebacking
and sexual risk taking. Although a clear consensus of the precise meanings of ‘trust’ and of ‘sex’ amongst the interviewees is elusive, all appear to agree that trust (as they individually define it) plays a significant role in their day-to-day functioning. In the absence of trust, what are often complex systems of rules and standards must be constructed to shield the individual against exploitation and opportunism (in the heat of the moment), if the ultimate intent is to counter the characterization of risk as ‘fun’ and ‘adventuresome’. Even these rules, as has been demonstrated, are blunt instruments that do not effectively produce the kind of social support that comes from the existence of trusting relations.

Trust is, after all, the product of two determinants – the nature of the uncertainty of the situation and the degree of the actor’s perceived vulnerability. If the social actors feel that their degrees of vulnerability are reduced by either chance, informed choice of partners, or by any other means, the level of uncertainty diminishes. On the other hand, if the level of uncertainty is considered to be high, then trust is correspondingly lessened; in this scenario, rule-making comes into play, and the individual chooses to participate in a game of chance, often betting ‘against the house’, but occasionally winning. The prize, in this instance is gratification, be it sexual or cerebral. But, unlike purported safe sex experts and health promotion activists, one should make no judgments about the value of the game – to some participants assuming risk for the sake of pleasurable outcomes is extremely important, and to others, it is relatively unimportant.
Current research on trust has focused on the functional properties of the notion. Guido Mollering (2001) suggests that:

Trust can be defined, first of all, as a state of favourable expectation regarding other people's actions and intentions. As such, it is seen as the basis for individual risk-taking behaviour (Coleman 1979), order (Misztal 1996), and social capital (Coleman 1988, Putnam 1995).

However there are a number of typologies of trust, as can be seen by the various interviewees' comments and definitions presented in this study. Trust can be produced through a process-base, as in the case of finding a lover who is new to the gay scene, or the (often false) assumption that HIV/AIDS is a 'big city' occurrence; a character-base, such as barebacking parties among close friends; or through an institutional-base such as having faith in the published information about the purported relative safety of unprotected oral sex. Regardless of the manner by which one comes to trust, however, all share what Simmel (1989:179 quoted in Mollering 2001), describes as 'idiomatic trust':

To 'believe in someone' without adding or even conceiving what it is that one believes about him, is to employ a very subtle and profound idiom. It expresses the feeling that there exists between our idea of a being and the being itself a definite connection and unity, a certain consistency in our conception of it, an assurance and lack of resistance in the surrender of the Ego to this conception, which may rest upon particular reasons, but is not explained by them.

Simmel makes a strong case for the importance of trust when he opines that “without the general trust that people have in each other, society itself would disintegrate” (1989:178). It provides agents meanings that serve as their bases for
realistic and functional behavior. For Simmel, trust represents a force that acts for and through people as well as human associations in general; it "manifests itself at all levels of society" (Möllering, 2001:405)

Niklas Luhmann (1979) embraces this notion of trust, but adds that there is an additional element — *indifference* — explaining that the "trick of trust" (p. 26) is that it condenses social complexities by generalizing within systems, thus exchanging inner certainty for external certainty, or in other words, shifting the onus of proof of trustworthiness from the self and one's own processes of trust building to more easily recognizable external, and concrete clues. In other words, the onus is placed on functional, structural or interpersonal social relations, rather than on reflexivity and self-examination. As he states:

> Although the one who trusts is never at a loss for reasons and is quite capable of giving an account of why he shows trust in this or that case, the point of such reasons is really to uphold his self-respect and justify him socially. (Luhmann 1979:23 as quoted in Möllering, 2001:409)

"Despite its apparent fragility and our many attempts to do without it, it is clear that, in many societies where it is well established, trust is remarkably robust." (Good, 2000) As infants, we generally learn to trust caregivers, and then to trust significant others. During early socialization in the family, it is the comfortable, warm and affectionate fiduciary trust coming from the parents — caring, helping, and sympathizing — that instigates the development of the trusting impulse. (Sztompka 1999:98) There is an asymmetrical reciprocity at this point, as the
child does not yet fully recognize, or have command over external values and social systems. As the child matures, new forms of trust manifest themselves in peer groups: play circles, team games and sports, and school-mates – the natural primary social groups that surround the growing child. The development of trust manifests itself in the axiological notions of fair play, loyalty, and the sharing and keeping of secrets.

When the child learns the meanings of trust in a tangible way through the practices of trusting someone with a valuable toy, piece of sports equipment, or information, more symmetrical expectations of reciprocity slowly crystallize (Ibid.). The slowest to surface are instrumental expectations about proficiency, effectiveness, and rationality, which begin to manifest themselves only in the occupational sphere for adults.

In each of these stages, the evolving range of trust may be met or violated, fulfilled or dishonored. If they are met, the trusting impulse begins to entrench itself in the individual. If, on the other hand, trust is frequently breached, the impulse may never materialize, or it may become censored, apprehensive or paralyzed. “The most devastating effects for the impulse to trust are brought about by the decay of the family . . . The trusting impulse becomes replaced with inherent suspiciousness, obsessive distrust, and alternative pathological developments in the social realm . . .” (Ibid: 98-99)
Sztompka suggests that, on an ontological level, there has been a swing from viewing action or behaviour as purely rational — "homo economicus" — toward a "richer picture including also emotional, traditional, normative, cultural components: value orientations, social bonds, attachments, loyalties, solidarities, identities" (Sztompka, 1999:2). This development evokes two streams of understanding: psychological meanings and cultural meanings. The former involves motivations, reasons, intentions and attitudes, while the latter emphasizes more culturalist aspects of rules, values, norms and symbols. Sztompka draws his support from Giddens' (1990:223) conception that "rational choice theory needs to be complemented with an analysis of social norms; and that norms provide sources of motivation that are irreductible to rationality". What this ultimately implies is that this duality tolerates a variety of "qualitative, interpretative, hermeneutical procedures" (Ibid: 3) useful in understanding the cultural characteristics of behaviour. Additionally, it reverses the standpoint of viewing behaviour as the dependent variable explainable by a rational evaluation of situations, by dealing with behaviour as an independent creative variable implicated in constructing, shaping and modifying other social objects.

Sztompka defends his use of these 'soft' variables by noting, *pace* Luhmann and Dahrendorf, the degree to which our own behaviour, in spite of various social dependencies (charismatic leaders, parliaments, innovators, social movements,
political parties, etc.) has migrated from societies based on fate (or the actions of others) to human agency; underscoring the need to employ trust in others who are involved in our lives and our own social realities. Just as Durkheim wrote about ‘organic solidarity’ in society, we are at a point in history where we are dependent on the cooperation of others, and therefore, dependent on both receiving and granting trust as “an essential condition for cooperation” (Misztal 1996: 269). Frequently, however, the notion of agency is lost when sexual behaviour and condoms enter the equation; in fact, there appears to be a return to an element of fate, or trusting others to make decisions, and an abdication of personal agency for sexual (and other) wellbeing.

Another reason for the burgeoning of both academic interest in trust, and the deployment of trust in society, is that social life has become more marked by threats and hazards of our own making: “The more technology is applied to nature and society, the more life becomes unpredictable. The complex interactions of technology as they bear upon nature and society create an ever larger number of unintended consequences” (Stivers 1994:91 in Sztompka 1999: 12). Coping with the increases in vulnerability in what has been coined the ‘risk society’ (Beck 1992) requires an enlarged pool of trust. Additionally, as people’s options for action increase along with opportunities created by the proliferation of new technologies, the less predictable are the decisions they (and their partners) might take. For example, in a macro environment, to choose among a
variety of actions (e.g., to support a particular political party, to purchase a particular brand of product, to consult a particular doctor or naturopath), we often have to resort to trust. Likewise, the uncertainty about how others will behave, when faced with their own collection of options (which policies the party will pursue, what effect the product will have, what the doctor or naturopath will prescribe) makes trust an essential component of our actions. On a micro level, the same holds true (e.g., choosing to ask a particular person for a date versus the fear of rejection, deciding whether or not to have sex on the first date versus possibly being perceived as promiscuous, deciding whether or not to negotiate sexual safety versus possibly being rejected, infected, or supported in the decision). All involve profound levels of trust.

Hence we routinely find ourselves in a condition of uncertainty about, and uncontrollability of, future actions. We usually cannot know and cannot control what other people will do independently of our own actions, and even more we cannot be sure and cannot completely safeguard how they will react to our actions. Thus to repeat: “What weighs on all social systems and what all social action must deal with is the unavoidability of an unknown [and, let us add – uncontrollable] future” (Barbalet 1996: 84). “Uncertainty and risk are integral to the human condition” (Short 1990: 181).” (Sztompka 1999: 24)

In circumstances when one has to act in spite of uncertainty and risk, trusting becomes the fundamental tactic for dealing with future outcomes. Generally, trusting others evokes positive actions towards those others. Trust is liberating, trust mobilizes human agency; it releases creative, uninhibited, innovative, entrepreneurial activism toward other people (Luhmann, 1979:228). Social actors
become more open towards others, more poised to initiate interactions, to enter into lasting relationships. Uncertainty and risk framing their actions are lessened, and hence "possibilities of action increase proportionately to the increase in trust" (ibid: 40). Additionally and perhaps most importantly, interactions with those whom we endow with trust are without anxiety, suspicion, and watchfulness permitting more spontaneity and openness. There may also be an additional bonus: our own trust may be reciprocated, and then we enjoy all the benefits of being trusted.

It stands to reason then, that diametrically opposed consequences are brought about by distrust. We may be reluctant to initiate interactions (and therefore may pass up opportunity), carefully scrutinize all our moves (remaining constantly vigilant) and follow safe routines (avoiding innovation and spontaneity). In some cases, we may also expect mutual distrust, with all of the harmful effects that it may bring.

As confidence declines, people develop a sense of defensive pessimism to protect themselves against further risk and vulnerability... they are likely to have relatively closed minds and to react as if they have concluded that their partner is not truly concerned about them or the relationship. Positive behavior by the other will be viewed with suspicion. (Holmes and Remple, 1989:241)

On the other hand, being trusted evokes at the very least, a temporary suspension of normal social constraints and ambitions: such persons, roles, organizations, and institutions obtain a "credit of trust", a temporary release from immediate
social monitoring and social control. The result of this 'release' is a wide margin for nonconformity, innovation, originality, in short — freedom of action. Additionally, being trusted by someone may be an argument for others to grant trust as well. The need of trust and the importance of trust grow as networks become more complex: "without trust only very simple forms of human cooperation which can be transacted on the spot are possible . . . trust is indispensable in order to increase a social system's potential for action beyond these elementary forms" (Luhmann, 1979:88). This is not to suggest, however, that unconditional trust is necessarily imperative or even desirable, especially in relation to macro social systems — unconditional trust may be inclined to license behaviour that ought to invite reactions of distrust.

Systems of trust may be schematized into four categories (although more frequently more than one category is present at any given time). Reciprocal trust develops most smoothly and acquires a self-enhancing capacity. Quite simply, trust breeds trust. It precedes and reinforces a culture of trust, turning trust into a normative rule for both the trusters and the trustees. However, if the nature of the trust is blind and naïve, it may produce a temporary culture of trust, but that trust will not ultimately be reciprocal. It binds the trusters, but not the trustees; therefore, it is subject to collapse as it accumulates substantiation of breaches of trust.
If the predominant situation is justified distrust, then a culture of distrust will inevitably emerge, and a self-enhancing vicious spiral of deepening cynicism and suspicion will commence. As with the case above, distrust breeds distrust. "This trust has an inherent tendency to endorse and reinforce itself in social interaction" (ibid: 74). In the most extreme case, obsessive distrust may provisionally attain normative sanction as the rule of suspiciousness. It too may also set off a vicious spiral: "once distrust has sent in, soon it becomes impossible to know if it was ever in fact justified, for it has the capacity to be self-fulfilling, to generate a reality consistent with itself" (Gambetta, 1988: 234). As we have seen previously, it is far easier to turn trust into distrust than the other way around. Good (1988) makes the point by stating that:

If presented with a clear breach of trust by someone, our faith in that person will be fatally undermined. However, if an untrustworthy person behaves well on one occasion, it is not nearly so likely that the converse inference will be made. (p. 43)

When trust becomes fixed as part of the cultural or normative system, it attains a measure of autonomy, acquiring functions and dysfunctions of its own. However, it is functional only if the rules are two sided, that is, it has been prescribed and therefore releases trust, but lapses must also be strongly condemned, therefore preventing breaches of trust. In other words, the functional culture of trust must comprise strong norms with positive sanctions and strong taboos with negative sanctions. When that culture is mono-
dimensional, prescribing trust but ignoring or condoning breaches of trust, it is more akin to a culture of naivety, and has dysfunctional consequences. (Sztompka, 1999:111-112) When it is manifest as a blind trust, prohibiting criticism and skepticism, it is even more dysfunctional. This is frequently the case with "group-think", described by Irving Janis (1982) – a condition when the extreme cohesiveness of the group leads to complete conformity and prohibits any dissent.

Sztompka (1999) describes five macro-societal circumstances as being conducive to the materialization of a trust culture. First is normative coherence, and its opposite is normative chaos, much like Durkheim’s anomie. In the normative coherence scenario, social life is unproblematic, orderly and predictable with fixed scenarios indicating what people should and will do. Feelings of security and certainty encourage anticipation of predictive trust. As well, there are enforceable norms more immediately relevant for trust, requiring honesty, loyalty, and reciprocity. In the anomic condition, the social rules regulating human conduct, as well as of the agencies enforcing obedience, are in chaos. Nothing is predictable except for the most egoistic, self-interested conduct. Insecurity and uncertainty lead to the withholding of predictive trust, and honesty, loyalty, and reciprocity are suspended.
The second structural condition relevant for the probability of rewarded trust is the *stability of the social order*, and its opposite, *radical change*. If the social order is long lasting, persistent, and continuous, it furnishes reference points for a social life featuring routine and habitual responses. It is easy to offer trust since one can expect trust to be returned. Social change is compatible with trust, providing that change proceeds gradually and in a constant direction. In times of rapid and radical social change, as in a crisis, instability undermines the existential fabric of social life. Faced with reshaped groups, new associations, and indeed new identities, feelings of estrangement, insecurity, and uneasiness arise. The odds that our expectations about the actions of others will not be confirmed, and that our predictive trust will be violated, are high. This cultivates suspicion and a tendency to withhold trust.

The third contextual, macro-societal factor is the *transparency* of the social organization, and its opposite, the organization’s *pervasive secrecy*. The availability of information about efficacy and levels of achievement, as well as failures and pathologies, provide a feeling of security and predictability. Even failure to succeed is more reassuring than not knowing what is going on. On the other hand, if the principles of operation are veiled in secrecy, the expectation that there is something to hide engenders rumor, gossip, and conspiracy theories. In this case, people fail to grant trust.
The fourth factor is the familiarity or the strangeness of the environment in which people undertake their actions. This factor is similar to the previous case of stability, as it also has to do with accustomed routine; however in this instance we refer to situations where people find themselves physically displaced, in a new environment rather than in a changing, but nonetheless familiar locale. The feeling of familiarity breeds trust. In its absence, feelings of uncertainty and anxiety run deep. This is frequently found in communities of immigrants as they try to relate to the majority culture. Often, and especially after one or two generations of integration, there appears to be a loss of cultural identity and the disruption of communities.

The last condition is the accountability of other people and institutions. Its opposite is arbitrariness and irresponsibility. This is a crucial factor in the development of trust or distrust, in that a stable, accessible, and properly functioning set of institutions will set standards and provide checks and balances with respect to conduct. People feel confident that societal norms will be observed, and that if abuse occurs, correction will be made in some manner. However, in the absence of accountability, no one can be certain whether or not others will choose to harm their interests, and if that should happen, whether there would be avenues of redress. Suspicion and distrust become natural responses.
Micro Perspectives on Trust

While Sztompka tends to focus on macro-social issues, he does not discount the micro processes that interlace social conditions. For example, when he discusses trust in relation to politics, he notes that ultimately, we have to trust people, not objects or events:

Intuitively we feel that trust must be vested in people, rather than natural objects or events. Even if we seemingly confer trust on objects, such as saying, “I trust Japanese cars,” or “I trust Swiss watches”, or “I trust French rapid transit”, we in fact refer to humanly created systems and indirectly we trust the designers, producers and operators whose ingenuity and labor are somehow encrypted in the objects. (Sztompka 1999: 19-20)

Since Sztompka acknowledges that his macro-analysis is germane to the level of the individual, I will restate his five conditions of trust in a form more conducive to the purposes of this study – a micro analysis of trust.

In terms of normative coherence and normative chaos, rather than limiting the analysis to suggest that only societies and social life can be orderly and predictable, or the reverse, Sztompka’s model could apply to people’s lives, in that they can be secure, and in the main, predictable, or they can be full of uncertainty and danger. For the former, repetition and predictability serve to engender a culture of trust (at least in the familiar); however, for the latter, social rules regarding the conduct of other people (and often themselves) are either unclear, unknown or unknowable, and life may be, as Hobbes states “solitary, poore, nasty, brutish and
short" (Hobbes 1651: 186), and fraught with mistrust, as is the case for many gays.

Sztompka's second structural condition, *stability of the social order* and its corollary, *radical change*, is perhaps the easiest of the five conditions to reduce to a micro social understanding. In a macro setting, the assumption is that the social order is long lasting, persistent and continuous. However, we already have acknowledged that to be gay involves a process of coming to the realization that one is different, stigmatized and considered an outsider, which in turn breeds a form of social mistrust, whether it is internalized or overt within the family, at school, at work or in general society. As Sztompka suggests, gradual social change is compatible with trust; conversely, the process of coming out is a radical personal change and should, in that case, engender mistrust. There is no reason to expect reciprocal trust, predictive trust is difficult to assess, and suspicion and a tendency to withhold trust results. This becomes clear when one examines the sexual behaviour of gay men who have recently come out – in general, they fear the possibility of infection and, having absorbed ‘safe sex’ messages, usually insist on condom use, at least until they become more acclimatized to their new life as a gay man. It is only at this point that Sztompka’s notion of a social order (albeit a new social order) is brought back into harmony with a more routinized and orderly life.
The third macro-societal factor, the *transparency* of the social organization can be seen in the ‘fish-bowl’ existence of gay communities. In most major centres, the visibility of gay-identified people and venues, as well as publications and social/recreational agencies act to insure that information respecting community strengths and weaknesses becomes widespread. This sense of openness is consistent with Sztompka’s forecast of security and predictability, which allows the individual to relate positively (in most cases) with community. As we shall see, (Kippax, et al. 1992), gay community involvement has a significant bearing on health behaviours, and on issues concerning rational choice when it comes to condom use, especially with casual partners. Of course, this visibility is a double-edged sword -- the hitch is that once one is identified as gay, social stigmatization generally will follow, at least from some elements of the social order. The question of whether to remain closeted or to be out, to a great extent, depends on the cost/benefit ratio of being a part of the gay community or a part of the mainstream community. For some people, it is difficult to immerse themselves in both.

Fourth, the *familiarity* or *strangeness* of the environment can straightforwardly be brought to a micro level. In Sztompka’s analysis, he uses the example of a stranger in a strange land. In a micro environment, one of the most compelling reasons for gay community development is the sense of comfort and safety these communities produce. In fact, wherever a gay man travels, if he is able to locate
the gay community (whether it is large or consists of only one bar) he would feel comfortable ‘being among his own’. Being around other gay men, this feeling of familiarity, is a comforting factor; one that would facilitate the granting of trust. On the other hand, the problem of familiarity, especially within one’s own community may foster a climate of mistrust, especially for those men who are sexually promiscuous, and have ‘had’ many people who circulate in their milieu. Knowing too much about someone’s sexual behaviour may be as socially problematic as knowing too little.

Finally, the accountability of other people and institutions, versus arbitrariness and irresponsibility is Sztompka’s fifth condition of trust. He refers to properly functioning sets of institutions that set standards and provide checks and balances with respect to conduct. This element is perhaps the most difficult to reduce to a micro level, since it is dependent on the observation of societal norms. However, a case can be made for a micro analysis of this concept, in that individuals are ultimately responsible for the development and maintenance of the norms – each person has the ability to choose whether or not to accept normative behaviour and its attendant rules and taboos. In an ideal situation, where one’s HIV-positive serostatus is not stigmatized, sexual conduct could be negotiated and, if necessary, sexual scripts could be modified to accommodate reasonable levels of intimacy, trust and safety. Therefore, the accountability of other people, even in a
one-to-one situation, can be likened to Sztompka's accountability of other people and institutions.

These micro conditions will be further illustrated in the following section, where the correlation between trust and risk-taking will be examined in light of the theoretical understanding of the nature of trust.

Bringing Trust and Risk-Taking Together

Nicholas Luhmann (1979:78) suggests that self-confidence makes one more prone to take risks involved in trusting others. Anthony Giddens (1991:79) agrees, adding that self-concept is the mediating link between resources and trust, arguing that as self-concept increases by the possession of resources (knowledge, self-knowledge, sense of identity), one has a more open, optimistic compassionate, relaxed attitude that translates into more trust toward others.

However there is another mediating factor to consider. Our instincts and expectation levels also serve as forms of insurance for our trust, because they may act to lower our relative vulnerability in case that trust is breached. People devoid of these resources tend to be distrustful, mainly because backup support is frequently absent, and vulnerability is higher. It is in this light, bearing in mind Sztompka's classifications that we will be able to examine issues of risk taking, and the psychological well-being of the sample subjects discussed earlier. There are of course, other factors that in combination may increase or decrease
purported trust – job stability, the plurality of social roles that individuals play, the robustness of other held beliefs, power, formal education, social networks, and the family (either biological or of choice).

In sum, when one considers issues of trust in conjunction with high risk sexual behaviour, especially in the case of potential infection and untimely death, that trust must be unshakable, or if it is not, there must be some other factors that permit something less than a 100% faith in someone else to mediate that trust. Several writers have acknowledged that there are mediating factors that do permit trust to be qualified.

In *Sex, Gay Men and AIDS* (Davies et al., 1993) the authors examined social perspectives on anal intercourse. Not surprisingly, they found an immense symbolic significance in anal intercourse as it relates to its pivotal role in the transmission of HIV, but they also found that there were different meanings men ascribe to anal intercourse. Central to this analysis, is an understanding that anal intercourse is not something men must do (and cannot help themselves from doing), but something they actively choose to do in some circumstances and not in others.
During wave four of project Sigma\(^5\), men were asked "How important is fucking to you?" The parameters employed in analyzing this question included the centrality of anal intercourse in their lives, how anal intercourse informs their social and sexual identities, the meaning of orgasm, the relativity of physical pain, closeness, love, intimacy, bonding, trust, relaxation and power. Many men mentioned trust. While trust took a number of forms, it was mostly related to receptive anal intercourse. Being able to trust the partner to stop if asked was common. Although trusting casual partners was an issue in general, prior experience of force was given as a concrete reason not to trust (almost 1/3 of the respondents, n=33). Trusting the insertive partner to use condoms properly and to check the condom frequently was also underscored.

Responses to the statement concerning trust were significantly associated with being fucked by a casual partner. Among those who agreed with the statement "I need to trust someone before I let them fuck me," only 19.3% had been fucked by a casual partner compared with 56.2% of those who disagreed ($\chi^2=41.94$, df=2, $p<0.001$). Response to this statement was also associated with insertive fucking with casual partners in the previous year: 28.6% who agreed had fucked a casual [partner] compared to 53.4% who disagreed ($\chi^2=16.81$. gd=2, $p<0.001$). This is attributed to the fact that fucking casual partners in the last year was much more common among those who had been fucked by a casual [partner] also (67.8% versus 21.5%, $\chi^2=82.71$, df=1, $p<0.001$) (Davies et al, 1993:135)

On a qualitative level, respondents in the Sigma study had a number of points to make about trust and anal intercourse:

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\(^5\) Project Sigma is an open cohort, formally titled Sexual Investigation of Gay Men and AIDS, operational in Great
A bit of trust is necessary and in one night stands you’re not sure how much you can trust them, to stop when you want them to.

It’s to do with a level of trust and I need to know more than if I’d just met them 5 minutes ago. The reason is I had a couple of bad experiences in my early 20’s.

It’s important to trust the partner. My ex-partner gave me trust, it could have been done safely and enjoyably, I knew he’d be careful with condoms.

In this relationship I prefer to be passive, partly because it’s him, I trust him and can relax.

It’s a question of trusting them for being fucked; I find it uncomfortable, need to be relaxed. (Ibid.)

These individuals, as well as the study group as a whole, had to learn trust and distrust. In most cases, prior experience was the main conduit to knowledge, confirming the distinction between casual and regular partners: trust is greater with regular partners than it is with casual partners. In Sztompka’s terms, this phenomenon can be linked with his second point – the stability of the social order – regular partners provide reference points of routine and habitual responses.

In sum, the adoption or rejection of trust modalities is significantly influenced by earlier life course events and direct experience. In turn, those modalities inform adult behavior, as well as beliefs, attitudes, and interpersonal relations.

Ultimately, I demonstrate that notwithstanding over 20 years of safer sex education directed towards both the general and the MSM populations, the
shifting dynamics of risk, trust and intimacy have confounded attempts to create and support metanarratives promoting positive health beliefs, given that decision-making with respect to one's own health and welfare is not based merely on cognition and social or institutional aspects of life, but also on a complex welter of emotional, historical and psychological factors.
CHAPTER 2 – GAY MEN, SEXUAL FREEDOM AND HIV

If proof is needed that social marketing metanarratives as they have been constructed, are fundamentally incorrect and sometimes even insulting, one need only look at AIDS infections data to see the lack of permanent results of these campaigns.

In 1994, Walt Odets wrote:

To date, more San Franciscans (90% of them gay men) have died of AIDS than died in the four wars of the 20th century, combined and quadrupled. Thirty percent of 20-year-olds will be infected or dead of AIDS by age 30 and the majority will become HIV-infected at some time during their lifetimes. The mean life expectancy of a San Francisco gay man between the age of 16 and 24 is somewhere around 45. (p. 1)

Fortunately, Odets’ prognostication is now somewhat off the mark. With the advent of protease inhibitors, life expectancy even with HIV is significantly greater than it was in 1994.

However, in terms of percentages of men engaging in anal sex, current and past data do not appear to have changed since even before the onslaught of the epidemic (50% to 60% of all gay men have anal sex). If there has been no change in the percentage of gay men who participate in anal intercourse, and subsequent to the tremendous upsurge in infections in the 1980’s and early 1990’s, new infection rates remained relatively stable for several years, it could be a safe
assumption that the social marketing messages have had, since then, less than the desired impact – that impact being a reduction in infection rates and an increase in condom use.

HIV/AIDS Statistics

Data on HIV prevalence (based on testing statistics) always lags behind the times. Due to inconsistent reporting (some jurisdictions require full reports, while others do not), and the fact that most participating clinics represent a convenience sample rather than a probability sample, data needs to be interpreted with caution, because persons who attend participating clinics and hospitals are not representative of all persons being tested, not to mention those people who do not seek testing at all. In an ideal world, from a statistical perspective, there would be one source of information that would provide HIV data on a consistent basis. Such a reporting system does not exist.

In Canada, data is maintained on reportable diseases, such as AIDS. The following tables illustrate the rise and fall of ‘full-blown AIDS’ cases from 1986-1997:
Table 2-1: AIDS Incidence Over Time. AIDS, Males, All Ages

(Health Canada, LCDC, 1999)

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate/100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>3.10</td>
</tr>
<tr>
<td>1987</td>
<td>4.50</td>
</tr>
<tr>
<td>1988</td>
<td>5.60</td>
</tr>
<tr>
<td>1989</td>
<td>7.70</td>
</tr>
<tr>
<td>1990</td>
<td>7.30</td>
</tr>
<tr>
<td>1991</td>
<td>6.80</td>
</tr>
<tr>
<td>1992</td>
<td>8.80</td>
</tr>
<tr>
<td>1993</td>
<td>7.40</td>
</tr>
<tr>
<td>1994</td>
<td>7.90</td>
</tr>
<tr>
<td>1995</td>
<td>5.50</td>
</tr>
<tr>
<td>1996</td>
<td>2.50</td>
</tr>
</tbody>
</table>

At first glance, table 2-1 suggests that infection rates have dramatically dropped. And indeed, in Canada, the reported incidences of AIDS have declined since 1995. However, there is a world of difference between being infected by HIV and having reportable AIDS. What table 2-1 does illustrate is the magnitude of the impact of triple drug therapy on AIDS cases, since the data reflects only

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6 NRTIs (Nucleoside Reverse Transcriptase Inhibitors): zidovudine (AZT), didanosine (ddI), zalcitabine (ddC), stavudine (d4T), lamivudine (3TC), Combivir™ (AZT + 3TC), and abacavir (Ziagen™).

PIs (Protease Inhibitors): saquinavir (Invirase™ & Fortovase™), ritonavir (Norvir™), indinavir (Crixivan®), and nelfinavir (Viracept®).

NNRTIs (Non-nucleoside Reverse Transcriptase Inhibitors): nevirapine (Viramune®), delavirdine (Rescriptor®), and efavirenz (Sustiva™).
full-blown AIDS\textsuperscript{7} cases, \textit{not HIV infection}. The dramatic drop in reported AIDS cases, from 1995 to the present, is primarily reflective of this new therapy.

However, it bears repeating that one must be cautious in that this data is only reflective of reported AIDS cases, not HIV infection. Until the advent of the use of triple drug therapy on a large-scale, in the mid-1990s, the average time from infection to symptomatic AIDS was approximately ten years. Therefore these data must be viewed with that time constraint in mind, coupled with data previously presented on new HIV infections.

The following figure (2-1) illustrates the age of the Canadian AIDS population. Again taking into consideration the limitations outlined above, the high incidence of 30 to 59-year-olds with AIDS may be misleading with respect to the time at which they seroconverted, and could reasonably be set back by at least five to 10 years. That would suggest that many men were becoming infected with HIV between 1987 and 1992. Interestingly, this was the time when major AIDS-based education programs were taking place in urban centres. Again, this may suggest that the interventions were having little effect on HIV prevention.

\textsuperscript{7} HIV infection is statistically converted to AIDS when one's viral load drops to a certain level (which varies...
Figure 2-1: AIDS, Males, 1997, Canada  (Health Canada, LCDC, 1999)

This can be contrasted with older information:

Table 2-2: Year 1994: Median Age Of First Diagnosis  (Health And Welfare Canada, 1994)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MEDIAN AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>pre 1982</td>
<td>32 years</td>
</tr>
<tr>
<td>1983 - 1984</td>
<td>27 years</td>
</tr>
<tr>
<td>1985 - 1990</td>
<td>23 years</td>
</tr>
</tbody>
</table>

from time to time depending on government, health insurance and medical input)
As can be observed, prior to 1990, the age of first diagnosis was dropping rapidly. This is primarily due to the increase in anonymous testing facilities, people being tested, and overall confidence and interest in the test itself. There is new evidence to suggest that the age of seroconversion has risen in the past decade, as follows:

**Figure 2-2: Year 2000: Median Age of First Diagnosis**
(Health Canada, 2000)

One of the reasons for this shift to an older median age of diagnosis may be the disappointment in the gay community that what was once a temporary measure to control the spread of HIV (condoms) has become a more-or-less permanent way of life. Early on in the epidemic, young men were unknowingly taking the majority of sexual risks. When testing became available, the statistics demonstrated the magnitude of the epidemic. However, now, men between the ages of 30 and 49 are the highest seroconverting group. This must be explained
in ways other than lack of knowledge about viral transmission. The logical explanation is that these men (like many others not diagnosed) have anal intercourse without condoms, knowing that risk is part of the sexual script. If this is so, then the undertaking of risk must be a calculated decision, for it is inconceivable that such a large number of men are having UAI 'in the heat of passion', or influenced by drugs and/or alcohol.

In any event, regardless of the age at which one seroconverts, HIV seroconversion rates, which were relatively stable until now, are now on the upswing (Craib et al, 2000). There is no doubt that the knowledge issues have been addressed by the media and the social marketing messages. What is at issue is the lack of gay men's response. Eric Rofes puts it thus:

Gay men may have been inculcated in safe sex behavior but inculcation has fallen short of ensuring protected sexual activity. The reduction of acts coded with meaning and historical context into consumer goods, underlies the gradual erosion of gay men's trust in community prevention efforts over the past decade. (Rofes, 1996:133) (italics added)

Framing the Debate

In January 2000, a letter to the editor appeared in Xtra West, Vancouver's gay and lesbian biweekly newspaper, referring to a previously run article critical of the practice of barebacking. Apart from sporadic articles and letters found in fringe publications and web pages, this was the first time gay Vancouerites were
confronted in a widely circulated publication by a sex-positive gay man who wrote unconditionally in favour of barebacking, and personal sexual choice:

Whatever my sexual practices are, they are about the adult choices that I make for me in my adult life. I live without the need for explanation, as I am without partner.

My sexual adventures, may they be in the park, at the baths, with someone from a bar or with that special someone after a Bad Boy's connection, are the kind of adult choices that I make for myself. Why should they be of anyone's concern if the only one I am responsible to is myself?

Most recently, I have found further liberation in the simple act of barebacking. I have found comfort in knowing that I am not alone. For the last two months, not one adventure has left me disappointed. Barebacking is the name for the times. A name that shouts rebellion, freedom and chance. Barebacking is truly a kickback to the decade(s) when life was lived with a sense of sexual and personal freedom. Thank God the Victorian Age has once again passed on.

Barebacking may be only a romanticized version of "getting fucked without condom", but what are my risks? People are not dying anymore. Not dropping off like flies, anyway. The quilt has gathered moss. The photos of loved ones no longer grace our community pages. We have obviously found an ointment for the scratch.

I live my adult life with the belief that if I want it, all I have to do is go there and get it. That attitude has served me well. I am a professional and a success. And truly, who loves me more than me?

Rob Hamilton, Vancouver, BC

(Letter to the Editor. Xtra West, No. 168, January 27, 2000, p. 4)

The letter provoked a heated and vituperative response two issues later, and in turn, triggered a reply from the original author. The initial letter (above) provides us with some interesting insights into how (at least) one gay man assesses risk: the second sentence exclaims that explanations are unnecessary “as I am without partner”. This suggests that Hamilton’s position is contingent on his relationship status, which is further reinforced in the second paragraph, where he states that “the only one I am responsible to is myself”. A second theme emerges in the third paragraph – one of defiance and rebellion: “I have found further liberation
in the simple act of bare-backing [sic]” and “A name that shouts rebellion, freedom and chance”. The act of defying supposed community norms (“freedom” from what, one might ask) is heightened rather than tempered by the acknowledged risk (“chance”). Additionally, Hamilton notes that he has “found comfort in knowing I am not alone”, implying that there was some initial sense of discomfort with either his previous sexual scripts, or perhaps something more broadly based – his sense of community.

While professing independence and freedom of choice, Hamilton questions the veracity of the putative risk “. . . but what are my risks? People are not dying anymore. Not dropping off like flies, anyway.” Presumably, Hamilton’s decision to have bareback sex is also contingent on medical advances that slow the progression of the virus, and perhaps unintentionally, given the fact that so many men have already died, an unwillingness to believe that there could be yet another epidemiological holocaust in the gay community.

In the last paragraph, Hamilton touches on two additional themes – both of which appear rather out-of-place, or non sequiturs: “I am a professional and a success.” and “And truly, who loves me more than me?” In the first instance, Hamilton’s socioeconomic status appears to have no relevance to his decision to bareback, and yet one must wonder if he is obliquely referring to people of lesser
means who may (in his mind) lack the capacity to call upon ambition, drive and persistence, suggesting that they may somehow be stereotypically unqualified to make independent health related decisions. Or, he may be referring to injection drug users (IDUs) who, like barebackers, are also at significant risk for HIV, in this case through needle sharing. Second, and perhaps more telling, is his concluding proclamation of self-love. Here he exhibits a number of qualities endemic to many gay men (and supported by responses from the interviews): narcissism, loneliness, a need for validation and the necessity of self-reliance.

Does Hamilton truly believe what he writes, or is hyperbole at play? On the face of it, one must assume that Hamilton is genuine in his acceptance of risk, and his proclamation of sexual freedom. However, his response to his critics suggests something else. First let us examine Jon Levitt’s response to Hamilton’s letter in the February 24, 2000 edition of Xtra West:

After first reading the letter about barebacking by Rob Hamilton (Issue 168, Jan 27), my initial reaction was anger and sadness for the warped views of the writer, but then I got increasingly angry at Xtra West for the placement of the letter at the top of the page with the edited headline: Barebacking Pleasures.

Why not? If the letter was from a street IV drug user, an appropriate headline could be, “The pleasures of sharing needles,” or how about a handgun enthusiast headlined with, “The pleasures of Russian Roulette,” or a letter from a youth in a small isolated town entitled, “The pleasures of glue sniffing.”

Where is Xtra West’s responsibility in journalism, let alone responsibility to our community? Where is your good common sense? Where is your conscience?
This letter was written by someone whose head is obviously buried in quicksand. Extolling the virtues of barebacking because it shouts “rebellion, freedom and chance”. Rebellion against two decades of trying to educate ourselves to rejoice in love and sex without succumbing to genocide/extinction? Freedom to say, “fuck you” to countless thousands of our loved ones who have died or continue to suffer from HIV/AIDS? Freedom to deny everything we’ve learned as factual about the transmission of one of the worst diseases ever known to humankind? Freedom to spread the dangerous view that barebacking is okay to impressionable horny youth who already think they’re immortal and immune to the older generations’ problems?

But Rob, how about the chance you are encouraging others to take?

Don’t you feel any moral responsibility to your fellow gay beings?

Jon Levitt
Vancouver, BC

It is interesting that Levitt first chooses to condemn the publication for allocating such prominence to Hamilton’s letter (it was the lead letter). His initial anger is also directed at the headline “Barebacking Pleasures” positioned “at the top of the page”, but quickly turns to the very fact that Xtra West chose to publish the letter at all. Levitt feels that it is irresponsible of the publication to give voice to such dangerous comments. Levitt questions Xtra West’s “responsibility in journalism, let alone responsibility to our community.” The irony is that both Levitt and Hamilton refer to community – Levitt in terms of silencing discourse concerning certain forms of sexual behaviour that should not be explicitly discussed, and Hamilton in terms of opening discourse and finding like-minded individuals in the community.

Levitt then turns his anger to the letter writer himself. Instead of addressing issues raised by Hamilton, and perhaps providing a rational counter-point, Levitt
attacks the content with an emotional plea to remember our history during the epidemic, and an insinuation that informing “impressionable horny youth” that barebacking “is okay” is “dangerous”. Levitt seems to make the assumption that these youth have not heard of, considered, or engaged in barebacking prior to Hamilton’s disclosure, and have just been provided an alluring alternative sexual script.

In that same issue, Rob Hamilton qualifies his first letter with the following:

> I make no apology for my letter on barebacking (Issue 168, Jan 27), as I felt it was an issue that needed another voice at a time when the safe sex message has all but disappeared from our baths, bars and community newspaper.

> The intent of my letter was not to make light of a serious issue, but to draw attention to the responsibility that we have to ourselves, our well being, and in keeping the safe sex message alive. Twenty years later, a new generation of young men are coming out into our/their community and we, as educators, are failing them.

> Our gay youth are not being met with the same bold awareness that greeted us in our not-so-distant past. If we are to learn anything from history, is it that history teaches us nothing? Why have we let our guard down?

> The bottom line on barebacking is that people are going to do what people are going to do. Awareness provides for the more informed choice.

> If my letter and the response to it has served as a reminder on the importance of condom use and safe sex practice, then our dialogue has not been without purpose. Let us not forget: SILENCE=DEATH.

> Our gay youth are counting on it.

> Rob Hamilton, Vancouver, BC

The overall tone of Hamilton’s second letter is inconsistent with his first one. In this latter missive, he extols the virtues of “keeping the safe sex message alive” — seemingly a reversal from his original statement that “Barebacking is the name for the times. A name that shouts rebellion, freedom and chance.” [Ital. added]
added] He indicates (without saying so) that his first letter was intended to be a "reminder on the importance of condom use and safe sex practices". If one accepts this position, it stands to reason that the first letter should be considered satirical in nature, much like Jonathan Swift's enjinder to solve the "Irish Crisis" by eating their babies. Yet Hamilton reinforces his original intent by stating that "people are going to do what people are going to do", a curious tautology implying that contrary to his previous statement that "a new generation of young men are coming out into our/their community and we, as educators, are failing them", there is little hope of stemming the tide of barebacking, which he seems to have welcomed in the first letter. He concludes that thought with "awareness provides for the more informed choice," yet does not suggest what we should be aware of. Is he suggesting that we should be aware that some people choose not to use condoms for anal intercourse? Or is he suggesting something more profound - that as a community (or communities) we should be aware that sweeping controversial issues under the proverbial rug does little to inform gay men of their options, and perhaps makes the 'forbidden' seem that much sweeter.

Oddly, and perhaps inadvertently, he concludes his letter with the ACT-UP slogan "SILENCE=DEATH". Originally, this catchphrase was used to rally adherents and conscience constituents in the battle to move the FDA (United States Food and Drug Administration) and the pharmaceutical companies away
from their highly conservative drug trial protocols, and urge them to release promising AIDS drugs (on compassionate grounds) prior to fully testing them. The use of the phrase is ironic in that while Hamilton initially suggests that his risks are minimal, since people aren't dying in the numbers they were before (or in other words, AIDS is a manageable disease), he invokes the mantra of AIDS activists who were dying.

In all, this public discourse points to a number of important themes that need to be expanded and examined more fully. First and foremost, as Hamilton and Levitt point out, it is important to qualify what constitutes a risk for HIV infection; and coincidentally, is risk, in this case, absolute or relative? Second, it is clear from the three letters that the problematic goes beyond risk taking and risk avoidance, into the realms of community and the politics of sex and HIV. Third, they draw attention to the fact that there may be links between knowledge, beliefs and everyday behaviour. These associations need some elaboration as well.

HIV and Risk Behaviour

In the early years of the AIDS epidemic, epidemiologists established the primary routes of transmission of a possible AIDS-associated pathogen, later identified as human immunodeficiency virus (HIV), and were confident that they were also able to identify the social groups, or networks that were associated with the
disease – gay men. They were so confident of this finding that the disease itself was initially christened ‘GRID’ – gay-related immunodeficiency. Thus, for the first time in recent history, a disease was classified by the identity of a social group rather than either the discoverer (such as Tay-Sachs or Chrone’s disease), site-of-origin (Ebola Fever, Legionnaire’s disease) or symptomology (Yellow Fever, Chicken Pox, and Retinitis). Although fraught with methodological issues and subject to erroneous assumptions, the popular notion of AIDS as a ‘gay plague’ took hold, both within and outside the gay populations of North America and Europe.

With the introduction of HIV antibody testing, a more precise understanding of transmission was realized, as the presence of infection in individuals could now be ascertained. Furthermore, the rate of infection could be measured in categories of people with shared characteristics and behaviours, and the relative risk of particular behaviours* vis-à-vis potential transmission could also be measured, refining even further the quantitative assessment of risk of infection. (Hart, 1995:55)

What this meant for gay men was that receptive anal intercourse without the use of condoms became hyper-stigmatized as the primary risk behaviour for potential infection, and other sexual behaviours (insertive anal and oro-genital sex) as secondary, but yet clearly identifiable, risk activities. Consequently, the medical

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*Non-penetrative sex, oral, vaginal and anal sex, injection drug use with shared needles.
model of risk reduction strongly advised gay men to abstain from all anal intercourse. Before long, AIDS Service Organizations (ASOs) developed guidelines under the rubric of ‘safe sex’ (USA) or ‘safer sex’ (Canada, UK, Scandinavia) to embrace sexual activities with varying degrees of risk. In the United States, the ‘safe sex’ message proscribed any fluid exchange (particularly semen and blood) and embraced a ‘100% safe, 100% of the time’ epistemology. Elsewhere, the notion of relative risk was promoted, and sexual behaviour was categorized as ranging from high risk to no risk, depending on the activity.

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9 Condoms, generally acknowledged to be effective barriers to HIV transmission are not 100% effective as they are subject to breakage, leaks, and mis- or non-use.
Table 2-3: “Risk Model” -- Mclure & Grubb (CAS\textsuperscript{10})

<table>
<thead>
<tr>
<th>RISK</th>
<th>BEHAVIOUR</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>Insertive or receptive penile-anal or penile-vaginal intercourse without condom, sharing needles or syringes, receptive insertion of shared sex toys.</td>
<td>All of the practices listed in this category present a potential for HIV transmission because they involve an exchange of body fluids such as semen, vaginal fluid, and blood or breast milk. In addition, a significant number of scientific studies have repeatedly associated the sex activities with HIV infection. Even when the exact mechanism of transmission is not completely clear, the results of such studies conclude that activities in this category are high risk.</td>
</tr>
<tr>
<td>Low Risk</td>
<td>Receptive fellatio without barrier (sucking cock), insertive cunnilingus (putting mouth and/or tongue inside vagina) without barrier, insertive or receptive penile-anal or penile-vaginal intercourse with barrier, injection of a substance using a needle and syringe which has been cleaned.</td>
<td>All of the practices listed in this category present a potential for HIV transmission because they involve exchange of body fluids such as semen, vaginal fluid, and blood or breast milk. There are also a few reports of infection attributed to these activities (usually through individual case studies or anecdotal reports, and usually under certain identifiable conditions).</td>
</tr>
<tr>
<td>Negligible Risk</td>
<td>Insertive or receptive fellatio /cunnilingus with barrier, anilingus, digital-anal intercourse.</td>
<td>All of the practices listed in this category present a potential for HIV transmission because they involve exchange of body fluids such as semen, vaginal fluid, and blood or breast milk. However, the amounts, conditions and media of exchange are such that the efficacy of HIV transmission appears to be greatly diminished. There are no confirmed reports of infection from these activities.</td>
</tr>
<tr>
<td>No risk</td>
<td>Kissing, solo masturbation, being masturbated by partner (without using semen/vaginal fluid as lubricant), using unshared sex toys, urination, ejaculation or defecation on unbroken skin, massage, touch, caressing, dirty-talk, body rubbing, injection of a substance using a new needle and syringe.</td>
<td>None of the practices in this group have ever been demonstrated to lead to HIV infection. There is no potential for transmission since none of the basic conditions for viral transmission are present.</td>
</tr>
</tbody>
</table>

\textsuperscript{10} Canadian AIDS Society, 1999:20-21
This 'relative risk' notion (Table 2-3) conforms to the Canadian (as established by CAS – The Canadian AIDS Society) and Northern European model of 'safer' sex. This is a significant departure from the American model of 'safe' sex whose prescriptive has been, and remains to this day, “100 percent safe, 100 percent of the time.” Therefore, in the American paradigm, upon which much of HIV/AIDS prevention work is modeled, the categories from high risk through negligible risk are collapsed into the 100% safe sex message. Faced with an almost certain inability to live up to the 100% dictum, especially with regard to negligible risk (and to some extent low risk), sexually active American gays and MSM came to realize that they had failed to uphold the supposed community standards surrounding safe sex, and many accepted this failure as proof that they were incapable of 'safe sex', and therefore engaged in high risk behaviour on the assumption that their failure is absolute, rather than relative. This notion of risk and failure has seeped into the Canadian psyche as well, primarily through the infiltration of American media, and on an academic level, the proliferation of papers and books on the 'crisis' in the gay community, a crisis of noncompliance. Unfortunately, what began as a benign strategy to curb an epidemic has been perpetuated as normative, authoritarian one that castigates the deviants and exalts the conformists.

HIV is only transmittable in certain circumstances (primarily the exchange of infected semen or blood) and with varying degrees of efficacy. Clearly, in the
absence of viral infection, transmission is impossible – one cannot share that which one does not have. In that case, and in the cold light of day, one might assume that that which is known not to be a risk would be a guide to inform attitudes toward marginally risky sexual behaviour. And ultimately, the adoption of safe sexual behaviours should then be promulgated with respect to high-risk activities. However, this does not appear to be the case. As early as 1991, when the data for the 'men's survey' (Myers et al, 1993) was collected, over 94% of gay men surveyed knew that anal sex without a condom was 'very high risk', yet almost 30% of the same respondents who practiced receptive anal intercourse did not consistently use a condom.

More recent statistics (January, 1997) from the Vanguard Data Base indicate the following:

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11 Myers et al (1993) Table 15, page 32

12 In this study, regular partners are defined as "Guys you have sex with, at least once a month", and casual partners are "Any guys you have sex with less than once per month, including one-night stands".
Table 2-4: Behaviour (Vanguard Project – Web Site)

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Regular Partners (%) N = 378</th>
<th>Casual Partners (%) N = 410</th>
</tr>
</thead>
<tbody>
<tr>
<td>anal insertive sex without condom with ejaculation</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>anal insertive sex without condoms without ejaculation</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>anal receptive sex without condoms with ejaculation</td>
<td>24</td>
<td>6</td>
</tr>
<tr>
<td>anal receptive sex without condoms without ejaculation</td>
<td>34</td>
<td>14</td>
</tr>
</tbody>
</table>

The difficulty in perceiving why, despite overwhelming evidence that certain sexual behaviours are associated with high risk of HIV infection, many gay men continue to have anal intercourse without condoms, goes beyond the boundaries of so-called normative rationality. Understanding it requires adopting a standpoint that does not characterize the individual as an autonomous entity, but as someone that considers risk conjoined with the person’s direct and diffused social site and context. This is not to negate human discretion or agency, but rather to maintain that risk is informed by engagements with other people, social organizations and institutional issues.
The letters discussed earlier in this chapter are illustrative of this dynamic. In Hamilton’s first letter he suggests that he is an autonomous individual – “adult choices that I make for myself”. However, his words are fraught with contradiction, in that while claiming that “the only one I am responsible to is myself”, he also makes note of the fact that he is “without partner”, thus acknowledging the possibility that he could have other responsibilities; his sexual “adventures” always involve other people; and most telling, he asks “who loves me more than me?” again leaving open the possibility that there could be someone else involved in this relationship of one. Perhaps without directly articulating it, Hamilton acknowledges the potential impact of other people and social institutions on his decision-making.

Clearly, Hamilton and others are making use of a variety of risk assessment strategies, both on conscious and sub-conscious levels. Both in deed and in thought, gay men, MSM and others operationalize some learned community social norms, adapt other norms or restrictions to suit their own needs, and disregard those that appear to be unattainable or undesirable. In order to better understand the combination of factors involved in how these decisions are reached, and how what appears to be irrational can in fact or in appearance be rational (especially with regard to risk assessment and risk taking behaviour), we need to examine some theoretical considerations.
Fishbein and Azjen's *Theory of Reasoned Action* (1975), and its successor, Azjen's *Theory of Planned Behaviour* (1988) propose that "behavioural intentions are the best predictors of subsequent behaviour. In turn, intentions can be predicted by the beliefs and knowledge regarding the behaviour in question, together with the subjective norms. These relate to the extent to which individuals believe that important others would wish them to engage, or not, as the case may be, in the particular behaviour(s). The relative influence of beliefs and subjective norms varies with different domains of behaviour." (Ingham et al, 1992 p. 163) The theory can be illustrated as follows:

**Figure 2-3: Theory of Planned Behaviour**

```
    FEELING TOWARD THE BEHAVIOUR
      ↓
    SUBJECTIVE NORM
      ↓
  PERCEIVED BEHAVIOUR CONTROL
    ↓
    INTENTION
      →
    BEHAVIOUR
```
This model is useful in understanding why HIV/AIDS organizations, government health departments, and other social institutions have adopted the KAB (Knowledge, Attitude, Behaviour) health prevention model in their campaign against infection. The functionality of the model suggests that if one can establish the target population’s feelings with respect to their current sexual behaviour (shame, guilt, pride, disinterest), relate this to how they perceive others feel (the subjective norm), and somehow determine what methodologies may influence behaviour change (media campaigns, posters, handing out condoms in bars, counseling in the bathhouses, public forums and so on), then one might be able to develop situation specific and appropriate intervention programmes designed to increase the individual’s intent to use condoms. If such an intention can be sustained, according to the theory, the likelihood of a real behaviour change is concurrently more probable.

This, as well as similar models13 are referenced regularly in the HIV/AIDS prevention discourses in attempts to refine the predictability of behavioural outcomes for HIV intervention programs. They have been used as ‘truths’ in the effort to develop publicity campaigns in the field of HIV education. The intended outcome – after the population has been informed of the facts surrounding HIV infection; the seriousness of the disease; the routes of

13 See Emmons et al., 1986; McKusick et al., 1995; Rutter, 1989 for examples.
transmission; and the potential consequences of deviating from proscribed safe
sex guidelines — is an alteration of the individual’s belief structures. The
knowledge, attitude, behaviour (KAB) model has been used throughout the
Western world for over 20 years. However, judging by the condom usage
statistics presented previously, KAB may be at best outdated, and at worst
counterproductive.

The condemnation of the KAB model stems from two points of reference. First,
its initial hypothesis is that altering sexual behaviour is no less complicated than
selling cars, or holiday vacations. The presumption that deeply ingrained social
systems, such as sex and sexuality can be ‘socially marketed’ is fallacious. One
need only point to the relative failures of other social marketing / public health
programmes: unwanted pregnancies, heterosexually transmitted STDs, and
cigarette smoking to name but a few (Odets, 1994). The mere fact that
HIV/AIDS education must speak to a stigmatized, and possibly persecuted social
minority whose core identity is intimately tied to the ‘target behaviour’ — sex in a
sexually vectored epidemic — strongly suggests that catchy one-liners and ‘pretty-
boy’ graphics are insufficient to effect behaviour change dynamics, even
minimally.

Second, the KAB models themselves are often homophobic misrepresentations
and moralizations that disregard the social realities of the epidemic, and do not
pay attention to the specific social and psychological issues that arise. (Botnick, 1995) I shall deal with these issues in detail further on when I examine some social marketing advertisements.

The assumption that traditional rationality is directly and inextricably connected to the understanding of sexual behaviour is not supported by the evidence. There are a number of impediments that prompt one to challenge the perception that there is an uninterrupted connection between knowledge, attitudes and behaviour (especially behaviour change).

The 'mens' survey' (Myers, 1993) reported that:

The probability of reporting a strong intention to use a condom for insertive anal sex varied between 12.0% and 96.0% according to the 3 predictors of The Theory of Planned Behavior. Men who are most likely to say they'll use a condom for insertive anal intercourse think the decision to use a condom would be completely their own; they think that using a condom would be extremely enjoyable and they believe most gay and bisexual men in their community think using a condom for insertive anal intercourse would be a very good thing to do. Men who don't like the idea of using condoms are unlikely to say they'll use a condom for insertive anal intercourse.

Perceived behavioral control emerged as the most important factor. For example, consider the men who believe it would not be enjoyable to use a condom but who think the gay community feels it would be a "very good" thing for them to do. Among these men, there is a 77.0% probability of expressing a strong intention to use a condom for insertive anal intercourse if they perceive they have complete control over the decision. If they perceive they have little control over the decision, the probability of expressing a strong intention to use a condom for insertive anal intercourse will be 27.0%.

Attitude was the second most important variable, and perceived social norms, although significant, was the least important. (p. 58)
It is important to note that Myers' study, as is common with most (if not all) studies that involve self-reporting, may not be wholly indicative of the situation. What people report they do, or think, is not always what they actually do or think. This may seem self-evident, but it is an important factor in motivational education and the statistical reporting of beliefs and behaviour, especially when employing techniques that involve anything other than face-to-face training. In general, experience has shown that attitudinal studies have found that positive attributes are overstated, and negative attributes are understated. These data, and the data yet to come, must be read with that limitation in mind.

Perceived Invulnerability

As a matter of record, gay men are generally cognizant of the seriousness of HIV, the routes of transmission and prevention strategies. (Abrams et al., 1990; Botnick, 1995, 2000; Myers, 1993; Kippax et al., 1993; Aggleton et al., 1995) Paradoxically, however, they frequently tend to rate their own personal risk as very low. Some simply deny the risk, perceiving that the issue is blown out of proportion. People who hold this view tend to have few, if any close friends who are HIV-positive, or have had little community contact with people whom they know are HIV-positive. Others relate to a more optimistic outlook for themselves – ‘it’s not going to happen to me’, a variant of the notion that life is
full of so many risks that HIV risk in particular should not be privileged over other risks.

An additional notion relates to the alleged trustworthiness and moral characteristics of sex partners. This attitude regarding partners that suggests safety include: their not being seen as promiscuous; that they have had only ‘serious’ relationships in the past; and that they created an impression through their appearance, general personality, family, job, place of residence and so on that they would not be the ‘type’ to infect someone else.

A further category of perceived invulnerability captures the mirror image of the above – a personal sense of invulnerability based on one’s own infrequency of sexual contact; the selective use of condoms when a partner is observed (rightly or wrongly) as a potential disease carrier; and the geography of the prospective partner (e.g.: the belief that HIV is less prevalent in smaller towns and cities outside of the perceived plague ridden cities of New York, San Francisco, London, Amsterdam, Vancouver and so on).

Many gays and MSM feel that risk reduction is too difficult to navigate, and is ultimately beyond their control. In the first instance, as previously indicated, the American public response to the threat of HIV was (and generally remains) “100% safe, 100% of the time”. This includes all fluid exchange behaviour, including oral-penile sex. Since virtually every study done in the past 15 years
(Adam, Schellenberg & Sears, 1998; Barillas & Garbo, 2000; Bloor, 1995; Dowie, 1999, Ekstrand & Coates, 1990; Gagnon, 1988; Gold, Skinner & Ross, 1994; Gold, 1989; Hart & Boulton, 1995) demonstrates that this American strategy for harm reduction (condom use for oral-penile sex) was all but ignored by sexually active gay men, by implication every gay man had already transgressed community norms and 'official' sociomedical advice. Having both failed to maintain putative community standards of sexual behaviour, and having admitted such failure, many men simply abandoned the doctrine entirely, believing that they were incapable of living up to such high standards.

Second, misconceptions (or self-delusions) give rise to a number of alternative meanings of safe(r) sex. One of the major doctrines of the 'official' advice is the use of a condom 'if you do not know your partner' (Ingham, et al., p. 166). However, what constitutes 'knowing' one's partner is not delineated, leaving its interpretation vague and subject to (mis)interpretation. The matter of knowing one's partner can take on a range of meanings, spanning casual acquaintance types of 'knowing', (perhaps limited to such matters as name, place of residence, sexual tastes, availability, and possibly age) to very deep senses of 'knowing' that come from years of cohabitation or 'dating'. Even then, as will be demonstrated in subsequent chapters, knowledge of one's partner, not-withstanding the presumed depth of knowledge, does not in all cases link with trust in one's partner – for example, the trust that they will not infect you. However, despite
the ambiguous nature of this admonition, it does seem to imply that if one does ‘know’ one’s partner, condoms are thus rendered less necessary.

This situation is best exemplified by the highly prevalent practice of ‘serial monogamy’. If, having been in a relationship for a few weeks or months, even if both partners re-test for the HIV antibody and test seronegative, it has been shown and will be re-emphasized in subsequent chapters, that the frequency of condom use drops off significantly as one gets to ‘know’ one’s partner (Godin, 2000). Unfortunately, and most important however, given human frailties and a propensity to avoid confrontational issues, is the reality that neither partner can be absolutely certain that the other is not having unprotected sex with other people as well. Both anecdotal information and empirical data reflect the high prevalence of ‘extra-relationship’ sex — when one considers that it is even necessary for the Vanguard study, for example, to differentiate between casual and regular partners, one can see the degree to which monogamous relationships, at least in the gay sexual sphere, are not necessarily the norm.

Earlier, the notion of sex for sex’s sake was introduced (Foucault 1982/83, Myers 1993, Gagnon 1988, Dowie 1999, Godin 2000). In many relationships, rule-making involves the negotiation of what types of sex can be had outside the primary relationship — whether it is location based (not in the same city as one lives), time based (when one partner is away for more than X days), whether it
must be done together (threesomes or more), and so on. Often, these decisions are reached as a compromise solution to the alternative of clandestine ‘cheating’ or the confines of strict monogamy.

Understanding So-Called Non-Rationality

In many instances, reputational issues figure prominently in decision-making with regard to risk. For example, I was an active participant at a spontaneous (and clearly unauthorized) sex party involving about 8-10 registrants attending an American conference on HIV/AIDS Education, at which time the participants did not use condoms. While the relation of this incident is not intended, in any way, to diminish the importance of such information-sharing and learning forums, in a post-conference ‘debriefing’, it was frequently noted that the use of condoms on this occasion was not even discussed — it was simply assumed that since the participants were all AIDS prevention workers, one's sex partner for the night was either HIV negative or if not, would inform their sex partners that they were positive. The crucial point is that a number of people, extremely well versed in ‘negotiated safety’, and allegedly familiar with ‘sex talk’ demurred to ‘negotiate’ in the heat of the moment. If this could be the case amongst some AIDS educators, how then is it possible for people who are less skilled at communication, more inhibited with regard to ‘sex talk’, less aware of potential risks, and less able to assert their wants, to practice safe(r) sex?
The following table from the 'mens' survey' lists some of the reasons study participants gave for not using condoms. It is interesting to note that the items marked with an asterisk (*) are reputational in nature – they point toward non-functional issues – issues that relate to the individual’s or partner’s personal history.

Table 2-5: Reason For Not Using A Condom  (Myers et al. 1993:37)

<table>
<thead>
<tr>
<th>REASON</th>
<th>Insertive Anal Intercourse (%)</th>
<th>Receptive Anal Intercourse (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>* He was my regular partner</td>
<td>49.4</td>
<td>61.9</td>
</tr>
<tr>
<td>The sex was so exciting</td>
<td>25.9</td>
<td>28.4</td>
</tr>
<tr>
<td>It makes me lose my hard-on</td>
<td>24.3</td>
<td>-</td>
</tr>
<tr>
<td>* I am HIV negative</td>
<td>23.9</td>
<td>20.1</td>
</tr>
<tr>
<td>I pulled out before cumming</td>
<td>21.5</td>
<td>-</td>
</tr>
<tr>
<td>I was using alcohol</td>
<td>17.9</td>
<td>13.4</td>
</tr>
<tr>
<td>* He did not want to use one</td>
<td>15.5</td>
<td>16.5</td>
</tr>
<tr>
<td>We did not have a condom</td>
<td>14.7</td>
<td>13.4</td>
</tr>
<tr>
<td>* He said he was HIV negative</td>
<td>11.6</td>
<td>22.7</td>
</tr>
<tr>
<td>I was using drugs</td>
<td>9.2</td>
<td>6.2</td>
</tr>
<tr>
<td>I never use condoms</td>
<td>8.0</td>
<td>6.7</td>
</tr>
<tr>
<td>* I am already HIV positive</td>
<td>4.0</td>
<td>8.8</td>
</tr>
</tbody>
</table>

Respondents who had anal intercourse without a condom in the past year were subsequently asked to identify separately the reason(s) that applied to their last condom-less episode, also distinguishing between reasons for receptive and insertive anal intercourse. (Two reasons applied only to insertive anal intercourse: “I pulled out before cumming” and “I lost my hard on”.) In general, the reasons

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14 While this statement can be construed as instrumental, it has been more appropriately classified as reputational because its meaning is taken to be one involving trust – “He did not want to use one and I voluntarily acquiesced”.

82
given for not using a condom for receptive anal intercourse fell into an expected order (this same order has been found in numerous other studies). The primary reason was "He was my regular partner" (61.9%) followed by exciting sex (28.4%). The significant difference in this study was the third most popular reason for not using condoms for receptive anal intercourse — the partner's self-reported HIV-negative antibody status. This reason was given by twice the proportion of men as those who gave the same reason for unprotected insertive anal sex.

A number of issues emerge from these data. Referring back to table 2-4, the definition of a regular partner is someone with whom one has sex at least once per month — it must be no less than that. Yet, there is nothing to suggest that this definition encompasses anything close to the concept of monogamy. In fact, the probability is that in many of the cases, monogamy is not a factor. What accounts for the high (almost 1/3) proportion of men who have receptive anal intercourse without condoms?

If some people in this sample are in a monogamous relationship, then the others, who are not, must be assuming some degree of risk. The rationales for assuming these risks are complex, ranging from total detachment (indifference) to total commitment (trust). What is common though, is that people did have reasons for what they did. There was no category for "I didn't know what I was doing"
(despite the opportunity for write-in responses), since it appears that people knew, possibly excluding alcohol (13.4%) and drugs (6.2%) precisely why they did not use condoms. This clearly demonstrates that some form of thought process was employed in decision-making. In other words, these episodes do not fall under the category of mistake or misadventure — in most instances they are examples of barebacking, rather than UAI (unprotected anal intercourse).

It is also important to note from these brief examples that the justifications offered are reasonable from within the location of the respondents' own standpoints. These diverse rationalities are at odds with, and frustrate, the 'received rationality' of official biomedical knowledge. One cannot even argue that what is observed is a situational aberrance — statistically there are too many incidences of non-condom use to suggest that this type of behaviour, and its corresponding rationality, lie outside of what should be a bell-shaped curve.

One could put forward the argument that there is nothing rational or reasonable about putting oneself directly in the path of contracting HIV, given the realization that HIV is, for the most part, preventable. However, there are numerous rational (if one accepts the notion of 'rational' to mean having or exercising reason, sane, or lucid — Webster's:1989) motivations that have been documented in favour of relaxing safer sex rules, or ignoring them altogether. In Meanings of Sex Between Men, Bartos et al. examined condom use in Melbourne,
Australia (N=97). Many men reported that it was hard to maintain an erection with a condom or that condoms were physically painful. For them it meant either refraining from insertive anal sex, or not using a condom. The more common reaction was a general dislike of condoms both in terms of an active dislike of condoms themselves, and a preference for unprotected contact.

I enjoy getting fucked. I don't like condoms. I know the man fucking me doesn't enjoy it as much if he's wearing one. They smell funny, the smell also turns me off. In the last month I've had ten different men. Six out of these ten fucked me up the arse and only one used a condom. Look, I've read about AIDS. I've even got information, but it's no good me saying to you that I won't fuck without them because I know I will. (VT, 57 years old, Retired Farmer) from Bartos et al (1994: 46)

One of the most common motives for rejecting condoms is that the negotiation of condom use will be a distraction to the sexual encounter. For many men, condoms are seen as mechanical intrusions to the natural flow of sex. They introduce a technological factor into an encounter that was intended to be unconstrained. Additionally, the negotiation of condom use presumes a level of communication that may not form a part of one's sexual repertoire.

Condoms, obviously, are emotionally associated with the risk of HIV. To introduce a discourse on condom use at any point in the sexual encounter is to also introduce a discourse on disease and contagion and along with it an element of distrust, which may be perceived as a disruptive influence to the sexual
encounter. Bartos et. al. report that there is further proof of this hypothesis, proof which emerged through their interviews. While for some of their respondents there was a clear intent to have safe sex, initially permitting then to negotiate condom use, during the course of the sexual encounter the condom came off, was removed, or broke. At this point, the safe sexual act became unsafe; however, once anal intercourse had commenced, it was difficult (and in many cases impossible) to interrupt the process in order to replace the condom. (Ibid, p. 47)

This suggests that, contrary to the theories of ‘reasoned action’ and ‘planned behaviour’, the formation of the intention to use a condom is not necessarily associated with carrying out or maintaining this intention throughout the course of a sexual act. It does suggest however, that there is a difference between the type of rationality employed during intention formation and that which is operationalized during sexual activity (Gold, 1994)

The Social Signification of Sex

Decision-making models of the types previously discussed presuppose a certain measure of autonomy and free choice, especially after one has been exposed to a reasonable amount of knowledge (the “K” of KAB). However, the models rarely incorporate the weight of various other pressures. As illustrated by Table 2-3,
there is clear evidence of formidable coercions to abandon condoms and engage in bareback sex.

Of those engaging in the highest risk behaviour – receptive anal intercourse – more than 28% responded that “the sex was so exciting”. This response would indicate that if the encounter was with someone who is either 'hot', sexually adept, or both, there may be desire to maximize the sensations involved in sex, which could be a stronger motivation than the desire for protection, since latex barriers are perceived to inhibit the maximization of pleasure.

For many men, to be sexually active is equated in one’s mind with being ‘in demand’ by peer groups. Perhaps historically fueled by a liberationist ideology, a rejection of what is seen to be repressive heterosexist codes of morality, and the highly sexualized ‘bar culture’ of most urban gay communities, the notion of being sexually attractive to one or more people signifies an external validation of self-worth as a sexual object – a status to which many gay men aspire.

As Jeffrey Weeks (1985:80) points out, the significance of sex to the individual has been viewed as the root of “our personal sense of self and potentially of our social identity”. Havelock Ellis (1933:3) suggests that sex is “all pervading, deep rooted, permanent” and the last resort of our individuality and humanity. While sex is the most enigmatic fact about us, it is also the component that has the deepest social signification. Sexual meanings are mediated through the traditions
and mores central to the use of different internal and external body parts, and the complicated symbolic labyrinths in which all eroticized activity is entangled. Some of the most important meanings are reserved for penetrative sexual practices. For many gays and MSM, only anal intercourse represents 'real sex'.

Standpoints have been put forth in 'common folklore' that heterosex and intercourse are the ultimate expression of one's love for one's partner, and the so-called 'natural' outcome of that intercourse is procreation. Historically, especially in the Judeo-Christian cultures, sex as pleasure has been looked upon as immoral, sinful, and wasteful. Homosex, in this context, has been especially vilified not only as the embodiment of non-procreative sex, but also as the symbolic abrogation of traditional masculinity (to be anally penetrated is equivalent to performing the functions of a woman). However, the cultural significance of homosex goes far beyond the rebelliousness of gender deconstruction and religious disobedience.

The formation and maintenance of a gay culture cannot rely on social bonds informed by 'race', religion, ethnicity, language, socioeconomic status, geography, educational attainment, or most other social constructions that customarily bring people together into 'community'. At best, what is common (to greater or lesser

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15 Leviticus contains many verses referring to sex – including "Thou shall not spend thy seed upon the ground", which has been taken to be a reference to masturbation, but could also be read as a reference to coitus interruptus.
degrees) is a sense of ‘otherness’—possibly aggravated by oppression, and one’s sexuality. When critics of the so-called gay lifestyle hone in on sex as the focal point of gay culture, they are not altogether wrong in their assessment. To be sure, there is more to being gay than sexuality—common stereotypes revolving around fashion sense, hedonism, the arts and so on all contain grains of truth. However, I assert that the single most significant common thread is sexual. For many gay men, meeting and getting to know other gays often includes sexual activity (or at least some forms of physical intimacy) prior to emotional attachment. As proof of this hypothesis, one need only consider the proliferation of sexually oriented sites for finding sex—bathhouses, massage parlours, personal and professional (hustler or rent-boy) ads in gay papers, chat lines dedicated to seeking sexual partners, and a host of bars and after-hours clubs that cater to ‘cruising’ men. Sex is the cultural glue that binds many gay men to each other.

In particular, to those who define sex as penetrative (oral or anal), and involving semen, anything else is considered foreplay, or ‘non-sex’. This sense of sexual meaning, and the one previous, will be more fully explored in the interview chapters—at this point, suffice it to state that these propositions were articulated most clearly by some study participants. There are two distinct explanations for this conception of sexual activity: the dominance of penetrative sex as the paradigm of heterosexual sex, and the symbolic cultural meaning of anal intercourse and fluid exchange.
This former concept can be more clearly understood when one considers homoerotic behaviour between boys or men, without penetration. The proverbial group masturbation events that most young, heterosexual boys engage in, at some point in their sexual maturation, are not considered 'sex', or 'homosexual behaviour', at least not in their eyes. Nor does participation in one of these events suggest that the participants are (latently if not overtly) gay. The same holds true for MSM who engage in quick, anonymous sex in public washrooms, truck stops and porno parlours. Their sexual expression, generally devoid of anal penetration, does not speak to the same emotions as gay sex. A third example (if one is needed) is the presence of seemingly overt acts of homosexual sex (often with penetration) in our prisons. While the outward behaviour mimics the homosexual notions of 'real sex', it is generally acknowledged that once released, ex-prisoners who were not gay before entering prison immediately revert back to heterosexual sex, and rarely, if ever, have sex with men again\(^{16}\).

The importance of anal intercourse between men is not just derivative of heterosexual penetrative sex. The symbolic meaning of anal intercourse and fluid exchange is more complex and more substantive. In its own fashion, but equal to heterosexual penetrative sex, it has substance as the most intimate of contacts with another person. As well, it has significance all of its own, as a particular type

\(^{16}\) Situational Homosexuality; also found in the military, boarding schools, and other all-male institutions.
of contact between men. Anal intercourse is a way of signifying that the sex is special, that the relationship or encounter is out of the ordinary. While heterosexual sex has always been 'normative', and accepted by society, gay sex, especially anal penetration, has historically been demonized. The transgressive nature of anal intercourse, for gay men (perhaps residing in an historical subconsciousness) makes the act all that more important physically, politically and emotionally.

In addition, the social significance of fluid exchange cannot be overlooked. First, and most obvious, is the intimacy that accompanies such an exchange. For example, most children can recall sharing their gum (already masticated) with close friends – a certain form of social bonding. Sharing food from the same fork is something that lovers often do, generally with more emotional significance than merely tasting. Deep kissing, as opposed to dry kissing, is generally reserved for intimate partners. So too, the sharing of semen can be seen as the ultimate form of intimacy, and not coincidentally, the ultimate expression of trust (since it is the most risky sexual behaviour vis-à-vis HIV).

Because anal intercourse is a mode of becoming nearer to another man, there is an inherent disinclination to use condoms, which are strongly perceived as barriers to the intimacy that is being sought. One particular way of intensifying the intimacy of intercourse is by ejaculating in another person, or even more fully,
receiving the ejaculate. For the receptive partner in anal intercourse, therefore, sex with a condom may be perceived as anticlimactic, and for the insertive partner, the physical and emotional sensations that a condom nullifies may make him feel 'cheated'.

Fucking is about being consumed and inside someone and they inside you. Condoms are a barrier to this. (CA, 54 years old, Teacher)

Fucking as a consummation is easy to understand: to the extent that penetrative sex represents real sex, it can readily amount to the highest point of a sexual relationship. When penetrative sex is unsafe it has added to it the elements of exchange of bodily fluids as a further expression of intimacy, and the implications of trust and mutuality represented by unsafe sex. (Bartos et al, 1995: 51)

There is rationale to barebacking. The sex itself is rooted in individualistic requisites — that is, sex is consummated with a special person in a special relationship (notwithstanding the fact that for some men, every night can be special!). The encounter is not necessarily related to or located in the context of wider behaviour; the sexual act exists on its own terms, with its own rules. Rules about such behaviour do not necessarily carry over from or to other social events.

The act of sex itself is also something that is often considered inspiring and outside real time ('losing oneself in the moment'). And if sex is 'time out of time', then the computation of future risk relative to immediate HIV concerns cannot operate. This is a different standpoint from the diminished future time span
associated with 'real' time, KAB and risk reduction models. Sex, in this continuum, may be experienced for the intensity of the moment, located in a transcendental space; which is neither the past, the present nor the future. This concept of 'time out of time' is a well-known theme in anthropology, and is predominantly related to ritual behaviour. In an era when numerous people no longer take part in organized religion, sex may be one of the few ritualized, transcendent experiences left. (Bartos et al, 1995:54)

The sexual urge, the quest for carnal pleasure, as opposed to procreational sex, has never been considered 'rational' in the conventional sense as a 'thought out' program; but most assuredly sex without condoms can be considered to have an irreducibly rational component.

Wider Social Contexts

Western culture has firmly circumscribed masculine and feminine attributes and roles. It places greater value on traditional male than on traditional female attributes. These value-laden dichotomous roles are grounded in the assertively contentious nature of our social structure. Aggressive spirit and energy make good entrepreneurs, and society prizes these attributes more than loving, sensitivity, sentimentality, generosity, and care-taking, which are viewed as more feminine virtues. We honor individuality when it comes to the deployment of a man's dynamic energy, but are prone to condemn it in the performance of those
aspects of his nature that are not perceived as conventionally masculine. One of
the most masculine of all acts is the ‘taking’ of a woman. The conventionally
masculine male does not easily share his role in the courtship ritual, nor does he
compromise his masculine prerogative with respect to what happens in the
bedroom. Conversely, in homosexual relationships, there are usually fewer
discernible power differentials (since the major issue – gender differences – is
absent) and mutual decisions with regard to sex are more frequent. This is not to
suggest that functional or emotional power differentials do not exist at all. There
can be differences in age, wealth, race, educational attainment, emotional stability
and so on. However, in comparison with heterosexual relationships, the point
must be emphasized that systemic gender differences are not important.

Michel Foucault understood this notion, explaining how modern homosexuality
came to be understood in terms of sexual act and identities, and to have little to
do with social relationships and other forms of cultural expression.

In the Western Christian culture homosexuality was banished and therefore
had to concentrate all its energy on the act of sex itself. Homosexuals were
not allowed to elaborate a system of courtship because the cultural expression
necessary for such elaboration was denied them. The meeting on the street,
the split-second decision to get it on, the speed with which homosexual
relations are consummated: all these are products out of interdiction.
(1982/83: 10)

Still today, if one chooses to gauge social progress through the lens of legislation,
our society does not encourage gay men to form stable, responsible, mutually
gratifying relationships, most probably since this would be a threat to the androcentric sense of propriety. As a society, we tend to socialize our children to hide their homosexuality. As this becomes an internalized way of life, gay men begin their sexual and sociosexual lives by finding secret ways to express their love and sexuality. It takes enormous effort for gay men to maintain their sensitivity and self-worth in a society that only very slowly and very recently has begun to legitimize and validate them and their sexuality.

In some cases, these external pressures become internalized, such that beliefs about what constitutes a ‘real man’ provide strong pressures to become sexually active at an early age. Internalized homophobic beliefs, difficult to shed, often may be acted out in ‘hyper masculine’ ways. Amongst these norms is the often-held opinion that ‘real men don't use condoms’. Among youth workers, there is a notion that young men subscribe to the three “I”’s – invincible, immortal and infertile (they cannot be harmed, will live forever regardless of risk-taking, and cannot make a female pregnant.)

However, as previously discussed, the desire to be close to someone, the need to be loved, cherished, and needed may lead many men to abrogate the safe sex messages in order to substantiate either their own love or their own masculinity. In the either case, the result is the same -- the risk of infection from HIV.
There are, in addition, advocates who believe that to be truly gay, one must at least take upon oneself the risk of contracting HIV, and possibly become HIV positive (Botnick, 2000). In order to fit in with the community, especially for those gay men who are already community-involved, risk taking becomes an integral part of being gay – not only from a sexual perspective, but by simply taking the substantive risks associated with being ‘out’. It is not surprising then, that gay men have unconsciously been coerced by a homophobic society as well as gay society, to some extent, into being ‘risk takers’.

Therefore, within the risk-taking paradigm, the nature of the individual and the context of the relationship appear to have significant relationships to either barebacking or the use of condoms (Myers et al., 1993; Botnick, 2000; Van Campenhoudt, 1997; Weeks, 1985). Numerous studies indicate that as intimacy grows, a lower salience is given to the potential risk of infection, and concurrently, a more pronounced avoidance of condoms ensues. Simon and Gagnon (1987) ascribe this phenomenon to the confusion resulting from conflicting messages (intimacy and immunology) and to the ascendance in the importance of trust as an integral part of the sexual script. This notion of rationalizing risk is acted out in numerous ways, not the least of which is the sexual interaction itself.
Since individuals engage in a variety of sexual interactions, with different expectations, plans, desires, capacities and histories, the sexual interaction and its attendant dynamics should be taken into consideration. Rademakers et al, (1992) proposed a dynamic model of sexual interaction as follows:

**Figure 2-4: A Dynamic Model of Sexual Interaction** (From: Rademakers et al, 1992)

In the center is the interaction. The locus of concern is any event characterized as transpiring during the interaction that has any significance whatsoever to the matter of interest, which for my purposes can be illustrated with anal intercourse with a condom. Thus for example, an anxiety focused on potentially failing to achieve or maintain an erection with a condom (not an unusual situation) may be
an immediate and pressing reason for not wishing to gamble on using them (availability and capacity to use condoms — in the outer ring). The inner ring contains factors that are directly relevant for interactional performance, or sexual competence. They include skills in presenting one's own and interpreting the other's wishes, skills in negotiation and interactional control, power and respect for the partner, and persistence (the ability to keep in contact with one's original wishes and desires). The outer ring contains factors that are relevant for, but not directly related to any one specific interaction. These would include risk awareness, behavioral intention (which may be either specific or general), the availability of and competence to use condoms, or having a plan and/or a concrete strategy (such as to impress one's partner with one's own sense of liberation, or to intentionally maximize one's own pleasure regardless of potential risk). In addition, this outer ring also depicts awareness of social norms and social support, and the emotional and cognitive significance of sexual contacts and relationships.

The merits of this way of examining sexual interaction are not only that the interaction is at the core, but also that individual and situational factors become salient only during the interaction itself, contrary to Myers et al (1993), and most health belief models. Outside the course of interaction, the intention to use condoms, tendencies to control situations, desires for dominance, and so on, have no immediate relevance. Factors in either ring may be ameliorated or
negated entirely depending on the influence and impact of the factors nearer the center.

Additionally, an intention to use condoms (in the outer ring) may be overruled either by factors from the inner ring (for example a power dynamic where an older person is interacting with someone much younger) or by something in the outer ring that occurs during the course of the interaction itself (such as a difficulty in putting on a condom).

No doubt, however, the utility and strength of this model varies with the development of individuals in terms of their sexual careers and the processes by (or through) which they acquire a range of competencies, alternative sexual scripts, and so on. Rademaker's model helps to explain the difference between 'cold light-of-day' knowledge, and heat-of-the-moment behaviour. The former is embodied in the oft-heard phrase "We shouldn't be doing this" while the latter is characterized by "I can't believe I did this". For some people, safety is paramount, and is so ingrained that to abrogate safety measures is a form of high dissonance; for example, for some people, riding in a car without a seatbelt is decidedly uncomfortable. More to the point, for some MSM, non-condom anal penetration is abhorrent (as we shall encounter in one of the interviews). Apart from the virological aspects of condoms, for some men, the issue of cleanliness (of the anus) dictates the use of condoms all of the time.
More importantly, Rademaker's model holds greater currency the more likely one is to hold non-essentialized sexual beliefs. As one matures sexually, and develops more-or-less fixed sexual scripts (i.e.: is less of an innovator), the less likely it becomes for elements in the outer two rings to serve as distractions to the core concept, whether it is to use condoms or to not use condoms. Certainly, this is the case with respect to the autonomic use of seatbelts for many people; and for some, the same principle applies to condom use. After all, it must be emphasized that, as was illustrated in the introductory chapter, the percentage of men who do not use condoms is significantly lower than the percentage of men that do use them.

It is crucial, however, to emphasize that the level of theory supporting the model differs considerably from patterns more traditionally employed in health related behavior studies (KAB for example). The essence of that distinction is the difference between prediction and explanation.

Current research has focused almost exclusively on issues of health, disease and prediction, to the detriment of understanding the centrality of the character of sexual interactions. Gagnon (1988) suggests that this mode of thinking has two consequences: the first consequence of this preoccupation with disease is “that what is interesting about sex is what the disease makes interesting” (p. 600).
Here, I suspect that Gagnon is referring to the Foucauldian notion that the discourse on sex and sexuality takes on its importance not through prohibitions or permissions, *per se*, but

... to account for the fact that it is spoken about, to discover who does the speaking, the positions and viewpoints from which they speak, the institutions which prompt people to speak about it and which store and distribute the things that are said. What is at issue, briefly, is the over-all "discursive fact," the way in which sex is "put into discourse." (Foucault, 1978:11)

What was once relegated to the domain of moral and/or legal arguments – promiscuity, libidinous behaviour, deviant behaviours (especially 'buggery'), and multiple partners (infidelity) has been pathologized as medical issues relevant to epidemiological concerns of contagion. HIV and AIDS have, in a sense, revivified old arguments used to condemn homosexual behaviour and homosexual identities, under the aegis of medical necessity, epidemiological research and harm avoidance.

Additionally, Gagnon notes that:

Even within the constraints of a concern for AIDS, a narrow view of sexual behavior may be effective if all that we are concerned with is social bookkeeping and epidemiological modeling, but it will be inadequate to the task of understanding behavior in the way that results in behavior change. Sexual conduct is embedded in culture and in social relations – as we begin to deal with this dimension... we will need to know a great deal more about the why. (emphasis in original - Gagnon, 1998:500)

If meanings of sexual ethos and its intersection with AIDS are embedded in culture and in social relations, yet at the same time appear to be incongruent
throughout the knowledge making communities, it follows that the interpretation
of meanings of sex and AIDS in the gay community must reflect the discordant
sources and uses of knowledge. Thus, for some, HIV is medicalized, for others it
is politicized, and for yet others it is socialized. We can however, distill at least
one common denominator from the various meanings surrounding the discourse
on sex and HIV/AIDS – and that is panic.

Panic is the key psychological mood of postmodern culture . . . In the
postmodern scene, panic signifies a twofold free-fall: the disappearance of external standards of public conduct when the social itself becomes the transparent field of a cynical power; and the dissolution of the internal foundations of identity (the disappearing ego as the victory sign of postmodernism) when the self is transformed into an empty screen of an exhausted, but hyper-technical, culture. (Kroker, et al, 1989:13-16)

Under pressure from a ‘loss of privilege’ and a daily anxiety over the loss of credibility of so-called expert knowledge, media pronouncements and indeed the liberal state as a whole, the mind oscillates to the other extreme. There is a retreat from participation in a public life, substantial and intractable, into a private inner experience of fantasy and illusion. “Reason gives way to private passion.” (Ibid.: 124) Given the deficiency of a safe public realm and the uncertainties of a sexually vectored social world, the individual tries unsuccessfully to establish a private area of emotional security, symbolized by the ideal of the Spenserian ego: privative, survival oriented and exploitative. (Ibid.)
The thoughts of Max Weber (1968), in *Economy and Society*, first published in 1956, help explain the complex and contingent character of ‘rationality’. He states that “the basis for certainty in understanding can be instrumentally rational, which can be further subdivided into logical or mathematical, or it can be of an emotionally empathetic or artistically appreciative quality” (p. 5). For most purposes of explanation, he adds, we are willing to accept a certain degree of ambiguity, provided that ‘it seems to make sense’. However, and most crucially, he enlarges this notion by stating that:

On the other hand, many ultimate ends or values toward which experience shows that human action may be oriented often cannot be understood completely, though sometimes we are able to grasp them intellectually. The more radically they differ from our own ultimate values, however, the more difficult it is for us to understand them empathetically. . . . sometimes we must accept them as given data. (pp. 5-6)

This is crucial to my argument, which will be made more evident as we move into the discussions of trust and risk. Especially for a heterosexual population unfamiliar with gay sensibilities, there are a number of elements regarding what appear to be nonsensical, or irrational that are indeed rational, or in Weberian terms, from the standpoint of gays, are esthetically or ethically rational but do not resonate with commonly perceived notions of morality, rationality or cultural values. One must, as Weber put it, accept it as given data, or, in other words, suspend any value judgments, such as heterocentrism.
Bearing in mind Weber's admonition regarding the ephemeral nature of rationality, we find additional evidence of the effects of cultural panic, and what at first appears to be non-rational in the works of John O'Neill. O'Neill sutures the cultural notion of panic with AIDS. He states that:

The experience of AIDS panics the sexual culture of global capitalism in several ways. In the first place, it has 'disappointed' those who were most committed to its ideology of sexual freedom... The AIDS panic, however, strikes most deeply into the legitimation process when it prompts the general population in a rationalized industrial society to question the probability value of scientific knowledge with demands for absolute certainty... (O'Neill, 1990: 335)

O'Neill argues that new developments in our knowledge and pedagogies relating to public education programs are confronted with the phenomenon he calls "socially constructed carnal ignorance" (O'Neill, 1990:330) - that is the experience of embodied interactions as a matter of 'unknowing', of 'spontaneity', of 'passion', of 'desire', or of 'fun' or 'fantasy'. (Ibid.)

The common thread running through all of these analyses is the need to understand the realities that what constitutes risk for HIV infection is contingent on definitions of risk itself; on the intersection of risk and intimacy; on how sex is perceived by both the individual and society; and on the impact of sexual interactions on beliefs and behaviour. In other words, embodied rationality is contingent, uncertain and complex, informed by ethical and emotional as well as technical and logical factors. In the following sections, we will explore alternative
theoretical explanations as to why risk and sex seem to go hand-in-hand for some gay men, and why in the face of what appears to be overwhelming evidence that contracting HIV/AIDS is to be avoided at all costs, for some, the cost of avoidance may be too high.

The Theory of Cognitive Dissonance

Festinger / Harmon-Jones and Mills

One of the most useful theoretical models employed to explain the binarism of rational / irrational behaviour is the theory of cognitive dissonance — the method by which people deal with conflicting data or data that runs contrary to their epistemological standpoints.

Leon Festinger (1957) developed a theory of cognitive dissonance, which purports to explain how people employ a form of rationality to assuage their discordant information in order to attenuate the conflicts created by personal knowledge (or cognition) that may be contradictory to personal behaviour, opinions or attitudes. This theory helps explain why and how a rational person can be seen to act irrationally, and yet, in fact, acts rationally.

Previously (Botnick, 1995, 2000) I wrote that opinions and attitudes tend to exist in clusters that are internally consistent. I suggested that people tend to frame their lives according to sets of opinions and beliefs that are complementary to
each other, and are acted out in a positive relation to those opinions and beliefs. For example, a person who believes that churchgoing is a virtue will very likely encourage his or her children to go to church; a child who knows that he or she will be severely chastised for a particular act will not commit it (or at least try not to get caught).

As an individual strives for internal consistency concerning his or her opinions and attitudes, a correlation develops between what a person believes he or she knows and what that person does with that knowledge. One usually mentally reworks or massages inconsistent beliefs or new knowledge that is contrary to one's assumed knowledge so that it becomes consistent — a process of rationalizing it into consistency.

As Harmon-Jones and Mills (1999) explain, the extent of dissonance between one cognitive component and the remainder of the person’s cognition is informed by the number and importance of cognitions that are consonant or dissonant with the one in question. Holding the total and magnitude of consonant cognitions constant, as the number or importance of dissonant cognitions increases, the magnitude of dissonance also increases. As may be expected, the reverse is also true: holding the total and magnitude of dissonant cognitions constant, as the number or importance of consonant cognitions increases, the magnitude of dissonance decreases.
This is an important contribution to the theory, since it helps to clarify how, and under what circumstances, one can change (or hold fast to) various beliefs. The probability that a specific cognition will change to attenuate dissonance is influenced by its resistance to change. Clearly, cognitions that are less resistant to change will change more readily than cognitions that are more resistant to change. More importantly, the resistance to change is based on the relationship between the cognition and one’s lived reality, and on the degree to which the cognition is in harmony with various other held cognitions. Opposition to change of a behavioral cognitive element relies on the magnitude of pain or loss that must be borne compared to the gratification obtained from the behavior. In essence, this is a ‘cost/benefit ratio’, or a variant of the natural choice model.

Dissonance is triggered whenever a person becomes involved in a disagreeable action to achieve some perceived beneficial result. Given the awareness that the activity is disturbing, it follows that one generally would avoid engaging in the activity. The greater the unpleasant effort (mentally or physically) required obtaining the beneficial outcome, the greater the dissonance. However, dissonance can be overridden by magnifying the worth of the outcome, which would then add consonant cognitions, or increase the power of the consonant cognition.
A practical example of this phenomenon would be the practice of hazing rituals in order to gain membership into a fraternity. No doubt, the activities pledges must undertake are, at the least, unpleasant. However, the intended outcome—membership in the fraternity—for most pledges, ameliorates the discomfort or embarrassment that the pledge must undergo, and even accentuates the pleasure of its ultimate achievement.

Put into the context of condom use, while people may well know the various HIV transmission routes, and may also harbour a certain amount of socially generated guilt if they consider barebacking, for some gay men the pleasure or the rebelliousness of the act of sex without a condom overrides, and under some conditions enjoyably enhances the dissonance. Furthermore, as indicated in the letters at the beginning of this chapter, social support and friendship networks of barebackers and fledgling social movements have begun to emerge, providing an increased worth (or validation) to the outcome, and a ‘fallback’ consonant cognition. As evidenced by Hamilton’s first letter to the editor, the issue is uppermost in the minds of some men, not only for the putative pleasure barebacking brings, but also in its form of presumed resistance to hegemonic control and medico-scientific fact. In other words, in this paradigm, the dissonance is made consonant because the perception of “punishment”

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17 People who seek out HIV-positive partners are sometimes described (pejoratively) as ‘bug-chasers’; HIV-positive individuals who seek HIV-negative partners are at times labeled ‘gift-givers’.
(contracting HIV, or infecting someone else) is evaluated less harshly than the rewards of pleasure, or the acts of resistance and transgression.

Alternatives to Dissonance Theory

Bem, Zanna and Cooper

One of the stumbling blocks with either Festinger’s original theory, or Harmon-Jones and Mills’ revisions to Festinger’s work, is the assumption that the impetus for behaviour change is a matter of degree – the explanation presupposes that a small incentive is relatively inconsequential in controlling behavior, while a larger incentive does the opposite. However, incentives are often difficult, if not impossible to compare and quantify – how does one compare contracting HIV or infecting someone else with the reward of pleasure?

Recognizing this conundrum, Bem (1967, 1972) advanced the proposal that dissonance effects were not the outcome of motivation to diminish the psychological discomfort produced by cognitive dissonance, but in fact “were due to a non-motivational process whereby persons merely inferred their attitudes from the behavior and circumstances under which the behavior occurred.” (in Harmon-Jones & Mills, 1999:10). This clearly suggests that the degree of cognition that Festinger proposes may be overstated in terms of conscious decision-making. In fact, if one were to accept Festinger without critique, one would have to assume that life is a never-ending process of conscious, calculated
‘Exchange Theory’ decision-making, continually weighing alternative choices in order to determine the degree of consonance and dissonance, evaluating the dissonance ratio, and subsequently acting on that decision according to the results of one’s internal deliberations. That individuals routinely behave in such a calculated and unemotional manner is hard to imagine, particularly in matters of sexuality. In many instances, people tend to act impulsively, or at least spontaneously — the notion of calculating every word and gesture obviates the roles of emotion, ‘gut-feel’, and other psychological influences on human behaviour.

Bern’s “Self-Perception Theory” was tested using a misattribution paradigm. In the misattribution paradigm, candidates were exposed to an external stimulus (a pill) that purported to have a determined efficacy on a person’s physical condition (produces tenseness). “If the supposed effect of the extraneous stimulus is the same as the actual internal state the person is experiencing, the person may misattribute the internal state to the extraneous stimulus rather than attribute it to the actual cause. If this misattribution occurs, the person may not respond to the internal state in the same way (e.g., will not change cognitions to reduce dissonance, to eliminate the negative affect or arousal)” (Ibid. p. 11). This hypothesis was tested by Zanna and Cooper (1974) by providing experimental subjects with a placebo that was characterized alternatively as a pill that would cause tenseness, relaxation, or have no side effects. The participants were then
directed to write a counter-attitudinal message (one that they personally disagreed with), some under duress and some in a calm state. For those participants who were told the pill had no side effects, their attitudes changed to be more consistent with the counter-attitudinal essay when they were in a relaxed state, but attitudes did not change when they were writing the essay under duress. However, those participants who were told that the pill would cause tenseness did not change their attitude in either mood state.

Zanna and Cooper concluded that the tension that was experienced due to the dissonance created by writing the counter-attitudinal message under duress was misattributed to the pill (which was, of course, a placebo) when the participants were told it would cause them to be tense. With the tenseness misattributed to the pill, there was no need to reduce the dissonance that was the actual cause of the feeling; therefore, attitudinal change was unnecessary.

Zanna and Cooper could not reconcile their results with Bern's theory of self-perception. If attitudinal change did not come about because of motivation to reduce discomfort, then the extraneous stimulus to which the discomfort could be misattributed should have no impact on attitudinal change. The notion that misattributed discomfort is ultimately powerless has direct consequences for KAB safe sex education.
In other words, in a manner analogous to Rademaker's theory, regardless of the intensity, frequency or logic of the safe sex message, the impetus to change one's behaviour can be undermined by extraneous issues — principally the degree to which the individual is receptive, at that time, to change. It is much like telling an alcoholic to stop drinking — while there may be an undercurrent of guilt and shame permeating that individual's life, unless there is both a willingness to change drinking habits, and an opportunity to change these habits, the alcoholic will continue to drink. The recovering alcoholic, the one who no longer drinks, does so as a result of a confluence of beliefs, events, attitudes, and social supports, not because someone else told them to change. This is not to imply causality, but it certainly points to the degree of influence extraneous issues may have on behaviour change.

Other Theories

Other studies have proposed modifications to Festinger, Bem, and Zanna and Cooper. For example, The New Look version of dissonance proposes that the observed attitude change results from the desire to avoid feeling personally responsible for producing the adverse consequence of having harmed the other participant. This rendition of the dissonance argument is, in this instance, most applicable to persons who are already HIV-positive, or people who feel that they are at serious risk for seroconversion (of becoming HIV-positive). One of the
leading reasons for the use of condoms for PWAs (Persons With AIDS) is the fear of infecting someone else.

What is interesting about this theory is that, while it sounds logical, it does not necessarily translate into practice. When the frequency of receptive anal intercourse by serologic status\(^\text{18}\) was examined in the VLAS\(^\text{19}\) cohort, (Schechter et al, 1988), it was found that:

Although seronegatives practiced receptive anal intercourse with casual partners less often than did seropositives, it was disconcerting to note that when they did engage in this practice, seronegatives utilized condoms less often than did seropositives ... it was disappointing to observe that ... as many as 15 per cent of seronegatives never used condoms during receptive anal intercourse with casual partners\(^\text{20}\) and only 64 per cent of this group report the usual use of condoms during this practice.

Essentially, while the theoretical notion of the New Look version of dissonance may have some degree of utility in specific circumstances, in accounting for matters that are either non-essential to one's life, or that relate to altruistic behaviour, it appears not to be particularly useful in explaining sex and HIV transmission from seropositives to seronegatives.

Despite the controversies surrounding the underlying motivation for the effects of dissonance, on the important issues there is general agreement. There is no

\(^{18}\) Serostatus (HIV+ or HIV-)

\(^{19}\) Vancouver Lymphadenopathy-AIDS Study
doubt that in dissonance studies some genuine cognitive changes do occur. Additionally there is general agreement that these cognitive changes are motivated in nature, and the origin of this motivation is a type of psychological discomfort.

However, there is no universal agreement about the nature of the motivation fundamental to the cognitive and other changes that follow dissonance. As further experimentation progresses, a greater understanding of the nature of the motivation basic to dissonance effects will have to take into account the intersection of cognition, motivation, emotion, behavior, and power.

Indeed, power imbalances are salient in relationships between gay men. Davies et al (1993) of Project Sigma analyzed sexual relations between younger and older men and found that younger men were significantly more likely than older men to be the receptive partner (the sexual activity that is the most likely to pass on the virus, if condoms are not used). This does not necessarily imply that being the anally receptive partner is an indication of social passivity, but it does suggest that there is an archetypal sexual response allied with power or at least generational imbalances. Social structural factors of risk behavior and exposure to risk correlated with power differentiations are made clearer in paid sex work, where for an additional fee, most hustlers will allow the ‘john’ to anally penetrate

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20 Regular partners are defined here as people with whom one has sex at least once per month and casual partners are defined as people with whom one has sex less than one time per month, including one-night stands.
him without a condom. "Power is mediated directly through the social organization of any particular activity." (Hart & Boulton, 1995:62) Receptivity in sexual relations carries a greater risk for infection than other types of sexual behaviour. Coupled with a power imbalance that may preclude condom use, age- or power-disparate relationships may well be indicative of higher risk-taking.

Gay Men and Risk Behaviour

In the 1980s, the term 'relapse' was introduced to characterize the behavior of what appeared to be a minority of men who had been practicing safer sex, and who were currently reporting that they were no longer so doing (Stall, et al. 1990). It became visible to researchers that there was a 'new' category of men – those who reverted to their 'former' sexual ways in what was believed (at the time) to be the latter stages of the epidemic. The methodological and conceptual bases of the concept 'relapse' have been criticized in detail (Davies et al. 1992; Hart et al. 1992), and a lively debate continues over the appropriateness of the term 'relapse' (Davies et al. 1993; Ekstrand et al. 1990; Kippax et al. 1993). However, it is worth noting here in relation to risk behavior that the "term serves to encapsulate and express the individualized focus of much behavioral work in the AIDS field generally, and on gay men in particular". (Hart & Boulton, 1995: 57 – 58) The debate is contentious because it uses an expression that is commonly used in penology, medicine and psychology to describe the course of a pathology that may progress, remit, or return. When 'relapse' is used in the
context of sexual behavior, the signification ascribes the ‘retrogression’ of behavior with processes that are internal to the individual. Consequently, this has privileged the notion of certain men as being prone to “a weakening of the resolve to maintain safer sexual practices and to succumbing to the temptations of unprotected intercourse.” (Ibid.: 58)

A less pathological and more sociological perspective of risk behavior frames barebacking as a social action, imbued with meaning and negotiated within a social environment. What is important is investigating the meaning behind the behavior, and its genesis within social relationships. As can be seen in Table 2-2, and as is confirmed by many other studies, one of the most prominent and invariable findings of behavioral research on gay men is that high-risk sex is more frequently reported with someone described as a ‘regular’ partner or a lover. A meaningful sociological focus with respect to non-condom use among regular partners is to examine the nature of regular and casual relationships, which may give rise to different meanings for condom-less sex.

A majority of men who have condom-less anal intercourse with regular partners do not perceive their behavior to be especially risky. This may be despite not knowing their partner’s HIV status, or whether their partner has had sex with other people during the course of the relationship. There is a degree of

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21 See, for example, Fitzpatrick et al (1990); Hunt, et al (1992)
emotional involvement as reported by most respondents (in chapters 5 and 6); condom-less intercourse in the context of an ongoing relationship is seen as a way of expressing love and commitment to a shared life.

Frequently, rules are negotiated that permit sex outside of the relationship, yet retain some semblance of sexual safety. These rules differentiate amongst sexual behaviors, partners and contexts, imputing specific meanings to each, operating as a joint schema to preserve the partners’ interdependent sexual health. Articulated and openly negotiated strategies regarding sexual matters may be exceptional; however, most couples comprehend where their shared boundaries have been set. Usually, these boundaries are situated in the context of community standards, friendship affiliations, and perceived social norms. What is most important, apart from rule making, is the actual occurrence of such rule making, which would not take place, or at least not be identifiable, without an understanding of the social norms of one's (gay) community.

Additionally, it should be noted that for those men who have sex with men, but do not identify themselves as gay or queer, rule making plays an extremely important role in determining sexual scripts. Men who live in a heterosexual context frequently adopt a strategy of restricting themselves to safer sex with their male partners, in order to preserve unrestricted (non-condom) sex with their
female partners, amongst whom condom use is neither expected nor easily explained. Bartos, et al (1994:49) examines this concept briefly:

It would appear that the assumption is that the men’s sex with women means vaginal intercourse. In a recent study, the most common sexual practice reported by women partners of bisexual men was vaginal sex without condoms, closely followed by dry kissing and mutual masturbation . . . . As responses on the various sexual practices were not exclusive, the total practice of vaginal sex, with and without condoms, may have been clearly the most common sexual practice.

If vaginal intercourse without condoms is normative sexual behaviour amongst heterosexuals, it stands to reason that the dissonance felt by bisexual men who also have male-to-male anal intercourse without condoms must be significant. If the fear of contracting HIV in itself is not a sufficient deterrent, it may be that the fear of discovery by the female partner that the male has not only been having sex outside of their relationship, but further, that the sex was with another man, is highly dissonant. Anecdotal information suggests that heterosexually identified MSM generally do not engage in receptive anal intercourse, and prefer oro-penile and insertive anal intercourse, thus consciously and strategically reducing the risk of contagion (as well as their self-perceptions of being ‘gay’).

Gay Community Attachment

Third, many studies have noted that men who strongly identify with a gay community are more likely to engage in versions of safer sex than men who are on the periphery of, or not engaged in the ‘gay scene’, whether or not they are gay
themselves. Of all Western countries, Australia and New Zealand have been at the forefront in research on the relationship between gay community involvement and sexual practice. The following information is taken from one of a series of studies undertaken by the New Zealand AIDS foundation.

Figure 2 – 5: Attitudes To Condoms By Gay Community Attachment (GCA) (From Saxton et al, 1998: 26)

In the above figure (2-6), GCA refers to ‘Gay Community Attached’ and NGCA refers to ‘Not Gay Community Attached’. As Parkinson’s and Hughes (1989:77) note, the gay community press had a “well established tradition of health reporting and gay community health programs were already in operation before the AIDS crisis arose”. Those people who are also more attached to the gay community are the same people who are more likely to consistently read the gay press. As beneficiaries of current safer sex information, privy to the various debates (such as the debate surrounding penile-oral sex), and interested in the welfare of the community in general, GCAs are more likely to adopt safer sex

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22 See Kippax et al (1992) for more on this subject.
practices. No doubt, there are many shared values, but there are also many areas of contested meaning. Nonetheless, there is a connotation of community and common interest amongst gay men, especially a shared culture that relies on a high level of trust and security usually established around a set of gay friends who are pivotal to the men's lives. Visibility is essential to this ideal of gay community. 'Gay community' is a concept with multiple meanings; nonetheless, central to the notion of gay community is some form of more or less organized social scene. Gay community attachment is therefore more likely to be found in larger urban centers, where gay bars, clubs, and organizations are more prevalent. It is still possible, of course, for MSM to be 'gay community attached' even if they come from rural environments. The type of community attachment may differ for these men — often including networks of gay friends contributing to a sense of community rather than participation in the commercial gay scene.

However, while for many men "being part of the gay community is a complex network of interaction of the social, sexual, cultural and political levels" (Ryan 1991:11), for others there is rather less cultural and political involvement. Generally, cultural and political involvement as gay men first and foremost is limited to middle-class (by and large 'white') professional men who are confident in their identity (Kippax et al. 1992, 1993). To be sure, Kippax's analysis contains an ethnic bias, since white males are significantly overrepresented in her sample. Subsequent data from Male Call (Saxton et al, 1998) replicates this bias, in that
“while both samples were overwhelmingly NZ [New Zealand] European/Pakeah, a higher proportion of those who were non-gay community attached were Maori (12.2% of NGCA; 7.5% of GCA)” (Saxton et al, 1998:9) In fact, when broken down by ethnicity, just over half (51.8%) of Maori respondents were GCA, which is statistically significantly lower than non-Maori (64.8%; p=0.003).

With respect to non-white gay men, other stigmas or oppressions may take priority over gayness and GCA; ‘race’, poverty, and religion are prime examples of conflict-making priorities. Joseph Beam, editor of In the Life (1986) wrote, in his introduction

... Black gay invisibility can be problematic. Because so little is pitched our way, concerns of critical importance, like AIDS, seem directed only at white gays. Similarly, Black gay history, not recounted by white gay media, compounds and extends our invisibility. Transmitting our stories by word of mouth does not possess archival permanence. Survival is visibility. (15)

Involvement in gay community, with gay media, and among gay community members may then, be of secondary or tertiary importance. When race is compounded by religion, as for example, the Southern Baptist Convention, the issue of being Black and gay can make for some difficult choices — as Beam muses, is he a Black gay, or a gay Black? This dilemma is real, and in certain situations, poses limitations on his ability to be attached to the gay community.
Additionally, it can be argued that the humanitarian ethos of what gay community is or should be often conflicts with a libertarian discourse of personal freedom. Some men may not feel comfortable, or have the ‘cultural capital’ to engage in gay community activities without restriction. For still other men the gay community is viewed as a fragmented, fractured entity (Botnick, 1995, 2000).

Their experiences of community are limited and often occur only infrequently and within specific contexts. Finally, some men's involvement in the gay community is relatively hidden and covert. These men may not even self-identify as gay.

Age also plays a factor in the determination of GCA. As Saxton et al (1998) note, respondents aged between 25 to 39 were significantly more likely to be GCA than those aged 15 to 24 or 40 and over. The following chart, taken from "Male Call - 7" illustrates that point:

Figure 2-6: Gay Community Attachment By Age
(Saxton et al (1998:9)

23 The Southern Baptist Convention is generally understood to be strongly homophobic, patriarchal and evangelistic.
Numerous explanations are possible to account for why younger people and those over 40 have less attachment to the community. The explanations are complex and beyond the scope of this thesis; in brief however, they relate to issues of identification and cultural location (queer = political, gay = social, homosexual = pathological), labeling theory, social activism, education and legal reforms, alternative identity formations (grunge, punk, skaters, druggies and so on). What is important to note, however, is that these subsets of communities are less exposed to the norms and prevailing values of the dominant gay community and therefore are less susceptible to the influence of gay community norms and values, and consequently are harder to reach with conventional safe sex programmes.
Additionally, since young men tend not to have as great an affiliation with the gay community, internalizing less of a sense of shared history, and because they have grown up in an age where HIV/AIDS is a part of their daily lives, many do not subscribe to the ‘crisis’ mentality that the 25 to 39 year-olds more frequently exhibit through their sexual behaviour and subscription to community norms. Concurrently, seroconversion rates among young people are on the rise, as will be illustrated further on.

A more detailed investigation of the influence of GCA on sexual practices indicates that respondents who are not attached to the gay communities generally tend to be more ‘conservative’ sexually. This is most apparent in the so-called ‘soft’ behaviors such as kissing, and continues through to ‘harder’ behaviours such as ‘rimming’ and ‘finger fucking’. However, as a part of the NGCA men’s sexual scripts, insertive oral sex with ejaculation and insertive anal sex with ejaculation remain popular. On the other hand, as the report indicates, the practices and sexual scripts performed by GCA men attest to a wider sexual repertoire, which in turn may provide sexual pleasure but simultaneously avoid potentially harmful behaviour altogether. More importantly, GCA respondents in the Male Call study were less likely than NGCA men to engage in sexual behaviors entailing semen transfer from themselves to their casual partners.

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24 Rimming is oral-anal sex.
Coupled with their higher rates of condom use, it might be that GCA men have more thoroughly embraced safer sex strategies with casual partners.

With regular (non-casual) relationships, GCA men also were inclined to express a wider range of sexual repertoires. To be sure, GCA men were more often in regular relationships than NGCA men. However, this might suggest that GCA men were more adept at renovating their safer sexual strategies by creatively developing fresh responses and sexual scripts in light of the potential threat of infection with casual partners. The large differential between GCA and NGCA men who have practiced receptive anal intercourse with a regular partner does not suggest that the former all are repudiating elements of risk, but it may well suggest that risk-taking is more premeditated and rational.

While safe sex behaviour was statistically significant in relation to GCA, highly unsafe sex was not statistically significant. In the above noted study, 19.9% - 22.4% of those men (CGA and NCGA) who had anal sex with a casual partner in the previous six months reported that they had engaged in highly unsafe sex at least once. This statistic confirms earlier theoretical arguments (especially Rademaker’s) that internalized mitigating factors are more important during the act of sex than external or structural elements. In short, while GCA has a bearing

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25 Receptive anal intercourse without a condom with a partner whose HIV status was unknown, or with a serodiscordant partner
on intentions to use condoms, it does not appear to be a sufficiently strong motivator, especially with casual partners, 'in the heat of the moment'.

Unprotected versus Unsafe Anal Intercourse

In a major study released June 1999\textsuperscript{26}, the GMHC (Gay Men's Health Crisis) in New York used an innovative model to differentiate between \textit{unprotected anal intercourse} (without a condom) and \textit{unsafe anal intercourse} (without a condom with someone whose HIV status is different/unknown). The survey provided the first solid evidence against which to consider current reports that gay men have 'reverted' to practicing unsafe sex; an analysis of 'relapse', discussed earlier. The results obtained counter reports of a rampant return to unsafe sex, in particular, of 'barebacking parties' where men exchange partners without either using condoms or discussing serostatus, that seem sensationalized and exaggerated in comparison to most men's lived realities. As in other studies, approximately half the sample reported either not having had anal sex or having had anal sex only with a condom. Approximately 39\% of the New York study reported unprotected anal intercourse (UAI) in the past 12 months. However, the majority of sex acts appear not to have been 'unsafe' in non-traditional terms of HIV transmission. Indeed, the men appear to be addressing risk strategically, even when not using condoms. The report continues to list several of these strategies:
1. Same serostatus partners: only 11% of all men surveyed had unprotected anal intercourse with someone whose serostatus they believed was different/unknown in the past year. Only 2% of men were positive and reported UAI with someone of unknown/different HIV status.

2. Fewer partners. Among men who had receptive UAI last year, 70% bottomed [were receptive] with only one man. Of the men who had insertive UAI last year, 66% topped [insertive] with only one man. HIV-negative men are even more choosy: of those who had receptive UAI, 77% of them bottomed with only one partner, and 71% topped with only one partner.

3. Roles in sex. When anal sex is riskiest, HIV negative men stay on top more, and HIV-positive men stay on the bottom. Men may be making choices based on the theory that the 'top' is less likely to be infected than the 'bottom'. Among positive men who had UAI with someone of different/unknown HIV status, they were more than twice as likely to be only on the bottom than they were to be only on the top. Among negative men having UAI with someone of unknown/different status, they were twice as likely to only be on top than to only be on the bottom.


Health Canada data supports these findings, and suggests that among adults aged 22 to 45, only 8.4% of men reported having two or more sexual partners in the previous year (Division of HIV Epidemiology, 1997). This is a decrease from an earlier study (1994) of adults that found that between 12% and 19% of men had two or more sexual partners in the previous year. Also, of that population who reported sexual intercourse with a non-regular partner in the year prior to the survey in 1994, only 26% of men indicated that they always use condoms with casual partners (Strike et al, 1995). The remainder (74%) either never used

26 “Results of the 1998 Beyond 2000 Sexual Health Survey”
condoms or did not use them consistently. According to Health Canada (1997), of those men who had sex with casual partners in the past 12 months, 27.7% did not use a condom the last time they had sexual intercourse.

Adolescent Sexual Behavior

The situation is not the same for younger boys and adolescents, however. A school-based survey (Poulin, 1996) found that approximately 61% of male grade 12 students reported having had sexual intercourse in the year prior to the survey. Of those who were sexually active, only 32% use condoms, and 40% indicated that they had had two or more partners in the past year.

The McCreary Centre Society (1993) reported that 55% of 17-year-old boys had had sexual intercourse and of those, 33% had four or more partners; of those who were sexually active, 43% of 17-year-old boys did not use a condom the last time they had sexual intercourse. The Ministry of Health's Bureau of HIV/AIDS, STD and TB has estimated that between 1975 and 1984, the median age of HIV infection in Canada was 29.6 years. Between 1985 and 1990, the median age of infection had dropped over five years to 24.5 years old. (Yan, 1996)

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27 The study did not differentiate between heterosexual and homosexual encounters.

28 Undifferentiated as to gender of sexual partner
Youth exhibit different social constructions of sexual activity: some are based on moral conceptions, and some on the concept of physical and impromptu behavior. Many of these constructions involve a core belief involving 'mystique'.

Countless young people are denied the opportunity to discuss sexuality with their parents, or encounter embarrassment by teachers who refuse to go beyond the strictly biological. The manner by which media uses coy language and double entendres is often confusing and frustrating for younger people. Clearly, this construction of sexual activity as mystical is an inadequate preparation for considered, rational thinking. (Ingham, et al, 1992: 169) This social construction also makes it undeservedly obscure when likely sexual partners try to talk to each other in specific terms about sexual activities, which in turn results in a general reliance on vague and evasive phrases (such as 'doing it', 'be careful', 'using something' and so on). This lack of effective communication tends to license people to behave in certain ways: "I don't know what came over me" or "I'm not usually like that" are justifications for what might seem to both their own and others 'deviant' behavior. In other words, given the examples referred to earlier, when people were distinctly aware of the disparity between what they should do and what they did do, this type of behavior can easily be justified internally and made acceptable (or consonant), since the scripting of sexual activity, in this case, embraces a presumption of mystical and uncontrollable forces.
Rather than viewing rationality as an inherent 'asset' of younger people, or conversely, an overwhelming force, we could regard it as an ongoing assumption. People can and do choose on what grounds they will make decisions — obviously subject to often-powerful constraints. In fact, even the notion of 'choice' is problematic, since choice involves the assumption that people act on the basis of some form of rationality, even if that choice is to not be conventionally rational. The social contexts in which such activities take place, as well as the nature of what is being accounted for, determine the extent to which 'rationality' is adequate justification for actions both for the others-as-audience and for the self-as-audience. (Gold, 1989) Considering rationality as an option has consequences for the manner by which we regard the concepts of 'costs and benefits', as used, for example, in the health belief model (HBM) (Ingham et al. 1992). More accurately, in grounding these terms of specific biomedical and health-preserving actions or behaviors, we privilege the importance of reputations and identities within particular social worlds.

A further obstruction to the adoption of a notion of rational and individual decision-making models concerning sexual activity is the obvious fact that sex is a joint endeavor. It is fundamental that 'negotiation' concerning safer sexual practices tends to be based on assertion and insistence, and in the past was primarily concerned with avoidance of conception rather than with avoidance of
infection. Historically, with respect to heterosexual sex, condom negotiation was unnecessary (in the main) because both parties usually tacitly understood that conception was either a desirable or undesirable outcome of having intercourse. However, in the case of younger gay men and potential HIV infection, the complexities of serostatus, power differentials (perhaps impacted by the use of drugs and/or alcohol), and a false sense of invulnerability combine to produce an elaborate sexual script that may be beyond the capacity of many younger people to manage.

Conclusion

The notion of a direct link between beliefs and behavior does not appear to be supportable, thus problematizing the notion of a linkage between the KAB model, social marketing based on that model, and concepts of virological safety entrenched in notions of trust, especially the trust that purportedly comes from ‘knowing one’s partner’. In the case of some of the impediments identified, it may be reasonable instead, to think in terms of a range of ‘rationalities’, depending on the identities and social worlds’ of the individual's concerned (Prieur, 1990a, 1990b). In other cases, people are cognizant of what is accepted to be the ‘rational’ or reasonable response, but have difficulty in complying with that kind of behaviour.

29 The very term ‘negotiation’ suggests a give-and-take scenario.
I began this dissertation posing the question "Is it not logical to assume that the preservation of life is the most dominant human endeavor?" What has been discussed in this chapter is a partial answer to that question — the answer, at this point is a tentative 'no'. I believe there are other factors that affect decisions regarding life-preserving strategies. I have examined how one man's need for "rebellion, freedom and chance" leads him to conclude that for him, the quality of life, as he defines it, is more important than the risk of dying from an incurable disease. He has demonstrated that risk is relative, not absolute, even in the face of danger. He is not alone. I have also demonstrated empirically that many HIV-negative men run a similar risk (Table 2-2). Notwithstanding the distinction between regular and casual partners, between 6% and 28% of the gay male population (at least in the Vanguard cohort), in the 12 months prior to the 1997 data analysis, had anal intercourse without condoms.

Through the use of a number of theoretical standpoints, it is possible to elucidate how people rationalize sexual risk. We have seen that it is extremely difficult to explain why they behave as they do. The difficulty in explaining why stems from our inadequate understanding of the dynamics of sex, partner selection, trust and intimacy. I have noted that many of the reasons given for condom-less anal intercourse relate to the notion of 'knowing' one's sexual partner, but at the same time, have acknowledged the ambiguity surrounding the concept of 'knowing'.
Additionally, I have examined, if only superficially, the subjective importance of fluid exchange as a symbol of manliness and as an expression of trust and love.

We appear to be left with the notion that sex is sex, but that it often is a social dynamic apart from, and independent of other forms of social expression. The difficulty many men experience in internalizing safe sex messages, to the point where using condoms is an autonomous reflex, is not so much a personal character flaw as it is a reflection of the futility many men experience in trying to train their emotional being to communicate with their cognitive mind, and indeed to surrender the emotional and inconsistent aspects in life to the guidance and direction of cognition. We know that this has not worked, or at least is very slow to take hold with respect to anti-smoking campaigns, the prevention of unwanted pregnancies, alcohol and drug abuse, the use of seatbelts in cars, drinking and driving and a myriad of other factors that are supposedly rational and good for the self and for society.

In the following chapters, I will examine what attempts have been made to stem the tide of HIV infection in North America and Europe, primarily through the use of social marketing efforts, and how a number of gay men view sex, risk, trust and intimacy in light of the omnipresent threat of infection. I believe that these examinations will assist in delineating the extent to which change can be
expected, and perhaps more importantly, identify areas where social marketing efforts are expecting too much.
CHAPTER 3 – SOCIAL MARKETING: THEORY AND PRACTICE

Given the previous discussion of rationality and panic, it is appropriate to reiterate several preliminary hypotheses before proceeding to analyze the theories and practices associated with social marketing. In the first ten or fifteen years of the epidemic, a key problem for gay men had been the association of condoms with heterosex. As children, many gay men were exposed to 'sex ed' classes, where condoms were portrayed as part of a process of pregnancy prevention, and, in some instances, a barrier to some STDs. It was also made clear that there were other forms of preventing pregnancy, such as 'the pill', intrauterine devices, the cervical cap, spermicidal foams and jellies, and so on. In other words, condoms were portrayed as one of many rational choices for preventing unplanned births. Condoms were, to be blunt, for heterosex. For youngsters, rarely, if ever, were condoms discussed as a tool to prevent STDs in homosex.

As a new generation of gay youth reaches sexual maturation, the issue of condoms, for many, takes on a different aspect – while for some people, sex ed (where it is available) still is redolent with condoms and pregnancy, however, for many gay kids, condoms are more associated with AIDS, contagion and death. As we shall see in the interviews (one in particular) homosex (with or without condoms) was decoded as an inevitable death sentence.
Additionally, in a heteronormative world, condoms (when they are used) are viewed as expedient measures to prevent unwanted pregnancies and STDs, with the full expectation that at some point, presumably that of marriage, condoms will no longer be necessary, in fact they would be contraindicated if one wants to start or add to one's family. This is not the case in homosex, where the "official" admonition is to use condoms all of the time, regardless of the circumstances, since anyone, even a trusted partner, potentially could be a carrier of contagion. Herein, the presumption is that once one is aware of transmission routes of HIV/AIDS, as well as other STDs, and the means to prevent infection (using condoms, limiting partners, avoiding high risk behaviour), gay men, both young and old will develop 'healthy' attitudes towards sex and contagion, and translate these attitudes into 'rational' behaviour, in line with the official thinking on risk and choice. This is the essence of the KAB model.

However, rational choice based educational theories, KAB, perceived invulnerability, and emotion-based choices are not truly crafted in theoretical models, rather they are more in line with hypotheses – probably useful, but not really proven to be metanarratives. In fact, the most that can be said in their favour is that they are micro-narratives that at best have some utility in explaining (but rarely predicting) probable outcomes of, in this case, sexual encounters. However, over the course of the epidemic, ASOs (AIDS Service Organizations) and government health branches have seized on these 'so-called' theoretical
epistemologies as a way to plan and predict the course of the disease, with a focus on its ultimate eradication. The most prevalent manner has been through the use of social marketing. In order to understand the strengths and especially the weaknesses of social marketing, we must first examine how these theoretical positions have been developed and utilized.

Much of the public HIV/AIDS prevention work has utilized various social marketing models. Social marketing is essentially the selling of an idea, rather than a product, generally through the traditional mass media of information exchange — television, magazines, billboards, pamphlets, and so on. Social marketing can be used to further a variety of 'public good' programmes, for example: political campaigns, charity appeals, and health/behaviour modification agendas, to name a few. This thesis focuses on the results of health belief social marketing — in particular the marketing of safe(r) sex. In what follows I argue that the social marketing of condom use to avoid contracting HIV has failed to adequately target the appropriate audiences with the appropriate messages, and hence because of this lack of efficacy in social marketing, negative connotations of condom use have either been reinforced or increased.

In this chapter, I discuss both theoretical and practical aspects of social marketing — the models that have been adapted (or, in some cases, maladapted) for health prevention work. Additionally, as the chapter unfolds, examples of various
AIDS/HIV advertisements are introduced, critiqued in light of the theoretical underpinnings they purport to employ, and deconstructed in an effort to specifically identify why they have, in the main, either fallen on deaf ears, or have unintentionally created side effects that have thwarted their objectives.

Furthermore, as will be demonstrated by the personal stories contained in the case studies in chapter 5, and thematic analyses in chapter 6, in many cases, the extensive and often misguided use of social marketing messages, coupled with a general reluctance on the part of many people to change their behaviour, has, for many, resulted in a culture of resistance to condoms.

To be sure, in the early days of the epidemic, when basic information about HIV/AIDS prevention was critical to the health and well-being of a community accustomed to frequent sex and multiple sex partners, the social marketing messages, in all probability, lessened the devastation that could have been, had there been no information at all. The very fact that a great number of MSM do use condoms for anal intercourse to this day points to the efficacy of the initial project, and is a testament to the ongoing usefulness of providing basic prevention information to each successive generation of MSM. However, as indicated in chapter 2, almost all studies have shown that the messages have influenced only a portion of those gay men who have anal intercourse (most studies indicate that approximately 50% of all self-identified gay men have anal intercourse) in a
meaningful way. Additionally, while health departments in general, and ASOs in particular would like to ascribe the safe(r) sex behaviour that is practiced by many in the MSM communities to the positive effect of social marketing, one must bear in mind that there are other factors that also hold sway in the processes of behaviour modification or reinforcement — peer group pressure, gay community involvement, levels of comfort with risk-taking, relationship status, and so on.

In short, this chapter examines some of the most pervasive social marketing efforts, in order to make the case that advertisements and posters are not the fundamental solution to stemming the tide of new infections.

The earliest versions of public health campaigns pertaining to AIDS prevention frequently depended on a morbid fear of infection to persuade gay men to change their sexual behaviors, and in particular, always to use condoms when having sex. Initially, social marketing was directed at 'populations at risk', most noticeably gay men. Over a period of time, as more data on potentially infectious sexual behaviours (and more importantly, behaviours not deemed quite as risky) and with a higher level of sophistication in AIDS marketing took hold, social marketing veered away from population groups and moved into behaviour groups. Initially, fear-based campaigns were the messages of choice, but, over time, as more epidemiological data was collected and analyzed, fear-based
campaigns were largely replaced by information-based campaigns (Adam 1992; Rosser 1991). As Susan Kippax et al. (1993:5) writes:

The dominant model of health education that has been adopted by many AIDS researchers, particularly in the United States, is a refinement of what may be called the KAP [or KAB] model: knowledge, attitudes, practices [or behavior]. The KAP model is a linear one, which initially assumes that knowledge shapes or determines attitudes, which in turn, shapes or determines behavior.

The KAB design is a 'rational man' model, the presumption being that the dangers of condom-less sex, having been conveyed, will be avoided by prescribed safer sex behaviors. It is true that a lack of knowledge continues to correlate with a lower incidence of safer sex practices, especially among Blacks, Hispanics, youth, and people with lower incomes and rates of literacy (Penkower et al 1991; Peterson et al 1992; Kelly et al 1991; Bochow 1990; Ekstrand and Coates 1990).

"These findings have led to the development of a range of 'culturally appropriate' educational initiatives designed to meet the particular needs of underserved communities." (Adam, et al 1998:7). However, despite the general rise in HIV/AIDS knowledge levels through the 1980s, it has become increasingly clear that rates of safer sex practice often fail to keep up with the growth in HIV/AIDS knowledge. A study by Fisher et al. (1994: 246) indicated that a KAB model was attributable to only 35% of the variance in gay men's AIDS-preventive behavior. Almost 2/3 of the variance in safer-sex behavior in their sample could not be explained by knowledge differentials.
Notwithstanding the merits of the 'informational approach', we may have reached or even passed a point of diminishing returns in continuing to use this (and similar) models. This model appears to have efficacy primarily amongst men with a marked internal locus of control: those men who believe that they can 'do something' about AIDS by practicing self-control and using active coping strategies (Martin 1993; Perkins et al. 1993, Adib, Joseph, Ostrow and James 1991). In a sense, KAB preaches to the converted. Supporting this notion, Clement (1992) argues that men with passive, avoidance, or fatalistic attitudes toward the potential for infection are more likely to have unprotected sex.

Many ASO's have moved to 'community-based' strategies of HIV prevention by applying models of collective solidarity among gay men (Kayal, 1993). Others have attempted to make safer sex appear erotic. The rationale behind the invocation to collective solidarity is that this approach may have some value among gay men by amplifying their sense of empowerment, and by improving gay self-acceptance, which may in turn promote safer sex behaviors. As noted previously, participation in the gay community has been shown to be associated with safer sex practices.

However, there are numerous psychosocial obstacles that marketing models must overcome in order to achieve any degree of measurable success. For example, Gold et al (1994) note that qualitative analyses indicate that HIV-positive gay men
rationalize UAI in a number of intriguing ways. These include being in a negative mood state, having nothing to lose, taking advantage of a sexual opportunity, disliking condoms, resolving to withdraw without ejaculation, and demonstrating confidence in themselves and their partners. HIV-negative men offered as their reasons for UAI: a belief that they could infer a partner's serostatus, being in a long-term relationship, wanting a break from the whole AIDS panic, disliking condoms, and like the HIV-positive respondents, being in a negative mood.

According to Kippax et al. (1993:2,5–6), the KAB model is critically restricted in its capacity to achieve an understanding of the way in which people are sexual, and why they adopt or do not adopt safer sex practices. This deficiency comes about because KAB presumes that behaviors are a consequence of pre-set attitudes, while it ignores the meanings that sex might have to the participants, the social processes from which sexual practices emerge, and their negotiation and definitions. The 'rational man' model homogenizes all homosexual practices, presupposing that a technological intervention (the availability of a condom) is a sufficient motivator for HIV risk reduction. However, preliminary studies of gay and bisexual men have accentuated the range of understandings about sexual practices that might influence decision-making around safer sex. For example, Kippax et al. (1993:53) observed that anal intercourse without condoms was rated as the most physically satisfying of all sexual acts, as well as being the most emotionally satisfying. Kippax also observed a correlation between condom-less
sex and "a style of sexuality associated with multiple encounters in settings where casual sex is informally institutionalized" (74-75). Prieur (1990:109) noted that for men who did not practice safer sex, "sexuality represents the only close interpersonal contact these men have, and safe sex practices are perceived as creating emotional and physical distance, distrust, and thoughts of death, as well as inhibiting the free expression of love and affection". While Prieur's findings may be somewhat of an hyperbole, in that it is unlikely that all men who do not use condoms do so because they lack “close personal contact” in their lives, his conclusion nonetheless points to the importance of skin-to-skin contact as an intimate emotional necessity in one's life.

Therefore, it would not be an exaggeration to posit that the key failure of social marketing efforts to reduce HIV transmission has been the tendency to overlook the integration of safer sex practices with sexual repertoires that encompass forms of behavior that intrinsically express intimacy, the symbolic value of fluid exchange (semen) and the ways in which self-validation presents itself through sexuality.

Nonstage and Stage Theories – State of Change

Like the KAB model, nonstage theories and models of preventive behavior (e.g., the Health Belief Model, Theory of Reasoned Action, and Protection Motivation Theory) conceive of behavior change as a linear progression. The
assumption is that the relative probability of someone altering behavior is a mathematical function of that individual's attitudes and beliefs. The factors included in the equation, their relative weights, and their interactions are assumed to be constant from the time one learns of a threat to the time action is taken (Weinstein, 1988). Fear-based campaigns are a good example of nonstage theory in action.

In contrast, stagist models regard behavior change as a sequence of movements or events that allow researchers to observe the transition towards a behavior change in people who have not yet fully attained the desired readjustment. Additionally, with this model, one can see the impact certain factors may or may not have had at the beginning of the process throughout the course of the change, rather than presuming that all factors have an impact on the end product of actual behavior change or adoption. (Prochaska et al., 1992; Weinstein & Sandman, 1992)

There are a number of stagist models that have been used in different fields, and at different times. Perhaps the most extensively used, and therefore the one that appears most frequently in the literature is the "stages of change" (SOC) model. This model propounds five stages: "pre-contemplative (PC) – not recognizing the problem for change; contemplative (C) – seriously thinking about the problem and the possibility of change; preparation (P) – making a commitment to change and
taking steps to prepare for that change; \textit{action (A)} — successful modification of behavior for a period of from one day to six months; and \textit{maintenance (M)} — continuation of change from six months to an indefinite period.” (Holtgrave, et al 1995: 26-27)

Numerous research studies have shown that relapse and recycling through the stages of behavior change happen as often as individuals attempt to stop or modify particular behaviors, such as dieting or quitting smoking. The linear progression model is seriously flawed and rendered ineffective due to this spiraling effect. Additionally, the influences (internal and external) that assist individuals to progress through the stages of behavior change vary from stage to stage. For example, awareness, emotional arousal, and environmental reevaluation are significantly influential processes for moving people from $PC$ to $C$, and decisional balance and self-reevaluation are crucial for moving from $C$ to $P$. (DiClemente & Prochaska, 1985; DiClemente, 1993; Prochaska et al., 1992)

Consciousness raising, one of the change processes underlying transition from $PC$ to $C$, is defined as “increasing information about oneself and the particular problem being faced”. (Prochaska et al., 1992) An increased perception of personal risk by people engaged in potentially risky behaviors (which would naturally include the absence of preventive behaviors) easily fits within this definition, and in fact is found frequently in the BDM literature. Movement
from $C$ to $P$ involves a person developing a commitment to a course of action, a process that by necessity includes selection from various options (at the very least to adopt or not to adopt the prescribed change). These options are informed by one's own decision-making perspective, the time horizon, and the importance of the various decision-making factors.

Decision-making however is not as straightforward as the models imply. The 'right' choice may appear obvious to some, and elusive to others. For example, Pinkerton and Abramson (1992) discussed under what circumstances unsafe sexual behavior might actually seem perfectly rational and reasonable to the participants. When decision analysis is employed in the normative sense, one of the initial steps is to outline the decision-making perspective. The social marketing communication designer's perspective is not necessarily concurrent with the message recipient's perspective.

For example, if the target market is PWAs (Persons with AIDS), and the object is to move from the $C$ to $P$ phase, it is crucial to know if the PWA is self-oriented, that is if he using himself as the primary model for decision-making. If that is the case, he may consider that since he is already infected there is little benefit in his using condoms; in fact there may be both a financial cost and perceived physical and social discomfort in his using them.
Alternatively, if he is 'other-directed', the task of behavioural change programmes is to shift his perspective to the well being of his sexual partners. Perhaps the financial cost and discomfort in using condoms may be ameliorated by his sense of altruism or community preservation.

The time horizon is also a critical component. Whether consciously or unconsciously constructed, all decisions are made, in part, by taking into consideration the time horizon over which consequences are to be considered. For example, using condoms all of the time as a temporary measure made sense in the early days of GRID and AIDS. The assumption was that a cure or at least a vaccine would be discovered in a relatively short timeframe, and in the interim other (temporary) protective measures were required. However, as a long-term strategy, consistent condom use fails to satisfy those people who are concerned with the quality of their sexual encounters and the lack of intimacy condoms engender. Movement from $P$ to $A$ in this latter scenario is far more difficult than in the previous case.

Another difficulty relates to age. Many gay men have expressed a significant disinterest in growing old (despite the fact that 'old' is an indeterminate construct). During the peak of the AIDS epidemic, when men were dying at an extraordinary rate, many gay men, believing that AIDS was inevitable, subscribed to the axiom that it was preferable to enjoy life while one could, and
‘leave a pretty corpse’. However, in today’s world, recognizing that HIV, if treated early is usually a slow progressing disease, many ‘older’ gays may consciously or subconsciously decide that condoms are irrelevant to their sexual choices, in that by the time they would be AIDS symptomatic, they would more likely either be sick or dead from a host of other possible illnesses.

Third, due to valuing or weighting the importance of various decision-making factors differently, people may vary in the option they choose concerning health behaviors. The most famous model is the "Multi-Attribute Utility Theory" (MAUT) developed by von Winterfeldt and Edwards (1986). To use an uncomplicated example, assume that there are four factors pertinent to the decision about whether or not to use condoms with a casual partner: (a) disease protection, (b) physical comfort, (c) cost, and (d) partner’s reaction. One person may decide to use condoms because he weights disease protection highly; another person may decide not to use condoms because his weighting privileges physical comfort. Another may not be able to afford condoms, while someone else may fear rejection if the issue is brought up at all. For the purposes of communication campaigns therefore, it is critical to determine both the factors being considered, and the weights people place on those factors in order to incorporate the most valued considerations of these into the program.
Fear Campaigns

In the designing of health promotion campaigns, there are a number of persuasive message strategies that can be employed. One of the strategies in operation involves the utilization of ‘fear appeals’ to promote better health. They are compelling messages that accentuate the harmful physical or social consequences of failing to comply with the message’s advice.

Cigarette packaging in Canada is a clear-cut example of this strategy. In Canada, all cigarette packages are required to give equal prominence to a health warning and the product branding itself. Quite apart from the dire written warnings (“Cigarettes are a Heartbreaker”, “Warning: Each Year, the Equivalent of a Small City Dies from Tobacco Use”, or “Cigarettes Cause Lung Cancer”) all packages also have photographs illustrating the messages (a damaged heart; a graph depicting deaths from murders, alcohol, car accidents, suicides and tobacco; a patient in a hospital bed hooked up to a breathing apparatus).

In another example, most of us can recall the infamous American commercial involving a frying pan and an egg. In the commercial, the voice-over states that the egg represents your brain. The actor breaks the egg and drops it into the hot frying pan. He then states, "This is your brain on drugs. Any questions?" The intention of the commercial is to graphically demonstrate that controlled substances fry (kill) brain cells. While the efficacy of the commercial is unknown,
the hyperbole is clearly inconsistent with the lived reality of those people who use recreational (non-prescription) drugs. It is unlikely that the commercial accomplished much more than preaching to the already converted, and reinforcing the 'drug panic' agenda.

More systematic analysis of the use of fear appeals to promote better health can be found in a study by Freimuth, Hammond, Edgar, and Monahan (1990). They analyzed the composition of public service announcements (PSAs) associated with HIV prevention. Fear-type appeals were used in approximately 26% of the PSAs. It would seem, in the 1980s the producers of health promotion messages believed that fear appeals were an effective health promotion strategy. The theoretical explanation for the efficacy of fear type campaigns can be analyzed using two categories: drive explanations and parallel response explanations.

Drive explanations presuppose that all fear-arousing content creates some sort of drive. Drives are bodily states, in this case activation, arousal, or anxiety, which result in some general response. (Newcombe, Turner & Converse, 1965) The more fear-arousing content embodied in the communication, the more potent the appeal is projected to be. A forceful directive fabricated to reduce high-risk behaviors related to AIDS should, according to this definition, depend on no-nonsense examples of fear-arousing content. However, in an unrelated study, Janis and Feshbach (1953) found that low fear messages lead to higher
compliance and argued that the drive or anxiety produced by moderate and high fear messages triggered defensive avoidance. (the inclination to ignore or deny the negative consequences portrayed in the message).

Often, as in the case of the egg and the frying pan, people believe that they do not behave quite as badly, or react quite as strongly as the message suggests. Therefore, the hypothesis that the more fear-arousing content contained in the message, the more effective the appeal is predicted to be, appears to be not only unfounded, but in fact the opposite. High fear messages appear to be counterproductive.

For example, consider the following advertisement produced by the Ministry of Health in St. Lucia:
Figure 3-1 is particularly remarkable, because it exhibits little else other than the fear factor – there is no consideration given to any elements of condom use, culture or environment: One possible and probably intended interpretation is that by wearing condoms, death is avoided. However, in the first instance, the hyperbole (if you don’t wear a condom you will die) exaggerates the threat factor
— not everyone has HIV, and not all sexual acts involving a penis are deadly. Second, HIV/AIDS is not a bullet — one does not die in the throes of "climax", as if one were shot in the head. It is true that AIDS is ultimately fatal, but so are many other things in life.

Perhaps more importantly, this advertisement transmits a confusing mixed message. On one hand we see a penis substituting for the letter “I” in AIDS. This alone is perplexing, in part because it suggests that AIDS is a man’s disease, without considering the fact that women may be infected by men, and men may be infected by women. But we also see a condom hovering above the penis like a spaceship preparing to dock. Is the condom coming on or going off? Is the presence of the condom counter-attitudinal to the text — could not one read the message that a condom is a climax of death? Most people would not make this latter association, but what about the uninformed?

An apocryphal story is told about family planning nurses in India. As they traveled from village to village extolling the virtues of family planning, and providing free condoms, they demonstrated the correct handling and use of a condom on a broom handle. A year later they were dismayed to discover that the birth rate in these villages was no lower than the year previous. “What happened?” they asked. The villagers replied “We used the condoms just like you
said—every night we put the condom on the handle of the broom, put the broom next to the bed, and had sex. Is this not what you wanted?"

The point is, if the message is not perfectly clear, if innuendo and interpretation are required of a population that may be incapable of making the mental connections, if ambiguity is not eliminated, a sophisticated and 'catchy' public health message is wasted on its audience, and may in fact, achieve the opposite effect.

In this instance, the drive explanation is subsumed by the mental picture of the penis as an instrument of death—it is tantamount to stating that when they have sex men kill women with their bodies. The end result may be that women should avoid having sex with their mates, lest they may die, perhaps forcing men to seek sexual gratification elsewhere, probably from prostitutes, thus creating an even greater element of risk than previously existed.

Another advertisement plays directly into the fear of failure. As mentioned previously, the American “100% safe, 100% of the time” message was counterproductive because it placed a great number of people in the position of having to admit (at least to themselves) that they were incompetent when it came to a) self-control, b) adherence to community norms and/or c) protecting either themselves or others while having sex. The following advertisement, prepared
for the Michigan Department of Public Health reinforces the negative fear message:

Figure 3–2: Michigan Department of Public Health
The text of the message reads:

Having sex without a condom is one game you can’t win. So if you’re going to have sex, play it smart and use a latex condom every time. For information call...

The ad is clever in that it uses the condom as a piece in a tic-tac-toe game (representing the “O”). However, the message is clearly a put-down to all the people who do not use condoms “all of the time”. The objective, if one can interpret the ad correctly, is to suggest that one should use a condom to be a winner, but by using a game theme, what it implies is that for every winner there must be a loser. And the people who do not always use condoms are losers. Presumably, no one wants to be a loser, so in the terms laid out by Janis and Feshbach, the ad would trigger defense avoidance, rendering it useless or possibly counterproductive. It could be seen as counterproductive in the sense that once one has transgressed, or in this case, if one is a loser, there is no going back. “Always” is an absolute term, and leaves no room for improvement – in effect it means one strike and you are out. (In fact, tic-tac-toe is notorious for being a game than one can almost never win.)

Additionally, the message does not differentiate ‘sex’ acts – all it says is that “having sex without a condom is one game you can’t win”. I have already discussed relative risk (chapter 1); this ad leaves no room for a reasonable interpretation of high risk, low risk and no risk, presuming that all sex is a
pathway to contagion. As we will see in the case studies, the meaning of sex is highly diverse, so the interpretation of this ad must be contingent on the particular meaning(s) ascribed to sex by each recipient.

There is also a subtle, and perhaps ironic element to this ad, as well. The condoms have a thick black line running through them, as if they were to be deleted, or are not to be counted, or for the uninformed, the condoms themselves are 'cancelled out'. Coupled with the negative imagery of the repeated heavy dark "X" in the other squares, the overall message is gloomy and forbidding.

A third example plays on the fear of embarrassment: This poster/ad is American, but the attribution is too small to read (even with a magnifying glass). It also uses fear as its message, and another double entendre, this time relating to dying of AIDS and dying of embarrassment. It does not provide any efficacy message (or cues) as to how to overcome the 'embarrassment' of talking about sex, nor does it suggest how a condom might be used effectively. Additionally, it is addressed to an adult heterosexual population, whose knowledge base of safe sex practices is probably less than that of gay men.

Less than truthful, it shifts the risk from that of AIDS to one of embarrassment. People do not die of embarrassment, as the ad suggests. While it may be so that 'sex talk' may be difficult for a lot of people, this is not to suggest that it is
impossible. A more effective message would be along the lines of 'Which is worse, contracting AIDS or feeling uncomfortable discussing protection?'

Figure 3-3: Don't Die of Embarrassment *(unattributed)*
The subtext, “AIDS is a killer” is clearly a fear message. However, the ad provides no resolution — no information about what to do to avoid infection, not even the simple statement that AIDS is an infection, a sexually transmitted disease. The statement “Use a condom” is inadequate — coupled with the graphic, it lies as a non sequitur at the bottom of the ad, in small type.

Insofar as parallel response models are concerned, Leventhal (1971) postulated that fear appeals stimulated two processes in the subjects of the appeals. His argument was that fear-arousing messages evoked both the emotion of fear and the need to manage the fear. Simultaneously, fear appeals stimulated a motivation to get rid of the danger posed by the message. This can be accomplished through denial, avoidance, distraction, or dulling the impact by engaging in this self-same behavior that the fear message condemns (somewhat akin to getting on the horse after it has bucked you). Fear control and danger control therefore serve contradictory purposes. Additionally this model does not elucidate the conditions under which a message recipient might opt for threat control, danger control, or some combination of the two. By far, the most effective threat-type messages must also include a prescribed, reasonable remedy to alleviate the threat. If the recommendations offer an effective method to eliminate the negative outcome, then the target potentially would comply with the message. However if the recommendations are beyond the capabilities of the target, or
dissonant with their lived experience, threat control in any of its manifestations would probably occur.

Ineffective Use of Fear Appeals

There are a number of factors incidental to the substance or structure of fear messages that can obstruct the efficacy of fear appeals. Three particularly salient issues must be considered: are the recipients receiving the message voluntarily or involuntarily, how old are they, and how anxious are they concerning the issue? If the targets are receiving the message voluntarily, for example in a seminar, bathhouse or in an environment where these messages are appropriately sited as opposed to mass media such as newspaper ads, TV commercial or billboards, there is more likelihood of eliciting a positive response. Many health communication campaigns that evoke fear appeals and use television do not succeed (Kohn et al, 1982). A possible reason for this effect may be that television viewers voluntarily watch programs, but involuntarily watch commercials. If viewers believe that commercials are an intrusion on their privacy and enjoyment they may resist the message and the messenger.

Fear appeals tend to be more effective for older audiences (Boster & Mongeau, 1984). Younger people, especially when it comes to sex, tend to subscribe to the three “I’s” — ‘invulnerable’, ‘impotent’ and ‘immortal’. They feel as though death and disease happen to their elders or perhaps to other young people but not to
themselves (Irwin & Millstein, 1986). Older persons in general, on the other hand, sense a palpable fear of ill health and a threat to their sense of well-being.

People who have direct or indirect contact with PWAs, or have lost friends, relatives or lovers to the disease may also be more receptive to fear campaigns, perhaps not in the traditional 'learning' sense, but more in the images and memories that the ads may evoke. This phenomenon is analogous to adult children quitting smoking after having watched a parent die of lung cancer.

In summary, fear appeals have some degree of efficacy for some audiences, but only under certain conditions. Their effectiveness is dependent on the structure of the message, and the vulnerability of the target. In the final analysis, using the frying pan and egg example, the overstated threat, the limited vulnerability, the lack of suggested personal efficacy to change behaviour, and response efficacy (the benefit of changing behaviour) of the message are nonexistent or so oblique as to render the message useless. It is, in fact, probably one of the best examples of the worst of the fear messages.

The Persuasive Health Message (PHM)

The PHM framework asserts that two individual aspects, the constant and the transient factors must be addressed before the effective development of a campaign message. The composition and characteristics of a convincing message are configured by the constant components of the framework. For example, “a
persuasive health message should contain a threat message, an efficacy message, various cues, and should be targeted toward a specific audience—regardless of the topic, type of message, or environment.” (Witte, 1995:146) The threat, according to Witte, is not the horrific threat discussed earlier, but an attempt to make the audience feel susceptible to a severe threat. The efficacy message also attempts to convince individuals that they are capable of performing the remedial response, and that the remedial response realistically foils the threat. Witte’s previous studies in fear appeal research (Witte, 1992) indicated that when individuals perceived high levels of threat and high levels of efficacy, they were motivated to protect themselves against the threat. Perceptions of threat must also be held in equilibrium by strong response and self-efficacy perceptions. That is, the recommended response must be received by the audience as sufficiently applicable to either eliminate or significantly reduce the threat before individuals will change their behaviors (Rogers, 1975, 1983; Witte, 1992). If the threat is too strong, such that individuals will believe that no response can effectively avert it, the message will backfire.

One of the more compelling advertisements produced utilized a double entendre to get its message across. Quite unlike figure 3-2 (Winners Always Use Condoms), this particular poster/ad sought to reinforce the use of condoms by praising individuals and the community for their efforts. The following sexually explicit GMHC ad exhibits many of the virtues of a good campaign. The ad is visually
pleasing (to its intended audience — gay men), supports the safe sex message with a reference for more information, and bolsters the efforts gay men have been making to sustain safer sex behaviours by encouraging them to “Keep it Up” (of course, the double entendre suggests both maintaining an erection, and ‘keep up the good work’) which is appropriately both sex-positive and community positive.

The ad also explicitly shows the use of a condom — a rare piece of visual instruction not usually found in most safe(r) sex advertisements. However, condom notwithstanding, the advertisement portrays a no-risk activity (kissing) while standing up; it could have been more effective if it wound the clock forward to a more immediate precursor to penetration, such as lying or kneeling on a bed. The message can be interpreted as deliberately ambiguous yet aiming to convey the impression that condoms should be used. However, an alternate reading could suggest that condoms are necessary for all erections (even if the erection is induced by a kiss) — a misleading and probably unintentional consequence of the 100% safe, 100% of the time paradigm. Additionally, the partner with the condom is not totally erect — his penis is being held up by the shorter of the two people. This is possibly a subtle (and perhaps unintended) reference to the difficulty many men experience in maintaining an erection while using a condom. Nevertheless, like the frying pan and egg advertisement, this ad clearly targets the already converted, but without promoting the sex panic of many other messages.
On the other hand, the following advertisement was produced by the CDC (Centres for Disease Control) in the United States. It has a number of elements worth noting: first, the double entendre of the headline suggesting that condoms preserve life is a devastating message when the ad is reinterpreted as ‘you will have to use a condom forever’, predicting that HIV will never be cured or
controlled, and implying a sub-message that all male penetrative sex is lethal. Second, the sub-head "Use a latex condom consistently and correctly for protection against HIV" fails to indicate what 'consistently' means (one assumes that it must be used all the time even in the instances where HIV is not present in either partner), and also declines to advise the audience as to what the correct usage might be.

As previously discussed, the persuasive health message should contain a threat message, an efficacy message, various cues to action, and some sense of the target audience. Very frequently, the target audience is identifiable through the graphic itself – young men playing a game, a couple kissing, two men holding hands, and so on. In this case, we are viewing what appears to be a rolled up condom (i.e.: unused) almost through a veil, side-lit shadows and slightly out-of-focus. The choice of changing typefaces for the word 'life' is also curious. There is an implication that this word, above all others needs to either stand out or to recede into the background. Given that the rest of the text superimposed on the condom is widely spaced, boldfaced, and a strong typeface (Times New Roman or Garamond), why is the word "life" in a lighter typeface, more like Bookman Swash or Calligraphy? Is it possible that the designers realized that the threat of having to 'partner up' with a condom was so onerous that they decided to reduce the impact of the word 'life'? Or is it supposed to tie in visually with the sub-head, which utilizes the same typeface?
Last, there are two relationships established in this advertisement – condom/partner and life/death. In the first instance, the condom is subjectified as if it were a real person — yet when one thinks of lifetime partners, a piece of latex is not an equivalent. By diminishing the stature of the ‘partner’, there is a subtle subtext, especially for gay men, that lifetime partners are easily obtained, disposable, and are a form of barrier from contagion – a highly unromantic view of couplehood. Second, the other message – a partner for life — is presumably a double entendre. On one hand, it indicates that condoms are life preservers, protecting one from HIV, but another reading suggests that HIV is not only lethal, there will never be a cure or a vaccine. Overall, this message presents a dismal picture of gay life – disposable partners, contagion, and no hope of salvation.
Figure 3-5: U.S. Centers for Disease Control & Prevention, Atlanta, U.S.A.
The next poster, developed for the information of high-risk commercial sex workers in Ghana, falls short of its presumed goals for a number of reasons. It a) uses ambiguous language (i.e.: “sleep with someone”), which may be misunderstood as slumber as opposed to ‘have sex’; b) it depicts the condom in the package, overlooking any suggestion as to how it is to be used; and c) uses as an illustration a rendering of someone who looks more like a housewife or professional woman, than a commercial sex worker. Additionally, commercial sex-workers do not “play it safe” – sex is not play, it is work, and as a workplace message, it would be more resonant with the intended audience if the copy read “Work Safely” – it would be hard, if not impossible for them to relate culturally to the message. The message is, apart from its misleading text, also patriarchal and patronizing, degrading ‘women’s work’.

Even assuming that the message is interpreted in the manner by which it was intended, the headline advances a panic message: “Anytime” is an absolute, and leaves no possibility for compromise or exceptional cases. As has been mentioned numerous times, in the absence of the virus, infection simply cannot occur. Yet this ad strongly suggests that absolutely no one is to be trusted, regardless of the circumstances. Since the ad is phrased in the first person singular, if ‘a life is at risk’ there can be only two explanations – either the recipient is a carrier of contagion or everyone else is. In the first instance, the ad is insulting to those people who are disease free, as well as reprimanding those
who are HIV-positive, and in the second instance, the suggestion is that the individual has no agency – no ability to make a judgment as to whether or not to use a condom in certain instances, such as the most obvious case of procreation. Also, positioning the message as an individual problem “You” and “Yours” fails to evoke the extremely important caveat that HIV/AIDS is a communal problem – that is the very nature of the disease – a disease that requires more than one person to transmit and most certainly more than one person to avoid.
Anytime you 'sleep' with someone a LIFE is at RISK

YOURS!

Play it safe - Use Condom
Within the persuasive health message paradigm, there is also a ‘cues’ component. Cues relate to variables that can influence the persuasive process in a more indirect manner. For example, if someone with high credibility or charisma delivers the message (e.g.: a rock or movie star), the message may be received and possibly accepted whether or not the person receiving the message actually believed the arguments (Petty & Cacioppo, 1986). Two variables function as cues – sources and messages. “Variables related to the source of the message, such as credibility, attractiveness, similarity, or power, can have subtle but significant impacts on whether the audience takes the message seriously and is motivated to act” (Witte, 1995: 148). Additionally, the way the message is organized, whether it is emotional or logical in nature, the amount of repetition, and the directness of the language all can influence the persuasive process (McGuire, 1984).

The final constant component is the audience profile. It is important because it requires the message to ‘fit’ the audience. The message must be worded in the language and style that is appropriate for the age group, education level, language, reading ability, and worldview of the audience. Selling condoms as an aid to preventing pregnancy while simultaneously attempting to convey the message that condoms serve as a barrier to STDs would not fit a group of gay men. Similarly, dire threats of rampant HIV infection are inappropriate for a high school audience that may not yet be having sex, and may also view HIV/AIDS as a ‘gay disease’ that has no relevance for them.
The goal of the message must be stated clearly and precisely. The message must answer at least two questions: what is the threat, and what is the recommended response? Additionally, salient beliefs about the threat and efficacy of the response need to be determined. This is a 'transient' component of the PHM (Persuasive Health Message) framework, at least transient in the sense that it varies from person to person, and from time to time. The second element of transient information is the cultural/environmental/preferential profile. Source and message preferences will aid in the production of cues: Who is best to deliver the message? What medium is most appropriate? The PHM framework is based in the Theory of Reasoned Action's 'salient beliefs' concept discussed earlier.

The synthesis of the transient information into the constant components of the framework brings the process together. First, the targeting of the audience's salient beliefs concerning threat and efficacy increases their involvement in and personal relevancy of the message. This in turn should lead to evaluation and acceptance of the message, which may ultimately yield lasting and stable attitude change (Petty & Cacioppo, 1986). Sometimes, however, audiences are inured and opposed to various messages (e.g.: safer sex) either because they have heard it so many times, or have come to discount the truthfulness of the message. Thus, cues are important in that the source credibility, attractiveness, or the message form may inject new life into an old script.
When this discounting of the message does occur, what results is a form of perceived false advertising, or what Odets (1994, 1995) terms "swallowed lies". Figure 3-7 proposes that "Good boys always wear their rubbers", suggesting that it is transgressive not to use a condom – condom use is not made optional (under any circumstances) unless one is prepared to be labeled as a 'bad boy'. Ironically, the very transgressiveness of non-condom use is in itself a turn-on for some people (see Chapter 2, Hamilton's letter to the editor). Additionally, there is no mention of agency or of what to do, nor is there an attempt to be culturally relevant – how does someone identify with somebody in a yellow raincoat and rubber boots? Why is this scenario relevant to gay men?

In addition, the small type at the bottom reads "AIDS. Protect Yourself". If we evoke the necessary elements of the persuasive health message, the fundamental conditions for effective intervention is the need for a threat message, an efficacy message and cues targeted toward a specific audience. The audience is "good boys" (whatever that entails), the threat is vague but presumably understandable, but what is lacking are the cues – in this case, the message is only directed at the individual, entreating him to protect himself. In the first instance, if he is HIV-positive, he has little reason to protect himself, yet absent is the suggestion that he may wish to protect others; in the second, if he is HIV-negative, there is no implication that he has a responsibility to the community – he stands alone in his need for behaviour change.
Switzerland provides a perfect example of Odets' notion of the 'lie' – the notion that condoms are more than what they purport to be – in this bumper sticker
illustration we are asked to believe that they are lovable. Additionally, for the uninitiated (not to mention non-English speakers) the message may be hard to decipher and the illustration of the condom is tricky to discern, since it is rolled up, and is pink (generally, they are opaque white).

Figure 3 - 8: Swiss AIDS Foundation / Swiss Federal Office of Public Health

(The subtext reads: "A prevention campaign by the Swiss Aids (sic) foundation, in cooperation with the Swiss Federal Office of Public Health.")

Australia, in one of a series of explicitly graphic ads, (following page) also commits the offense of generalization and hyperbole without providing any of the basic elements of a good campaign. "All of us fuck with condoms – every time," is an unreasonable statement to make in light of people's cognitions and/or lived behaviours. Additionally, the message (should anyone actually
believe it) alienates all of the people who do not ‘always’ use condoms, stigmatizing them as deviant, out-of-the-loop, and failures.

Notwithstanding the appearance of the word “always” on his penis and anus, one might also question why that word also appears on his arms, legs and chest, since erotic play in these latter body zones is considered safe (provided there is no fluid exchange). This part of the message may be considered confusing.

Symbolically, the word ‘always’ is inscribed all over the body – arms, legs, chest, penis (wearing a condom) and anus, but the face is bifurcated, and square. The symbolic message is that the body is autonomous, remaining or becoming consistent in its use of condoms, but the head is not certain of its position – it is faceless, ambivalent and non-human (+/-). One reading of the +/- symbol could suggest that ‘always’ applies to both HIV-positive and HIV-negative MSM. Another reading suggests that as MSM, one is always (potentially) HIV-positive, or in epidemiological terms, anyone who is sexually active and whose serostatus is negative cannot be 100% certain that he is indeed HIV-negative, since he could have seroconverted since his last antibody test. This fuels the notion that gay sex is ‘always’ equivalent to contagion – a false and homophobic statement. A third (and one would hope, most probable) reading could be that ‘when an HIV-positive man has sex with an HIV-negative man’, condoms are ‘always used’. In fact, if ‘should’ is substituted for ‘are’, the message is basically the same as the
'good boys' ad. While this may be desirable, it is not the practice, since we already know that seroconversions are not 0%. Ultimately, the ambiguity of the graphic lends itself to far too many interpretations to be effective, persuasive and clear.

The notion of 'always', whether it applies to condom use, serostatus, or MSM in general is extreme and uncompromising. It does not allow for any interpretation of 'safer' sex, nor does it even allow for the possibility of two HIV-positive men having condom-less sex, let alone two HIV-negative men.
Some of us have HIV, some of us don't.
All of us fuck with condoms - every time!
In a second advertisement in this series, (figure 3-10) The AIDS council of New South Wales targets ‘lifestyle’ in a manner that suggests that those people who live a ‘party’ life are somehow deviant and trapped in a world of addiction. It is also interesting to note that the right arm has inscribed on it “cocktails”, the sobriquet for HIV drugs. This is not a reference to alcohol, as may be surmised, because that genre is covered by the left shoulder’s text “booze”. While professing to promote safe sex (“All of us fuck with condoms – every time”), nonetheless, the hands are seen separating the buttocks, to reveal the anus as the focus of attention. One might suppose that 3-9 is directed at tops, and 3-10 is directed at bottoms, but the subliminal message is that with the party lifestyle, one is more inclined to be anally receptive. The list of pharmaceutical consumables in the ad is strongly suggestive of losing control, and having UAI, leaving it to the viewer to provide evidence to support this claim.

One of the most disturbing aspects of this advertisement is the moral tone taken with respect to lifestyle. The headline “Some of us get out of it, some of us don’t” is a strong condemnation of all of the elements inscribed on the body and the background – party, bar, alcohol, recreational (non-prescription) drugs, ups & downs (ambiguously referring to mood swings, or tops and bottoms, or types of drugs). Coupled with the more sex positive messages on the hands: “deep” and “heat” – presumably referring to ‘hot’ anal sex, the message on one hand is
chastising, and on the other hand is inviting. What is one to make of this
dichotomy?

Figure 3-10: AIDS Council of NSW, Inc.
Lest one think that the above examples have been selected from old advertisements that have been chosen to support a particular standpoint, one need only look to a very recent campaign to note that little has changed in the last decade or so.

One of the great difficulties in assessing the campaign worthiness of any PHM is audience reaction. Clearly, this can be looked at two ways. In the first instance, an advertisement or campaign is only effective if it attracts an audience, and keeps the audience interested. The following campaign, run in Toronto, Canada in the summer of 2001, did generate considerable community awareness (of the campaign at least). It included newspaper ads, bus shelter posters, posters for use in bars and bathhouses and television commercials. Community reaction to the ad was expressed via articles and letters to the editor in FAB and XTRA! 30 respectively.

I shall consider the imagery and text first, the reliability and validity of the information second, and then community reaction.

30 Gay community newspapers
Figure 3-11: Condom Country, ACT, Toronto, Canada (2001)

Welcome to Condom Country.

HIV is on the rise in Toronto. Ride Safely.

acttoronto.org

ACT

416.340.2437

(FAB Magazine, July 5, 2001)
The illustration is of two ruggedly handsome men astride a pinto, both gazing off to the right of the camera, with the ‘passenger’ tenderly resting his left arm on the others’ shoulder, and the rider’s hand on the passenger’s thigh. In the television commercial, the scenario is as follows:

In the first scene, a lone, shirtless, smooth skinned cowboy is driving in fence posts along a fence line. He is sweating, and one can see the sweat run down his chest between his well defined pecs onto his 6-pack abs. The scene shifts to the corral, where another cowboy, equally handsome and rugged, yet fully clothed, mounts his horse and rides out of the scene.

In the third scene, the rider arrives at the fence post installation, reaches down and gently touches the face of the other character, and then proffering his hand, helps to swing the fence-post cowboy onto the horse, behind him.

In the final scene, they are seen riding away from the camera, the ‘passenger’ holding on to the waist of the ‘rider’. The voice-over captions are the same as in the above advertisement.

In the commercial, as with the advertisement, there are a number of explicit as well as implicit statements. On the surface, we see a touching scene that euphemistically advises people to “ride safely”, or implicitly to use condoms for anal intercourse. Few gay men would miss the implicit message of riding as intercourse, but many non-gay MSM might. The rationale for the advertisement “HIV is on the rise in Toronto”, however, is more problematic: it is based on statistics — statistics which are hotly contested by knowledge makers. I shall consider this matter shortly.
The graphic illustrations send mixed and highly contradictory messages. Most obviously, this ad is a ‘take-off’ of the “Marlboro Man\textsuperscript{31}”, in other words, a social marketing message is modeled after a product message that is a symbol of risk and rebellion, selling cigarettes, which are clearly unhealthy, yet in this campaign, the implicit message is one of health protection. Second, especially in the commercial, but also evident in the printed material, the ‘passenger’ is riding ‘bareback’ – his feet are not in the stirrups, and he is seated on the horse, not in the saddle. He is ‘barebacking’ in the truest sense of the word, which is incongruous with the explicit message; unless the subtext is intended to suggest that ‘safer sex’ can include barebacking, which then evokes a contradictory interpretation.

Third, the main printed and vocalized message “HIV is on the rise in Toronto” can be understood two ways. In the first instance, it could mean that the incidence of new infections is increasing – I believe this is the intent of the message.

However, the other interpretation, as Carl Strygg of HEAL (Health Education AIDS Liaison) states\textsuperscript{32} : “It’s pretty clear that one really can’t claim that there’s been an obvious increase in incidence. Clearly there’s an increase in prevalence

\begin{footnotesize}
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\item \textsuperscript{31}© Philip Morris
\item \textsuperscript{32}FAB, July 5, 2001:10
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but that can be taken to mean there are more healthy people living with HIV, which is supposed to be good news."

In fact, Dr. Robert Remis of the University of Toronto, in the same article, indicates that ACT has confused incidence with prevalence; according to Remis, the *increase* in prevalence among MSM in Toronto in 2000 was actually 1% lower than it was between 1998 and 1999.

Community reaction was randomly and anecdotally tested by XTRA!, and reported in their July 12, 2001 edition. Five letters were printed, ranging from outright condemnation to high praise. Tyler Fleming, a 22-year-old student writes:

I saw one of the ads in a bus shelter the other day... The imagery was a neat play on the barebacking thing with all the horses – riding with or without a saddle. I don’t know how intentional the reference was, since not everyone’s familiar with the term “barebacking” so it’s like an *inside joke*. (italics added)

I don’t think it would change someone’s mind about using condoms or not, especially in the heat of the moment. I don’t think even the best campaign could be that successful, until AIDS affects someone personally. (italics added)

In this instance, Fleming got the ‘insider’s joke’, but deemed the campaign ineffective anyway. Bonte Minnema, a 25-year-old Queer Boy Scout Leader had a slightly different take on the ad, but the same conclusion regarding efficacy:
The image is comical to me because I grew up on a farm and I know two guys can ride the same horse and it has nothing to do with sex. There is sex implied, but there is a clear difference between this campaign and the really racy stuff they used to do — where they’d have two muscle jocks and a guy holding his hand over a condom-covered dick, saying something like “Get it on, get it hard”...

I’ve been to the bathhouses since the campaign launched, and I have to say that it hasn’t really affected people’s behaviour.

Perhaps the most telling comment came from Michael McGaraughty, a 39-year-old business student. He writes that:

I think it’s a very romantic campaign. I think the underlying theme of intimacy is really big . . . like a Harlequin romance. I remember a campaign from at least five years ago, with a series of different faces — people infected and affected — which I found to be incredibly effective. I would say that for the last few years I felt that ACT had become just another layer of bureaucracy in terms of HIV and AIDS . . . the timing during Pride Week [indicates that they are recommitted].

The issue of timing will be discussed later, in the context of ASO self-promotion, and possible motives for social marketing other than behaviour change.

The campaign garnered reasonably good reviews, for the graphics and tone of the ads. It failed on the truthfulness of the content. As Strygg states: “I think you can encourage people to talk about healthy lifestyle choices, and you can encourage people to talk about whatever opinions a given organization feels need to be presented without being dishonest. I think using dishonest means to accomplish that end totally invalidates the entire effort because it’s based on a
false premise. You don’t need to lie to encourage people to talk about the choices they are making in their sex lives.” (FAB, 2001)

In sum, the development of an effective and persuasive message entails the determination of transient information, both on the threat/efficacy level, and on the cultural/environmental level. Without the use of either primary or secondary research, done afresh with every campaign, there is a greater risk of campaign failures.

The process can be illustrated as follows:

**Figure 3 - 12: A Framework for Developing Culturally Specific Persuasive Health Messages** (from Witte, 1995:148)
The difficulty with the Witte model is its reliance on homogenizing the items listed in the first column – threat, efficacy, cues and audience profile. Witte assumes that these factors are reductable to simplistic definitions, or universal absolutes, where in fact, they may be as varied as the people to whom the messages are intended. Given at least 10 variables, it is possible to assume that there could be a minimum of $10^{10}$ different combinations, and in all probably there are many more than that. Moving to the second column then becomes problematic, since it too adds iterations of at least $2^6$ times. It can be seen, mathematically, that $10^{10}$ times $2^6$ yields a huge amount of factors to consider before developing a persuasive health message.

"Condom Country" epitomizes the type of social marketing campaign that Witte seems to advocate. While the campaign identifies the threat “HIV is on the rise in Toronto”, it fails to identify the susceptibility of the target market – in fact the target market is not specified either. The efficacy message: “Ride safely” may be germane to some insiders, but the aphorism “ride” may also be lost on many potential constituents, especially in a centre as culturally diverse as Toronto. The cowboy theme is also problematic, in that it does not resonate with many people – for persons who grew up on a farm, riding bareback was not equated with sex, and for city boys, cowboys may be the stuff of fantasies and pornographic videos, but they are not the lived experience to which one can realistically relate. It is, in short, culturally out of place.
Unfortunately, assumptions need to be made in all categories, and regardless of the data employed, the net result must be a compromise, which may suit some of the audience, but cannot resonate with all of the audience.

Do These (or any) Campaigns Work?

Early in the epidemic, KAB AIDS education probably had utility. However it is doubtful that those types of social marketing campaigns have retained much efficacy. In the first instance, most of the ads illustrated above violate the theoretical models that they purport to follow. Either through a misunderstanding of the principles of effective communication, or an unwillingness to compromise 'a good creative idea' for the sake of effective, but less sensationalistic 'sexy' advertising. The vast majority of social marketing messages failed to achieve their stated objectives — a long term reduction in HIV transmission. This is not to suggest that they have been wholly ineffective. As will be demonstrated, HIV infections per 100,000 population did decline for a while, in part due to these campaigns. The main issue is that the models, and indeed the theoretical bases for the models, are no longer appropriate.

In this regard, one of the potential problem areas with regard to the development of social marketing messages is the question of who is devising the messages, and how they come to determine what those messages should be. In general, those who are most likely to be affected by the messages (HIV-negative gay men, and
to some extent, HIV-positive gay men) are rarely consulted in a meaningful way. This is not to suggest that there is no consultation, but in the main, consultation between the ad makers and the community is limited to a few focus groups of ASO volunteers, who are predisposed to accept whatever is presented to them, and are already conditioned to the 'corporate culture' of the ASO. In many instances, drug company and/or government funding is crucial to the financial wellbeing of the ASO, and therefore these stakeholders' political, religious or moral interests must also be considered.

While the ideas and approaches (both in terms of the messages and the philosophies that underlie the messages) have remained largely unchanged, with the possible exception of being more 'politically correct', historical, social, psychological and medical issues have intersected to transform the nature of people's understanding of and relation to the epidemic. Historically, AIDS now traverses three decades, and it appears that it will cross at least into a fourth before an effective vaccine is developed. For many gay men what is needed is education about a permanent way of life. For some, the specter of AIDS looms large; for others (and more to come), it is a part of everyday life, no more or less salient than many other life course risks.

"Marketing strategies often encourage men to consider sex acts as narrowly defined and circumscribed, requiring only a simple, discrete adjustment to be
made safe, like an automobile with bad brakes” (Rofes, 1996:131) However, while gay men may comprehend that anal sex without a condom is generally not safe, they may be incapable of the introspection that would or could identify their personal psychological relationship to risk. Erotic activity is intricate and diversified, too complex to classify and control, and is replete with contested meanings. It is hard to hoodwink gay men, especially when they perceive they are being treated disrespectfully. When the intricacy of human sexual response is oversimplified or debased, trust may swiftly disintegrate. Numerous social marketing campaigns have expunged the meanings and the values from sexual activity and reduced elaborate social acts to a few key messages. We are besieged with messages specifying how one should behave in bed (or elsewhere for that matter), but no social marketing campaign to date has suggested that in the absence of the virus, transmission cannot take place (i.e. two uninfected men having anal intercourse without condoms), nor have we seen messages that empower two HIV-positive men to enjoy sex without latex. “Surveys show that over one-third of the uninfected urban gay men are occasionally engaging in unprotected anal intercourse, while being fully aware of the risk involved, which provides evidence that knowledge of infection risk is inadequate motivation.” (ibid.: 132)

It is also improbable that any one social marketing message can satisfy every constituency. Regardless of the chosen message, the likelihood of offending
someone, excluding certain classes of people, and/or further marginalizing some aspect of gay social life is inevitable. There will always be some segments of the community that will seek to debunk and counter the message. For example, there is a very small, but vocal lunatic fringe that continues to deny any linkage between HIV and AIDS, claiming that HIV is not necessarily a precursor to AIDS – AIDS is a totally separate and distinct disease.

Conclusion

"We must change, only show me the Theory...Show me the words that will reorder the world, or else keep silent. If the snake sheds his skin before a new skin is ready, naked he will be in the world, prey to the forces of chaos. Without his skin he will be dismantled, lose coherence and die. Have you, my little serpents, a new skin? Then we dare not, we cannot, we MUST NOT move ahead!"

Aleksii Antedilluvianovich Prelaparianov, Perestroika, Act I, scene 1

(Kushner, 1994)

We have seen that the various forms of ‘public health’ campaigns fall considerably short of their intended goals. Some, to be sure, are better than others, but overall, they fail to live up to the needs of their intended audiences. The approach to health related campaigns in general, and HIV/AIDS in particular, has not been founded on solid theoretical grounds. HIV awareness campaigns have not been laced with psychosocial insight regarding sexuality, the most enigmatic and abstruse of human behaviours. Nor have they been
employed to appeal to the complexity of feelings, both conscious and subconscious that are a part of living in an epidemic.

In a general sense, homophobia and sexphobia have created the expectation that gay men must transcend human nature and its frailties, be more acquiescent, more galvanized, and more disciplined in this epidemic than any other population would have been counted upon to be. This expectation is perceptible in the idea, popularized in so many formulae, that all things considered, the gay community is ‘doing well in the epidemic’ – doing well in the areas of compliance, community education and adherence to a strict sexual code of protection and caring. This perception is fallacious, as we have seen. The reality is that many gay men feel distressed, angry, and hopeless about the loss of friends, lovers and their sexuality. Why should they not be expected to act out these frustrations?

The issue of misrepresentation, the withholding of information and lying promotes internalized homophobia, divides the community into factions pro and con, and stigmatizes all gay men as promiscuous, self-centred and irresponsible.

Many gay men experience protected sex as restrictive, inadequate, or unacceptable, and in denying that we do not establish community norms of behaviour, we force the issue into the closet. There, like closeted homosexuality itself, the practice of unprotected sex develops a secret life with immense destructive potential . . . he experiences shame, guilt, and a fragmentation of his life; and he begins to form an identity around his feelings and behaviour that reinforces rather than inhibits the behaviour. (Odets, 1994:4-5)
In the following chapters, I will examine the social and psychosocial implications of this 'veil of silence', the very recent 'outing' of unprotected sexual behaviour, and the lives of some of the men who employ well rehearsed rationalizations, from the monogamous couple to the fatalistic barebacker.

This lack of trust in community norms has manifest itself in a lack of trust in oneself and with each other, as we shall see in the case studies in chapters 5 and 6. However, before I explore the life course events that have led up to individual assessments of risk and trust, I shall examine the theoretical aspects of risk and trust.

This line of inquiry becomes relevant to the thesis when one considers that, to this point, it has been demonstrated that there is no single identifiable line connecting condom use and traditional health promotion. In other words, cause and effect appear to be absent from the equation, thus far. What we do know is that seroconversions continue to happen, and in most jurisdictions are on the increase (Vancouver, Toronto, San Francisco, Los Angeles, New York, to name a few; Vanguard Data, 2001, unpublished). We also know that gay men are, for the most part, wary of social marketing messages, especially when they perceive that they have been inundated with false information, false hope, and impossible-to-reach goals.
When one questions why barebacking continues, and in fact appears to be on the rise, one must consider the initial questions: Why, in light of known facts surrounding HIV contagion, would one deliberately put oneself at risk of infection? If an MSM knows that infection is a possibility with UAI, what motivations could there be to disregard that knowledge, and to have anal intercourse without a condom? The answers potentially lie in the manner in which one assesses one’s own personal risk, the degree to which the contraction of HIV is considered a threat to one’s lifestyle and longevity, the confounding factors of trust in oneself and in one’s sexual partner, and the strength of those convictions, relative to the perceived reliability of existing scientific knowledge.

In the following chapter, I will examine the notions of risk and trust, and suggest that they are powerful motivators – perhaps even more powerful than knowledge itself, or at least so powerful that knowledge, in these contexts, cannot be expected to influence behaviour independently.
CHAPTER 4: ENACTING RISK AND TRUST

Introduction

At the end of chapter 1 and again in chapter 2, I discussed the theoretical underpinnings of the notion of risk. In this chapter, I will examine this theoretical ‘problematic’ as it applies to various health belief models, and, in a more concrete manner, how it informs the behaviours of some of the subjects in the study group. However, before moving to those specifics, there are several additional points to be made about risk analysis, and how extreme risk-taking can be viewed as reasonable action, given particular circumstances, psychosocial meanings and understandings, and other social factors, including age, experience, social and sexual identity, socialization and overall belief systems.

We might begin by examining how our notions of risk and trust are first formed by drawing on the work of Jean Piaget’s (1932) notions of cognitive development and socialization. Social experience and interaction depend upon an autonomous process of developing cognitive structures, as well as the nature of the interaction system in which they are included. It is useful to consider socialization as an adaptive process. First, facing a new situation, the individual is guided by his cognitive resources and by the normative attitudes resulting from the socialization process to which he has been exposed. The fewer experiences or exposures the individual has had, the less likely he will have the cognitive tools to deal with the
situation, and the more likely he will rely on what others believe, his own instinct and his emotions. This interaction paradigm is in no way incompatible with the fundamental hypothesis of optimization according to which, in a given situation, a person's behaviour corresponds as closely as possible to what he likes best, and to his interests as he perceives them.

Second, the optimization hypothesis does not imply that the person will choose the best solution per se, i.e., the solution which an outside observer would be likely to identify as the best solution for that person. Previous socialization (or the lack thereof) can be the reason behind an inadequate assessment of the situation; normative attitudes impose constraints that are detrimental to the social actor. Video melieraprologue, deteriora sequor (I see what is good, I approve of it, and I do what is bad). This aphorism can be easily understood in the framework of the interaction paradigm — social structures and the socialization process that results from them may lead the members of some social categories to appear to comply with what other people prefer (for example, lying on a questionnaire, or not telling the doctor the whole truth about their smoking habits, or espousing a position that they don't practice — as in the case of a 'safe-sex' educator not using condoms for intercourse) while actually forming preferences and/or behaviours that are opposed to their supposed best interests.
Third, the degree of internalization of normative and cognitive frameworks produced by socialization is an important consideration; obviously, different learning experiences vary by degree of difficulty and the time required to learn them. Generally, mechanical learning (such as learning to roller blade) is more quickly absorbed and less difficult to master than more cerebral endeavors (such as learning to play the piano). When faced with a new situation or a new environment an actor will usually have the ability to alter certain effects of the socialization to which he has been exposed. However, the more deeply the internalized value, the more difficult it would be to revise.

Fourth, the interaction paradigm is useful in distinguishing each of the internalized elements according to their constraining power. While some values or norms can be interpreted unequivocally ('thou shalt not kill'), others are polyvalent. For example, in the context of HIV/AIDS prevention, the notion 'know your partner' can take on a rainbow of meanings, as has already been demonstrated.

Fifth, and perhaps most important, the interaction paradigm helps differentiate between primary socialization and secondary socialization. (Berger & Luckman, 1966). Part of the primary socialization – corresponding to the childhood period – is interrogated by the secondary socialization to which the teenager, and later the adult, is exposed during his life.
Alan France (2000) argues that secondary socialization processes which contribute to the experience of being young have undergone significant changes with the rise of the 'risk society'. Traditional transition routes and forms of social reproduction open to young people are changing. Relationships and links between the family, school and work have been weakened and although there may seem to be a greater number of choices available to the young, pathways into adulthood are becoming more problematic. (Furlong & Cartmel, 1997) Individualization and feelings of greater vulnerability have increased young people’s insecurity and heightened their awareness of risk. These changes are having a major influence on young people’s willingness to take risks, which in turn explains increased risk-taking in areas such as smoking, illicit drugs, the abuse of alcohol, and unprotected sex. (Ibid: 65)

The HBM [health belief model] proposes that health behaviour is located within individual (and not societal) rationalizations of risk. Individuals must perceive themselves as being vulnerable and susceptible to a particular risk that will have serious consequences. If they are to take protective action, then these remedial acts must be perceived as both effective and must outweigh the costs (Bloor, 1995:20). Therefore, risk assessment is seen as a cognitive process where individuals make rational choices about their behaviour – risk-taking, therefore, must be a function of either a lack of information, or a breakdown in cognition.
Additionally, there is a claim that adolescents act, as Cooley (1902, 1916) and Elkind (1967) suggest, in a manner that indicates that the development of cognitive thought processes help individuals anticipate the reactions of others to themselves, a manner by which adolescents continually construct or react to an imaginary audience.

The notion of the personal fable is seen as a key to understanding risk-taking. Rather than seeking understanding in rational, deliberative thought, adolescents (and many adults as well), according to this hypothesis, assume risk as if it were non-risky, seeing themselves as virtual supermen.

At a somewhat different level, this belief in personal uniqueness becomes a conviction that he will not die, that death will happen to others but not him. This complex of beliefs in the uniqueness of his feelings and of his immortality might be called a personal fable, a story which he tells himself that is not true. (Elkind, 1967, p. 1031)

A more commonsensical and widely held argument has been proposed by Irwin & Millstein (1986) and Jack (1986). They argue “risk-taking is a part of normal transitional behaviour during adolescence” (Jack, 1986:124). Risk-taking fulfils a basic developmental psychological need related to gaining autonomy and forming identity. Risk-taking may then have constructive or damaging outcomes: starting or changing careers, moving to a gay neighbourhood, falling in or out of love, experimenting with promiscuity, drug taking, and so on can be viewed as part of this maturational process.
However, all of these theories or hypotheses fail to take into account the disjuncture between psychological and biological change and problematic behaviour. Hendry et al (1993) drawing on the work of Coleman’s (1979) notion of age/type relationship patterns, concluded that at different stages in the life course, different types of relationship patterns become either more or less important, and no one pattern is specific to any given age. Since, as Coleman & Hendry (1990) suggest, adolescents are unable to focus on more than one crisis at a time, the most important crisis gets their attention:

We believe that most young people pace themselves through the adolescent transition. Most of them hold back on one issue, while they are grappling with another. Most sense what they can and cannot cope with, and will, in the real sense of the term, be an active agent in their own development. (p. 205)

Furthermore, Hendry et al (1993) asserts that youth risk-taking takes place through their innate pursuit of pleasure. This is an intrinsic characteristic that propels young people toward finding stimulation and adventure in their lives. In short, risk-taking fulfils a need.

Given the propensity to acquiesce to risk in adolescence, it is not too far a leap to apply this notion to some (if not many) gay men. Parallels can be drawn from the overall adolescent maturation process, and ‘coming out’, for example. As Hendry suggests, pacing oneself with respect to dealing with issues is an adolescent coping mechanism – the same measured performance and (relatively) single-
mindedness can often be seen in people as they come out to friends, family, schoolmates, co-workers, and indeed, themselves, regardless of chronological age. It would also be reasonable to consider that for many gay men, the need for sexual risk-taking may very well be associated with one's maturity or immaturity as a gay male. It should also then be apparent that chronological age has little to do with it — in fact, anecdotal information has shown that chronologically mature men, in many instances, experience a 'second adolescence', especially after some traumatic event (such as a marriage breakdown, heart attack, business success or failure, the 'empty-nest' syndrome, and so on). In this second 'adolescence', activities that would normally be shunned as immature or risk-prone become major focal points in one's life.

The Study Group Methodology

While copies of the methodology employed in developing the sample group can be found in Appendix 2, some information with respect to the makeup of the group will be useful in understanding the following excerpts.

In the spring of 1999, working with the team at the Vanguard Project\(^{33}\), and an independent psychologist who is employed by the provincial government in the field of HIV/AIDS prevention and counseling, I developed a set of criteria to search the Vanguard database for likely prospects to interview. The criteria were

\(^{33}\) A detailed explanation of the Vanguard Project can be found in Appendix 2.
somewhat flexible, in that apart from two absolutes (all had UAI in the past year, and were not currently under the care of a mental health professional order not to conflict with any therapy programmes in progress) – the potential candidates, in order to be considered for this project, did not have to fit all of the rest of the ideal criteria, which were based on 21 questions in the Vanguard questionnaire.

309 potential candidates were identified in the first search – they had disclosed, either in the baseline questionnaire or on their most recent follow-up questionnaire that they had had UAI, and they were not currently under the care of a mental health professional. (150 of them reported UAI at both intervals.)

Subsequent to this first cull, we refined the search to determine the following: level of education, income, social support networks, sex exclusively with men (in the past year), high risk sex (anal insertive and/or anal receptive), non-consensual sex, drug/alcohol use, a mix of regular and casual partners, suicide ideation, lower than average depression scores (Rosenberg), and coping skills. With respect to alcohol use and self esteem, since it was determined that in order to obtain qualitative information relative to potential multiple causations of non-condom usage, and in keeping with the overall psychosocial profile of the Vanguard cohort in general, as determined by year-to-year Vanguard statistics, each subject
had to score from low to medium on the Rosenberg self-esteem scale, or have at least a moderate score (≥ 1; range is 0 to 4) on the C.A.G.E. alcohol test.

Each variable was given an arbitrary value of ‘1’. With the exceptions of depression (lower two quartiles) and drug/alcohol (must answer ‘yes’ to something on the C.A.G.E\textsuperscript{35}. questions, the other variables permitted random scores (in order to maintain as close to a random sample as possible, it was not necessary for the candidates to score in any predetermined manner on any of the remaining variables).

Two letters were sent simultaneously to each of the 309 prospects — one on Vanguard letterhead, one on UBC stationery\textsuperscript{36}. Each envelope contained the two letters, a reply card and a pre-addressed, stamped envelope directed to the Vanguard office at St. Paul’s Hospital. Of the reply cards received (N=>100), twenty people were randomly\textsuperscript{37} selected to be interviewed (15 actually showed up for their interviews), and their statistical information was again verified by cross-referencing them to the overall Vanguard database.

Out of a possible overall score of 21 positive criteria matches (See Criteria — Appendix 2), 5 people scored 6 or fewer (minimum was 2) and 10 scored 11 or

\textsuperscript{35} C.A.G.E. is an alcoholism test comprised of four questions — see questionnaire in Appendix 3, follow-up questionnaire, questions K2-K5

\textsuperscript{36} All documentation is contained in Appendix 3.

\textsuperscript{37} The reply cards were tossed in the air, and the first 20 that landed on the desk were selected.
higher. The actual scores were as follows: 2, 2, 4, 4, 6, 11, 13, 13, 13, 14, 15, 15, 16, 19, 20, for an average score of 11.14 (which is within .06 of the theoretical mean of 10.5). This analysis confirmed that the sample (apart from having had UAI and not under a professional’s care) was indeed almost perfectly random (of those people who had UAI in the past year).

The fifteen prospects were contacted by telephone and initial interviews were set up. The interviews took place in an office at The Centre (the gay and lesbian community centre). Prior to each interview, the subjects were provided with two copies of a consent form, which they read and when necessary had sections explained to them. Once the audio tape was rolling, it was reaffirmed that they had read the consent form, understood its contents, and had agreed to the terms and conditions. Each participant kept one copy of the form, and the signed copy was filed in my office.

I followed an interview schedule (Appendix 4), and the interviews were tape recorded and subsequently transcribed.

Of the original 15 interviewees, eight people further volunteered to attend 10 discussion groups over the course of the fall and winter (one per week). These sessions also were audio taped and transcribed. None of the volunteers were paid any money for their efforts. They were all treated to a nice dinner after the tenth and final discussion session.
The excerpts that follow, both in this chapter, and in subsequent chapters, are the comments of those people who were ultimately recruited.

Risk Behaviour, and Coming Out in the Sample Group

In the sample group interviews, the issues of self-esteem, coming out, sexual beliefs and behaviours and self-determination were explored in the context of life-course events, and how people felt about themselves at each significant life-course juncture (pre-school, grade school, high school, university and the present). Interviewees were asked to rate their overall life satisfaction on a scale from 1 to 10: one being extremely low (or awful) and 10 being very high (or fabulous). This life-course evaluation was accompanied by an inquiry into the age at which they realized that they were different from other boys – the first stirrings of gay identity.

Max realized he was different at around age 5 or 6:

Dreams – I noticed being close with other men, being naked with them, sleeping with them, like sleep sleep – not the euphemism sleep. That’s probably how it manifested itself.

He did not come out to himself until age 18, and to his family until he was in his mid 20s. His first experience in coming out was with his best friend in university at age 21. Max had unprotected anal sex from age 18 – 19 (before he came out to family and friends). At that time, his own ranking of overall life satisfaction had
dropped from a 10 in high school to a 6 or 7. Justin, on the other hand, rated his life at the time of the interview as a 7. Primarily, the reasons for his dissatisfaction were functional—he wanted a better job and to make more money. His personal life made him feel “pretty happy.” Although he could not pinpoint any particular age at which he felt different from other boys, he did recall an incident where he had “a sort of sexual relationship with one of my friends when I was younger, like about 14, 15 . . .” After trying college for six months, at 18 he dropped out and worked in a video store. What he wanted was to work on a cruise ship. As he states:

Stuck here in Winnipeg — I wasn’t out yet either — so it was — I wasn’t thinking that I needed to come out or anything. I was just — it wasn’t something on my mind — I was just thinking I’m just not happy, I didn’t really know what it was.

Winnipeg was a low point for Justin, and sex with men was not, at that time, a consideration. However, he did eventually get a job on a cruise ship, came out as a gay man, and after 5 years (intermittently) on board, decided to live in Vancouver. His self-esteem fluctuated while he was on the ship, and improved when he decided to live in Vancouver. Although Justin intellectually remains committed to the notion of safer sex and condom use, when asked whether there has “ever been a period of time when you only had safe sex?” he answered in the negative.
Justin's self-esteem appears to be nomadic; that is, it varies with structural and/or functional issues going on in his life at any given time. This nomadic self-esteem has led Justin to vacillate on condom use as well. Although he indicates that with respect to anal insertive sex "I would definitely use a condom", he goes on to provide several examples where his rule-making was compromised:

Well, there were several times when I hadn't [used condoms for anal receptive sex] and it was with this guy that I was seeing that I told you about earlier from Bellingham where it was — I mean — we were in a relationship . . . monogamous. There was another time when I did, which — I mean I remember it still, I just didn’t want to do it . . . but I let him penetrate me . . . It bothered me a little bit, but not a lot . . .

Tim also had a happy childhood; in fact, he recounts a high level of self-esteem (8 — 8 ½) until he came out "with a bang" — dropped out of school, quit his job, drank too much, and ended up working in an all-male 'massage parlour'. At this point, he rated his overall life satisfaction as no more than 2. Although he does not recall ever feeling different from other boys, he relates how he felt 'special' (he used this term to describe himself frequently in his interview), a feeling abetted by both parents and grandparents. Tim recalls his grandmother speaking about her gay brother as being 'special' too, and suspects that "maybe everyone's always known that I was gay and that's why I was special." In any event, sexual identity realization for Tim came when he was 20 or 21, when one of his friends

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38 This particular establishment offered nude sessions, and a 'sensual release' (masturbation and/or mutual masturbation)
came out to him. Tim subsequently had his first sexual experience with a man, and shortly thereafter began living with another man.

Brought up in a strictly religious family, Tim rationalized that sex with a man was not overly sinful, only premarital sex with a woman was highly problematic. When he first came out, he was still in denial — conflicted about his sexuality:

It went backwards and forwards for a while — I'd be — 'yes, I'm gay' for a while, and then not go to the bar and wouldn't do anything — be in total denial, got to get a girl friend, so I go with a girl, start dating — we'd get as far as kissing and that would be it — I couldn't make myself do any more. Because it was OK to sleep with a man — in my mind this is how messed up it was — you can't sleep with a woman unless you're married. But you can sleep with a man — but now in my mind, is how I justified it because you could never marry a man, so it didn't really matter. You weren't ruining that marriage thing.

When Tim did start dating men on a regular basis, and was introduced to anal sex by someone who was experienced enough to show him how to do it properly ["and then I realized that it was actually really good"], he became, in his own words, a 'slut':

Times that I've been unsafe — when I first came out I was, I mean I was a bit of a slut, I guess. I guess I really was. My roommate at the time . . . we would go to the bar to see how many guys we could bring home in a week. Of course, I had to make sure that I won, had to be Number One. So I fooled around with a lot of guys.

Tim exemplifies adolescent risk taking behaviour, not only in the revelation of having had unprotected anal intercourse (UAI), but in the thrill seeking dynamic of having sex with strangers, in the risk he took of picking up someone who
could potentially cause him physical harm, and in the “challenge” itself – how many different men could be had in a week. Josh recounts a hard life, from an early age. His parents were poor, struggling and unhappy. When the family moved to a rural community in Alberta, he was “quickly labeled a fairy and was an outsider”. Nothing improved in his life until he set out on his own after high school, left home and married at age 19. After a number of years, however, he became increasingly questioning of his sexual identity, and was under a lot of stress. Four years into the marriage, he told his wife about his sexual feelings, and in turn, she told him she was pregnant. Ultimately they separated (4 years later), and struggled with issues of custody and visitation.

However, when questioned about early sexual experiences, Josh recalls playing ‘doctor’ with another boy at age 5 or 6, and again when he was 8; developing crushes on older boys by the age of 10 or 11, and then entering puberty understanding that he “definitely had sexual feelings that were gay”. Josh did not come out until after his separation from his wife, at age 27.

When asked whether there had been a period of time in his life that he had only safe sex, Josh said “Not for any substantial amount of time, no, actually. I would say that I was more vigilant when I first came out, but it was always by way of the quality of the relationship that led to practices that couldn’t be regarded as safe.” The quality of relationship to which he refers involves monogamy and being in
love, a 3 - 6 month period of using condoms, being tested for HIV antibodies, and then deleting the condoms from his sexual repertoire. In essence, this is not a classic definition of unsafe sex, since two monogamous HIV-negative partners do not put each other at risk for STDs. Josh’s experiences go against the grain.

On reflection, one can understand why Josh never indulged in the freewheeling sexual escapades that characterize so many other gay men’s first experiences. He had been married for several years, had the responsibility of being a father, and had come to his ‘gayness’ only after much reflection and deliberate thought. However, it is interesting to note that his self-esteem level, from an early age onward, was consistently low. It is only in recent years that this affect has changed to a higher level. Far from being nomadic, Josh has been relatively stable albeit low) with respect to self-esteem for a good part of his life.

Martin presents an interesting contrast to Josh. His self-esteem has been nomadic for most of his life: preschool was “about a 10, because I didn’t have any worries as a kid.” However, “When I got into school, I guess it would be about a 6 . . .” By age twelve, his self-esteem dropped further to a 3 or 4 “ . . . by the time I got into my teens people were calling me names and yelling ‘hello’ to me in a really high voice. Still couldn’t understand why, but I sounded like a girl.” By the end of high school his self-esteem rose back to a 5 or 6; “People trusted me, seemed to talk to me more. I seemed to be able to associate with people.”
Martin came out, after a few heterosexual encounters, when he was 20. It was, in his terms, a process of flinging open the closet doors. He became very promiscuous:

I was just having sex like mad. So, any guy that would hit on me, I would [noise and finger snap], all of a sudden I turned around and became this big slut. I slept with anybody that was anywhere.” Later he added: “I think I was making up for lost time, definitely. I liked it, I was liking sex. I hadn’t had sex in so long so I constantly wanted it. Because I like it. And it was a bit of self-esteem – it made me feel good that I was getting all these guys.

Interestingly, when Martin moved to Vancouver, he saw the geographical change as an opportunity to “smarten up”. “I wanted to build a life that I could be proud of, I guess you could say.” While Martin still does not use condoms with sex partners he knows (i.e.: close friends), he does use them most of the time with casual partners. However, this is a departure from the pre-Vancouver days, where condoms were used only sporadically.

What makes this particularly interesting is the conscious move from “slut” (or interpolating Piaget’s terms – the preoperational stage) to “respectable” (or concrete operational stage) coincidental with the move to Vancouver. Clearly, there was a cognitive decision to ‘clean up his act’, so to speak, and progress from an adolescent to a more mature personal standpoint. Moreover, with it came a particular change in self-esteem, as he notes: “It’s about an 8 now”. However, he still is a risk-taker; he still frequently uses recreational drugs, and continues to
have unprotected sex with regular, but not monogamous partners. He is somewhat typical of the adolescent who exhibits the three “I’s— invulnerability, invincibility and immortality (some would add a fourth “I” – irresponsibility).

Clearly, Martin’s gay maturation process has a bearing on his behaviour – perhaps more strongly than in the other examples. As he moved through his development as a gay man, his goals and perceptions changed. His deliberate move away from his hometown was to escape the life he was leading, and to start anew, in a different modality.

The examples cited above point out that maturation (and gay maturation) have a significant impact on health beliefs and risk taking. Martin’s conscious decision to “clean up his act” coincided with new responsibilities, a higher level of self-esteem, and a desire to behave more rationally. No doubt his decisions were not wholly internally motivated – he had tried the ‘slut’ phase, and found that it no longer suited his needs or desires. Martin drew on other community examples to reformulate his life-course choices, indicating that the decision to change was, at least in part, social.

It may be useful to consider the coming out process, and its attendant sexual risk behaviour patterns as transitional, and in many cases, anomic. For many recently ‘out’ men, lacking gay affirmative reference groups means that the individual is obliged to recreate his life along the lines of ‘learned’ or ‘observed’ behaviour. If
the reference group is based on socially constructed stereotypically gay\cite{19} behaviour (as all too frequently portrayed in the media), it is more likely that these mannerisms and beliefs will be adopted, often unconditionally. We need only refer to the comment of those subjects who self-described themselves as 'sluts' when they came out, to realize how forceful and influential the power of outside influences is on the formation of, at least early, gay identity.

With this background, we can now turn to a more theoretical explanation of what appears to have occurred with Martin, and several of the other gay men mentioned above —an examination that focuses on health beliefs and their relationship to risk behaviour. This analysis will lay the groundwork for an interrogation of trust — a concept that is key to understanding how barebacking is understood, rationalized or rejected.

Health Beliefs and Risk Behaviour

Health beliefs are rooted in wider socio-economic structures in which people live their lives. Attesting to the importance of health beliefs, Nettleson (1995) suggests that through the study of health beliefs one can learn which ideas, beliefs and practices are embedded in any particular society. Lay beliefs do not arise out of ignorance, or a rejection of expert knowledge, but are actively constructed in an effort to understand contradictions and confusing experiences that people may

\footnote{By this I mean effeminate, sex-absorbed, self-centred and seemingly in perpetual crisis.}
have, or may come to learn. Nettleson also suggests that social location and division inform health beliefs – be they socio-economic, gender based, age-related or cultural in character.

In Ingham et al.'s study (1992), young people’s decision-making about when to undertake safe sex was mediated by wider social and cultural understandings of sexual relationships in general. Young people acknowledged the notion of ‘know your partner’ as being valuable in decision-making, but social conventions about how sex itself was performed influenced what young people comprehended about the notion of ‘knowing’. The concept of talking to their partners about previous sexual history, or asking them if they were HIV-positive was contrary to the social norms of how sex was done. ‘Knowing’, for them, was characterized as being acquainted with someone for a period of time (even if only on a superficial basis), or with having knowledge of a person’s social and/or demographic background.

In another study, Shiner & Newburn (1997) found the continual bombardment of the official messages about ‘drugs and danger’ unhelpful and confusing to young people. Adolescents tended to rely more on local and experiential sources. However, the most influential factors permitting the construction of their health beliefs were local urban myths and stories that broadcast accepted wisdoms, organic knowledge and modes of behaviour about both the positive and negative
effects of drugs. Young people deemed the balanced information more reliable and relevant as a source of information, especially because they were founded on local experts' real experiences of drugs and drug taking.

Clearly, beliefs about risk and risk-taking are important, but merely focusing on individual knowledge (K of KAB) fails to recognize the significance of the social context of action. Individual choice cannot be dissociated from peer groups, social etiquette and social or community norms. For example, in a study of male prostitutes' management of risk, Bloor et al. (1992) demonstrate how the behaviour of younger male prostitutes was rational and reasonable to them, and best understood in the context of social relationships and the specific conditions of each sexual encounter.

It is clear, therefore, that risk and risk-taking must be acknowledged as a negotiated and mediated process, which is a product of social interaction. Apparent risk situations are frequently seen as safe because of sexual intimacy and trust embedded in close relationships. Risk and choice therefore, are seen to be mediated and negotiated through social relationships.

All of the interviewees were asked at what age they were first exposed to 'safe sex' messages, in what context were these messages delivered, and what was their initial reaction to the messages themselves. Their responses indicate a clear bias toward one of two factors – school, where the message was either convoluted or
deemed irrelevant, or peer groups, where the message was clearer, and more relevant. The following excerpts illustrate this point:

**Questions**: At what age do you recall first hearing about safe sex or safer sex? Can you pinpoint it from a sense of whom or how you heard of it? Do you remember what your first impressions were when you heard about that?

**Phillip**: I guess in my 20’s, I’m not sure. I don’t remember it in sex ed – if I even had sex ed, right. Probably you know, just from TV – Trojan [a brand of condoms] commercials and whatever. And after that I think the first time I was ever out in a bar pretty well by myself, I was standing up against a wall, having a beer or whatever, probably. And Sister C[^40] scared the shit right out of me – gave me a condom and whatever and said something cheeky and off she went.

**Jim**: Probably around grade 6 or 7 – I don’t know how old I would be. I think we all went and bought condoms but we really didn’t know what to do with them. We just thought it would be cool to buy them. Most safe sex is about pregnancy, which really wasn’t a concern of mine. I almost kind of thought it was irrelevant. At that age, anyway.

**Brad**: I’m sure it precludes, but I would guess, I mean sex ed. The condom. I think it was grade nine. Like nothing from my parents – no conversation, no birds and bees. My first impression was attentive and curious. But unresponsive. Quiet and shy.

**Patrick**: I believe it was in school – sex ed class – where we had to put the condom on the big wooden dildo. It was all heterosexual sex, I guess. And STDs and pregnancy. It translated into gay sex as well for me. I thought it was a good idea because in school we were swamped with things about AIDS and STDs and all that kind of stuff. That’s what scared me when I came out – that’s what I - I associated AIDS with gay people. I don’t know where I got that from, but when I came out, I thought ‘oh no’ I’m gonna get AIDS if I sleep with a man. [Patrick was the youngest of the subjects, and had only recently left high school.]

[^40]: Sister C was a man in Nun’s drag (very campy) that visited all of the gay bars on her skateboard, handing out condoms and safe sex information. He has since retired.
Max: Probably around 17, 18. It was probably from the media, because that was the start of the epidemic, not from school. It didn’t strike off alarm bells for me that I had to change that much in what I was doing at that time. Perhaps a bit of that oh, well, we’re here in rinky-dink Alberta and why do we really have to care?

Harley: I would have been 15, 16. My brother’s Hustler magazine. I’d been flipping through it and there was a joke with gun sights on a very extravagantly dressed man with purple tights and big hair going like this (gestures with arms akimbo). And it says, “It knows you’re gay.” I didn’t see myself as gay, so I just kinda thought it happened to fags. I had sex with my best friend at the ages of 9 and 11 — when I became sexual it was with my girlfriend at 18 — and it was clear we were using condoms . . . for birth control.

To summarize the experiences of this sub-sample (bearing in mind that all of these people have had UAI in the year prior to their interview) we find the following:
Table 4-1: Sex Education by Age, Source and First Impression

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>SOURCE</th>
<th>FIRST IMPRESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phillip</td>
<td>20's</td>
<td>Television Ads, Sister C (in a bar)</td>
<td>Scared</td>
</tr>
<tr>
<td>Jim</td>
<td>11 or 12</td>
<td>Purchased condoms</td>
<td>Irrelevant</td>
</tr>
<tr>
<td>Brad</td>
<td>14</td>
<td>School</td>
<td>Attentive, curious, unresponsive</td>
</tr>
<tr>
<td>Patrick</td>
<td>14 or 15</td>
<td>School</td>
<td>Good idea, but believed he would get AIDS if he slept with a gay man</td>
</tr>
<tr>
<td>Max</td>
<td>17 – 18</td>
<td>Media</td>
<td>AIDS doesn’t happen in rural Alberta</td>
</tr>
<tr>
<td>Harley</td>
<td>15-16</td>
<td>Media (Hustler cartoon)</td>
<td>AIDS only happened to fags</td>
</tr>
</tbody>
</table>

As one can see in table 4-1, there are as many variations as there are people. Age ranges from 11 – 20 years or older, the source of information can be formal or informal, academic or experiential, and the impressions retained range from fear to irrelevancy to ignorance and denial. Essentially, this table illustrates the manifold understandings of harm reduction (as the dependent variable) in light of the independent variables of age, source of information and outcome of K or A or B. In short, none of the subjects received the information as originally intended, thus reinforcing the individualized nature of learning and message absorption.
Comparing Knowledge and Attitude

Regardless of the manner by which knowledge with respect to HIV/AIDS is acquired, as previously demonstrated, the individualized nature of message absorption suggests that there will be different interpretations born out of the same or similar information. Thus, in respect to attitudes regarding risk and potential HIV infection, it would not be surprising to see a wide range of attitudinal perceptions.

In a recent study (2001 – Craib et al.) researchers attempted to examine optimism in light of new HIV drug therapies and its association with sexual risk behaviour among gay and bisexual men in Vancouver.

Between 11/99 and 12/00, 431 participants completed self-administered questionnaires eliciting data regarding socio-demographics, HIV status, unprotected anal intercourse (UAI) with regular (i.e. at least once/month) or casual (i.e. less than once/month) partners during the past year, and responses to measures of HIV-related optimism. Responses to these measures of optimism by men who reported engaging in UAI were compared with those of men who reported always using condoms in the past year.

What they found was that:

The median age of respondents was 28 years (range: 17-36). The majority was university/college educated (77%) and employed (73%). Ninety-four percent of respondents were HIV-negative. A total of 321 (75%) men reported having one or more regular or casual sexual partners in the past year. Among men who reported engaging in receptive anal intercourse with their regular partners (n=241), 163 (68%) reported not using condoms at least once during the past year. Men who reported insertive UAI with their regular partners were less likely to agree with the statement: "Until there is a complete cure for HIV/AIDS, prevention is still the best practice,"
compared to men who always used condoms during this practice (p=0.021). A total of 95 (46%) of 205 men reported engaging in insertive anal intercourse with casual partners. Men who reported insertive UAI with their casual partners were more likely to agree with the statement: "If a cure for AIDS were announced, I would stop practicing safe sex," compared to men who always used condoms during this practice (p=0.004).

This study suggests that HIV optimism may be associated with higher levels of unprotected anal intercourse among young gay and bisexual men in Vancouver.

On an international basis,

In 2000, a minority of gay men in Australian, Canadian and European cities were optimistic in the light of new HIV drug therapies. While there was an association between HIV optimism and high-risk sexual behaviour, the magnitude of the association was modest and causality could not be established. The lack of a consistent association between HIV optimism and either HIV status or age across the cities highlights the heterogeneous nature of gay men's responses to HAART in different countries. It is unlikely that HIV optimism alone can explain the recent increase in high-risk sexual behaviour among gay men in these countries. (2002, Kevin JP Craib et al).

However, in Vancouver, 352 Vanguard participants were asked the following question:

*Considering the new drug therapies available to treat HIV, do you agree or disagree with the following statements?*

Participants were asked to rate the statements on a four-point scale, from strongly agree to strongly disagree. The following table reveals the responses obtained:
TABLE 4-2: ATTITUDES TOWARD HIV THERAPIES AND POTENTIAL INFECTION. (Vanguard, 2000. Private Correspondence, Keith Chan)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Frequency</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>A person with undetectable viral load cannot pass on the virus.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>8</td>
<td>2.5</td>
<td>8</td>
<td>2.5</td>
</tr>
<tr>
<td>Agree</td>
<td>37</td>
<td>11.5</td>
<td>45</td>
<td>[14.0]</td>
</tr>
<tr>
<td>Disagree</td>
<td>145</td>
<td>45.2</td>
<td>190</td>
<td>59.2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>131</td>
<td>40.8</td>
<td>321</td>
<td>100</td>
</tr>
<tr>
<td>New HIV treatments will take the worry out of sex.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>18</td>
<td>5.3</td>
<td>18</td>
<td>5.3</td>
</tr>
<tr>
<td>Agree</td>
<td>109</td>
<td>32.1</td>
<td>127</td>
<td>[37.4]</td>
</tr>
<tr>
<td>Disagree</td>
<td>124</td>
<td>36.5</td>
<td>251</td>
<td>73.8</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>89</td>
<td>26.2</td>
<td>340</td>
<td>100.0</td>
</tr>
<tr>
<td>If every HIV-positive person took the new treatments, the AIDS epidemic would be over.</td>
<td></td>
<td></td>
<td></td>
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<td>If a cure for AIDS were announced, I would stop practicing safe sex.</td>
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People with undetectable viral load don't need to worry so much about infecting others with HIV.

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Until there is a cure for HIV/AIDS, prevention is still the best practice.

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HIV is less of a threat because the epidemic is on the decline.

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HIV/AIDS is a less serious threat than it used to be because of new treatments.

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It is never safe to fuck without a condom regardless of viral load.

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<th>Strongly Agree</th>
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Because of new treatments, fewer people are becoming infected with HIV.

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The percentage of misinformed or harmful health beliefs are identified by numbers in boxes. One may be tempted to dismiss these statistics as low and relatively insignificant in the overall representation of gay mens' knowledge of HIV/AIDS, but to so do would be to discount the thousands of men who were not sampled. A substantial number of gay men hold untenable health beliefs.

The data demonstrates both a lack of knowledge with respect to the virus and possible transmission, and a surprising attitudinal disregard for personal safety in the face of potential contagion. Misinformation or lack of concern regarding HIV ranges from 7% ("Until there is a cure for AIDS, prevention is still the best practice") to an alarming 37.4% ("New HIV treatments will take the worry out of sex"). However, regarding the response to viral load:

There are no "magic" numbers for viral loads. If your viral load is 75,000, we don't know how long you'll stay healthy. We don't know if 150,000 is twice as bad as 75,000. All we know so far is that lower is better and seems to mean a longer, healthier life. An international panel of doctors suggested that anyone with a viral load over 5,000 or 10,000 should be treated with antiviral drugs. Some people may think that if their viral load is undetectable, they can't pass the HIV virus to another person. THIS IS NOT TRUE. There is no "safe" level of viral load. Even if your viral load is undetectable, you can pass HIV to another person. (Presentation at XIII International AIDS Conference, Durban, S.A. July, 1999: http://www.immunet.org/FactSheets/413-viral-load.html#anchor152371) (Italics added)

Fourteen percent of respondents believe that a person with an undetectable viral load cannot pass on the virus. This is false information, and clearly, these people are at significant risk for infection. Curiously, when asked the same question in a
different format: “People with undetectable viral load don’t need to worry so much about infecting others with HIV”, only half that number agreed with the statement (7.5%).

At the same time, fully 22.2% of the respondents believe that HIV is less of a threat because of new treatments. If their definition of ‘threat’ is infection itself, they are unmistakably misinformed, since the new antiretrovirals do not prevent the spread of HIV, they only slow down the disease’s progression. Additionally, there is some considerable debate as to the value of viral load tests themselves:

Some scientists think that only 2% of the HIV in your body is in the blood. The viral load test does not measure how much HIV is in body tissues like the lymph nodes, spleen, or brain. HIV levels in lymph tissue go down when blood levels go down, but not at the same time or the same rate. Viral levels in semen seem to be unrelated to blood levels. The viral load test results can be thrown off if your body is fighting an infection, or if you have just received an immunization (like a flu shot). You should not have blood taken for a viral load test within four weeks of any infection or immunization. (Ibid.)

If however, they define ‘threat’ as one’s quality of life if one is infected, then they may be more or less accurately assessing the information. In addition, 16.1% disagreed with the statement “It is never safe to fuck without a condom regardless of viral load”. This response is, from a knowledge basis, false. On an exam, it would be considered a ‘trick’ question. As indicated above, viral load is a very poor predictor of the potential for infection.

41 There is considerable debate on this issue. The statement may not be correct.
While the sample size is not large, and these sub-populations are smaller, one must bear in mind that even at its lowest level (7% - prevention is the best practice), a statistically significant number of people disagree with the most prevalent and widely advertised health belief.

Given this lack of correct information, it is not surprising that attitudes toward new drug therapies and risk are also distorted. Over a third (37.4%) of the respondents believe that “new HIV treatments will take the worry out of sex”. This misperception bodes ill for prevention efforts, especially in light of the power of ‘organic’ knowledge as opposed to so-called ‘official’ knowledge (discussed previously). In addition, the misbelief held by 10.6% of the sample, that “If every HIV-positive person took the new treatments, the AIDS epidemic would be over” clearly reinforces the perception that combination therapy is a magic potion – an effective form of immunization against spreading the virus.

One must bear in mind that the series of questions and responses noted above were all answered by Vanguard participants – by definition HIV-negative, between the ages of 18 and 34. Generally speaking, this cohort, by virtue of Vanguard membership, newsletters, annual (or more frequent) visits to healthcare providers, and other forms of communication, are generally better informed about HIV, risk prevention, and new information than the general MSM population. Additionally, there may be a component of the ‘Hawthorn Effect’ at
play as well. In other words, the data presented may actually understate the general knowledge/belief, logic prevalent in the larger MSM population. It is, however, unlikely that the data overstates the problem.

Throughout this study, I have relied on the assumption that knowledge about HIV transmission is widely known, and more importantly, clearly understood. Table 4-3 appears to dispute that position in a most compelling manner. While there is no doubt that the basic information — contagion occurs with the transference of infected blood or semen from one person to another is widely known — the new medical breakthroughs appear to confound the notion of infection. It seems clear that when old knowledge confronts new information, the new information must be properly and thoroughly explained. Some messages bear repeating, and notwithstanding my critique of the KAB model, there will always be a case to be made for basic information campaigns (K) regarding HIV, risk and the new AIDS drugs, in light of new discoveries, especially directed towards younger MSM and street-involved youth. However, reliance on the automatic 'kick-in' of the other two aspects (A and B) cannot be taken as 'given'.

Nonetheless, people do not make their decisions regarding risk based solely on facts — there is a major element of trust in oneself, in others, and in social institutions that is intertwined with rational decision-making. Misztal (1996), as quoted in Sztompka's introduction explains the relationship of trust to human
societies: “Trust becomes a more urgent and central concern in today’s contingent, uncertain and global condition.” Before proceeding to the case studies, where trust figures prominently in the discourses, I will examine some of the theoretical underpinnings of trust.

Practicing Trust

Trust is operationalized in a variety of ways. As Patrick (one of the study participants) eloquently put it, part of his trust is based in selflessness; an attempt to conform to social norms and knowledge about HIV transmission, yet also to satisfy his partner (at any cost):

I didn't feel comfortable with the idea [of not using condoms for anal sex] because I was so used to using condoms all the time. But as I got to know him I felt more comfortable, and I knew that he hasn't slept around or anything. He's very new to the gay community - the gay lifestyle - so I felt comfortable with him and he just said he couldn't cum when he wore a condom and I believed him. And I wanted to give him the satisfaction of cumming. So he - so I agreed for him not to wear the condom.

Brad had a similar experience. When he was living in Winnipeg he:

... felt very comfortable, very safe and a lot of the fucking may have been unsafe. He said that he was negative. [It was] ongoing - the first night - it was a few weeks into after we met.

However when questioned whether he or his partner were tested for HIV antibodies, he replied: "No. And that went both ways. Neither tested, I fucked him, he fucked me."
Notwithstanding the fact that both Patrick and Brad barebacked, their experiences illustrate the veracity of Sztompka’s notion of ‘normative coherence’ – their social life was unproblematically orderly – for Patrick, the deciding factor was the unlikelihood of infection, since his partner was “new to the gay community” (i.e., not promiscuous); for Brad, it was the reliance on a fixed scenario: both participants were (presumed to be) HIV-negative.

On the other hand, Philip, discussing trust and monogamy, initially appears to be far more confident in his decision-making capabilities:

I have to take it on face value that if a person says they’re not cheating, then they are not cheating. But if they were negative and not cheating, I would still use condoms. Because I can’t be sure truly. I can be 99% sure if I’m clear in my connection, there is no emotional charge. But because I’m in a relationship, there’s an emotional charge so I can’t be sure on reading whether they’re telling me the truth or not.

Philip exemplifies Luhmann’s notion of distrust, even in the face of evidence of seronegativity, in that he recognizes that his self-confidence in decision making is impaired (or at least compromised) by his emotional ‘charge’ with a partner. He is not alone in this perception. Philip’s early years include a history of drugs, alcohol, sexual abuse and abandonment, which bolsters the contention that distrust breeds distrust.

Drugs, alcohol, sexual abuse – there’s a story of me being – I guess I was probably two and a half, three – and I had learned how to break out of my crib – I’d go out of the house – in my grandma’s basement – and go
across the yard through the gate, across the back alley, through the gate into another friend’s house, because I knew I could get breakfast there.

My Dad died when I was ten, my Mom was in and out of jail quite a bit before that. I don’t know if she got out of jail the last time, shortly before or after my Dad died.

Well, we moved all the time. My records show that I went – on average – to two schools a year for the first eight years of school.

High school was just tough. My Mom died when I was 14, so that was just – and that was kinda like the icing on the cake for me. And my step dad was just an awful man, awful man.

Phil’s behaviour exemplifies the obverse of Sztompka’s notion of accountability – irresponsibility. Having been habituated to the lack of standards, and constantly not knowing where the boundaries were set, his distrust manifests itself not only in his behaviour, but more significantly, in a lack of trust in his own decision-making.

Alan, in discussing his sexual scripts, was asked if he felt that his discomfort with being a bottom (anal receptive) would be lessened if a cure for AIDS were to be found. Even in the light of a hypothetical, incontrovertible medical breakthrough, he states:

I think it goes much deeper than just AIDS or HIV — and being the bottom. I think it goes a lot to what we were talking about earlier with my childhood — the perception of what a man is — is really quite — on another level let’s say, like in my subconscious — I think that my perception of what a man is and how man is proven to be is completely skewed from my childhood. And I think that has had an effect on how comfortable I can be with another man and be what I would term as
being vulnerable and I don't like that. I don't like thinking that being the bottom is being vulnerable.

The issue, as he puts it, is clearly not HIV or AIDS. Previously, he had stated that:

I can easily be the top -- back then we didn't use condoms and easily be the top and not have as much to worry about -- I thought. But being a bottom was just not enjoyable for me, because I was scared, always scared. So it had a major effect on the amount of sex that I had I was younger. Now that I'm older it - I do not have - I'm not the penetrated partner without a condom - I still will not. That's been years.

His fear, or more particularly his lack of self-confidence denies him a pleasure he actually desires. His belief [stated earlier in the interview] that being anally penetrated was tantamount to being infected, and being denigrated as a man, is illustrative of the accountability of oneself and others. In this instance, the distrust is contingent on the destabilization of identity. In Sztompka's terms, Alan's mistrust is illustrative of 'normative chaos' – the lack of predictability in the face of variable scenarios (in this case, top or bottom).

There is a complimentary point that is relevant to an analysis of risk, and that is the notion of pleasure. "Pleasure as a concept or experience is entirely absent from public discussion of health and risks." (Hart, 1999:8) People indulge in the use of alcohol and drugs, pay for casual sex, drive at speed limits far exceeding the lawful limit, and participate in extreme sports simply because these are pleasurable experiences – the enjoyable sensations are produced precisely because
there is an element of 'controlled' danger present. Therefore, the pursuit of personal gratification through these specific forms of risk (and in this case sexual risk) should be viewed as central to their occurrence, and must inform our perception of the framework and situations in which these actions take place. As will be seen in the following chapter, this notion of 'pleasure' and personal gratification weighs strongly as a counterpoint to safety. In simplistic terms, pleasure and sexual safety, for some gay men go hand-in-hand, while for others, they are diametrically opposed to each other. To trust is a pleasurable act in and of itself, while distrust (as a negative mood state) is not generally gratifying. Trusting, or at least avoiding distrust, can be less arduous than actively distrusting people.

How Do People Trust?

How we decide whom to trust and what the differences are between high trusters and low trusters in society has been addressed by Bacharach and Gambetta (2000). They set out to determine how people solve the primary problem of trust -- that is, 'Can I trust this person to do (or not to do) X?' They locate the source of the uncertainty in the truster's lack of knowledge concerning the payoffs of the trustee and the extent to which the trustee will in fact turn out to be trustworthy. They label this latter problem the 'secondary problem of trust' -- the problem of determining whether to trust the signs that someone is trustworthy.
Bacharach and Gambetta also analyze in detail the significance of signs of trustworthiness for the 'primary problem of trust' using signaling theory and game theory. They use these paradigms to decide when and whom to trust, and about what. In part, they conclude that if trust is accurately communicated, the trust is justified. The shortcoming, however, as they acknowledge, is that trust can be mimicked, and opportunism or greed can mask insincere signals of trust. In fact, much of their analysis is focused on the trusters rather than on the trustee—‘How can I, who am trustworthy, convince the truster that I am indeed trustworthy?’ They conclude that while positive and healthy intentions are the signals put forward by a trustworthy individual, these signals may be overlooked or misread by a potential trustee, thus leading to a clash of understandings or meanings.

However, Toshio Yamagishi (2000) analyzes trust as a form of ‘social intelligence’. He develops the argument that high trusters are not necessarily gullible, as some may assume, but are in fact more discerning in their attitudes toward others. His experimental evidence suggests that high trusters are more capable of detecting and processing proper signs of risk in social interaction, whereas low trusters tend to avoid such risks. Applying this theory to a broader base, Yamagishi speculates that the people in societies that are generally distrustful are less likely to enter risky social interactions and more likely to interact in relatively closed circles, even at the risk of giving up new opportunities.
In this case, the development of trust is not easy; not only does distrust feed on itself, breeding more distrust, but individuals in these societies must make conscious efforts to develop the social intelligence required for detecting risks and taking risks when appropriate.

It then follows that those people who are low in trust are more prone to making mistakes in sign detection — thus it is more prudent for them to assume the worst about human nature to avoid being victimized. This appears to be the case with a number of people who were interviewed, and as a general condition, also true about the social marketing messages that present condom use as an absolute, a message that suggests that no one can really be trusted. In some cases, this applies to partners in committed relationships as well — in essence, family.

Within the gay community, very often ‘family of choice’ has more significance than ‘family of birth’. In the absence of kin-like relations or access to family members, people often turn to close associates or fellow group members for assistance. John D’Emilio writes that:

Gay men and lesbians are well suited to play a special role. Already excluded from families as most of us are, we had to create, for our own survival, networks of support that do not depend on the bonds of blood or the license of the state, but that are freely chosen and nurtured. (D’Emilio, 2001: 246)

Gays and lesbians live in a social milieu that transcends the boundaries of the heterosexual nuclear family. Communities and families have formed in that social
space. Survival and liberation rely on the ability to preserve, develop and solidify that terrain, not merely for gays, but for everyone. That means, in some measure, championing issues that broaden the opportunities for living outside traditional heterosexual family units and providing a material basis for personal autonomy. This entails carving out personal spaces and structures beyond the nuclear family that provide a sense of belonging, a proxy for the emotional security that was (is) otherwise deficient. And a great part of that emotional security is intricately interwoven with trust.

The distribution of trust varies with the degree of proximity to the individual. Clearly, we are more likely to trust ourselves than total strangers, but bracketing these polarities are questions of trust in intimates and trust in professionals. The degree of social capital invested in oneself and in others will in turn depend on the trustworthiness of prior information, decisions and behaviours that have provided the fodder for trust or distrust. What we have found so far is a certain degree of mistrust in ‘expert’ knowledge, and (in many cases) an inordinate degree of trust in intimates. Additionally, pace Kippax, we find a significant degree of trust, or social capital invested in community.

Political scientists argue that trust is a kind of social capital that facilitates cooperation and civic mindedness and makes democracy work (Putnam, 1995). One kind of generalized trust is the voluntary organization – in this case, the gay
community (or communities to be more precise). Gay community association, as I have argued earlier (pace Kippax) forms a basis of cooperation and information sharing. However, Stolle (2000) found that generalized trust and openness to strangers in the community does not increase with longevity of group membership. Rather, generalized trust appears to be affected more by personal resources and characteristics (e.g.: age, income, personal experiences of betrayal, and so on). Group members trust those who are respectful, caring, benevolent, fair, and trustworthy. It is this kind of information, often conveyed through signals and signs that permits mutual expectations of self-denying behaviour to bridge differences in beliefs and boundaries, under the right circumstances. In other words, social trust capital is a currency that can permit gay men to trust one another, in the face of supposed evidence to the contrary.

Conclusion

We have examined the production of trust both quantitatively (as in the issue of comfort with HIV) and qualitatively, through the voices of some of the study participants, and have concluded that trust encompasses a plethora of cognitive, emotional and historical constructs. The functioning of trust is bipolar – that is there is a process of giving trust, and a second process of meeting the trust thus endowed. Additionally, we have found that the two are not necessarily present simultaneously.
We normally presume that trusting others is virtuous, and distrust is both limiting and potentially harmful. However, it has been demonstrated that a healthy dose of distrust may also be a positive influence in protecting people against further risk and vulnerability. In either case, it has been unmistakably demonstrated that trust has the inherent tendency to endorse and reinforce itself in social action.

Through the use of Sztompka's classification system, we have also examined some case evidence regarding the notion of trust, revealing its complexity in a number of ontological contexts. This has provided us with a more robust method of examining trust and its relation to risk, and shown that in the long run, the formation of trust is an integral part of people's lived experiences.

We have come to see that one's psychological assets (or lack thereof) have a significant bearing on how trust or distrust will manifest itself in decision making with respect to risk taking. Refining the argument further, we have also demonstrated empirically, through the Sigma Project qualitative data, that there is a strong and significant correlation between trust and sexual risk. We have also learned that education, family life, school experiences, historicity, personal experiences and moral sensitivity heighten one's ability to trust. Life-course events have a particular bearing on trust levels – we have learned that through the voices of the study participants.
The operationalization of trust (or distrust) and risk can be pragmatic or naive, and frequently is both. Within the study group, gay men who have unprotected anal intercourse, on either an infrequent or regular basis, indicate that their rationales conform to one or more of the five modalities Sztompka elucidates. This information persuasively suggests that wholesome health beliefs alone are inadequate motivation for behavioural change. For example, the allure of pleasure and personal gratification radically alters and confounds normative and simplistic perceptions of risk.

In short, risk behaviour is not a series of random acts that are laden with hazards great and small. Risk-taking is, first, part of a lifestyle, socially constructed in a manner no different than other socially constructed human traits. Second, risk and trust are symbiotic, and usually tend to act in inverse relationship to each other. Third, risk, trust and distrust are normative states; normative at least in the sense that they are found within each person, and form part of the social make-up of society. Attempts to wholly eliminate risk, therefore, are doomed to fail.

Compounding the issue is the level of maturity in the thought process itself – we have clearly demonstrated that an adolescent is more prone to discount (or not even recognize) risk. Additionally, much to the detriment of HIV/AIDS harm reduction education, experiential (and second-hand experiential) learning enables wise choices more readily than cerebral reflection and self-cognition. The more
internalized the value in question, the more difficult it is to modify or reverse risk behaviour patterns. Furthermore, it may very well be, as Irwin & Millstein (1986) argue, risk taking is a part of normal transitional behaviour during adolescence. Last, if it is true, as Hendry et al (1993) note, that risk taking is an intrinsic part of the human drive to pursue pleasure, there may be no way by which sexual risk behaviour might be reduced to the levels desired by health providers and harm reduction strategists.

Individual beliefs are a fragment of peer group beliefs and social norms. Behaviour, risky or otherwise, must therefore be associated with social relationships and specific conditions of sexual encounters. Clearly then, risk and risk-taking, trust and trust-giving must be recognized as a negotiated and mediated method of social interaction.

In the following two chapters, I examine the social relationships, beliefs and conditions of sexual encounters of a number of study participants. The case studies (chapter 5) and the thematic discussions (chapter 6) make liberal use of the participants' own words, sometimes in response to specific questions, and more often, as digressions from the original question. From time to time, I interrupt the monologues to comment on what is being said, or to relate the comments back to the theoretical arguments presented in the past four chapters.
What shall become clear is that issues of risk, trust-giving and trust-receiving are complex, multi-faceted, and highly contingent.
The Purpose of the Case Studies

The objective of this dissertation is to demonstrate how some gay men assess sexual risk, in light of their knowledge about HIV/AIDS and contagion. In previous chapters, I have examined both theoretical and practical considerations of risk, trust and sexual behaviour in general. However, theoretical ideas and behavioural facts may prove incongruent, even within the orbit of a given paradigm. As Kuhn states:

Scientific fact and theory are not categorically separable, except perhaps within a single tradition of normal-scientific practice. That is why the unexpected discovery is not simply factual in its import and why the scientist's world is qualitatively transformed as well as quantitatively enriched by fundamental novelties of either fact or theory. (Kuhn, 1962/1970: 7) (Italics added)

While it would be a misnomer to consider the evidence produced thus far as a 'novelty', it does point to a number of anomalies in the theoretical explanations of trust and risk. Human beings do not necessarily follow set patterns, nor do they always behave in what is generally considered to be 'logical' fashion. In the following case studies, we shall see that there are a number of confounding factors that militate against traditional notions of rational choice, and by the same token, a fair number of life course events that reinforce traditional rational choice.
The subjects selected for a case study analysis have been chosen because they represent the range of backgrounds and life-course events of the group: they vary in age from younger to older, have very different coming-out experiences and timelines (some were gay as a young person and others came out later in life), they range from a extensive to no gay community affiliation, span the gamut of having been exclusively gay to bisexual to having been married with a child, they do or do not use condoms for anal intercourse, and so on. In short, they represent a range of the most salient factors discussed previously related to risk, trust and condom use (or the lack thereof).

All of the case studies have been edited for length and content – nothing has been added, but plainly irrelevant or tangential discussions (chit-chat, repetition, and discussions about other people) have been eliminated. Items in italics are my questions to the interviewees. The interviews, conducted in a private room at The Centre, were carried out after an extensive literature review, a pre-testing of the questions, and of course, Ethical Approval from UBC.

The Vanguard database contains a significant amount of highly confidential information. As can be seen by the questionnaires (Appendix 3), the questions are designed to elicit information on sexual behaviour, self-identification, life course histories and a number of psychological profiles.
There is a complex system of checks and balances in place to preserve the confidentiality of each respondent. Only one person has access to the names and the data – Stephen Martindale, the project coordinator. Each participant is assigned a code number by Martindale, and this number is recorded on both the blood samples and on the questionnaire. Martindale is the sole proprietor of that key. The data entry and retrieval is managed by the subject’s code number.

Since I was interviewing actual subjects, I was not privy to individual questionnaire results – all database information provided to me was in the aggregate. Apart from that which the participants chose to share through their interviews and in the discussion groups, I had no further information on individuals.

In turn, I have assigned aliases to all of the participants in my study. I am the only one with that key. Any references to real names have been expunged from the transcripts. There has been no communication between myself and the interviewees or discussion group members since the farewell dinner.

In some of the analyses that precede or follow excerpts from the transcripts, I include pertinent information that was presented in other parts of the interviews, but not reproduced herein. While this may seem, to some readers, to be ‘admitting evidence’ in an improper manner, it is expeditious in this thesis, in that to add each reference as a quotation would significantly lengthen the monologues
in order to add one or two facts. The entire transcripts are available (on a need-to-know basis) in order to verify the veracity of the added information, should that be necessary. 43

Case Study — Christian

Christian is a white male, approximately 27 years old, and openly gay. He is currently single. He works for himself in a service type job, and spends most of his day interacting with clients of all ages, and all lifestyles.

*If you could imagine your life as it is now — on a scale from 1 to 10 - 1 being very low (or awful) and 10 being very high (or wow, fabulous) how would you rate your overall life satisfaction?*

I would say 7.

*Why do you feel that way?*

Because I think I have a pretty good life and I am quite happy, but I think that there's a couple of things I would like in my life that I don’t have right now that would bring it closer to an 8 or a 9.

*What would those be?*

My job for the moment - I’d like to change that. Maybe finding a regular partner and start something that's gonna be long term. More money. And traveling more, that’s one of the things that I kind of miss right now.

Significant in this response is the fact that Christian identifies his need for settling down with a regular partner, and forming a family (“something ... long term”) This may be in part a result of his upbringing, which was characterized by close family ties. In fact, this yearning for a relationship was so instrumental in his life,

43 The transcripts will ultimately be archived with the University of British Columbia.
that Christian has constructed a fairly novel living arrangement with his ex-lover.

Below, Christian talks about the importance of a social network to his sense of well-being.

I live with somebody that I’ve been living with for five years and he’s an ex-boyfriend of mine. So we were together for a year and a half, we broke up and we moved in together two weeks after that and we’ve been living together ever since. And then we actually bought a condo together also - that we’re moving into two years from now. So it’s kind of long-term commitment so to speak, between him and I. And then that’s very important for me. My family - I’m quite close to my family, even if they’re all back East, but I’ve a very fun and loving family so that’s also good. But I have a very good group of friends, great friends here in Vancouver and in different cities that I go visit regularly, which is mostly in the U.S.

Christian also discusses why he believes it is so difficult for him to connect with a new ‘significant other’.

I just wonder why it’s so hard - why it seems so hard for people to connect with other people?
I guess it depends. I mean in my case, I kind of know what I want and maybe the down side to this is that I don’t give some people a chance. They would like to date me, because I feel that it’s not gonna work. And I think I’m probably right. But I don’t have the patience of even trying it, because some people do try it and say OK, give it a chance. But I just know and I don’t do. So because of that it just doesn’t happen that often that I meet Mr. Right so to speak, right. I had a boyfriend for nine months and it just finished last February. So that was the first one I was seeing somebody regularly since Michael and I broke up five years ago. And he’s had so many boyfriends and he always comes back to me. And the reason also in my personal case why it’s so difficult is because I have - I think that I have the best of both worlds so to speak - I have somebody at home that I get along so well with. We have that amazing relationship - we’re best friends, we’re good companions and stuff. But then I can have as much sex as I want on the side. So there’s no limitation on that side. And that really - I’m not really missing that much - the boyfriend things - unless once again I feel that Michael is gonna find someone and I will be- (voice trails off)
Christian believes that he has 'the best of both worlds' – a domestic arrangement with his ex boyfriend, and all the sex he wants (on the side). This arrangement appears to be no different from a non-monogamous relationship, except for the fact that Christian no longer sleeps with his 'lover' – his roommate. Christian confirms this belief:

*So you’re almost lovers in everything but in bed?*
Yes, exactly. And there is never, ever any sexual thing between him and I. Since we broke up five years ago. You know, some people sometimes sleep with each other - I said no - him and I - never. It’s not even an issue. And maybe why it goes so well, because there is no sexual tension whatsoever. And I’m not a jealous person.

Not atypically, Christian knew that he was gay when he was quite young, but did not come out until much later. When I asked him about how he felt as a teenager, he related his angst at being gay, his sublimation of his sexual desires, and being closeted.

*When we’re talking about when you were younger, can you remember at what age you realized you were “different” from other boys? Even if you didn’t have a term for it?*
Um, yeah. Grade six.

*Was there anything that might have happened or that you saw or you heard that triggered anything? That would be when you were eleven, right?*
I just think - because I cannot recall - because I think I became a teenager, right. So the hormones kicked in and then I remember very clearly being sitting at the back of the class in grade 6 with this guy. That as far as I can remember, I found him attractive and he was telling me about jerking off, which I had no idea what it was about. So he told me what it was, he told me how he does it and then of course, I went home and I tried it and stuff. And I had a crush on him obviously at that age.
But nothing ever happened between him and I, and that’s when I realized that there was something different. Right?

I was just curious and I think then I went from curious to not wanting to be - to feel like this or wanting to be different. So I had girl friends and stuff to try to do like everybody else. And I was always involved in sports, so that’s not some place where you - even if I was - I guess, maybe that’s not true.

When asked about his comfort level prior to coming out, Christian relates how he sublimated his sexual desires, as best as he could:

I think the only time where it [his self-comfort scale] was probably low is when I came out, right. Actually that coming out period took about - my God - I had sex with the first man I was 13 - and I came out, I was 21. So I wouldn’t say that these were the happiest days of my life but they were not unhappy. Because what happened is I focused on something else and I was a track athlete doing Canadian championship, and stuff. So basically I transformed that sexual energy into something else and the day that I came out, the performance in track just went down the drain and I quit - it just happened the same time.

And I did a degree in phys ed, which is very un-gay, and which is maybe one of the reasons why I did it. And I was always with - you know - those guys. And I spent basically those six years falling in love with straight men, right. They didn’t really know for sure that I was gay. But I knew. But I didn’t want to come out - so I kind of had very good friendships with no sexuality whatsoever. And then when I realized that I wanted more, then I was switching to another straight guy for some period of time until finally I gave it up - enough already.

What did you do for sex between that?
I used to - the age of 13 when it happened for the first time, I was in the public washroom at the fitness centre - he was about 45, I think. And that was the very first time. And there were men in that town that used to pick up people to - I remember having some little jerk-off session in the car with those men.
The very first time I had anal sex I was 21, so basically from the age of 13 to the age of 21, there was nothing but - sucking and getting sucked and stuff.

One of the significant variables in the maturation process for gay men is the assimilation of information on safer sex. We explored this issue, and Christian related how his information was obtained from friends, not official sources.

At what age do you recall first hearing about safe sex or safer sex?
Well, when the AIDS came out - I don't remember how old I was but as soon as AIDS - I heard people talking about AIDS, then I heard about safe sex. That would be mid '80s – like '85 - I was finishing high school. Probably through my friends, because at that point, I went to college and some of my friends were gay at that point. And I was hanging with a group of intellectuals so to speak, right? So I think that we had discussions a lot about those kinds of things and stuff. And actually – three – actually all the guys that we were together, we were all gay, but none of them was out of the closet.

When asked how he actuated his information about safe sex, he equivocated. It seemed that he was asking me, rather than telling me how he defined safe sex.

As you probably know or surmise, very few people are able to state that they have NEVER had any unsafe or potentially less safe sex. However, it is not totally unknown. Thinking back on your sex life to date, has there ever been a period of time - first of all - when you only had safe sex?
We're talking - sucking is not considered unsafe, right? We're not talking about - we're talking about fucking without a condom, right?

I'm letting you define it.
OK. I'm gonna define it - for me, unsafe sex is anal sex without a condom. And even more than that it's me getting fucked without a condom.

Several issues are at play in the preceding statement. Initially, Christian defines all UAI as unsafe, but quickly modifies this definition. However, he immediately confirms that he is certain that his being the receptive partner in anal intercourse
without a condom is not safe. As he recounts other unprotected experiences, his memory gets sharper, and more incidents are recalled:

OK. So you say unsafe equals bottom - no condom. Yes, I want everybody to define it for themselves.
Yes. So that’s what I mean for me. And I think that the very first time I had unprotected sex without a condom I was 22. Once - with a boyfriend that I was seeing at that point. We were always safe, but that one time we were not. So that’s the first time.

Then after that there was never any occasion of unsafe sex until – well, it’s very simple – there’s two other occasions. It happened once probably about two years ago at the baths and I was completely drunk and somebody fucked me without a condom. But he just basically got in and I pushed him right out and stuff so that was the end of it. So there was no ejaculation for sure, not much going on. And then after that, the guy that I was seeing for the last nine months of this past year - we started dating each other and then after a month and half, we both got tested again. And because we both were negative, then we started deciding that we were not gonna have sex with condoms any more. And then that’s the last one.

As he continues this account, another experience comes to mind, and with some prompting, he discussed the one-sided nature of his negotiating safe sex, apparently after the fact, according to the tense he uses in his answer:

Well, actually I did fuck somebody in the last two months without a condom, myself.

Did you know their HIV status?
No. But I remember telling him that - well, first that this shouldn’t have happened and number two, that he doesn’t need to worry about me because I’m negative. I just told him that - I thought he was gonna answer back. That’s kind of the reason I was telling him - that he needs - oh, OK. So....
You didn’t say anything?
No. And I didn’t cum into him or anything. And I don’t have precum whatsoever, so...I guess it’s not that much risk. But....

We explored the nature of the relationship when he and his partner abandoned condoms. I was looking for a rationale – a cognitive decision, and the basis for that decision. The answer, not surprisingly, was predicated on trust. However, as he explains, there was also an element of mimicking heteronormative relationships, as well as the operationalization of the ‘pleasure’ factor, discussed earlier.

And then last year - after being with this guy for a couple of months - you got tested and then decided not to use condoms. How did you come to make that decision?
Um, well once again, it was on trust. I trusted him. Because we talked about him - he was coming out of an eight-year relationship with the same person, where he told me he was monogamous for eight years, right. And they were tested all the time, so he was always fine. He came out, he met me six weeks after he broke up with him and we started dating each other. And then I just thought that - well, first because I mean I like it better without a condom. So that’s the reason when I find out that him and I were gonna be monogamous and be together and he was negative and I was negative, then I didn’t really feel the need of having a condom. And that’s one aspect.

The second aspect is that straight people don’t do that - straight people who get - I mean I think that straight people who fuck around should always use a condom, but straight people who start dating, first they probably don’t even get tested for HIV. But they don’t use condoms. If she’s on the pill, they’re not gonna be using condoms after a little while. And I feel like sometimes we should be like straight couples - I mean, to a certain point. Because isn’t it women who get the highest rate of infection right now? They should be concerned more - almost more than we should be. And if my partner tested negative and I know I’m negative, and we’re not planning to fuck around, and if we do then we should be safe, then there shouldn’t be any risk more than those straight people who are doing it. That was my logical way of thinking.
So it’s a matter of relative risk?
Yeah. Because I didn’t consider myself at risk at that point. Until of course, I found out that he was cheating on me. Which then put me back into perspective. And I mean - I should have said now I know better - but it’s not really true, because I knew better from before.

This last comment is important – rather than expressing regret, and vowing not to repeat the error, Christian acknowledges that there was no error – it was a conscious choice made in full knowledge of the risks, but significantly however, Christian seemingly had already decided that the risk of ‘unfaithfulness’ did not outweigh the trust or the pleasure operands, or both combined.

We then turned to definitions of sex. As indicated in earlier chapters, people perceive sex in many different ways, and ascribe a wide variety of meanings to sex.

How do you define sex? That is, what activities come to mind that constitute sex?
I could go with that question - I don’t mind answering. Because I like looking at naked men, whether it’s in a park -I go to Wreck Beach all the time or something. And whether it involves me going into bushes with somebody who’s hard and we both jerk ourselves off . . . each other without even touching each other - I could count this as one. But on the other hand, I could not count them because I actually didn’t get into physical contact with them. So I don’t know -

Well, it’s your definition of sex.
OK. Well, if we count everything where I was in the presence of one or more men, where there was a hard on and there was cum, that’s one point.

I also asked about his lifetime number of sexual encounters, and how many of them he would define as safe. This question also required him to construct his own definition of ‘safe’.
OK. Of those times - of those 260 times - about what percentage of the time do you feel that you had “safe sex?”

All the time, except with this guy. And then this guy could count as - how many was the total?

260

OK, 260. Minus basically 80 which were the different people, so that’s a 180 - let’s say 180 with him - that was unprotected sex. But however, a lot of it was not necessarily fucking. So you can cut that also in four. So I would go down to 45 times that I had anal unprotected sex.

I deviated from the script at this point – I had completed the scheduled questionnaire, and was curious about something he had said previously. I wanted to know about his early sexual experiences, and what they meant to him, whether they had any influence on his current behaviour, and whether he had any regrets about becoming consensually sexually active at a very young age.

There is something I’m curious about that’s not on my schedule. You became sexually active at 13 - that’s a young age. I have heard from very few people - spoken to very few people - who were sexually active at that age. How did it come about? What was in your mind and so on?

I guess I just wanted to - I just had to experience whatever, have been since the age of 11 so that’s two years where I finally discovered sex. And it just - from the age of 11 to 13, I used - my parents used to drive us to the sports centre at the university - my brothers and sister used to swim - for the whole day until they pick us up at the end of the day. And I used to spend a lot of the time in the shower. So we were swimming and I was leaving my brothers there and I was going back into the shower and I had my bathing suit on. And I had a hard on, but I was thinking oh, I have my bathing suit nobody can see it. And of course that man saw it, right. So then he asked me to follow him and then I did. I mean, I knew what I was doing, but I just - I was shaking I was nervous, very very nervous. But I just knew I had to do it because -

Did you enjoy it?

I was very nervous, I did enjoy it. But also I remember when he walked me back - because we had to go somewhere else because it was obviously busy so we went to another faculty [building] that was closed on the
weekend, so we could have sex in the washroom there. And then when he walked me back I remember I went to the bathroom and I vomited - I made myself vomit - not because I was disgusted - well, because I was disgusted because I had the taste in my mouth and didn't taste good, because he had so much precum, it was like - and when it's your first experience that's the last thing you want to have... So I just remember I was trying to vomit because it was like so disgusting and then I went through the shower and I washed up and stuff. It must have took at least a year and a half or two before I had sex with a man again after that.

And then - you were 15 then?

And then after that it was just - it was kind of getting less traumatic each time so to speak. I was more - I was feeling more ready and stuff so it was not bothering me as much. I was probably feeling a bit of guilt but nothing that I couldn't live with. But something about the fact that I had sex with that man, in a public washroom, influenced my sexual patterns after that.

In what way?

In a way that I've done a lot of those after that, and public places like trails and parks and cars and stuff like that. And sometimes I wonder if the - and the fact that he had a big penis - I don't know if that affected the fact that I'm looking for big penises - right. And the thing is, I have this thing about seeing people's penises - I don't necessarily need to do something with it. I just like seeing it and then I could walk out and step aside - it doesn't matter to me. I have this thing about I want to see how big somebody can get and after that the rest is kind of irrelevant - to a certain point. If something else happens, then good, but if not then it's no big deal.

But the fantasy has been fulfilled?

Yeah. And I don't know - I wonder - the fact that he was - it was a public place and he had a big penis. I wonder if that has something to do - would I have always been like this - all my life, if that wouldn't have happen. Would I have, if I fell in love with a nice guy my age when I was 16? Would I be in a relationship today just because I started in a love relationship as opposed to having a pedophile having sex with me in a bathroom - I was 13, he was 44.

Christian's interview highlights a number of social dynamics that speak to the ephemeral nature of the relationship between knowledge and behavior, risk and
trust, and sex and sexuality. As a young boy he knew that his actions with an older man were transgressive, but was nonetheless excited by the prospect of male to male sex. In fact as Christian remarks, he was erect in his bathing suit in the shower, which to the other man was correctly read as a signal of sexual arousal and interest. While this does not in any way excuse pedophilia (his choice of words), it is significant that his first experience at such a young age is characterized as being consensual, not coercive. That Christian was physically attracted to a man 31 years his senior, and acted on this feeling as it turns out, simply because he was an available male and had initiated the contact that Christian only fantasized about, is also telling in the fact that it demonstrates how early in life overt sexuality can manifest itself.

Christian also relates how he handled his internalized homophobia — through sublimation and displacement. While he abstained from sex for two more years, and then began to only have oral sex from the age of 15 to 21, he rejected other notions of gayness — choosing to live a closeted life of a straight student and athlete. His encounters were primarily anonymous and took place in public places (the parks, bushes, cars), so as not to self-identify with gay community or gay lifestyles. When he came out, at age 21, as he states, “the performance in track just went down the drain and I quit — it just happened at the same time”. He became gay — which obviated the need for sublimation, or as he puts it, being “un-gay".
His knowledge of safe sex, learned from his friends, did not exempt him from UAI and from barebacking, however. His rationales for the two, being drunk the first time, and trusting his partners the other times, resonate with the distinction between UAI and barebacking postulated in Chapter 1. Also, his definition of safe sex complements some of the rationales for barebacking.

The unique part of his interview was the second reason he gave for not using condoms: "straight people don’t do that..." There is an element of wistfulness, even though Christian came out in the age of AIDS (he is under 30), there seems to be a longing for the ‘good old days’, a time before AIDS when condoms were not a requisite part of the sexual script. The notion, however odious it may be, that condoms are one’s partner for life (as one advertisement clearly stated) is rejected by Christian as being homophobic. He implicitly asks why should we use condoms if ‘they’ don’t?

Last, it appears true that the things we learn as children remain a part of us for life. Christian, to this day, seeks sex in public places, from men with big penises, mimicking his first sexual encounter. In fact, his fascination with penis size, even as a voyeur, limits his available choices of sexual partners, and might in part explain his early comments about not giving people a chance to connect with him. Additionally, since he retains his relationship with his ex-lover (albeit not a
sexual one), he has no need for further stability or maturity in his relationships — he is free to have casual sex whenever he wants, without recrimination.

One can conclude, with respect to Christian’s bifurcated sex/love dynamic that his previous sexual encounters, tempered (or abetted) by his earlier closeted lifestyle is an example of what Sztompka refers to as ‘soft variables’ — dealing with behaviour as an independent variable that constructs other social objects — in this case, Christian’s relationship with his ex-lover, his choice of sex partners, and his ambiguity with regard to condom use. His behaviour cannot be considered a dependent variable, explainable through a rational evaluation of the situations in which he finds himself. The relationship with the ex-lover is in marked contrast to his sex life, populated by multiple partners, with whom he does not form lasting attachments. The urge to retain the familiarity of the known situation however, is somewhat mystifying in light of Christian’s comments that the reason he does not have a lover, in the complete sense of a love relationship, is that he doesn’t give people a chance to know him, and he to know them, thus precluding the development of a meaningful and complete relationship, as evidenced by his almost wistful question at the end of the excerpt: “Would I be in a relationship today just because I started in a love relationship, as opposed to having a pedophile having sex with me in a bathroom, when I was 13, he was 44?”

44 Interpersonal , humanistic, meaningful images of action – “exemplified by symbolic interactionism, phenomenology, hermeneutics, cultural studies” (Sztompka, 199: 2)
Christian's comment speaks volumes to the difficulty in surmounting early life experiences, experiences which in his case seem to preclude fully trusting others, while at the same time, apparently inhibiting his own sense of self-mastery — not trusting himself and his instincts.

To reiterate what Good (1988: 43) states, “If presented with a clear breach of trust by someone, our faith in that person will be fatally undermined”; we can see that in this instance, the breach of trust was with himself — from the earliest sexual encounter through his life-choices to be “ungay”, celibate, and closeted. This lack of self-trust is hard to undo — Good continues: “However, if an untrustworthy person behaves well on one occasion, it is not nearly so likely that the converse inference will be made.” (Ibid.) which may well account for Christian’s continued lack of trust in himself and his decision to place his trust in someone else (namely, any of his sexual partners) rather than himself and ultimately, not to use condoms “because . . . I like it better without a condom” and “straight people don’t do that”.

Case Study – Patrick

Patrick’s background and life experiences are entirely different from Christian’s. While Christian held a master’s degree, Patrick was a high school dropout. Christian had a loving and caring family life; Patrick came from a dysfunctional family. Christian had consensual sex (albeit with an older man) when he was very
young. Patrick was sexually abused at an even earlier age. Patrick came out at 16, while Christian waited until he was 21. Patrick is a 21-year-old aboriginal gay man. He was the youngest of the interviewees, and the youngest member of the discussion group. His mannerisms are, to some extent, effeminate, and his voice is soft and delicate. He immediately expressed dissatisfaction with his life, at the time of the interview, primarily because he did not like his job (he was a governmental clerk), and he felt that he had too few close friends. He rated his current life satisfaction as 4/10.

Presumably, there were times in your life when you didn't feel like life was a four. So let's start with pre school - you were still living at home, you were a little kid.... I don't know. I think I was pretty happy - about maybe eight.

Why were you a happy kid?
I think because I was a child and I didn't know much and I know a lot was going on but I didn't really care - I was kind of carefree. All my family was together, we all lived together, everything was somewhat normal, like a regular family.

So did anything happen when you got to grade school?
Well, I started realizing things were going on in my family that shouldn't be going on. And my family was kinda falling apart.

What was grade school like for you?
Grade school was really good. I did really well - I was a wonderful student - I was like the teacher's pet.

How did you get along with the other kids?
I got along really well. I hung around with girls mostly - didn't like the boys.

Did they tease you?
No. That came along later.
Patrick came from a dysfunctional family living in a small Northern village. Both parents were alcoholics, and when he was in high school the family was forcibly split up – one brother joined the army and his sisters were apprehended by Child and Family Services. He and his little brother were left at home in the care of his alcoholic mother and stepfather.

OK. Then I realized my Mom and my stepfather had a drinking problem - they were alcoholics - and that’s when I started getting bothered a lot in school - people were calling me ‘fag’ and ‘Patrick’s a girl’ and all this, because I didn’t have a girl friend and I hung around with all girls, all my friends were girls.

So at some point - you were in grade ten - and you left school?
Um, well, I actually - I was in - when I finished grade eight, I left home. I was 13, I was in grade eight, I think. Or I just finished grade eight and then I asked my Mom if I could go live with my older sister in Winnipeg, because I was - I didn’t want to stay at home, it was just too crazy there. So I wanted to go live in Winnipeg - live with my sister and finish my school. Just live in a better environment I guess. So I asked my Mom, she kind of flipped out, she got all offended and stuff. But she eventually agreed and I moved there - to Winnipeg - with my sister.

What was high school like there?
It was different; it was a big adjustment for me, because it was a really big high school. Because I’m from a little tiny community, where I knew everybody. There, I didn’t know a soul, I was on my own and then that’s when I got like - I guess I dated a few girls - I still didn’t know I was gay - and I had maybe one or two girl friends. I didn’t do anything sexual with them. It was when I had the second one I turned 14 - and that’s when I kind of figured there was something different about me I guess.

What about living with your sister? Was that better than living at home?
Well, I guess for me it was. But really it wasn’t because of my sister. She allowed me to get away with all kinds of things. Like she let me drink and smoke pot and smoke cigarettes and I thought it was cool. But that wasn’t my plan, but eventually - I don’t know, I guess I got right into the drinking and drug scene.
So you left school - tell me about that.
Well, I did a bunch of moving around before I actually quit - like I didn’t quit school until 1996 - like I did a ton of moving around.

Patrick came out to his family at age 16, when he ran away with a man he knew.

However, as he relates his history, he knew he was gay when he was 14.

I lived with my sister for about a year and then I went back home figuring that the city was too much for me. So I went back home and I realized the city was much better than living at home, so I went back to the city and lived with my sister again for another year and then after that my other sister moved to Winnipeg and she wanted me to come live with her because she knew my other sister was letting me get away with all kinds of crazy stuff. She was more kind of strict with me and stuff. And with - well, by the time I had moved in with her, I knew I was gay, because that’s when I went to my first gay club and got into the whole club scene, and - I didn’t tell anyone though.

I know when I was living with my second sister that’s when I kind of - I met a guy at a club and he asked me if I wanted to go to Toronto and of course I was very unhappy and I felt I needed freedom, so I figured just to run away. So when I was 16, I took off to Toronto with this guy. And just kind of disappeared for about six months and then got in touch with my family and they flipped, bawling their eyes out and everything and then the police got a hold of me and then they sent me back to Winnipeg, and then I was placed in the care of Child and Family Services. Placed into a group home. But when I was in Toronto, that’s when I came out to them - kind of told them over the phone.

Can you remember at what age you realized you were “different” from other boys? Even if you didn’t have a term for it? How did it manifest itself?
When I was 14. It was one night when I was going to a vendor with my sister. Went to the vendor, we came out and then there was a club right across the street and I’d seen all these lights and I told my sister - I said, wow, I’d like to go in there, looks like a lot of fun. And she goes, no you don’t want to go in there - that’s a fag bar. And then that’s when my mind got really curious - I’m like they actually have bars for gay people? And so one night I kinda stole my sister’s boyfriend’s ID and snuck off to that club. And I went in there and boom, I knew. Like I felt - there was just this huge relief - like, wow, there’s tons of other people like this. I was just ecstatic.
Patrick’s coming out was epiphanal for him — it appears that for the first time in his life, he felt he belonged somewhere. His experience is not unique. Anecdotal information suggests that the process of coming out is both daunting and liberating at the same time. His realization that there were “tons of other people like this” evokes the power of community and gay community attachment. Additionally, it would seem that for the first time in his life, gay role models were available to him. However, his elation in realizing that he was not alone was tempered by his fear of discovery by his family.

_How did you feel about yourself at the time?_
After I went to the club and.... well, I guess I was kind of scared - I was really scared about my sisters finding out. I was really scared about my family finding out, because I knew they wouldn’t accept me. Because I’m from a Catholic family. Especially my Mom, I knew she’d kind of freak. Otherwise it felt really good that I felt somewhere - found somewhere that I fit in.

_Apart from having gone to the bar that time - anything else that sort of reinforced the fact that you fit in?_
Well, I had sex with a guy......and I loved it.

_You hadn’t had sex before?_
I had - but it wasn’t consensual sex I guess. Because I was sexually abused by a close relative from about – maybe seven until twelve. Well, until I left home. That’s probably another reason why I left home too.

_At what age do you recall first hearing about safe sex or safer sex?_
That’s probably when I was 14.

_Do you recall from whom or how you heard of it?_
I believe it was school - sex ed class - where we had to put the condom on the big wooden pole. It was all heterosexual sex, and STDs and pregnancy. I translated it into gay sex as well for me.
So what were your impressions of it?
I don't know, I guess - well, I thought it was a good idea because I know in school we were swamped with things about AIDS and STDs and all that kind of stuff. So I took it pretty serious. That's what scared me when I came out - that's what I - I associated AIDS with gay people. I don't know where I got that from, but when I came out, I thought oh no, I'm gonna get AIDS if I sleep with a man.

To this point, we have learned that a male relative had frequently sexually molested Patrick, yet he still expressed his sexuality with another male early in life. Additionally, he received safe sex education in school, and although he assumed that if he slept with a man he would get AIDS, he did so anyway. The question to be examined is whether or not the drive for sexual satisfaction without a condom outweighs rational thought. Or, in other words, is cognitive knowledge of HIV neutralized by emotional needs or wants? I asked him about this.

So how did - OK, how did you assess the risk of getting AIDS, when in your mind you associated AIDS with gay sex, with sleeping with a man? How did you work that out in your head?
Like how did I - well, I knew we had to use a condom. I knew that like right away. I said OK, if we're gonna do anything, you have to put on a condom. And like even double it. He didn't seem to be too happy with that but he did it anyway.

How old was he?
Oh, he must have been about 29.

And you were 14. Who came on to whom?
He came on to me - I kinda - I just kinda stood there and all these people came up to me and he just started talking to me and made me feel comfortable and asked me to stay late and then asked me to come over and I did and I just went along with it.

Do you think it - was it - when you're looking back on it, was it consensual or coercive? I'd say it was consensual. I was scared to go with him, but I did because I wanted to.
Patrick was a hesitant but willing collaborator in this sexual encounter. Given his irrational fear of gay sex (at that time), which suggests that the sex ed was either too effective (confirming the lack of efficacy of scare tactics, discussed earlier) or less than effective, his emotions and sexual desires were privileged over his presumed knowledge. On must bear in mind that Patrick was fourteen years old, naïve, and, because of HIV, afraid of gay sex in general. Notwithstanding the use of condoms in this instance, Patrick previously stated that his perception was that *gay sex equated with AIDS* (“when I came out, I thought oh no, I’m gonna get AIDS if I sleep with a man”)

Patrick states that he always used a condom for anal intercourse from the ages of 14 to 19.

*Why did you have only safe sex for that five year stretch?*

Probably because the people I slept with also practiced safe sex and I was very - I was just worried about getting a disease or something. Because I had some other friends that got HIV and so I was very cautious. Because I’d heard about it all the time and I never thought that it would happen to me or anyone close to me and boom next thing - my best friend has HIV. So that’s probably what kept me very cautious.

When he was 19, that situation changed:

I got involved in a very intimate relationship with somebody - a monogamous relationship.

*How did you guys decide not to use condoms?*

Well, I was - I didn’t feel comfortable with the idea because I was so used to using condoms all the time. But as I got to know him I felt more comfortable, and I knew that he hasn’t slept around or anything. He’s very
new to the gay community - the gay lifestyle - so I felt comfortable with him and he just said he couldn't cum when he wore a condom and I believed him. And I wanted to give him the satisfaction of cumming. So he - so I agreed for him to not wear the condom.

_Had you or he been tested for HIV?_  
Yes. And that was another - sort of a condition too. We both went in for tests before this happened and we did - we both came out negative - so that gave us some more comfort, both of us.

_And obviously there was a high level of trust for both of you?_  
Yes.

_Was the relationship totally monogamous?_  
I hope so. From what I know and what I feel, yes, it was.

Again, as in the case with Christian, the decision to bareback was made on the basis of trust. However, it appears that while Patrick’s sexual behaviour has not changed, his rationale for barebacking has.

_And so what’s happened in your sex life with regard to condoms in the last year?_  
Well, I noticed I’m not protecting myself like I should be. Like, I’ve been taking major risks - why I don’t know. I guess I’m just stupid, but I know I’ve been very reluctant to use condoms. I even slept with somebody that I knew is HIV positive and had unprotected sex with him. Which I figured would give me a wake up call, but then it didn’t. So I had unprotected sex three times. I think it’s a spur of the moment - because I know in my mind I would like to practice safe sex because when I go on trips, I bring condoms, I bring lube with me. But then I don’t always carry them with me and then when things happen, I don’t have it with me or things just get - move so fast you don’t want to take the time to go through the hassle.

Clearly, Patrick has relaxed his standards of safe sex, in part because of expediency, and in part because he appears not to care (enough) about the possibility of infection. I asked about his criteria for deciding whether or not to use condoms for anal intercourse.
OK. This is coming back to our earlier discussion about condoms. How do you decide whether or not to use condoms for anal sex? 50% of the time you did, 50% of the time you didn't.

I don't know. I just - I just kinda get to know the person and get a feeling for whether they've slept around a lot and - and I ask them whether or not they're HIV positive or negative and I can get a pretty good feel on whether or not I can trust them and - sometimes I don't even have to ask questions. Like one of those guys – he'd never been with a guy before, so I kind of - really believed him because when we did the thing -

Given his reluctance to use condoms, I asked him

What would have to happen in your mind or body or environment or whatever - that would cause you to say I will ONLY use condoms if I'm having anal sex? Is there anything?

I don’t know. Unless they came up with some fabulous condom - I guess.

OK. On the other side of the coin, what would induce you to NEVER use condoms. Or does that take any inducement?

Well, for one if I was in a monogamous relationship, I don’t think condoms would be an issue. That’s the only time I could think where I just wouldn’t care about condoms anymore - is if I was in a monogamous relationship.

Patrick’s responses to these last two questions are confusing. When asked under what conditions he would only have sex with condoms, responded with a functional answer – he indicated that he would use them if there was a more sensitive condom available (thus allowing the maximization of pleasure), but at the same time, when asked the reverse question, under what conditions he would abandon condoms (which he apparently already has), he was most emphatic about not using condoms only in a monogamous relationship. Yet, as he previously stated, even his casual encounters do not usually involve condoms. In other words, his ideal behaviour is far removed from his actual behaviour.
It appears that Patrick’s lack of adherence to safe sex guidelines dates back to his early experiences, both in school where he learned about condoms, his presumption that gay sex is lethal (“I’m gonna get AIDS if I sleep with a man.”), and his laissez-faire attitude towards HIV infection.

Patrick’s case is illustrative of, among other things, the ineffectiveness of HIV awareness campaigns. It was fortunate that Patrick was randomly selected as a case study, in part because he was the youngest of the group, and had no history or recollection of male-to-male sex before AIDS and condom use were on the scene. Also, he was exposed to safe sex campaigns in his early years in school, where the instruction “. . . translated into gay sex as well for me.” He used condoms for the first several years after he started having sex (from age 14 to 19), but when he became intimately involved with someone whom he trusted to be monogamous, he stopped using condoms.

Patrick trusted his partner – a trust not unconvincingly supported by HIV tests and the fact that the partner was “very new to the gay community”. (Whether the relationship was monogamous or not, Patrick was still HIV-negative at the time of the interview.) However, since the breakup of that relationship, Patrick has continued to not use condoms, even with a known HIV-positive sex partner. Condoms are for him, ultimately “a hassle”.

266
If Patrick's gay community involvement, education and experience combined are still insufficient to convince him that condoms are worth the 'hassle', notwithstanding intensive bombardment by safe-sex campaigns, then what might change his behaviour? As he states, even with a more sensitive condom, he is unlikely to use condoms all of the time, especially if he is with a 'committed' partner.

Case Study – Martin

Martin is unlike both Christian and Patrick. A mid-twenties waiter, he works two jobs to be able to afford to live in a nice apartment with his roommate, and to enjoy a 'party' lifestyle. He rated his life, at the time of the interview as 7/10. His major satisfactions were his work, friends, home, cats and income. However, he did express that he would like to have more leisure time, and would like to have a "love life" which he classified as "pretty non-existent these days".

Normally, the subject of the interviewee's sex life would come later in the interview schedule. However, since he brought up the subject, I followed up that opening:

My sex life is improving I guess. I was going through a dry spell and I thought about it too much. When you think about it too much, about something you usually dwell on it and it starts to become an obsession, and you spend more time thinking about it than doing something about it. And I think that's what I was doing, I was thinking too much about why I wasn't getting sex instead of just going after it. I started getting at least like, building all these stupid insecurities about myself. It was so it started growing and growing, growing until I finally started having it off with my roommate, actually. And that just kind of got rid of those insecurities. Because I never
had them before when I had sex before, I guess it was just building up the longer I was going without sex.

What kind of insecurities?
Oh I don’t know, it’s hard to explain. Because when you look at yourself, the way you are sexually, you could be two totally different people. And when you’re not, that person comes out with your having sex, that has stayed dormant for so long, you forget what he’s like. And you start to feel like when you’re going to have sex with a person, the regular you will come out. And I was observing how I would be in sex and everything and during sex, and not thinking about it had just doing it. I thought about it too much and I think I was thinking too much, it kind of ruins the whole...

Well, how would you compare the you that you project publicly to the you that is having sex?
Okay, I have a bit of a reputation among my friends, and at work, and everything like that. And, I guess a part of me doesn’t realize as much as my friends seem to carry on, that I have the same sort of reputation, they’re kind of trashy themselves. And you know it’s kind of, especially if you go without sex for long time, you kind of forget its okay to be trashy, I guess you could say. And, I had not been having sex for so long, that I pretty much forgot what it was like.

And what is it like?
Was sex like? Sex ... is like letting yourself go, being totally free. And, no inhibitions and experiencing pleasure and I think that’s one of the things I was having problem with, because in my normal self I do have sort of inhibitions when it comes to people. But when the clothes come off, it seems to, where normally ah, when I think about it I get uncomfortable, but when I actually go and do it, I am totally comfortable, and my inhibitions are gone -- trashy Marty comes out and, let’s go! But when thinking about it I am uncomfortable, because maybe it’s because I watched too much porn or something like that, I don’t know but, because of thinking about the whole transition so much, I’m thinking about it logically and not with my own human instincts. I think the way to engage in sex, something that lies dormant in you, your natural instincts kind of take over; but when you’re not having sex, and when you’re thinking about it in a non-pleasurable way, you kind of think about it, you can kind of look at it negatively. There’s a lot of negative things you can look at about sex, things like disrespect and there’s also HIV and blah, blah, blah, and all that stuff. So when you start thinking about the negative things too that kind of gets in the way of your wanting or needing for it.
Rademaker’s model (Figure 2–2) of sexual conduct is instructive at this juncture. Rademaker proposed that the interaction is mediated by a number of intervening variables, which can be classified as having anything from a moderate influence to having a powerful influence. In brief, his proposal suggests that the interaction is at the core of the issue (in this case having sex), and that individual and situational factors only become salient during the interaction. Martin’s behaviour clearly illustrates Rademaker’s dynamic when he states that when the clothes come off, he loses all inhibitions. In other words, whatever cognitive behaviours and reticences he may have that would restrain him from having sex become lost in the moment. Additionally, if Martin’s low self-esteem (“in my normal self I do have sort of inhibitions when it comes to people”) can be reversed through sex, Weeks (1985) notion of sex being the root of one’s personal self and social identity makes sense. Psychologically, one could consider Martin as having two personalities, or two identities, or as he puts it, the conservative side and “trashy Marty”. However, it may also be that Martin exemplifies the notion that for him, sex is really ‘outside real time’. In that case, as indicated in chapter 2, the computation of future risk relative to HIV infection may fail to operate, as we shall see further on in the interview.
Briefly, Martin began life as an unhappy kid in an unstable family. He admits that he was a brat, and prone to tantrums when he did not get his way. However, by grade 7, things began to change for the worse.

There's been times in your life where you haven't felt like a 7 or an 8. Looking at preschool, grade school, high school and so on, starting at preschool, was life for you then? And what would you rate it as?

Oh, I guess I rated probably a 10, I didn't really know what life was like bad. As a kid things seem peachy keen and you have no worries when you're a child. I know, I spent a lot of times alone just because my parents would shove me back and forth -- they were divorced when I was 4. So when I go to see my dad, I had no friends so I spent the day in front of the TV, but when I was with my mom I had all the kids on my street to play with. But it never really affected me, I was really good at entertaining myself -- I had a pretty wild imagination, especially when I was a child.

When I got into school, I guess it would be about a 6. I was a bit of a brat when I was a child, being an only child, so, once I started socializing, being a brat, I wanted my own way, when I didn't get my own way, tantrums. I was being abusive verbally to kids at school for absolutely no reason. I got to be a brat. Kids wanted to beat me up after school and I couldn't understand why and all that stuff. I was very effeminate, so I was also teased a lot. They called me "Mary", and called me a girl at all that stuff. And I remember in grade 2 and 3, kids would be waiting outside to beat me up everyday. But, I kind of deserved it, in a way, because I would be so mouthy in school, I would like, tell them off or whatever, or I get them going because I would feel so safe and protected, and not thinking about what would happen outside. I learned that, my lesson.

How old were you then?

I was 12 by this time. And then I moved to Ontario and it turned out that my friend moved to Ontario with me, thinking that I was starting off a new life - I was born in Nova Scotia, by the way - starting off a new life, making new friends. I knew more how to respect another person and so forth. But what happened when I got to Ontario - and this brings my life down to about 3 or 4 - I had a very high voice when I was the Halifax Boys Choir -- an alto or soprano and my voice was getting higher and it barely changed with puberty. So by the time I got into my teens people were calling me names.
and yelling hello to me in a really high voice. Still couldn't understand why, but I sounded like a girl.

Did you think about why?
No, I didn't. But I remember kind of reaching up through elementary school in Ontario and then some grade 9 to grade 11 in high school. By grade 12, people were starting to ask why I didn't wear a dress: but grade school was definitely a drop - grade school was definitely a crappy, crappy time in my life.

And, I think surviving high school, knowing I can survive high school and my childhood, and the stuff that went on with my family as well, which was kind of bad, when I was in high school, my mother married two alcoholics who were both very abusive, verbally and physically to my mother. Her second husband was abusive to me, third husband wasn't. [The second husband] would hit me, smack me around, yell at me, call me faggot, queer, her third husband wouldn't dare, because I was too big for him to push around. If he started pushing me around, I stood up to him

I didn't have any confidence when I was a kid. I didn't have any self esteem at all, didn't think myself worthy of anything because so many people were so mean to me, I just thought like, I would wonder why people would be so mean to me. And I would just figure it's just because I'm not worth being nice to.

Martin's low self-esteem has followed him into his adolescent and adult life, as we shall see. He started college, began to drink and use drugs, and dropped out in his second year. He recalls his sex life at that time as confusing and closeted.

What about your sex life in that year?
It was nonexistent. I didn't really start having sex . . . I had sex once when I was 17 with a man who picked me up on the street, and we had sex in his car at some resting point on the highway. Didn't have sex again till I was 19, it was after college and that was with a girl. I was drunk; see college started a big drinking problem for me — I used to drink a lot. I guess I was [going] through a depression. I guess, as I was getting older I was dealing with my sexuality, and more or less denying my sexuality, because knowing how the kids treated me all through school, and everything, that it was not cool to be gay. So I'm not to be gay, I'm going to force myself to sleep with women. I
had to drink to get sexually aroused with women, and so I had about 3 girl
friends before I flew open the closet doors. I'M GAY!

When did you do that?
I was almost 20 – 19. I went to a gay bar with this man I met on Man Line
[an interactive chat line]. He came and picked me up. He lived in Markham, I
was living in Hamilton. So he drove two hours down from Markham to
Mississauga, picked me up and we went to Hamilton, my old town, and this
bar, called the Embassy Club -- it was grand opening night, and I go in and
this is going to go back to a story when I was in high school, and worked at
McDonald's and this man, Sam, would cruise me. And him and his boyfriend
would come into McDonald's and make me feel really uncomfortable. Well,
Sam ended up managing this Embassy club, and I was walking up the stairs
to the second level, and Sam stops me and says: “You're Marty right? You
used to work at McDonald's.” And I go “ yeah”, and he goes “ you want a
job?” And the very next night I started bartending there. And I worked there
for a year before moving out here.

Talking about flying out of the closet . . . Working in a gay bar!
Yeah, no shit. Well, at the beginning I said I was bisexual, but still, you know,
still not used to the idea of letting people know that I was into guys, but the
more I was, and like the whole gay scene, like, talk about like, letting it smack
you in the face, I had no experience in a gay life whatsoever, and next night
I'm in the gay bar, and all these guys are coming on to me, and giving their
numbers, and giving me all these looks; I didn't know how to take that. It
was like WOW!

This experience, while extreme, is not wholly inconsistent with the coming out
process, for some gay men. Martin’s extreme promiscuousness is, in some ways,
both typical of many young gay men’s experiences, and feeds into the popular
notion that all gay men are promiscuous.

Well, coming from a life of rejection and being picked on, all of a sudden you're the ‘flavor of
the month’.
And the thing is, I was still nervous because I wasn’t sure if these people were
being honest, or if there was an ulterior plan to do something mean to me,
because I was so used to people being mean to me. I didn’t trust anybody.
So even though I was getting all these come-ons, I was very . . . and so I was a bitch, I really thought I was a bitch and a smart ass.

Oh, attitude.
But it really wasn't, I was really scared. And that I met one guy, and we had a little fling for about a month, but he really wasn't my type. The first guy I could actually feel comfortable with, and stuff like that, and then after my first good sexual experience, I was just having sex like mad. So, any guy that would hit on me, I would [noise and finger snap], all of a sudden I turned around and became this big slut. I slept with anybody that was anywhere, a minimal standard I would sleep with.

Is that a self-esteem issue or proving something to yourself?
I think it was making up for lost time, definitely. I liked it, I was liking sex. I hadn't had sex in so long so, I constantly wanted it. Because I like it. And it was a bit of self esteem — it made me feel good that I was getting all these guys.

Martin made no mention of sexual safety, and shrugged his shoulders when questioned about condoms, indicating that it was not an issue for him. What can be discerned from his comments is that Martin was behaving sexually just like he did when he was a young child — a spoiled brat — alternatively cocky and afraid. He still was exhibiting the youthful traits that got him into so much trouble as a teenager. Ironically, what he does not mention is the fact that since he was working in a gay bar, he was effectively participating, on an ongoing basis, in the gay community life. He was being recognized as a gay man, socialized with gays, and lived a gay lifestyle. If Kippax et al. (1992) are correct, his degree of gay community attachment would suggest that he should have been adhering to social norms of the time, and using condoms. But apparently this was not so.
We talked about GCA (gay community involvement) and his network of friends in Vancouver.

Well, here I didn't really get a crowd of people until about a year and a half ago. That's when I met my group of friends. I totally chose my friends. I went after those I wanted as friends. Pretty much all my friends, though, are the ones I chose, well some of them chose me but they had to earn my friendship, but I also had to earn a lot of friendships that I had made. And, it makes me feel good to look at all the people in my life that are very close to me, and how well I regard them, and how well they regard me. It actually helps build your self-esteem and confidence. When I go out, I feel very confident because I have a group of people around me that I feel secure with, and I know they'll always be there for me, no matter what. No matter what I do, whatever stupid mistakes I make and stuff like that, because they understand.

Given his past experiences with a ‘wild life’, this transformation to living within a small circle of close friends entails several alterations in behaviour as well. Moving from “a bitch and a smartass” to a group member whose relationship is based on mutual respect and trust necessitates a personality shift; self-centred behaviour must change to a more communal decision making process, and so on. It is not surprising that Martin, as he matures, would seek the comfort of an intimate group of friends, especially since that was the component he lacked as a child and as a younger man.

I shifted gears and reverted back to the original questions. After discussing his past sex life, I wanted to find out how he saw sex and sexuality in general.

*What do you define as sex?*

Getting intimate with a person. Well actually I guess it wouldn't just be getting intimate with a person, it would be exploring anything that explores
your sexual side — jacking off to a porno, talking about it over the phone, anything that kinda gets you aroused is sex. Well, I don’t think just ejaculation or penetration. I think, um, the declodiing, and basically the touching of each other’s private parts, you could say. It can also be a purely mental thing. You can have sex with somebody mentally - just from a conversation, or even an intense sexual conversation. It’s when it stirs emotions, gets you excited, it gets you erect - that’s when sex is entering the picture.

So, anything with a hard on . . .
Yeah. I think sex is always involved if you are aroused. If you don’t get aroused there’s nothing sexual about it, but if you do you get aroused then there’s something sexual about it – that’s sex.

Marty’s definition of sex is related to erections. Anything that is arousing is considered sex; if arousal does not take place, there is no sex involved. This perspective differs from that of Christian who considers anything that does not involve a climax non-sex, and Patrick, whose initial definition of sex was more tentative, but apparently seemed to suggest that oral and/or anal penetration would be clearly ‘sex’ while other activities ‘could be’ sex.

While these definitions may seem to be an exercise in semantics, they are critical to understanding how safe sex messages are perceived and incorporated into peoples’ sexual scripts. Messages that attempt to persuade an audience to use condoms whenever they have sex are nonsensical if the individual’s definition of sex is broader than mere anal (or oral) penetration. In the case of Martin, sex to him includes such things as masturbation and mutual masturbation – both of which are not considered a risk at all; Christian sees sex as something erotic and not necessarily an exchange of fluids, while Patrick knows that anal sex requires condoms (even though he does not use them very often), but oral sex is not considered high risk45. As we shall see in other case studies, these definitions vary greatly, and as such speak to the individualized notions of safe sex, UAI and barebacking. They also reinforce the previously indicated necessity of tailoring the messages to specific behaviours, within specific situations, to specific audiences.

45 Oral sex is only considered high risk if there are open sores, or bleeding gums. (Canadian AIDS Society Guidelines)
I then explored Martin's current sexual habits:

*The sex that you've been having in last six months, would you defined that as safe sex or not safe sex or somewhere in between?*
Somewhere between. Sometimes I've been safe, and sometimes I haven't.

*What do you define as unsafe and what you define as safe?*
I define unsafe as when you use penetration without a condom. Unsafe is having sex with somebody you don't know and you're not using condoms, at all. I find safe is when you are using condoms, and I find safe when I feel safe not using condoms with friends. I've had a few sexual experiences with close friends lately, which have been pretty good. I think that's one of the reasons why my sex life is better. A few longtime friends and I started having sexual relations very casually, and it's very comfortable, and it's nice and there are no expectations. We're still friends like we always have been. We hang out for reasons other than sex. And sex is not a condition for our friendship. But, it's kind of nice – we have a certain freedom with a few people, if we ever feel like were not getting enough, or we're just in the mood for sex and we're both around, we can do it, and there's no problems or hang-ups about it. It's kind of nice. And it's safe. I feel safe.

Of all the interviewees, Martin was the only one to articulate the notion of trust with casual partners as explicitly as he did. Key phrases in his answer are “I feel safe”, and “I find safe when I feel safe not using condoms with friends”. Martin's definition of safe is conditional and contingent – with friends – i.e. with members of the 'inner circle'. But in reality, he does not know with whom else they are having anal intercourse, and the degree of safety involved in those liaisons. Nor do they know if he is possibly a carrier of HIV. Safety is defined as an emotional issue, rather than a mechanical or medical question for Martin. Ironically, when he first heard about safer sex, he was unimpressed. He related how homophobia provided a definition of AIDS for him:

*Do you recall from whom or how you heard of it?*
What does AIDS mean? AIDS spelled backwards - Stick Dick In Ass. Or Ass Injected Death Sentence.

He readily admits that he has no solid criteria for decision-making about the use of condoms. When asked about those times when he did use condoms as to what his thought process was, he replied that he had no such thought process.

I don't think there really is one. It's spontaneous. I think I more or less would let them decide, because I really don't care. But when me and my friends talk about sex, even before we were having sex, would always talk about how we hate using condoms. We just hate it. And like, it's not like we casually talk about it, we talked about it in depth. And we talked about when we would use condoms, and when we don't, and that's probably the reason why we started having sex, because it's nice to have sex and not use condoms. We all are negative, and we all do practice safe sex with strangers, so we all feel comfortable being unsafe around each other.

In Martin's lexicon, what he describes as unsafe is, in fact, reasonably safe; i.e.: two (or more) presumably HIV-negative people having sex. He is somehow assuming that any unprotected sex is unsafe (judging by his last sentence), however he then reversed his comment, echoing Rademaker's scheme:

Well, basically I decide - it all comes down to the moment at hand - there's no before, thinking about stuff like that. It all comes down to "at that moment", whether you're going to decide to have safe sex or non-safe sex. It all depends on - is there a condom available? Sometimes there isn't, then it comes down to do I really want this sex or, you know, should we just - you know - go about something else? It all comes down to that moment, that person. And the history with that person.

When you say the history, what do you mean?

How long you've known them, a short time, did you just meet them - those are contributing factors in deciding whether you're going to have safe sex or not. And sometimes, it could be . . . I could have just met this guy, but I haven't had it in a few months and goddamn it, who cares, you know. It all comes down to the moment. Because you could be thinking - you could
always think - oh, I'd never do it or whatever. But you don't know what you're going to decide until that moment arrives.

*So, your definition is that it's all safe sex.*

To me I feel safe, but it's not like I'm totally 100% risk free. You can never be. But, for the long run I feel safe.

In this instance, risk is assumed to be an integral part of the sex scene, but not perceived as a major factor. Most telling is his comment: "I think I more or less would let them decide, because I really don't care." Not atypically, Martin (and some of his friends) is fed up with condoms, traditional safe sex messages, and being denied the sexual pleasure to which he feels entitled.

His definition of casual partners varies from the Vanguard model, but he states that he does use condoms with those whom he defines as casual partners.

*And what about with casual partners?*

I always will wear a condom, or have them wear a condom. Just because I don't know who they are. But with my friends I haven't been using condoms.

*What percentage of the time, would you say, would you use condoms for receptive anal sex?*

About 80 percent of the time.

*What about insertive anal sex?*

More like 40.

Martin's knowledge of the risks allows him to make a distinction between anal receptive and anal insertive. The risk of infection from anal intercourse as a top (insertive) is generally acknowledged to be seven times less than that of a bottom (receptive). Martin calculates the odds as 2:1, which is stricter than
epidemiological experience indicates. Of course, some people suggest that even 7:1 odds, when it comes to life and death risks, is still too high.

I asked about the interaction of drugs with sex, and while he did state that one time he came home with a stranger when he was on GHB (gamma hydroxybutyrate), they used a condom. Otherwise, he states:

But with my friends, and the two friends that I slept with, it was drug-related, we were both on drugs, and at one moment we were by ourselves, and as soon as you touch, all of a sudden... it was like “fuck it -- let’s just do it”. And, no regrets, no regrets about it. By either party.

Martin also discussed his lack of fear about infection:

I’ve also kind of lost a lot of my fear for HIV. I’m not afraid of it as I used to be. Not to say that I want it but I’m not so afraid of getting it. I knew other people who have had HIV for years, some are on a decade, and they live happy, normal, healthy lives and they just take care of themselves. And I’m at a point in my life where I’m not gonna be young forever and it’s kind of exciting to throw caution into the wind I guess you could say. Not that I’m trying to play Russian Roulette or gamble with life or anything like that, but it’s - it all depends on the people I am with. And both were people I had known for years before having sex with them.

I probed this question, because it seemed key in understanding Martin’s laissez-faire attitude towards condoms:

What do you think would change your mind about using condoms ALL OF THE TIME? Is there anything you can think of that would make you decide to ONLY have safe sex?

I guess if I was going to literally “die” from it. Right now, the biggest threat is HIV and I don’t find that big of a threat these days. I think if I did ever come down with HIV I would still be able to live a quite normal, everyday life. I live quite healthy as it is anyway, I don’t think a more regulated diet or strict diet would bother me, because my diet’s pretty strict on my own. I’m
not much of a junk food lover and I love vegetables and enjoy eating healthily.

Is there anything that would make you decide NEVER to use condoms? Or - never's pretty strong - almost never anyway?
Probably - I'm at the point where it's really - doesn't matter to me at all, whether I get HIV or not. And I can see that point coming, I can see that I've got that time coming, probably after 30, when I settle down more and stuff. I certainly don't want to live a really long life. I view the elderly with a sort of sympathy, the inability to do things you used to be able to do when you were young. The inability to be able to go to the bathroom when you need to. I don't think that's an attractive quality in life - I . . .

I also asked him if he were to seroconvert, would he use condoms. His answer surprised me . . .

OK. Say you were HIV positive - and you met somebody and you got to know them and there was this emotional connection as well as a physical one and you wanted to have sex. And you said, well, I've got it, I don't want you to use a condom. Them knowing that I was HIV positive?

Yes.
I wouldn't use one. Because they probably could be having the same thoughts about it as I do. Maybe I'd have them sign a consent form - I don't know... This is the thing. People have all these opinions and theories about how they would do things or how they would handle things in certain situations. That's great, it's all in theory. You're all playing this out in your head. You have no idea what you're gonna do when it comes down to the moment. So why don't you just stop thinking about it and live life - you know. Exactly. And when that moment comes, then you can either think about it or you can not think about it. But - why waste your time thinking about all that stuff when you could be out doing stuff.

Martin is not afraid of contracting HIV (although he is not out looking for it, he says). He is more afraid of getting old. His attitude exemplifies the statement recounted earlier that 'it is better to have fun when you can, and leave a pretty
corpse'. A key to understanding Martin's beliefs and behaviour can be found in his life course history — he was highly independent as a child, making his own decisions on a regular basis, but also frequently making inappropriate life choices — alcohol use, drug use, quit university, came out in a torrent of sexual activity, and so on.

Martin exemplifies, in an exaggerated way, many of the dynamics surrounding risk and trust discussed earlier. He is able to trust sexual partners who do not use condoms because he is unafraid of contracting HIV — the risk element is minimized, while his pleasure-seeking side is maximized. Additionally, since he trusts his circle of friends to (at least) attempt not to infect each other, the risk with what he considers to be regular partners is also lessened. Where he does perceive risk — sex with total strangers, he states that he does use condoms. In the end, his philosophy is "why waste your time thinking about all that stuff when you could be out doing stuff."

Case Study — Josh

Josh is a white male, 32 years of age. Currently, he has a partner in Victoria, whom he sees less frequently than he would like, and he has a 10-year old son who lives in another province, whom he sees infrequently. He states that while his income is less than what he feels he is worth, he is nonetheless able to live on
that income. At the time of the interview, he rated his life as 7/10. However, this was a significant improvement from his early years.

My parents were very unhappy at that time [childhood] and I remember a lot of discord at home that was associated with that. They were also poor and struggling, so there was lots of stress and tension involved in that. So that's at about age eight. I felt pretty good about school.

And at ten, we moved and things got worse, I guess, so I would associate our rating scale of maybe four out of ten. We moved to Alberta, rural Alberta, and I was quickly labeled a fairy and was an outsider. Found it very difficult to make male or female friends. There were - I put all this together as an adult - there were very strict sex roles that were more so in Alberta than in Winnipeg, where we had come from. I only figured that out later, but that was certainly what was going on and what was behind the ostracism that I felt. So there was physical fighting at school and I started to learn that my smarts at school weren't very valued because they just fed into this label of being a fairy, being a bookworm, being a girl. So I really felt like an outsider and that went on for a number of years in public school.

What happened as you got into high school? Did it change?

No, it got really bad. I wouldn't say that things improved at all until I was out of school. I was totally miserable and I had kind of devalued learning myself - became part of the wrong crowd - developed a major attitude according to teachers - and I really did enjoy books and learning and ideas through all those years. But I had learned very well that that wasn't an asset. So I had to kind of - I was determined to scorn it as a way of developing friends.

He abandoned rural Alberta after high school, and began living with a woman.

What was that like for you?

Well, initially it was good. I certainly loved the woman I was with. We were very young and we were - in some ways both running from things - and so there was a sense of safety together, stability, some security.

Did you come out at the same time?

No, no. I actually married when I was 19. And was married for seven years, nine years, something like that - can't remember any more. We cared a lot about one another - it was a relationship that was very much based on friendship beyond everything. And it was good for those reasons. It was stressful within a couple of years of the marriage, though, because more -
increasingly I wanted to talk about this sexual identity of mine that I wasn’t understanding at all, but needed to talk about nonetheless. And that created a lot of stress.

*Did there come a point where you did talk about it?*

Yes. It took a number of years - I kind of insisted that I needed to find out more - I needed to talk to somebody else - I needed help for myself, because I felt in some ways like I was coming apart. That was at least four years into the marriage though before that happened.

*It must have been very hard on you? And on her.*

Yeah. Yeah. Yeah it was. For her, it signaled the end of the relationship. She just equated it - it was one and the same thing and so it was devastating to her. And it was very shortly after that that she found out that she was pregnant and it was an unplanned pregnancy. And so for - as much as on the one hand I wanted to be a parent - on the other I was very conflicted, because I wasn’t sure that I wanted to be a parent on these terms. And the relationship was quite troubled - because of my identity. So it was - yes, a stressful time.

Even though Josh knew he was gay at an early age, peer pressure, external and internal homophobia, and fear kept him from disclosing his homosexuality to family and friends.

*We were talking about when you were younger. Can you remember at what age you realized you were “different” from other boys? Even if you didn’t have a term for it? How did it manifest itself?*

Oh boy, realization is such an elusive thing. I mean - when I look - when I consider my childhood and the ways in which I was different - playing doctor with another boy at age 5, 6 - again when I was 8 - not understanding why girls - already at that age, were talking about marriage - you know, I just thought it was such an alien concept. I’m just trying to think of when I actually started to develop crushes - I’d say that’s probably by the time I was 10 or 11 - I was aware of being attracted to particularly older boys who would have been like young teenagers at the time. And then coming in to puberty, adolescence - I definitely had sexual feelings that were gay. It was just a matter of interpretation and denial and ignorance and fear that I didn’t reckon with them. I certainly was realizing difference all through those years, but I wasn’t really reckoning with it. Gay identity, gay culture - all of that was
in San Francisco and that was like some - I don’t know - some oasis or something that was very foreign to me.

How did you sublimate it? Or ignore it?

Oh, well, the fear was quite enough. I mean - being beaten up by the time I was ten years old and being called John Boy Walton and fairy and - that was quite enough to keep my effeminate behaviours in check. Or to - I don’t know that I could even keep them in check - but I was becoming aware that they were certainly devalued. How else did I sublimate them? Well, I didn’t entirely - the frank reality is that by adolescence I was stealing magazines from the Red Rooster, Blue Boy and Numbers46 and I fooled around with a friend in high school. And just denial, lots - denial in that I just really wasn’t giving it much thought. I wasn’t really defining who I was because there wasn’t enough - I didn’t have enough information to really understand it as part of my identity.

I asked how he rationalized staying in the marriage when he knew that he was gay:

I can see where that would add additional stress - having - if not physically, emotionally left the relationship and then finding out that you’re gonna be a parent. What kind of a parent - what kind of a role as a parent are you then entitled to - in your mind? Must make it very hard.

At that time, I guess - I determined - I mean, I was quite used to playing mental tricks on myself for rationalizing why I was in this marriage and yet trying to understand my sexual identity that was in direct conflict with it. And so with this news, I kind of determined once again - OK, I’m gonna give this a go. I know that I’m not the textbook het47 male, but I’m still gonna commit to this because I was very committed to the idea of being a father and I thought - hoped - in vain that it would be enough to sustain me in the relationship. If I just committed to the idea of being a father. Because that I believed in, even if I couldn’t believe in being a straight husband. But you know, foolish me - it’s not....

So ultimately, it couldn’t be reconciled and we had to separate and at that time my son was three or four. It was as gentle a parting as it could be.

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46 Gay soft pornographic magazines.
47 Heterosexual
At the age of 27, Josh separated from his wife, moved to Calgary and came out.

The experience was not at all what he anticipated.

**So when did you come out? And how?**

Oh, I was what - 27, I think. So after I separated from my wife and I moved to Calgary, deliberately to separate myself from my family and to come out. I thought this is where I’m gonna wrestle with the angel and I needed a buffer - a safe buffer - because my immediate family was living in the same area as my wife and I were. So I needed a buffer because I anticipated full rejection from them, so I wanted some safe distance.

**Were your anticipations correct?**

No, they weren’t. I was utterly flabbergasted actually - the separation of my wife and me was really devastating for the family and again - in hindsight I understand that’s part of their own reckoning with my inevitable coming out. I mean, they knew so much earlier than I did - I really resented that actually, because there was just such a fortress of silence - I was gonna say it was a veil - but it was a fortress of silence around it. So there was already grieving going on about the marriage break up. And as I say in hindsight, they knew so much more than I did even. So again, it’s sort of a measure of defense - measure of self protection - I kind of wrote my big letter to my parents making an announcement and also kind of as defense telling them that - because I was anticipating such rejection and based largely on religion - I wanted to argue the point right away with them. But I was only willing to discuss so much and kind of told them what the nature of the conversation could be about. But I wasn’t gonna hear any more - what I felt to be really hateful stuff based in religion. And when they received it and when my parents responded together on the phone to me -

**That’s your Mom and your Dad...**

My step dad - they were very - they were as accommodating as they could be about it. They freely admitted that they didn’t understand - they don’t understand it - but that they did support me. And that they knew and were just waiting for me to tell them. “It’s a good thing I didn’t kill myself, Mom, because I was planning to” - I certainly felt alone in the family structure. And I know that from my step dad - what was really difficult for him to reckon with is that when he was a boy - not even an adolescent, but a boy - he was sexually molested by the town doctor. And so he grew up - he was actually a fag basher himself - my step dad - he’s like an ‘Ubermann’ - and he grew up - until he knew me - associating pedophilia and homosexuality together - there was no difference, And then all of a sudden, he’s living with
this woman who has this fag son and it’s clear as day that he’s a fag. And he’s
got to live in this house with him. But he grew to respect me actually. It
really changed....

Well, people who have fears about other things often have fears about sexuality in general.
That would make sense. Turning the subject now to sex - specifically sex with men. At
what age do you recall first hearing about safe sex or safer sex?
Safer sex - but we’re so American influenced, I remember safe sex, frankly.
That would be about 1992.

So how old were you?
25.

So it was more or less around the time you were - you came out at 27 - so you heard about
it before that?
Yes.

Do you recall from whom or how you heard of it?
There was an Out Rights’ Conference that happened here in Vancouver.
And I attended it and there was a plethora of literature - there was a ‘Man-to-
Man’48 table - that I was terrified to approach - oh my God, OK. Because I
remember the posters there and they were amazing posters and I actually - I
think they were produced in Britain or something. And they all focused on
safer sex. And I just thought they were incredibly erotic and incredibly well
done - Oh, they were amazing - that’s the most vivid memory I have of being
introduced to safer sex.

Well I guess your first impressions were erotic? I was going to say - do you remember what
your first impressions were - I’m talking about safe sex?
Well, there was still - there was a lot of mystery surrounding it to me, because
- even at that time, literature and research - it was kind of burgeoning at that
point. So there was still a lot of mystery associated with it for me. And -
that’s the primary –

Had you had any sexual experiences with men at that point? Other than fooling around in
high school?
No. No, because I never - while I was married that was - no, I never had
man-to-man sex. It was also wishful thinking I guess - some day, I was going
to have it and it was going to be of my choosing and - just something that
happened. But then I was wistful....it was also very empowering, I should

48 Man-to-Man is the gay education outreach project of AIDS Vancouver.
make a point of saying that. I mean, for me - since - at that Out Rights Conference, sitting in a group of people - that was actually the first time that I admitted that I was gay, in fact. And I'll tell you, when I saw those images I was so blown away and it wasn't just about it being erotic, but it was about it being amazingly empowering. The images were so strong and they were so loving and sex positive that it really made an impression on me. No wonder I was wistful at the impressions it made - I was actually hopeful about being able to have sex with men, be in a relationship with a man, relate to a man, and it be a good thing. And that as well was a pretty radical idea for me at that time.

Josh's coming out experiences were gradual and thought out. Unlike the previous case studies, where all of the interviewees indicated that, at some point, they flung open the closet doors (so to speak), Josh's experiences were related to empowerment, loving, relationships and not specifically to sex (notwithstanding the 'safe sex' point of the posters he saw). This process may account for the fact, as we shall see, that his sexual experiences, especially involving condoms, is quite different from the others.

As you probably know or surmise, very few people are able to state that they have NEVER had any unsafe or potentially less safe sex. However, it is not totally unknown. Thinking back on your sex life to date, has there ever been a period of time, first of all, when you only had safe sex?

Not for any substantial amount of time, no, actually. I would say that I was more vigilant when I first came out. But it was always by way of the quality of the relationship that led to practices that couldn't be regarded as safe. But at that time - so for a period of maybe a couple of years when I first came out - I was certainly more vigilant.

When you say the quality of the relationship - can you talk a little more about that?

Yes, it was just a - if it was to be a monogamous exclusive relationship and if I was in a loving relationship, then the sex practices changed.

About - if you can try and pin it down - from the time you would meet someone and start having sex to when this would change as you say - about how long would that take?
Three to six months.

*And was HIV testing involved?*
Yes.

*Has there ever been a period of time when you had - decidedly had unsafe sex?*
No, I can’t say that there has been. Because if there were - as there have been - casual partners involved, then my practices are different than if I’m in a trusting relationship with someone.

*So a casual partner’s always condoms?*
Yes.

Josh relies on trust and HIV testing within a relationship, but is resolute about using condoms for casual sex. His experiences with coming out, safe sex and condoms is similar to the other case studies with respect to trust in one’s ‘committed’ or monogamous partner, but at variance with the others with respect to casual sex, which doesn’t appear to be a major factor in his life (based on other comments, not recorded here). However, it is important to also take into account the evidence of his prior history – he had sublimated his sexuality for many years, when he did come out he was devoted to his son, and his parting with his wife was (initially at least) amicable. He appears to be very mature in many other respects, emotionally and sexually.

Josh also has a fairly conventional definition of sex:

*How do you define sex? That is, what activities come to mind that count as sex?*
A typical male response - anything that involves the genitals. Kissing and all that doesn’t count. But if there’s genital touching and anything, everything else, it’s sex.
Since Josh was one of the few who always used condoms for sex outside of a committed relationship, it was pointless to ask about non-condom use. However, I did want to understand more about his notions of rule-making, so I probed along a slightly different line:

*Within this relationship - are there consequences if someone says, well, we have to use condoms again for the next six months? Are there consequences if either my partner or I...*

*You or your partner say to each other - say to the other one - I think we'd better use condoms?*  
*Whoa... well...*

*Because you were talking about an open type of relationship...*  
*Yes - which also means that we have never - we communicate very honestly and openly - so we know about every sexual dalliance that either of us has. There's nothing to hide. And I would say that if somebody announced that to me, that's based on maybe some distrust or somebody's got something to hide. And I'm not in a relationship like that right now. So if my partner announced that to me, I'd be pretty alarmed. That would give me pause and I'd really want to know what that was based on. Because to this point and through our relationship, it has been one that's based on honesty and openness. And that's largely how we're able to make the choices we have when it comes to sex together.*

Trust and honest communication are the safeguards that appeal to Josh. In his mind, trust that his partner would tell him if he had an unsafe encounter, is sufficient justification to abandon condoms within the relationship. While it is possible that their relationship is worthy of that trust, and Josh was sincere in his expectation that both he and his partner are faithful to one another, it is not an uncommon situation to eventually discover that such trust has been misplaced, as had happened to Christian.
In sum, Josh’s behaviour is different, and perhaps atypical, at least compared with the other interviewees. He is in a semi-monogamous relationship where condoms are not used, but he always uses condoms with casual partners. His “miserable childhood” taught him *not to trust* others, especially with his sexual feelings “I had learned very well that it wasn’t an asset. So I ... determined to scorn it as a way of developing friends.” His *internalized homophobia* “I definitely had sexual feelings that were gay. It was just a matter of interpretation and denial and ignorance and fear that I didn’t reckon with them” and *lack of self-awareness* kept him in a marriage that was not right for him: “I didn’t have enough information to really understand it as a part of my identity”, which in turn exacerbated his denial.

However, when he did leave the marriage, and came out to friends and family, he was faced with more ignorance and sexual identity issues: “They [his parents] freely admitted that they didn’t understand – they don’t understand it – but [that] they did support me”. This type of ‘support’ often takes the form of ‘don’t ask, don’t tell’ – or more directly, “We don’t agree with your lifestyle, but we still love you as our son”. This conditional acceptance is often a source of friction and/or distress in that it signals a lesser (or conditional) form of trust and/or love (it is, for many, redolent with homophobia).
At this time he revealed his suicide ideation and his feeling of being alone in the family structure. In short, this was a time of low social support. When at an AIDS conference he saw erotic safe sex posters depicting men who were intimate with each other, his primary reaction was not one of longing for male-to-male sex (although that was there too) – it was of a need to feel empowered, to be in a relationship with a man, to “relate to a man, and [have] it be a good thing”. This longing, coupled with his family background strongly suggests the depths of his loneliness and his need for some form of gay community attachment.

Since Josh is one of the few participants who always used condoms outside of a committed relationship, it is worth noting his process of rule-making and its basis for decision making. Honesty and trust with a committed partner are cardinal rules in Josh’s life “… we communicate very honestly and openly – so we know about every sexual dalliance that either of us has …” He indicated that if the rule was broken, “I’d be pretty alarmed”, and that would signal “some distrust or somebody’s got something to hide”. He seems to successfully negotiate the condom issue by being in monogamous relationships, even though he knows that he must both trust and be trusted, both of which may ultimately prove to be misplaced.

It is interesting to note that all the participants made distinctions between casual and regular partners. There was not one instance of complete monogamy; rather
those people who were in a relationship had open relationships — casual partners as well as their regular partner.

Case Study – Alan

Alan is in his late 20s, a university graduate and currently single. Initially, he rated his life satisfaction as 8/10, citing personal relationships, career and finances as the major contributing factors to his current happiness. What he is most proud of, however, is his personal development — how he pulled his life out of the ashes (metaphorically). His greatest personal failings, he states, are his temper, his impulsivity in financial matters, and his inability to say ‘no’.

Life was not always so comfortable for Alan, however. His early childhood was one of poverty, abuse and neglect. As he gained some independence, his self-awareness grew, and he was able to make choices for himself.

Looking at your life from say pre-school, grade school, high school, university and beyond - can you break those down and give me an idea on the same scale of one to ten - starting with before you went to school. How you felt.

As a child - I didn’t feel very well at all. I was raised in a very poor family environment, neighbourhood, and lots of addictions, alcohol, and abuse. Even at a very early age, I knew I was different in terms of my sexuality, but I couldn’t put that into words.

That’s the next question.

But it affected how I thought others perceived me, because I had this big secret. But that was - those early years I recall as being not good ones for me. Although I didn’t let anyone else know.

What about when you got to grade school?
It got better because I got - I was able to hide it more, my dissatisfaction, my unhappiness I suppose. And I found companionship more with fellow students. I liked school, I liked sports and I really liked to achieve - because I felt that it took away from many bad things I had, like secrets and what have you. So it got better.

*How about high school?*
I liked high school actually. It's kinda funny because most gay men that I speak to always say that they hated high school and I'm one of the gay men who actually enjoyed high school – I really liked it. My studies went really well. I was popular. I had awareness. I started seeing myself... I had awareness about my sexuality. And about class issues.

*Were you still living in a poverty neighbourhood?*
Yes. I realized then what my sexuality was - when I was in high school I realized I wasn’t just gay - that I was attracted to all kinds of different people. So the fact that I hadn’t vocalized to anybody that I had sexual feelings towards men didn’t - it did affect me to some extent but also it didn’t affect me, because later on when I came out of the closet I didn’t tell people that I’d had sexual feelings towards women either. So it was actually kind of a - at one point I was seeing both a girl and a boy. And I really liked it.

*And you went to university?*
Yes. I did have a really good time, there - like the awareness - but with the awareness came a lot of pain. Because I was coming out of the closet and out of the closet with various people - family members. It was just....

*They weren’t living in Ottawa though?*
No. I had family living in Ottawa. But my immediate family was living in London, Ontario. I also had met someone and began a sort of torrid love affair and - which was bittersweet - so that could have definitely affected me. The awareness was - in retrospect, it was good - but it was painful. So it made me into the man that I am now. But at the time it was excruciating. So we would probably end up dropping that scale back to like a 2. That and my awareness of drinking - alcohol and drugs. At that time, my family had such a history of alcoholism and during that period I drank and did a lot of drugs. More so than in high school.

Not only did Alan have a traumatic childhood, he was cognizant of his sexuality from an early age.
It was at pre school you said - you realized you were different from other boys. What age would that be - about?

God, that would be like 4. That - and I just had an awareness that I was different. I just recall having a sense, a feeling of camaraderie with other boys. I think more so than what I gathered to be normal. And that would be the very earliest point of awareness I think. It was just a sense - and of course, it became more obvious as I got older - to me.

A precocious child, Alan learned very early how to mask his feelings towards boys.

As a little kid did you get involved in any - well, it wouldn't really be sex games - but playing doctor...that kind of stuff?
I did, yes.

With boys?
And girls.

And girls?
Yes. And at that time I kind of realized that if I get caught with a girl, I'm not going to get in as much trouble as if I get caught with a boy.

Um. That's very intelligent for a four year old.
Yes. Oh, I knew.

Was your family overtly homophobic?
Yes.

So that's how you knew?
I knew that way, yes.

How did you feel about yourself at the time?
It didn't feel - I didn't feel well about myself. It motivated me though - not as a preschooer but maybe a little as a preschooer - but as I got older it motivated me so that I wanted to do more - I wanted to impress people more - to take away from any type of questioning about myself. So on the outside you would have seen - probably like a happy-go-lucky little boy trying to please everybody. But inside it wasn't in me - I did not feel well.
Are there any specific behaviours or incidents that could illustrate how you felt? Things that you recall?

Yes. Not as a preschooler, but probably a little older in grade school. I remember watching television and - for the life of me I'd really like to know what the movie was - but it was like a television film. It may have been out in the theatre at some point, but it was definitely on TV. And I was young - I was probably about 6 or 7 - and I'd already been playing doctor with boys and girls and I knew that I preferred to be playing doctor with boys. And I remember watching this movie and it had something to do with two men being in prison, eventually going to prison. And being there for a very long time, and that they were having - they eventually ended up having a sexual physical affair - but that didn't develop into I guess what would be called the traditional jailhouse sexual romp. It was - there was tenderness involved. And the one man - I'll never forget this because he was blond - portrayed as being very very blond and the lighting that they did in the film was very golden when they began to have a sexual relationship on the film. And then it faded. And I remember my mother freaking out at that.

That the light faded or the...

That there was this scene with the men together. And I of course was absolutely enthralled. Because it was probably the first time I'd ever seen the depiction of two men sexually - not just sexually but also in a caring way. So I remember feeling - oh, good Lord, this is amazing. It happens like this, I'm not the only one in the world - I'm not the only freak, you know - trying to get my friends to take off their soccer shorts. But then that was contrasted with my mother's reaction. And the next day I was with my mother and we were playing and my mother called me over - my brother's older - and she was just hugging us and I remember asking her about the movie. My mother's a very open person about all kinds of things - very liberal. Her first boyfriend was a black man, a black boy in high school, so it was a very unusual thing for her in those days. But her reaction to anything about homosexuality was just off the wall. And I now know why - at the time of course I had no awareness whatsoever. And she just hugged my brother and myself and I remember her saying something about "oh don't worry about that, I just know that my boys aren't like that". And of course, in my mind I'm thinking, but I am. And I felt absolutely horrible. I felt right then and there like crying, because I thought I'm really disappointing her because she doesn't really know me. And if she did, she would hate me.

It appears that Alan is describing The Kiss of the Spider Woman starring William Hurt and Raoul Julia.
Given his mother’s homophobic attitude, and Alan’s fear of losing her love, it is not surprising that he waited about 10 years after that incident to come out.

Shooting way forward just to finish up that thought - when you did come out - what was her reaction?

Well, the first person I came out to was my older brother S., and he’s your typical sort of Ontario rocker-peg, I guess you’d say. And - but in his - I find with people like that, they tend to be very libertarian. Because rocker pegs were always getting judged by the people - your hair’s too long, you’re too dirty, why do you listen to that loud music. He doesn’t judge people, he didn’t judge me. The only thing he said was don’t tell Dad.

My Dad’s a grease monkey - a mechanic, you know, very typical male - very traditional looking. But he didn’t say anything about our Mom, because - like I said my Mom had always been very liberal, very, very liberal. Like she was a raving Socialist at a time when that was considered - the RCMP would be investigating you, kind of thing. But I had to tell her because we were very close - we had a very close relationship. And when I did tell her, I was 17 and I told her. I actually told her the truth but I - I told her that I felt I was bi-sexual. Which in retrospect was true but at the time I wasn’t telling anything gay specific, because I thought it would be easier for her to take and she flipped out. She just had a major flip out. And I started realizing at that point that this was an unusual reaction for someone who’s supposed to be so very, very liberal. Years later, she told me that she had been gay all of her life.

She has been gay from as early as she can remember - probably even earlier than what I recall in my life. But she has repressed it, up until she was in her 40s. She thought that she made me gay - that there - she thought that there was either some behaviour thing that she passed along, or that there was some genetic thing that she passed along. So which was why she was so homophobic throughout my childhood - was that she wanted to instill - and she told me this before - she wanted to instill that that is not right. Because she hated herself....

The coming out process is rarely easy for anyone; however, in this case, Alan experienced both positive and negative feedback that was significantly divergent from what he expected – a homophobic mother who was a closet lesbian, a biker
brother who was totally accepting (with the exception of his comment about not
telling Dad), and ultimately a blue-collar father who struggled with it for a while,
but was always accepting of Alan as his son.

Given this mélange, I wondered about how he perceived safe sex messages – he
had lived a vicarious gay life for a decade, and now was facing the real thing for
the first time.

*At what age do you recall first hearing about safe sex or safer sex?*
I was in university as an undergrad. So it would have been - I was about 20, I
imagine.

*Do you recall from whom or how you heard of it?*
I was a volunteer peer counselor at the university’s student centre and we got
training in all kinds of various issues, one of which was sexuality. And that
was probably the first time I heard about safer or safe sex. And was just sort
of fleeting - sort of passing - we had a counselor talking about birth control,
various methods of birth control - and she had mentioned - she’d used the
term safe sex with regards to condoms and she said it could be used to
prevent STDs as well as pregnancies. It wasn’t gay specific, though. That’s
just was how it was put.

*Did you relate that to gay - being gay specific?*
At the time I didn’t, no. No, I didn’t.

*About when did you make the connection?*
Probably shortly thereafter, because we started getting literature on gay male
safe sex practices. Up until that point I just recall government literature,
things that you’d read in the papers, gay papers, was basically ‘reduce your
partners and you reduce your risk’.

*Well, that is one form of safer sex: ...*
That’s right, yes. It didn’t say anything about altering your behaviour.
Because that just wasn’t how it was done.

*Do you remember what your first impressions were when you heard about that?*
I - it was not good. I just felt - I felt - we don't have to wear these things to prevent pregnancy for God's sake. Now we have to. That's what I felt, I guess.

Sort of a burden?
Yes. A burden. But now the way I look at it - also at the time, you had to stop and make preparations for any sort of penetrative sex. So - and I just - now I think that you have to soften and you're recognizing - you can't just say oh I went with the flow - you actually have to stop and say, we have to prepare for this. So it is a certain type of recognition. And I think in retrospect I'm thinking - when I was 20, 21 - I just didn't want to be there. I didn't want to recognize that, it was just kinda like we were drinking and it just happened. That kind of thing. But you can't do that when you're talking about putting on a condom and getting lubed up.

It can't be spontaneous?
Right, it's not spontaneous. So you can't use it as an excuse...

Alan's comments, like those of many of the other interviewees, embodies previous comments regarding behaviour and cognition. In terms of Rademaker's model, Alan, without realizing it, reifies the salience of the outer ring - factors in an interaction that are relevant for, but not directly related to any one specific interaction; the impact that any one of the consequences, such as risk awareness or perceptions of social norms, can have on the ideation of using condoms. Additionally, he embodies what O'Neill termed 'carnal ignorance' - being caught up in the heat of the moment, and while cognitively aware of the need for protection, he is reluctant to break the mood by stopping to find or use a condom. We continued by exploring issues relating to UAI and barebacking:

As you probably know or surmise, very few people are able to state that they have NEVER had any unsafe or potentially less safe sex. However, it is not totally unknown.
Thinking back on your sex life to date, first of all, has there ever been a period of time when you only had safe sex?
Yes.

When was that? And under what circumstances?
When I only had safe sex ...

Yes, only had safe sex.
Well, there was a period of time when I didn’t have sex.

OK, so no sex.
Yes. And it was early - yes, it was - yes, I was really very depressed and I just was not sexual. For about eight months - in my early 20s. Around 21, 22. So that would be the ultimate in safe sex.

Any other periods of time?
Well, yes - probably in the past 3 or 4 years.

So something changed in between the early 20s and three or four years ago.
Yes.

What happened at that time?
The disease with the little name had got a bunch of faces. And that - it really had a major effect on me.

In what way?
There was reality to it. It wasn’t just something that you’d see on TV. And I’m not talking about - I remember - I’m old enough to recall when people were really dying and I remember seeing people - friends of mine who were older - seeing people on Davie Street for instance - clearly with KS\(^50\) - or they were being wheeled in a wheelchair down Davie. And a friend of mine - who’s older, he would be - I remember him when, he used to be a dancer, he used to be this, he used to be that. I mean, I remember those instances - they didn’t have that much of an effect on me because I didn’t know those people. What did have a major effect on me is when ex-boyfriends of mine - that happened. My roommate at the time came home and was just like ‘I am positive. And I’m ill’. So that really had a major effect on me because it’s like this is - it’s here it’s staring me in the face.

\(^50\) Kaposi’s Sarcoma.
It has often been stated that experience is the best teacher. As is the case with other risk events, learning about them in the abstract rarely has as significant an impact on behaviour change. Pace Odets, we can look to other forms of social marketing – unwanted pregnancies, smoking, drug use and so on to see how it is only when one personally experiences the consequences, or is close to someone who had so done, that the messages have relevance.

So in the past three to four years then - what's happened then? Is it still all safe sex?
Yes. I've had occasions where I've not used a condom when I was the top. But I just couldn't - how can I put this - I couldn't perform. Because I just didn't feel right. So I would stop and say we really should use a condom.

For a lot of people it's the opposite.
Yes. For me, in the past - this is really odd, but in the past that's the way it was before. I put a condom on and then lose my erection. And couldn't perform. Nah, let's go to bed. So it is very ironic. Because it's been a switch.

What about being bottom - or are you ever bottom?
I do occasionally. It's interesting, my boyfriend right now - almost all of my boyfriends - significant boyfriends, or even lovers for that matter who've been - I shouldn't say insignificant but of less duration let's say - have almost always been predominantly younger than myself. My friends call me a terrible chicken-hawk, although I prefer not to use that adjective - it's terrible.

So - but I always will inevitably have the question about safe sex and HIV status and what have you. And I'll tell them that when I was their age - for instance when I was 20 - I really, really, really wanted to be a super slut - like a total 'ho' - but I couldn't.

My first awareness was - I had a boyfriend and we had sex, but you didn't have sex with anyone else. And you were monogamous - there was no other question about it. And you stayed with him. And that's - when I was 18 I met S. and that was it - we were in love and we were boyfriends. And because I was petrified, and if I was the bottom in the relationship - or a time

51 Someone who prefers young men,
having sex with him - I didn’t feel comfortable because that’s where I thought you got infected and that was it. I can easily be the top - back then we didn’t use condoms – and easily be the top and not have as much to worry about - I thought. But being a bottom was just not enjoyable for me, because I was scared, always scared. So it had a major effect on the amount of sex that I had when I was younger. Now that I’m older - I do not have - I’m not the penetrated partner without a condom - I still will not. That’s been years.

I was in a relationship for two years and we went through this whole process of getting tested - waiting six months and monogamous and all that kind of stuff. So we could not use the condoms any more. And we did that for a few months but I just didn’t feel comfortable. I just couldn’t do it. But it has a lot to do with the trust issues that I find.

While Alan uses condoms routinely, relative to the other interviewees his resolve to practice safer sex is far more resolute. As we shall see, even with an HIV-negative monogamous partner, Alan’s tenacity is unwavering. While this is highly reasonable and rational with regard to sexual safety, one must wonder how it affects his relationships in general, and how he and his partner negotiate trust in their relationship. I asked him about that.

*Is this an issue of not having trust in your partner? Or is it about not trusting yourself?* Trusting the partner. I didn’t have the problems when I was a top, but as a bottom, I couldn’t - which is also I think this - when I explain things like this to partners - I think I was really having a big personal moment at the time when say Rock Hudson died - there was a huge awareness about my sexuality. And that had a major effect on me, because it put a face to AIDS. And I think my ability to enjoy anal sex as the bottom has been dramatically affected by this disease. It’s not that I don’t enjoy it - it’s just that I can’t enjoy it. I never get to the point - I rarely get to the point - I shouldn’t say never - I rarely get to the point where I trust the person enough - even someone I love - that I’m not constantly worried.

*Even with a condom?*
Even with a condom. Yeah, yeah. Which is really unfortunate.
In the past 12 months, about how many times how you had sex with a man?
A rough estimate - probably about 150 times. I'm pretty much three times a week I guess, if I'm involved.

How many partners?
About six.

OK. That wasn't a trick question, but it was a tricky question because I asked you how many times you had sex - but I didn't define what sex was. Because the next part of that question is - what qualifies as sex? That is, what activities come to mind that constitutes sex?
That's a good question - that's a very good question. And I know that I have a problem - for me it's a problem - because sex for me is penetrative sex. For me - I've had partners that it's just a problem with because it's - that's how I consider whether or not I'm getting laid. Everything else is foreplay.

Alan's definition of sex is similar to many others, but more restrictive - one answer involved erections, another required erections and ejaculation. Alan appears to define sex only in terms of anal or oral penetration; however, given his response about "getting laid", one can surmise that he is only referring to anal intercourse. I asked him to recall his behaviour, and indicate what instances were safe sex activities. Not surprisingly, whenever anal penetration was involved, he reported that condoms were used. What was surprising, was that after provoking a longer response by pausing and waiting for more information, Alan acknowledged that he had had anal intercourse without a condom more than once. I was aware, through the screening process, that all the subjects had reported UAI in the past year; therefore, rather than revealing my prior knowledge of his behaviour, I was determined to 'wait him out'.

302
OK. Of those 150 times in the last year, about what percentage of the time do you feel that you had "safe sex?"
It depends on your definition of safe sex.

No, it depends on YOUR definition of safe sex...
My definition of safe sex - right, yes. For instance, in oral sex I never use a condom, never use a condom in oral sex. So of those 150 times, if there was oral sex involved it would be without a condom. If there was anal sex involved - of the 150 instances - there was always a condom involved.

(It was here I paused and waited.)

Save and except - I can recall two instances where I was topping with this young lad and he was almost always insisting that I do it without a condom. And I couldn't continue unless I had a condom so... There's one time which was - the whole idea about safe sex for me - and my practice changed - was it was - I can remember the weekend - it's actually very difficult to talk about but - friends of mine - very close friends of mine - had disclosed that they were ill and I was freaked out about the whole thing. And very depressed and I started drinking, heavily. And I ended up with this man and we had sex and I was the top and then I was the bottom. And both times - when he was the top - he didn't have a condom on. And I made him stop. But the feeling that I got was overwhelming -

Overwhelmingly good or overwhelmingly bad?
Overwhelmingly bad - to the point where I just wanted to curl up in the fetal position and I was absolutely devastated. And I was actually convinced that I was dying - as of that moment I was dying. And that got to me because of my - first of all - I realize that it sounds horrible because I think it sounds horrible - it wasn't just that I was dying - I made a pact with my older brother - you're not gonna get AIDS - just don't do that to me. And I was like don't worry - I'd made a bond with him that I wasn't going to get AIDS for him - as opposed to for myself. And I had thought at that moment I've broken this bond with my brother.

I went and got tested and tested and tested - and it was the most wicked six months of my life. That ordeal changed me so much - just - it's just like I'm not gonna through that again. Not for getting drunk and just having a fling - it's not going to happen. I don't want to do it again.

Do you know this guy's sero-status?
No, I don't.
So you don’t even know if there was any risk involved at all?
No. I’ve no idea whatsoever. My assumption was high risk. I just automatically assumed he’s dying and so am I.

Alan’s response to being penetrated, especially since he did not know his partner’s serostatus, is associated with dying. He scared himself, and suffered through the waiting period before being able to be tested, and then had to wait until the test results came back. It appears that he has not forgiven himself for his lapse, especially as he states, he is not being safe just for himself; he is doing this to honour a commitment to his brother. Whether or not this rationalization is his way of enforcing his commitment to safer sex is impossible to discern.

Like virtually all other gay men, Alan does not use condoms for oral sex. Since he was so insistent on using condoms for anal intercourse, and was profoundly afraid of contagion, I asked him about this.

How did you make the decision not to use condoms for oral sex? Or on what basis?
I guess it was -I just sort of analyzed the risk involved. It wasn’t uneducated risk taking - it was like I read as much as I possibly could about transmission. Plus, there’s also the whole concept that I just don’t like - I don’t really get off on oral sex when I’m being blown first of all. With a condom on it’s gonna be even worse. That’s one thing. The other thing too is when I’m giving it it’s just like - the taste of latex is not the best taste in the world. It’s one of the worst. So there’s those practical aspects. But also in terms of just risk -I just didn’t think there was much. But I’m very much aware - like if there’s any sores in my mouth or brushing your teeth, your gums bleeding - that kind of thing.

Since Alan appeared not to be wholly committed to the ‘100% safe, 100% of the time’ dictum, I was curious to know more about his fear of AIDS, and how he
reconciled taking any risk whatsoever. I asked him if he would care to comment on the interview in general, and on his issues with HIV and AIDS. At first he was hesitant, but after he thought a moment, he said:

I'm not sure. I think it goes deeper than just - I think it goes much deeper than just AIDS or HIV - and being the bottom. I think it goes a lot to what we were talking about earlier with my childhood - the perception of what a man is - is really quite - on another level let's say, like in my subconscious - I think that my perception of what a man is and how a man is proven to be is completely skewed from my childhood. And I think that has an effect on how comfortable I can be with another man and be what I would term as being vulnerable and I don't like that. I don't like thinking that being the bottom is being vulnerable.

That's interesting, because most people say that the bottom has more power than the top. Oh, God, yes. My boyfriend just now - he's like - I just said to him you know I'm whipped. He's like yes, I know. I get him everything, whatever he wants I go get it. And the irony of - of course, with me - is that I think being the bottom as being vulnerable. Which is - I'm smart enough to know that that's absolutely ridiculous.

I would like to think that perhaps in the future, I could get to the point where I trusted my partner enough. And that if we had gone through a period of time of being tested and were involved in a monogamous relationship and trusting. I would like to think that maybe I could get to that point. I just don't think that's going to happen at the moment.

With this partner or with any partner?
With any partner.

It appears that Alan does not feel comfortable trusting anyone. He believes this is because of his prior life course events, but he does not fully explain them. Being vulnerable is a natural event for a child - albeit some children are more vulnerable than others. Alan does not seem to have recovered from his
childhood traumas, which is clearly signaled in his fears of the unknown, the 'bogey-man' of AIDS, and trusting other people. In order to verify this hypothesis, I asked him what would happen if both he and his partner were HIV-positive—would he then not use condoms? His answer confirmed that his fear would not be alleviated.

So you would still use a condom for anal sex.
Even if my - if I had sero-converted and my partner was also HIV positive. Because my understanding is what I've read and things - there's some studies that I've read - is that that's not - it's not the usual - you can get re-infected.

While Alan may be correct, in a virological sense, that it is theoretically possible to be reinfected with a different strain of HIV, most people who are HIV-positive would tend to find this risk minimal. The effect of reinfection is a potential resistance to some or all medications, and perhaps an earlier demise, but there is no evidence to suggest that this is Alan's primary concern.

Alan's case demonstrates the lasting effect of childhood abuse and trauma ("very poor family environment, neighbourhood, lots of addictions, alcohol and abuse"). These social conditions are not conducive to a high level of self-confidence, which precedes trust in the sequential equation. Extensive research has been done on social-contextual conditions that augment or weaken self-determination and the development of self. For example, conditions which afford only contingent love, forcing one to sacrifice autonomy to acquire love, impair
intrinsic motivation and interrupt extrinsic motivation, resulting in either contingent or low self-esteem. (Deci & Ryan in Kernis, 1995:42-43)

Therefore, as Luhmann (1979) indicates, it follows that one’s positive self-confidence makes one more prone to take risks involved in trusting others. Conversely, lacking self-confidence (“I didn’t feel well about myself”) from his early years onward (with respect to his relationship with his mother: “I felt right then and there like crying, because I thought I’m really disappointing her because she doesn’t really know me. And if she did, she would hate me.”), Alan hid his early awareness of being ‘different’, since if it were to be discovered, he would “get in … trouble”. His family was overtly homophobic, which he realized at a very young age.

In university, Alan was a volunteer peer counselor, and received his first exposure to safe sex messages. However, “It was just sort of fleeting” and did not relate to men having sex with men. When he did receive ‘gay’ sex ed, it was through “government literature, things you’d read in the papers, gay papers, [suggesting one] reduce your sex partners and you reduce your risk”, but nothing in the literature suggested “altering your behaviour”. It is not remarkable, then, for him to have felt that condoms were ‘a burden’. His attitudinal change came about when AIDS was personalized: “I’m old enough to recall when people were really dying and I remember seeing people – friends of mine who were older – clearly
with KS, or they were being wheeled in a wheelchair”. In this case, *sex ed* and *public health messages* brought about a feeling of inconvenience regarding condoms, experiential evidence and ‘cold light of day’ reality provoked behavioural change so profound that Alan went from being unable to maintain an erection with a condom, to the reverse – being unable to maintain an erection without a condom. The *fear of HIV*, for Alan, became overwhelming, and has led to (or perhaps merely reinforced) his inability to trust other people. As Alan previously stated: “I think my ability to enjoy anal sex as the bottom has been dramatically affected by this disease. It’s not that I *don’t* enjoy it – it’s just that I *can’t* enjoy it. I never get to the point … where I trust the person enough – even someone I love …”

This *lack of trust*, as evidenced by Alan’s last comment, has resulted in his inability to fully enjoy a relationship, now and, as he speculates, in the future. “I would like to think that perhaps in the future, I could get to the point where I trusted my partner enough … I just don’t think that’s going to happen at the moment” with this partner or “with any partner”.

While Alan practices safe sex, what suffers, by his own admission, is the *quality of his relationship(s)*. As Yamagishi (2000) opined, people who are low in trust are more prone to make mistakes in detecting signs that point to trustworthiness, and therefore it becomes more prudent for them to assume the worst about human nature, in order to avoid becoming victimized. Yamagishi’s hypothesis stands the
test, as Alan states "I think my perception of what a man is and how a man is proven to be is completely skewed from my childhood. And I think that has an effect on how comfortable I can be with another man and be what I would term as being vulnerable and I don't like that".

Conclusion

We have examined a representative sample\(^52\) of five of the fourteen completed interviews — Christian, Josh, Martin, Alan and Patrick. These particular interviews were selected because they best exemplified the range of responses I received from the group; they ranged from an "I don't care" attitude towards contracting HIV to "I am worried sick about AIDS", and responses that were distributed along the range.

Without a doubt, there are limitations to the interview and reporting technique. One of the prime limitations in this study is the use of interviews and discussion group transcripts — first from the perspective of representativeness of the gay communities, and second from the perspective of prediction. In the first instance, while all attempts have been made to ensure a fair and equal representation of all points-of-view, one can never be certain that any interviewer's bias is not present. In the second instance, it is foolhardy to

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\(^52\) The other interviews, while all somewhat different, were consistent with, in most major and important respects, to at least one of the reported interviews. Reproducing them, and their subsequent analysis would provide little additional information.
presume that this sample of gay men is wholly representative of a broader population. Statistically, they appear to be, but without controlling for a myriad of unstudied factors, such as age (all Vanguard participants were between the ages of 18 and 30), socio-economic factors (most Vanguard participants are middle class), and ethnicity (only two of the interviewees and discussion group participants were not Caucasian), one can not be convinced of the universality of the findings. To be sure, each of the fourteen interviewees had somewhat different definitions of safe sex, and indeed differed from each other on their definitions of sex itself. The assessment of sexual risk, one of the key components of this study was also reasonably distributed. All interviewees (including the ones that were not reported as case studies) agreed that oral sex was, in their opinion, of sufficiently low risk as to not require condoms, and all were cognizant of the risks associated with anal intercourse, including the risk differential between being the insertive partner and the receptive partner, although there were inconsistencies in the degree of risk differential. Nonetheless, several of the fourteen interviewees mentioned that their use of condoms depended on whether or not they chose the insertive or receptive position. The five case studies analyzed reflect a range of situations and responses.

The second major component was HIV/AIDS prevention education, the context in which it is received, and its relevance to gay men both at the time of reception and at present. We have learned that for the most part, AIDS education in
schools was bundled with other STDs and pregnancy issues, with HIV/AIDS barely being covered. For Patrick, the message translated into male-to-male sex; for others, the message either was totally absent in their formative years, or somehow got lost in the translation. This is especially true for those people who were not aware of their homosexuality at the time of the education. This points to a larger problem — one of relevance. Social marketing messages appear to have some relevance not only when they actually address the problem, but also when the intended audience is prepared to listen and receive the messages. Clearly, messages about condom use are not heeded in the throes of sexual passion (as indicated by a number of interviewees), pace Rademaker, regardless of their cold light of day knowledge. Even Alan, the most emphatic supporter of the ‘100% safe 100% of the time’ paradigm, admitted that on two occasions, once each when he was the insertive and receptive partner, he initially did not use condoms — all the while without knowing his partner’s serostatus.

In addition to definitions of safe sex and HIV/AIDS prevention education, the most important component of the argument concerning the non-use of condoms for anal intercourse revolves around trust as a key factor in the decision to bareback. Christian trusted a casual pick-up and was therefore able to be the insertive partner without using condoms; even though he did not know his partner’s serostatus. With regard to his more regular partner, he abandoned the

53 Sexually Transmitted Diseases
condoms after two months, because in his own words "I trusted him. Because we talked about him - he was coming out of an eight-year relationship with the same person, where he told me he was monogamous for eight years, right. And they were tested all the time, so he was always fine".

Patrick appears to be more naïve, in many respects. When he was 19, after using condoms consistently (largely at the request of others) for the previous five years, he became involved in an intimate relationship, and as he began to ‘know’ his partner, he agreed to forsake condoms. His reasons for trusting were reputational and situational — reputational in the manifest trust that his partner was new to the gay scene, and Patrick’s belief that “he hasn’t slept around or anything”, and situational in the fact that the partner insisted that he could not climax with a condom, a gift Patrick wanted to give him. In the intervening three years, we note that Patrick’s rationale for his non-use of condoms changed from one of reasoned action to autonomic reflex — he became relatively unconcerned about contracting HIV, relying on the hope that new drug regimens will serve him should he seroconvert, and as he puts it, condoms are a “hassle”.

Martin presented a challenging interview to deconstruct. While he is certainly well informed about the risks associated with barebacking, he differentiates partners by whether or not he believes he knows them well enough to trust that he (and a few other close friends) can have bareback sex amongst themselves, but
not with outsiders to this elite group. Not only is he willing to trust his immediate friends, he also takes for granted that he can trust his friends’ judgment about other friends – a kind of ‘six degrees of separation’ scenario. Interestingly, Aaron Lawrence (2001) did an analysis of this phenomenon and came up with some startling figures.

If you have slept with, say, 10 people, and they have each slept with 10 people, that means that you are less than two degrees of separation away from 100 people, four degrees away from 10,000 men, and six degrees away from a whopping 1,000,000 sexual partners.

As further indication of the risk involved, Lawrence also notes the following STD’s per million gay male population:

- 535 have hepatitis A;
- 142 have syphilis;
- 1,420 have gonorrhea;
- 3,333 have HIV;
- 85,714 have HPV; 
- 107,000 have herpes (Ibid.)

In his interview, Martin indicated that he had sex with men 30 times in the previous 12 months. In his case, the numbers Lawrence cites can be tripled to arrive at Martin’s STD ‘risk quotient’. Nevertheless, as Martin states, he has no regrets about barebacking, since he has become indifferent to HIV. In fact, he clearly states that he is a consummate risk-taker, enjoying the thrill of transgression: “And I’m at a point in my life where I’m not gonna be young forever and it’s kind of exciting to throw caution into the wind I guess you could

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54 Human Papaloma Virus – a form of anal warts often found to be a precursor to rectal and prostate cancer.
say.” As previously discussed, barebacking can be a sexual adventure, which, in this case, heightens the pleasure of sex itself.

Josh appears to be the more cerebral of the group; as he was coming out he was struck not by the sexual aspects of being gay as much as the empowerment of being able to express his sexuality (including relating with a man, being in a relationship, “and it being a good thing”) without fear or guilt. Even though Josh was quite vigilant about using condoms with casual partners, within his relationships condoms are not used. The issue of trust, for him, is paramount. As he pointed out: “Because the determination for me is if I'm gonna have sex with a casual partner, because my partner and I are in a mutually determined open relationship, then I'm gonna use condoms for fucking... And the same behaviour is expected of my partner – my committed partner.” Trust is established and relied upon – both the trusting and accepting the responsibility of being trusted are components of their relationship and of their respective sexual scripts.

As we have seen in the case studies, the stories reveal several important meanings about life course movements, the coming-out process, sex education, trust and risk, definitions of sex, loneliness and isolation, and intimacy. As Luhmann points out, much of what we notice about these revelations is related to issues of self-respect and social interaction. Key to this analysis is the elements of trust, in their various manifestations, that continually crop up in the interviewees'
comments. While it would be impudent to suggest that a model coordinating these factors can be drawn from five case studies, no matter how representative they may seem, some recurring themes can be discussed:

**THEME 1:** There appears to be a direct relationship between family dysfunction and the capacity to trust and make reliable decisions concerning trust, sexual risk and partnership intimacy.

Early socialization has a significant bearing on the formation of personality and cognitive development. Infants and young children come to rely on their caregivers for virtually all of their needs, at least up to the time they begin schooling. If they come not to trust the reliability of the caregiver, or in fact learn to mistrust the intentions of the caregiver, they soon also come to realize that any request or demand on their part brings with it an element of risk; risk that they will be ignored, chastised, or even physically or emotionally abused. The lack of trust and the possibility of negative outcomes lead to a self-protective distancing of the self from the caregiver – an inverse relationship to intimacy. Additionally, as young people attempt to become reliant on their own wiles and cunning to survive in such a hostile environment, lacking moral guidance, and perhaps also lacking physical attention, the judgment of young people with respect to life-choice decisions can frequently be immature and lead to unproductive or even harmful choices. Eventually, realizing that one’s life-choices have not been the
most efficacious, one learns how to avoid making decisions, either by procrastinating or by relying on others’ appraisals of situations – in effect, ‘going-with-the-flow’.

Second, the symbiotic relationship between a culture of distrust and a culture of dysfunctionality is apparent when one considers the structure of dysfunctionality. Alcoholism and/or drug abuse, chronic unemployment, low self-esteem, depression, homophobia, and low scholastic attainment all point to a lack of faith in oneself, a lack of self-efficacy or mastery over one’s life. If the child internalizes these dysfunctions, and emulates the caregiver, as most children do, they learn that, in general, one ought not to trust one’s own abilities. It is therefore probable that early socialization will be imbued with this feeling of helplessness, which in turn manifests itself either in a sense of fatalism or as a ‘rage against the machine’ of society. In either case, trust suffers, risks are taken, and intimacy is hard to come by.

THEME 2: There appears to be a direct relationship between an early lack of trust in oneself and/or in gay men and the denial of one’s sexuality, which impacts one’s ability to trust other gay men and leads to sporadic and anonymous sexual risk-taking as one fully enters gay life.

Internalized homophobia strikes at the core of one’s perceived identity. By denying one’s sexual character or by repressing one’s sexuality altogether, sexual self-discovery is arrested or diverted towards other ends. During adolescence,
experimentation with one's sexuality is a healthy process of self-actualization. It is during this time of life when the body, propelled by hormonal changes, begins its process of maturation. Along with this process comes the development of the sexual self. If this process is subverted by an over emphasis on 'who I am not', rather than a focus on 'who I am', the development of a positive vision of the self is imperiled. As a result, the individual avoids, rather than confronts the feelings of 'otherness'. This may manifest itself in displays of hyper-masculinity, sometimes to the point of overt homophobic actions, such as gay bashing or overt denial (e.g.: Christian).

In other instances, the fear of stigmatization (as a gay person) may be so strong that the individual feels compelled to act out the role of a heterosexual male, all the while retaining sublimated feelings of homosexuality. Rather than confronting the conflicting feelings, the individual may exist in a constant identity struggle, fearing what may come about if they were to 'come out' and yet also fearing that he will be unfulfilled if he doesn't 'come out'. Frequently, this situation results in the individual leading a double life – seemingly straight, but also seeking homosex on the side, more often than not in casual encounters in public spaces where anonymity and social distance is endemic to the venue (washrooms, parks, beaches, and bathhouses). The lack of emotional gratification in these encounters quite often reinforces the already held beliefs of gay stigmatization, and results in continued self-loathing. In addition, the reported
incidences of unsafe sexual practices in these types of sexual encounters is greater than would be found in more conventional meeting places where one has the ability to get to know, at least to some degree, one's partner (bars, dances), thus exacerbating the stigmatization one feels — not only engaging in homosex, but also in physical or virological unsafe homosex.

THEME 3: The social meanings ascribed to notions of 'trust', 'risk' and 'intimacy' are contingent and unstable in the gay world; meaning that attempts to communicate MSM risk-avoidance health messages must acknowledge and account for ambiguity and multiple meanings in their communication objectives, strategies and messages.

Social marketing messages that do not specify what they mean when they propose 'safe sex' (i.e.: anal intercourse) cannot help but fall on deaf ears if the recipient's definition of sex or love are at odds with the conventional message — it would appear that, as crude as it may sound, "don't fuck without a condom" would have more impact than most euphemistic slogans, 'cute' plays on words or arresting graphics. In other words, trust in advertising, a rare commodity in most cases, regardless of the product or social message being touted, must be generated through scrupulously honest communication in both the graphics and text if the advertising is going to resonate with the audience.

Additionally, life course experiences, family and peer group understandings, religious, cultural and/or ethnic backgrounds all contribute to one's
understanding of, and reactions to sex, love, trust, risk and intimacy. One of the major failings of most safe sex social marketing is the assumption that the intended audience is comprised of a homogeneous group of people, be they younger or older, white or non-white, gay community involved or not involved, highly sexually active or not quite so active, consumers of non-pharmaceutical drugs or alcohol or not, religious or not religious, and so on. While it may be true that the behaviours addressed may be similar, one cannot assume that the meanings ascribed to the behaviours are homogeneous. The relevance of safe sex messages received early in life differs greatly from one member of the subject group to another, depending on their own social and sexual development. The uptake of these messages is highly dependent on the individual’s trust in so-called ‘knowledge makers’, their own degree of trust in their personal ability to interpret and implement safer sex messages and then apply them to their own sexual risk situations, and the degree to which their intimacy needs override their safety concerns.

THEME 4: Since safe sex education intrinsically concerns risk and trust, it is more salient when received in situ from someone deemed to be trustworthy, rather than in formal, bureaucratic settings or via mass audience appeals.

The supposed reliability of safe sex education is intrinsically linked to the source of the education. Organizations that exhibit strong biases towards one position
or another are less likely to be perceived as credible as organizations that are positioned as value-neutral information givers. For example, it is doubtful that the Catholic Church would be deemed a reliable source for safe sex messages given its moral stand against both condoms and homosexuality. The same could be said for schools if their general attitude is not open and tolerant of diversity. In short, one must trust the source of the information before trusting the information itself.

It has long been an axiom in the business world that ‘word of mouth’ is the best advertising campaign imaginable. This is because the source is perceived as highly credible. In the same light, NGOs and government sources alike are suspect when it comes to safe sex campaigns. In the first instance, as has already been discussed, there are particular agendae that are fostered in AIDS service organizations – one that, in the main, promulgates the ‘100% safe, 100% of the time’ paradigm, and a second agenda that seeks to support and reaffirm the relevancy of the agency itself. There are times when these two schemas may come in conflict. However, as recently as the summer of 2000, a full 49.1% of a convenience sample (N=541) agreed or strongly agreed with the statement: *It is unrealistic for AIDS organizations to expect people to practice safer sex every time.* (Datalounge, July 2000) As such, what was once considered ‘expert knowledge’ had been discounted in light of lived experience and other ‘organic’ information.
Clearly, if the AIDS organizations continue to expound their 100% message, their efforts will be, in the main, ignored.

Like trust, risk is also relative. One of the cofactors with respect to sexual risk taking is age – for some people, especially the younger groups, risk is an everyday element in their lives. To be an adolescent is to assume risk. The risk of contracting HIV is only one of many that need to be assessed on an ongoing basis. For older gay men, risks unrelated to HIV abound in their lives as well – risks of other diseases, isolation, loneliness, and all the attendant social and medical problems that come with growing older. Additionally, this is usually faced without the comfort of a spouse and children upon whom to rely. For the middle-aged group, those between the ages of 25 and 40 or 50, the risks tend to fall into other categories – the risk of becoming less physically attractive to potential sex partners or mates, the risk of not having enough money for retirement, the risk of being perceived as ‘middle-aged’, and out-of-touch with a community that valorizes and glorifies youth.

For each age group, the risk of contracting HIV is but one of many risky situations that need to be navigated, negotiated, mediated or eliminated, **but differently.** To be sure, some people manage to deal with risk more effectively than others, if not eliminating it, at least understanding the prioritization of one risk to

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55 Non Governmental Organizations
another. However, for most people, prioritizing risk is difficult, especially when the risk is bound up with emotional issues, such as love, intimacy or sex.

In the Datalounge study cited above, 82.5% agreed that most gay men I know fully understand how HIV is contracted, and 63.6% agreed with the statement that most gay men I know fully appreciate the dangers HIV infection poses to their long-term health. Yet, 53.7% also agreed that the concept of 'barebacking' is personally very erotic. Herein lies the conundrum. Knowing the risks, over half the sample at least fantasized about high-risk sex, if not actually participated in it. It seems, therefore, that the peer reference group messages hold more sway than the AIDS service organizations’ messages.

It seems evident that cognitive decisions about sexual risk and trust are being made, and they are based on life-course events, lifestyle considerations, fear (or the lack thereof), and personal choices with regard to intimacy and/or pleasure. This suggests that unprotected anal intercourse is not a uni-dimensional event, and that barebacking cannot be understood simply by labeling it as irresponsible behaviour. Nor can it be considered in terms historically familiar to AIDS health workers – 'epidemic', 'crisis', or 'plague'. Notwithstanding the fact that HIV transmission is again on the rise, the incidences are not understandable with conventional epidemiological logic. This is not the flu, or a cold; indeed it is not transmitted without the recipient's knowledge, or presumed knowledge of the
risk. A great number of people who have become infected can easily pinpoint the particular partner, or event at which time they became infected. While they may, at the time, have discounted the risk, they were aware that a risk was present, and they made some sort of cognitive decision to assume the risk.

In the next chapter, I will explore the nature of trust, both as a social phenomenon in general, and in terms of its importance as the 'trigger behaviour' that may explain why so many of the study participants have rejected, consciously or subconsciously, the notions of safe(t) sex, either partially or in toto. Bound up in these behaviours are three key elements – trust, risk and intimacy – which, sequentially, may lead one to put oneself in jeopardy of HIV contagion. This exploration will revolve around the above noted themes, examining one case study per theme.

What I will demonstrate is that the operationalization of trust in order to either 'reorganize' risk, or alternatively to purposefully fail to acknowledge risk is, to the participants in the study group, not only a reasonable alternative to the reduction of complexity, it has become a part of the fabric of each participants' particular social order, and as such, allows the case study participants' social interactions to proceed in what passes for routine.
In this chapter, I shall review what the preceding chapters have revealed with respect to the factors that impinge on trust, risk, and intimacy. By identifying some key dynamics of social interaction and psychosocial considerations that have a bearing on sexual behaviour that can lead to HIV infection, we may be able to identify some common factors that might reduce such outcomes. However, it must be made clear that the recognition of maladaptive circumstances cannot necessarily reverse these circumstances and lead to a significantly greater degree of safer sex compliance. People are complex animals, and gay men in particular, carry a lot of hurt and pain, whether it is apparent or not.

In two exceptional articles, “Internalized Homophobia and the Negative Therapeutic Reaction”, and “Internal Homophobia and Gender-Valued Self-Esteem in the Psychoanalysis of Gay Patients” (1995 and 1999 respectively) Friedman and Downey write insightfully about the genesis and systems of internalized homophobia. They note that a recent study of socialization among gay men indicates that children who will be homosexual adults are often brought up in heterosexist and homophobic environments, and that by age 6 or 7 they begin to internalize the negative view of homosexuality expressed by their peers or parents. The authors write, “The patient’s developmental course was one in which early childhood was filled with self-hate, which was condensed into
internalized homophobic narratives constructed during later childhood.” (1995:102) The authors add, “. . . many children who will become gay men are labeled ‘sissy’ or ‘fag’. They have been teased, threatened with physical violence, ostracized, and even assaulted by other boys.” (Ibid.) As we examine the life-course events of the interviewees, we will see the connection between early childhood trauma and current self-destructive behaviour.

The question of how people can transcend their past traumatic experiences, cease acting-out the powerful and often conflicting emotions these scars have wrought, and move on with their lives, is a vexing one. For centuries shamans, medicine men and women, exorcists, clerics, men and women of science, physicians, educators, and behaviourists have tried to exorcise the demons that live in us — large hulking demons, and smaller, less menacing ones. One need only look to recent headlines to see the proof of these demons – the Duplessis kids (Quebec’s infamous orphans of the 1930s), the Mount Cashel orphans (who were physically and sexually abused), the Dionne quintuplets (put on display like prize pumpkins at a county fair), First Nations people who were incarcerated in residential schools, and Catholic priests who have been accused, decades later, of molesting young boys and teens – the list is practically endless.

One of the coping mechanisms frequently employed is the ‘promise’. A commitment to God that if s/he delivers one from a difficult situation has a
profound influence on believers. Likewise, like making a commitment to God, involving someone else in rule making and maintenance is a technique that tends to work for many people. This premise is important in a number of respects – in the first instance, as has been discussed, social norms and folkways (especially within the gay community) are fundamentally a series of rules, formal and informal, that sanction or prohibit various behaviours. For example, while the existence of many internal community disputes tend to present an insider with a picture of a fractured community (on issues of effeminacy, promiscuity, masculine identities, ‘kink’\(^{56}\), sex in public places and so on), when the community is assailed from the outside, most of these divisive elements are temporarily suspended in order to engage the more essential threat. In this regard, community norms (of laissez-faire) resurface, and tend to reinforce one’s sense of gayness, and for some, provide the jumping off point for further community involvement.

As Saxton notes, gay community involvement means more than just adherence to a higher standard of sexual safety – it is also is implicated in such issues as place of residence, socioeconomic status, social milieu, disclosure of one’s sexual orientation, social integration into the gay cultural scene, consumption of gay media, and level of HIV testing. (Saxton, 1998: 31-34)

\(^{56}\) Kink involves a wide variety of non-hegemonic behaviours, including (but not limited to) fetishism, leather and bondage, SM, public nudity, and piercing/tattooing.
Additionally, we know from anecdotal information, people who make covenants with God, or particular Saints, tend to follow through on their promises.

Kenneth Head (1995) defines a promise as:

... the voluntary giving of one's word that, if and when a particular circumstance or situation comes about, one will undertake to act in a manner defined by the terms of the promise one has given. (1)

The individual who makes a promise of this nature does so because he believes in something and desires some end that seems to justify the promise constitutes a reason for undertaking it. For Alan, to promise his brother to preserve his health and perhaps his life by having safe sex seems to qualify in this regard.

Jeremy Bentham's *Principle of Utility* (1879/1982) underscores this notion, in that the principle approves of an action insofar as it has an overall tendency to promote the greatest amount of happiness — in essence, a moral utility that either tends to promote the good, or at least moral unity.

As we have seen, in this particular case Alan's promise to his brother obligates him to at least make a concerted attempt to live up to his word, thus upholding the norm of family unity in the face of adversity.

In keeping with the notion of making commitments to others and/or to society in general, many gay people who, while young, adopted socially acceptable gender stereotypes and survived childhood apparently intact, such as Christian, are not
left unscathed by internalized homophobia. They may feel, consciously or unconsciously, that they are not truly esteemed in areas entirely separate from their erotic lives—in the workplace, at home, or at school—because they perceive that those who consider them gay believe them to be inferior. "A negative view of the self as inadequately masculine functions as an organizing unconscious fantasy". (Ibid.) Such people frequently trace this self-hatred to the fact that they are gay.

On the other hand, Friedman & Downey also see a brighter picture: "We believe that many gay men and women truly leave the consequences of their childhood behind them, and integration into the gay subculture is instrumental in facilitating this felicitous pathway." (1999:343) A positive gay social environment primes people to feel security, self-esteem, a strong personal identity, and love.

What appears to be common among the interviewees, and certainly among the group participants, as we shall see in what follows, is the impact of the residual negative aspects of their life-course events, and in a few instances, gradual assimilation of the gay subculture. Alan, whose upbringing was a classic case of Friedman and Downy's 'homophobic environment', is highly mistrustful when it comes to safe sex, relationships and trust in one's partner; Christian lives in a social world that he suggests is the antithesis of 'white picket fences', domestic bliss and fidelity (if not sexual then certainly emotional); Tim is the anomaly in
the group — he generally practices safe sex, and has more fully come to terms with
his past; and Patrick, while professing concern about contracting HIV, no longer
uses condoms, and considers himself “stupid” for his behaviour — an
unambiguous indication of self-loathing. As I progress through the discussion
group and interview excerpts, I will examine these life-course themes, cognitive
adaptations and maladaptations, and emotional / intimacy issues.

Before so doing, however, I shall situate these conversational exchanges into their
methodological context. As explained in the methodology section, eight of the
fifteen original interviewees agreed to participate in weekly discussion groups to
be held from September through December 1999. The remaining seven people
either had schedule conflicts, or were not interested. While I was present as an
observer at all of the sessions, the groups were actually led by Dr. Bill Coleman
(Bill), who is both a forensic psychologist (50% of the time) and a counseling
psychologist (50% of the time), with the Vancouver/Richmond Health Board, in
which capacity he focuses primarily on group therapy involving newly diagnosed
HIV-positive individuals. The decision to have a professional leader was three­
fold: in the first instance, I did not want to bias the discussions with my own
thoughts and feelings; second, the use of an impartial professional facilitator
would lend more validity to the process and third, I was concerned that the
intensity of some of the discussions, and the feelings and buried hurts that might
arise out of those discussions might require professional intervention (which
Fortunately was not the case). However, in this latter instance, I felt a greater sense of comfort knowing that there was someone who could deal with an emotional crisis should one occur.

While the group participants were Patrick, Jim, Alan, Martin, Steve, Josh, Tim, and Christian, the focus of this chapter is on the operationalization of the themes contained in Chapter 5, and how four of the participants—Alan, Christian, Tim and Patrick—exemplify the themes. Interviewer or facilitator comments are identified by *italics*.

What follows is an amalgamation of various interviews and group discussions; thus the contents are not necessarily chronological. It should be noted that the comments that follow reflect a range of the types of responses the participants provided, and are not necessarily representative of all the participants, the members of the Vanguard cohort in general or of all gay men.

**Theme One – Family and Early Socialization**

*There appears to be a direct relationship between family dysfunction and the capacity to trust and make reliable decisions concerning trust, sexual risk and partnership intimacy.*

In almost every session, regardless of the thematic topic, the participants willfully gravitated to discussions of their family life, which suggests the top-of-mind magnitude of one's social history and life-course events in everyday life. Bill, the facilitator, decided to capitalize on this unplanned discussion topic of early
socialization in more depth, probing for histories that might provide clues to the etiology of risk and trust based on childhood experiences, family relationships and the disjuncture of functionality and dysfunctionality.

Alan was raised in a family characterized by "... a very poor family environment, neighbourhood, lots of addictions, alcohol, abuse". In addition, he realizes that his social environment is a social construction, as evidenced by the following statement regarding how he has become the person "who my friends weren't".

The person that I am now - the things that I do and the person that I've become - it's like I said before - it's expressed in the negative - I've become the person who my friends weren't and that to me is a good thing, right. But the other thing too is that my brother and I have this amazing bond - because we went through so much shit together at that point right? And I think that's amazing - I've always said that, because my relationship with my father - with him fucking off the way he did - he always set up that when any man says to me that he loves me, I just say yea, fuck off. And so, I've always known that that is probably the thing - that is going to be the hardest thing in my life is to accept....So, the men in my family - good luck with the track record! So even my great grandmother, when she was alive, talked about her husband taking off on her. It's like, Holy Shit - they just went like that. And it wasn't like it was any good. My grandfather took off when his wife was pregnant - she had an infant and my Dad was the oldest. And that was back at the time when there wasn't welfare - social services. The church looked after you. My family's been doing this for ever. So I just kinda think well, you know, this is my - this is the crux that I have to get over. I always put it in terms of relationships - if I can accept the fact that a man might say to me that he loves me and that it's true. But - I know no one will love me like my brother loves me - he's a man - and I accept that, right. Because of what we went through, it's sort of opening up....
Not only was Alan’s relationship with his father typical of the ‘track record’ of abandonment so prevalent in his family, his relationship with his mother was also problematic. As he indicated in his interview, his mother, a closeted lesbian, was overtly homophobic, which made him feel that if he were to come out to her, he would be a disappointment as a son, and “she would hate me”. Her internalized homophobia, as he discovered later in life, was the cause of her own self-loathing; a feeling that Alan assimilated.

As Sztompka indicates (1999), the sharing and keeping of secrets is a highly evolved level of trust. Alan was unable to share his secret with anyone but his brother, and most especially not with his mother or father. Yet, on a parallel plane, his mother was keeping secrets from Alan and from her husband. This mutual lack of trust, coupled with the general dysfunctionality wrought by alcoholism, abandonment, abuse and poverty infected Alan with an innate sense of distrust of others, including his boyfriend:

*It must be confusing for boyfriends....*

I do sit them down and say here’s the package - I usually I let people know because I do want dates. Like this whole week my boyfriend’s been away, I am thinking he’s up there riding this cowboy and no reason to distrust him but usually I say when I’m dating somebody you have to merit once again, so already you’re in the negative on a trust level. You work your way up and I might start to trust you...

*Whoa, you’re tough....*

Oh, it’s really horrible, yes.
Alan's distrust extends far beyond his relationship with this boyfriend. When asked, as mentioned earlier, under what conditions he would consider abandoning condoms, he admitted that he was conflicted about the issue: stating that notwithstanding 'cold light of day' reasonableness – i.e. HIV testing, getting to know one's partner, monogamy and so on, not only does he feel that he cannot trust his current partner, but moreover, could not trust “any partner”.

However, Alan has had unprotected anal intercourse, leading one to believe that his lack of confidence in his abilities to make decisions about sexual risk are well founded.

There - as you said - there are - I would accept certain risks. I mean, I don't think that I would knowingly or willingly let someone who was HIV positive fuck me without a condom. But I don't know to be honest with you, whether - I know what I've done in the past - but I don't know what I'd do now. Maybe I would fuck them without a condom - because there is a lower risk in that.

Alan states that he would accept some risk in his sexual life, albeit a more one sided risk – while he wouldn’t allow someone who was HIV positive to penetrate him, he believes he could be the insertive partner, since “there is a lower risk” as a top. This admission is at odds with his previous statement that he did not believe he could ever trust any partner enough to engage in bareback sex.
The etiology of Alan's distrust comes from his background of not trusting anyone, and his fear of sex itself. As he indicated, “... sex terrified me” from age 17 to age 21.

... because being alone when you're growing up, not having any friends, I didn't have anybody to talk to about anything. I didn't have anybody to talk to - tell me about what they were going through either. I just had no idea about sex and I just felt totally unattractive. I just felt - I had no confidence, I was petrified - even when I first started having sex, I couldn't have an orgasm. I was almost embarrassed to - afraid to. It took me - I was 23 I think when I started to enjoy sex. I used to be totally scared of sex...

Even knowing that his partner is HIV negative is not sufficient evidence for Alan to trust his capacity to make a reliable decision about not using condoms. How trust in relationships is, at least in part, a function of early socialization is critical for understanding discussions on sex and risk. As Sztompka asserts, a culture of trust or distrust manifests itself early in life, and informs all subsequent relationships. This culture of trust is also a key component in the development of self-esteem, which in turn, has an impact on behaviour. On this point, Rosenberg (1986:260) argues that the self-esteem motive is a constant force in our everyday lives, and in order to operationalize the self-esteem motive, the notion of selectivity – the motivated choice from among available options, must be employed. As Alan demonstrated, his ability to be selective is undermined by his rigidity (for the most part) in not accepting the notion of choice with respect to the use of condoms, whether or not to trust his current (or any) partner, or to
even trust his own ability to discern those who are trustworthy from those who are not. In essence, he distrusts his ability to see where his future lies, other than in negative terms – he would not trust *any* partner.

As Lewis and Weigert put it (1985:972) “Trust in everyday life is a mix of feeling and rational thinking”. The added element to cognition is emotion. Emotion is part of the “unitary experience and social imperative” of trust. Or, as Simmel puts it, *trust combines good reasons with faith*. (Simmel, 1989)

The looking-glass self (Cooley, 1902) version of the reflected appraisals principle holds that the individual’s self concept is importantly influenced by his perception of others’ attitudes toward him. As has been illustrated, not only Alan, but many of the other discussion group participants bore negative affects of early socialization, and as such, were actively engaged in ‘changing themselves’ to reflect the characteristics of the person whom they perceived others wanted them to be, rather than carrying on the characteristics of the person whom they felt they had been. Since their earlier significant others (in many cases) neglected, abused, abandoned or smothered them, their self concept came to expect similar treatment from friends and lovers. They were, in other words, actively engaged in confirming their self-concepts by selectively associating with those who saw them as they saw themselves – in Alan’s case, as worthy of trust.
The irony of this theme, as exemplified by Alan, is that while Alan practices safer sex almost all the time, he does so for what appear to be the wrong reasons, and undoubtedly at a horrific emotional cost. Instead of incorporating safer sex into his risk/benefit analysis, and using safer sex as a part of his sexual script, irrespective of his emotional involvements with others, Alan is obsessively focused on the epidemiological aspects of sex, rather than the intimacy of sex. Sex, for the most part, especially without a condom is “totally fear based”.

However, Alan’s fear of HIV is, in part, eclipsed by his fear of intimacy with a man. By his own admission, he fears being perceived as weak, or vulnerable, which in turn has an impact on his sense of self, his ability to be emotional, or emotionally vulnerable:

I think that my perception of what a man is and how a man is proven to be is completely skewed from my childhood. And I think that has an effect on how comfortable I can be with another man and be what I would term as being vulnerable and I don’t like that.

In sum, it appears clear that Alan epitomizes the essence of theme one – having come of age (emotionally and sexually) in a dysfunctional environment, he has relied on others’ extreme perceptions of what is defined as safe or unsafe sex (most notably the information gleaned from safe sex educators and books), without having questioned the veracity of the information, or interrogated the reliability of the sources of information (see also theme four). While Alan’s
behaviour conforms to a conservative notion of risk avoidance, his dysfunction manifests itself in his lack of trust in others, which in turn reveals a lack of trust in his ability to make reliable judgments of others, which appears to stem from a childhood and adolescence in which ‘trust’ was a scarce commodity.

Theme Two – Internalized Homophobia

There appears to be a direct relationship between an early lack of trust in oneself and/or in gay men and the denial of one’s sexuality, which impacts one’s ability to trust other gay men and leads to sporadic and anonymous sexual risk-taking as one fully enters gay life.

The process of ‘successful’ maturation relies on a boy to observe and very carefully take note of older males. Among other things, the boy must learn how to think, talk and act so that he precludes being erroneously taken for a girl. To be labeled a girl is a curse, even more traumatic than a physical handicap. There are many signs that a young boy can read to determine if he is being accepted and respected in his socially prescribed gender role – families, schools, churches and other agents of socialization devote considerable time and energy to teaching sex-role distinctions and reinforcing ‘appropriate’ behaviour, as well as vilifying ‘inappropriate’ behaviour. The signs of acceptance are most significant when they come from someone who is held in high regard by the boy – a parent, older sibling, other male relative, cleric, or neighbour – the older male imbued with the power of the role model.
When a role model's power and influence is utilized to coerce a boy into a relationship that involves exhibitionism, fondling, inappropriate touching or penetration, the criteria for sexual abuse are present. Risin and Koss (1987) suggest three criteria for sexual abuse: a significant age discrepancy between the child and the perpetrator; the use of some form of coercion; and/or the perpetrator's abuse of his role as a caregiver or authority figure. Current thinking suggests that the 'and' be removed so that any one of the criteria meets the test for sexual abuse.

Apart from the obvious and immediate concerns about child sexual abuse, there is a more insidious element to consider. The perpetrator exerts immeasurable psychological leverage, so when sexual abuse is involved, he (or she) can effectively silence the victim. The victim is frequently manipulated so that he cannot distinguish between abuse and closeness/attention/status. The young boy yearns for acceptance, as previously noted. And the perpetrator provides that kind of attention, masquerading as 'love', which inevitably causes confusion, shame and disillusionment (Grubman-Black 1990:6). No doubt, both gay and straight boys are sexually molested. Nonetheless, in disproportionate numbers, gay men can recount tales of childhood sexual abuse. (McCreary Centre Society 1993, Gonsiorek 1988, Herman 1992, Kippax 1992, Odets 1994) It is, however, a misnomer to suggest (or even to think) that childhood sexual abuse causes homosexuality; rather, it is the perceived vulnerability of young gay boys that may
would-be molesters. This vulnerability has been described elsewhere, in terms of being 'different', being teased, taunted and beaten up by classmates. In the following excerpts, we read first hand Christian’s narratives of how he was sexually active at an early age. It must be noted that Christian does not suggest that he was sexually abused — in fact his first experience (at age 13) was consensual. “I mean, I knew what I was doing, but I just - I was shaking I was nervous, very very nervous. But I just knew I had to do it because ...I was very nervous, I did enjoy it... It must have taken at least a year and a half or two before I had sex with a man again after that.” His first experience, unlike a number of the other participants, drove him back into a sexual closet. The links between abuses, the inability to trust, and most importantly, the sublimation of gay sensibilities are discussed later.

Christian’s early sexual experience, consensual as it may seem, and as he recalls, still meets the documented, agreed upon criteria for sexual abuse. The age disparity between an eleven-year-old boy and even a more mature teenager, let alone a forty-four year-old man is sufficient confirmation of exploitation, regardless of any other circumstances, at least in law and in social policy. Christian’s curiosity and disagreement with naming what happened as abuse notwithstanding, his subsequent revulsion and two year celibacy may be implicated in his distrust of gay sex, and sex in general. While an argument may be proposed that an eleven-year-old boy is too young to be having sex in the first
place, the fact remains that Christian was sex-curious at that age, and took it upon himself to experiment because he “had to do it”. The impact, however, was long lasting in a number of ways: he did feel some pangs of guilt, but they were “nothing that I couldn’t live with”; he recognizes that his early experiences “influenced my sexual patterns after that” in that he has become an aficionado of sex in public places, a ‘size queen’, and to an extent, a voyeur. However, seeing, for him is the ultimate sex act: “I have this thing about I want to see how big somebody can get and after that the rest is kind of irrelevant - to a certain point. If something else happens, then good, but if not then it’s no big deal.”

Christian acknowledges that his sporadic and anonymous sexual behaviour may be a result of his earlier experiences, confirming the hypothesis that, at least for him, there have been lasting effects:

**But the fantasy has been fulfilled?**
Yeah. And I don’t know - I wonder – the fact that he was - it was a public place and he had a big penis. I wonder if that has something to do - would I have always been like this - all my life, if that wouldn’t have happened. Would I have fell in love with a nice guy my age when I was 16? Would I be in a relationship today just because I started in a love relationship as opposed to having a pedophile having sex with me in a bathroom - I was 13, he was 44.

Christian’s sexual scripts primarily focus on anonymous sex – sex in public places with casual partners. The overwhelming lack of intimacy in such sex, in

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57 Size Queen – someone who seeks large genitalia in their partners.
terms of place, time and partner selection clearly illustrates the inability to 'know your partner'. If this is the case, one would logically expect a heightened sense of safety with respect to sexual behaviour, but as Christian states, this is not the case:

With some people you can tell that they are [HIV-positive], just because their cocktail is doing a lot of changes to their body that are very easily recognizable. So now - it wasn't like this a few years ago, but now it's very simple and you can just tell just by looking....

I think as the years go by, unless I changed my practice - but I have this feeling that if I were to catch it tomorrow I would probably not die from it. Because soon people will find a cure or something before it happens. I have had many positive friends that I've had for many years - so it's just - I just feel like you don't - kind of catches up to you, I will probably be fine.

I think too with age - one of the things that I think about is how old do I want to live to? Will I be 120? So is it as critical for me to be worried about it as it is for someone say who's 16? Because for me that seems to make a difference too.

Christian clearly is far less concerned with contracting HIV than Alan, as both his behaviour and his conversation indicate. In Alan's case, the attribution is early socialization in a dysfunctional family. Christian came from a loving, close functional family, but despite this closeness, was unable or unwilling to 'come out' to either himself or his family until later in life.

However, notwithstanding Christian's current comfortably out status with his family, his earlier denial of his sexuality manifested itself in sublimating all sexuality into sports. When Christian came out, around age 22, he quit the
track team. He had no further need for his ‘straight looking, straight acting’ mask. However, during his years in the closet, by his own admission, he lost the potentiality of developing a loving trusting relationship with another boy or boys. As a result, his current relationships are short and unemotional, as are his breakups.

Well, that’s what I was going to ask you next – how that affects you in your relationships?

I think the only way that I see it is that I’m not - sometimes I can be a very cold hearted person - you know, like I don’t miss - missing is not part of my feelings that I have. So I don’t miss my friends - I’ve been moving from like Sherbrooke to Montreal to here and I have friends all along the route. . I never miss - like I know that if I were to leave here tomorrow, there would not be that many people that I would miss and it’s not because I don’t love them. And always have something to fall back on - maybe that’s why. I don’t need to have that eight year relationship or friendship or whatever it is that people need and maybe shared for 15 years. I’m like, Oh my God, that’s a long time - 15 years. I think it’s great but I mean I don’t have those because I seem to be moving along...

Christian’s relationships ‘with no regrets’ must then be less deep than others – the lack of emotional attachment also manifests itself in his increased sexual risk-taking, not only in his choice of sex venues, but also with more ‘traditional’ liaisons.

I’ve had sex with people I didn’t know were positive before I had sex with them. It didn’t stop me from having sex with them and more than once. Because I don’t worry about it. I didn’t find it a risk.

A lot of people spend their lives trying to keep - stay alive. They spend their lives preventing HIV.

.... when I - talking about if we get HIV or if we get cancer or if we get diabetes or multiple sclerosis or any of those hundreds and hundreds of diseases out there. I mean we only focus on the one disease - HIV -
there's tons of things we could die from - tons. To worry about that and we can't prevent risk from a lot of types of cancer - there's a lot - like there's things we can go about like eating bran and things like that we can do to prolong our life. But basically - we're gonna die of something and whatever it is - I'd much rather be dying of some sort of disease where at least I have time to prepare for the inevitable. Instead of getting smack - hit by a bus or worse getting like maliciously killed by some serial killer or things like that. That's a horrible way to die. I think getting a disease is one of the better ones. Just because you are able to come to terms with your mortality and come to terms with your death.

Clearly, Christian exemplifies the second theme – he was sexually active at age 13 with a 44 year old man, which then led to a two year hiatus in his active sexual life; after which he sublimated his sexuality in an early version of 'don't ask, don't tell' not only to others but also to himself. When he did come out, his relationships were brief and underdeveloped – when they ended, they ended with no regrets. He didn't trust his emotional safety to others, although his sexual safety was not of concern. His current attitudes and behaviour suggest that nothing substantive has changed.

As discussed earlier, coming to understand and accept one's sexuality as an adolescent is always difficult.

Christian's behaviour appears to support Hirschi's contention, in that he sought sexual experiences from the time he was thirteen, albeit clandestine and anonymous sex in public places. It was not until his twenties that he came out to himself, and accepted his homosexuality, by which time his patterns of
behaviour and his distancing from his sexual partners had become both ingrained as emotionless (or ‘cold’ in his words), and unmindful of the potential health risks. It seems clear that Christian manifests theme two — that his lack of trust in himself and other gay boys and men led to his internalized homophobia, which in turn has numbed him emotionally, inuring him to ‘normal’ fears of contagion and infection.

Theme Three — Contingency and Instability in a Sexually Vectored Gay World.

"The social meanings ascribed to notions of ‘trust’, ‘risk’ and ‘intimacy’ are contingent and unstable in the gay world; meaning that attempts to communicate MSM risk-avoidance health messages must acknowledge and account for ambiguity and multiple meanings in their communication objectives, strategies and messages."

Whether one grows up gay, or comes out in one’s twenties or later, one must, eventually, surmount the heterosexual socialization that preceded the gay identity and learn how to manage oneself in a heterosexist environment. Inevitably, the ‘family values’ one has come to accept as ‘normal’, and the importance of kinship ties may be, at the least, upset, and quite possibly shattered. What was once accepted as social truths – monogamy, marriage, children, family responsibilities, and the heteronormative lifestyle are exchanged for a stigmatized, and frequently labeled, deviant life. The transition from a life that considers sex as a precursor to marriage, or indeed a sacred part of marriage itself, to a sexually vectored life
where marriage (or its equivalent) is far less central to one’s sexual expression, is fraught with other emotional and instrumental changes.

While the opportunities or proclivities for premarital or extramarital sex in a heterosexual world are somewhat constrained, within the gay milieu sex is the engine that drives community, marketing, social contact and self-image. One need only look to the wealth of available sex partners in bars and baths, sex chat rooms, sex phone lines, personal advertisements in gay publications and sexualized venues in the gay community to verify the nature of this sexually vectored social system. Given this sexualized social world, it should not be difficult to understand that sex and love, especially in a gay track, are relatively easily separable, and are indeed, frequently incompatible. For many gay men, anonymous, or at least nameless sex, is a part of their everyday sexual undertakings. For others, the notion of ‘knowing one’s partner’ may amount to little more than a name and (possibly real) phone number. For a few, a deeper sense of knowing is required. However, the prohibitions and taboos that one has learned in the heterosexual world are, for the most part, abandoned when one enters the world of homosex. Thus, it is reasonable to portray gay sex as contingent and less stable than heterosex.

Cruising (the seeking of sexual partners) is endemic to the gay social scene. One either is into it, is fatigued by it, or both. Nevertheless, it is a rite of passage that
almost all gay men experience. Along with cruising comes the inevitable rejections, sometimes at a heavy psychic cost, but more frequently accepted as a part of the process, with no more import attached to it than 'having a bad day'. It is no wonder, then, that many gay men disassociate love and sex, if for no other reason than emotional self-protection.

Given that love and sex are, or can be, discrete issues, it follows that trust, which is more closely aligned with love than with sex is also contingent – at least to the degree that sex is disassociated from love and affection. In this manner, we can envisage two types of gay sex – one that is based on physical attraction, or lust, and one that is grounded in love – emotive sex. In the first instance, virological safety should be of significant concern to the participants, since they do not have much interaction with each other, nor have they (usually) established ground rules for their liaison; while in the latter instance, sex that is virologically safe, or monogamous, or some combination of the two can be the product of discussion, negotiation and rule-making.

This is not to suggest that even so-called 'couples' don't break the rules; on the contrary, research has shown that more 'unsafe' sex occurs between partners who know each other than with casual partners (Kippax et al, 1993; Myers et al 1993; Rhodes & Quirk 1995; Vanguard Project, 1999). In other words, while anonymous or casual sex can be unquestionably risky, unprotected sex with a
partner who is classified as 'regular' (someone with whom one has sex at least once a month) also seems to occur on a significantly regular basis. Therefore, trust, risk and intimacy are demonstrated to be contingent, regardless of partner category.

With this in mind, the third element of the gay/straight differential is the issue of risk. While HIV knows no sexuality, gender, race or socioeconomic status (in North America at least), the MSM population that is HIV-positive far exceeds that of any other demographic sub-group, both on a percentage basis and in real numbers (the debate over ACT's statistics (chapter 3) notwithstanding). The incidences of STDs in the gay population are again on the rise (ACT, Toronto, 2001; Vanguard Project 1999; Health Canada 2001), which is a clear indicator that unprotected sex is happening more frequently (on a per capita basis). As has been amply demonstrated, this increase in STDs, and especially in HIV has a direct link with the assumption of sexual risk, or what on the surface appears to be the avoidance of cognitive rationality. Thus, as theme three states, the notions of sex, love, trust and risk are contingent in the gay population, and more subject to idiosyncratic rather than conventional interpretation.

Researchers and community activists regularly question whether unsafe sex is rational or irrational, but the debate, as is so often the case, is predicated on
binary categorizations: condomless sex is rational or it is irrational — with no middle ground.

However, even the most deterministic standpoints on trust, such as exchange theory, transaction cost economics or rational choice theory have relaxed the assumption of perfect rationality a long time ago, thus permitting a subjective concept of rationality to reflect the diversity of interpretations of reality. It is recognized that, at least in trust, rationality is imperfect (or as Simmel would have put it, 'weak'). (Möllering, 2001:412)

This line of thinking resonates with Good's (1988:42) astute observation that to be non-rational in a certain way may be dogmatically rational as a strategy for coping with the limits of one's own rationality. Furthermore, as previously discussed, according to Lewis and Weigert (1985), apart from cognitive/calculative interpretations, trust may also spring from affective (emotional, intuitive) grounds.

Davies et al. (1993) argue that having unsafe sex is not particularly due to a collapse of rationality, but to the logic of the sexual script dominating over the logic of safety; which is in fact a form of prioritization, not a form of irrationality. Yet, according to Turner (1997), the reality of the situation is most likely fuzzier than even this analysis allows.

One form of rationality feasibly does not replace another. Instead, some sex is potentially more or less rational than other sex, and safer sex is less rational than safer sex. Instead of one type of logic replacing another, or irrationality taking charge of a man's actions, it may be that the logic of safety is simply reduced by the sexual conversation and the ... sexual domains leading to arousal. (119)
However, to imply a reduction in logic with respect to sexual risk is not the same as labeling individuals as 'deficient', 'pathological', 'incapable', or 'the other' (Davies et al. 1996; Odets 1995). *Pace* Rademaker, while the sexually aroused man's logic surrounding risk may be somewhat deficient at the sexual moment, imbuing sex with spontaneity and a pleasure goal, a lapse of logical risk analysis ought not to be considered as all encompassing, at least not to the point of total mental incapacitation.

Niklas Luhmann, in *Familiarity, Confidence, Trust: Problems and Alternatives* indicates that

trust ... requires a previous engagement on your part. It presupposes a situation of risk ... You can avoid taking the risk, but only if you are willing to waive the associated advantages. You do not depend on trusting relations in the same way as you depend on confidence, but trust too can be a matter of routine and normal behaviour. (2000:97)

The distinction between confidence and trust rests on perception and attribution – if one does not contemplate alternatives, one is, according to Luhmann, in a situation of confidence. However, if one deliberately chooses a particular action in preference over another, in spite of the possibility of being disappointed by the actions of others, or regardless of the risk, the situation is one of trust. In the case of confidence, one reacts to disappointment by external attribution. However, in the case of trust, one needs to consider an internal attribution, and come to regret one's trusting choice. As was discussed earlier with respect to safe
sex education, and unsafe sexual behaviour, the theories of cognitive dissonance, in great measure, disallow internal attribution of blame, and as such, it is easier to mentally rework the internal attribution into external attribution — for example, to blame someone else for not disclosing that they are HIV-positive, rather than to castigate oneself for not using condoms, or at least, not negotiating sexual safety. However, Luhmann also suggests “the relationship between confidence and trust becomes a highly complex research issue. The question is not simply to assign expectations to types and sort them according to whether they are based respectively on confidence or on trust. A relation of confidence may turn into one of trust if it becomes possible (or is seen to be possible) to avoid that relation.” (Ibid.) In other words, trusting is an easy alternative to having confidence in oneself or in others — trust merely requires faith (as can be seen in, for example, the faith that God exists), while confidence necessitates evidence, which in turn requires information or research of some sort.

Bearing in mind this hazy contingency, we should return to the main topic — the intersections of trust and risk as they apply to unprotected sex. Biology and culture are not contradictory, as the ‘nature vs. nurture’ debates often suggest. They are interactive. (Kosko 1993, Tuzin 1995) It is the intersecting middle ground between biology and culture that informs sexual behaviours and sexuality. In terms of the issue at hand — risky sex and pleasure — while there may be a biological drive to seek pleasure, culture and life-course events play a mediating
role (to a greater or lesser extent) to give meaning to the sexual encounter for the individual, as well as presenting the means of both expressing and constraining those encounters. (Abramson and Pinkerton 1995; Edgerton 1992; Greenberg 1995; Meyer-Bahlberg 1995; Udry 1988; Weinrich et al. 1993) In other words, culture, as we shall see, allows for and provides defined borders for pleasurable and non-pleasurable experiences.

If biology drives culture, the reverse may also be true. For example, anthropologist Robert Edgerton (1992) puts forward the notion that there is a basic human drive for novelty – the need to shake off boredom – which culture attempts to restrain. This instinct can lead to “socially disruptive, deviant behavior as people violate what they experience as stifling cultural constraints” (73). Or, as Diane Ackerman puts it, “Sometimes our senses wantonly crave novelty, for no other reason than it feels good” (1994:165)

In gay culture, there has been an historical tension between the norms of sexual liberation, which are fantasized about long before one ‘comes out’ into the gay orbit, and the norms of monogamy, which are taught to most gay and non-gay boys during their heterosexually informed youth. Additionally, since the emergence of AIDS, this tension is also played out via the norms of sex and safer sex education. One set of norms allows for total sexual pleasure, while the other
attempts to constrain it, opposing cultural norms that become evident in the discourse that follows.

An historical part of the safe sex education message has always been “know your partner”; more recently, the term “negotiated safety” has been employed. In the first instance, while the connotation evoked an ambiguous sense of ‘familiarity’ associated with the medico-social injunction to limit one’s number of different partners to minimize risk, the latter has made room for multiple experiences, provided that some form of discourse about sexual safety has been included in the pre-sex script.

Tim recalls his early sexual socialization as being conflicted and guilt ridden. As we shall appreciate, this initial introduction to a formative gay identity influenced his future understandings of his own identity, and subsequently, his understanding of safer sex, negotiated safety and health information uptake.

I remember at a very young age, having talked about or doing sexual things, which I wouldn’t either as a child or as an early adolescent - always keeping it a secret and feeling ashamed for it. I remember convincing myself that I wasn’t gay - I wasn’t a fag. Because fags weren’t like me - and I didn’t understand myself - no, it’s just because you want to be such good friends with these guys - that’s why. And actually at one point I remember - about grade seven, grade eight, I convinced myself that really all I wanted to do was be really close friends. It wasn’t just that I wanted to fuck with men. And then I realized later -many years later - that was just like a form of denial and I was conning myself to deal with the shame. And I got the shame - the only place would be - I thought - was from my parents. Because they totally had outward, outward, vehement homophobia. And so - and I was having these secretive gay experiences. So it was major, major shame. So I remember for
the longest time - probably up until my 20s - every time I would cum, I would have massive feelings of guilt. And I’m not even Roman Catholic. And it took forever for that to go away. And it affected everything about having sex. The guilt feelings from it.

Tim’s early years were asexual, at least in deed if not in thought and fantasy. He recalls how he felt that he ‘missed out’ on having an adolescent sexuality complete with crushes and heartaches. What is of importance in this monologue is the fact that Tim discusses emotions, as well as behaviours. His notions of sex, love, trust, and later on, risk, are emotive as well as carnal.

We grew up in South Africa. I remember having sexual feelings fairly young. But I didn’t know what they were. And I never had sex with a man until I was - or anyone - until I was in my 20s. But just being able to put a label on it - to know that you’re - even if people say that you’re not something - because I didn’t even know what not was. Like I’m always envious when I see gay friends of mine - like when you’re cruising around when you’re 12 - (laughter)... No, just being 15 and having a 19 year old or a 17-year-old guy that you’re in love with or having crushes - like I missed out all that.

I know in my head it’s not as glamorous as people maybe make it out to be. But I think that definitely shapes your outlook on sex and about yourself. I could stand up now and ask what’s up, but back then they would go inside and they’d all be having sex at 12, 13, 14 and I would be the only one out of it.

Tim’s past and current relationships reflect social meanings ascribed to intimacy and friendship that go beyond the bounds of what, for example, Christian exhibits. As Tim states, “It’s the actual establishment of a relationship with people that I really enjoy. It’s not the sex.”
This admission that it is not the sex, but the relationship that counts, is the antithesis of what one would expect from a stereotyped member of a purportedly hedonistic, sexually vectored community. The point to be made here is that not all gay men are slaves to their penises; that some (if not many) define sex, love and trust on a level deeper than is generally ascribed to them.

When Tim first heard about safer sex, the concept eluded him, for a number of reasons, one of which was his religious upbringing. He was about 19 when he first heard about safe(r) sex from his friends. While he condemned them for having pre-marital sex, he did recognize that at least they were using condoms to avoid pregnancy. However, in Tim’s case, the safe sex message was 1) irrelevant, because he was not having sex at the time, 2) condoms were to prevent pregnancy, a situation that he felt was not applicable to him, because 3) sex outside of marriage was a sin. Moreover, the message he received was directed to a heterosexual population, to whom AIDS was not an issue, since, at the time of his indoctrination into safer sex, only gay men got AIDS.

In a subsequent discussion, when one of the group participants stated that if he got AIDS, it would be a relief, at least in knowing that the waiting was over, Tim commented that he understood that feeling: “A lot of the guys I know do - in a sense.”

I don’t think I’d be too freaked. Well, oh no, I have to start taking all this medication and diet and blah, blah, blah. There are negative and positive
points to either/or. I would feel in a sense relieved just on a sexual level - of my sexual practices - I would feel relief in that way.

However, for Tim, sex and intimacy are the ideal pairing, although by his admission, he has had one without the other. It is ironic that Tim focuses on a 'sexless' relationship, rather than one that lacks intimacy. "But my dream is that it's gonna go together. I don't want another sexless relationship." One would expect the reverse, since he has only had sex with "about six or seven guys". That minimal experience notwithstanding, he has had some experience with sex and HIV, but has decided that the two are now incompatible for him. While he states that he has "gone out with guys who are positive", he would not continue the practice, calling it "an odd juxtaposition of putting someone who's HIV-positive and someone who is HIV-negative" and realizing that "they're both gonna die eventually".

From this information, it seems that Tim has dated a number of people with whom he has not had sex, obviating the need for safety altogether. If we assume that he has had sex with at least one of these HIV-positive dates, the issue of risk is revisited. In fact, as he states:

You can always go about the basics of just assuming everybody is... [HIV-positive]
That's what I do...

But in fact, this has not always been the case. In the past, Tim has had unprotected sex, both with his former and current boyfriends in the last two
months of their relationships. I asked him why they switched from protected to unprotected sex:

We both got tested and I felt comfortable enough with both of them at the time that we made that decision together that they hadn’t been fooling around. We got tested when I first started going out - had safe sex - got tested again and - because I definitely prefer having sex without condoms - for me, I guess as most gay men would say - more enjoyable, you don’t have to worry about a lot of other things and it’s a different sensation as well. So I guess that’s why - that’s what changed. I mean - I don’t know - is that still safe sex then - after? I don’t know. I guess technically not.

Apart from sex with these two boyfriends, there were other incidences of barebacking, especially when he first came out. In the main, he didn’t use condoms with men whom he “knew or was going out with”, except for one occasion when, as he states “I did have anal sex - with a guy that I’d just met. In a bit of a drunken stupor.”

Notwithstanding Tim’s short work on the periphery of the sex trade (at a massage studio) and his prior knowledge about safe sex, Tim has, on occasion, abandoned condoms because of pleasure and trust factors – trust in his partner (“they hadn’t been fooling around”), medical testing (“We got tested when I first started going out - had safe sex - got tested again”), and trust in himself (“we’d only have safe sex and I only had sex with him”). The one time he had unprotected sex with a total stranger, he attributed it to alcohol having lowered his inhibitions.
In order to examine the second half of this theme, one needs to compare and contrast Tim's understandings of the relative weights of sex, trust and intimacy with both mainstream gay men, and with other members of his cohort. We have already come to understand that Tim's prior behaviour suggests that, at least in the past, he had privileged intimacy over sex – as evidenced by his comment that he would like to have more sex in his relationships. His doctrinaire religious upbringing had convinced him that sex was reserved for married heterosexual couples in a committed (married) relationship; his definition of sex itself, therefore, reflects his emotive (as opposed to carnal) epistemology -- ... both people have to have the intent of orgasm when they're together” – ejaculation is not necessary, in his view, in fact, as he states:

I mean there's some times - I don't know - there's some times when - I mean you could just - you could suck a guy off and that's all it is - you're sucking them off. And I wouldn't classify that as sex. But I could be with somebody else and neither of us cum - and neither of us orgasm - and not even have oral sex - just be together kissing, massage, manual stimulation, whatever. And neither of us actually orgasm. And I would still classify that as sex.

Tim's ambiguity about what constitutes sex is unstable in and of itself (“sex isn’t a definitive thing in my head”) – in this one statement, he defines sex as non-masturbatory; not necessarily involving orgasm, but including the intent to orgasm, whether or not orgasm actually takes place; sex is “kissing, massage, manual stimulation, whatever”; “more of a mind thing”. In comparison, if we examine Christian’s definition – “If we count everything where I was in the
presence of one or more men, where there was a hard on and there was cum ...”,
or Patrick’s: “Well, it could range from oral to anal sex. That's about it – that's my
definition of sex”, we find that the three answers encompass a range of
behaviours and emotions varying from the purely emotive to the purely carnal.
Clearly, in the emotive paradigm, condomless sex does not constitute any risk,
while in the purely carnal paradigm, condomless sex is unmistakably risky.

The disparities in the definitions of sex (and there were several other definitions
in the cohort) point to the ambiguity of what constitutes sex and by extension,
the instability of a clear definition of risk. Therefore, any message that suggests
that gay sex is intrinsically dangerous fails to consider the individual definitions of
sex and risk. Tim’s desire to trust his partner, as well as his confidence in testing
leads him to consider risk from a perspective that allows individuation, as he
states:

Essentially, people are tired of AIDS, they’re AIDS exhausted. They don’t
want to hear about it any more, they don’t want to think about it any more,
it’s - as you said, it becomes manageable like diabetes - and yes, if your life
span is shortened, well, tough shit. But that’s just the way it goes. And I
think a lot of people are beginning to think that or feel that and yet there’s
this other side that’s pulling in the other direction saying thou shalt use
condoms. Or the wrath of God and AIDS Vancouver will come down
upon you.

It seems clear that the theories of communication described in previous chapters
depend on a fixity of objectives (as Rademaker, et al 1992 suggests), on a stable
and homogeneous population and on a coherent definition of the problem. When population groups extend their definitions of the situation (sex), problems (safety), and potential solutions (trust, fear, dogma, conditioning, peer pressure, repetitive conditioning) risk-avoidance messages are obliged to take into account the multiplicity of meanings ascribed to the whole state of affairs, rather than focusing on any particular singular solution or message. In the previous example, the vast majority (if not all) of the advertisements presented earlier would not have appealed to Tim's notion of sex, and would therefore fail to resonate with his decision-making processes regarding his need for protection from infection. The challenging task is to develop an intervention process or set of processes that take into account the multiplicity of social meanings ascribed to risk, safe sex and intimacy in the gay sex world.

Theme Four – The Messenger

Since safe sex education intrinsically concerns risk and trust, it is more salient when received in situ from someone deemed to be trustworthy, rather than in formal, bureaucratic settings or via mass audience appeals

Patrick was raised in an environment that was fraught with instability – alcoholism, lack of secondary education (he only completed grade 8), frequent changes of caregivers, early abandonment from childhood nurturing, and inconsistent and unreliable parenting. His early life on his First Nations reserve was devoid of positive sexual experiences (in fact he was sexually abused from an
early age), and his subsequent migration to a larger city was expedient only in the sense that he was able to escape some of the abuse and neglect he had been experiencing.

As we shall see, while Patrick (the youngest of the cohort) did receive safer sex education both in the schools and from his peers, the messages, for reasons other than their lucidity, were ignored or abandoned, at a certain point in his life. However, I shall begin by exploring what he learned, where, and from whom. He first heard of safe(r) sex at the age of 14 in school — sex ed — where "we had to put the condom on the big wooden dildo". While there was no mention of gay sex in the programme, he states that "It translated into gay sex for me as well". When asked of his impressions, he stated:

I don’t know, I guess - well, I thought it was a good idea because I know in school we were swamped with things about AIDS and STDs and all that kind of stuff. So I took it pretty serious. That’s what scared me when I came out - that’s what I - I associated AIDS with gay people. I don’t know where I got that from, but when I came out, I thought oh no, I’m gonna get AIDS if I sleep with a man.

Patrick appears to have received sufficient information concerning safe(r) sex in school (he was living with a sister in Winnipeg at the time) that he was able to assess risk, and for the first few years of his sexual exploration, insist on precautions. Thus far, it is safe to assume that whatever safe sex information he received, notwithstanding its original heterosexual content, was adequately imprinted and subsequently translated into homosex. However, something
happened in Patrick’s mind that speaks to the lack of reinforcement of the message. While he used condoms for the first five years “Probably because the people I slept with also practiced safe sex and I was ... worried about getting a disease or something” and because he had friends who had contracted HIV, when he was 19 he became involved with someone in an intimate and monogamous relationship. This marked a change in his risk-behaviour:

**How did you guys decide not to use condoms?**
Well, I was - I didn’t feel comfortable with the idea because I was so used to using condoms all the time. But as I got to know him I felt more comfortable, and I knew that he hasn’t slept around or anything. He’s very new to the gay community - the gay lifestyle - so I felt comfortable with him and he just said he couldn’t cum when he wore a condom and I believed him. And I wanted to give him the satisfaction of cumming. So he - so I agreed for him to not wear the condom.

**Had you or he been tested for HIV?**
Yes. And that was another - sort of a condition too. We both went in for tests before this happened and we did - we both came out negative - so that gave us some more comfort, both of us.

**And obviously there was a high level of trust for both of you?**
Yes.

**You said it was and then it wasn’t - what happened - what changed?**
I think at that point - it may change again. I was really totally in love at that stage in the relationship.

**What was the meaning of the happening - at the time? That led to not using the condom?**
I don’t know. Just strengthened the bond, I guess.

**Yes, because that means you have to trust the person. Is trust hard to come by?**
I like to believe that people are not sluts.

**I just asked if trust comes easily or if trust comes hard.**
Trusting a person or having a person trust you?

Both - trusting somebody like if they tell you they're negative or deciding that you're -or that they won't cum in you - or whatever.

I don’t know. I think more of the ways that I go about - I actually enjoy watching guys shoot. And I tell them - I want to see you shoot. It turns me on incredibly and they used to pretty much accommodate me.

Was the relationship totally monogamous?
I hope so. From what I know and what I feel, yes, it was.

Initially, it appears that his conviction that his partner was “new to the gay community” lent them some degree of immunity from HIV (a gross misconception – especially in light of typical sexual behaviour when one first comes out). Additionally, they both were tested for HIV and were found to be HIV-negative. Ultimately, as he puts it, they trusted each other, and condomless sex “strengthened the bond”.

However, testing and trust notwithstanding, they were only together for one year, so one can infer that the relationship was not as well established (in terms of time) as one would expect when assuming such epidemiological risk, and second, that there was an added risk in that the window period for HIV infection to show up in standardized tests (generally taken to be 3 – 9 months) was ignored.

Subsequent to this relationship, Patrick’s behaviour toward condom use changed even more dramatically:

What’s happened in your sex life with regard to condoms in the last year?
Well, I noticed I’m not protecting myself like I should be. Like, I’ve been taking major risks - why I don’t know - I guess I’m just stupid, but I know I’ve been very reluctant to use condoms. I even slept with somebody that I knew is HIV positive and had unprotected sex with him. Which I figured would give me a wake up call, but then it didn’t, I guess. So I had unprotected sex three times.

I think it’s spur of the moment - because I know in my mind I would like to practice safe sex because when I go on trips, I bring condoms, I bring lube with me. But then I don’t always carry them with me and then when things happen, I don’t have it with me or things just get - move so fast you don’t want to take the time to go through the hassle.

Without getting over-involved in the intricacies of Patrick’s psychosocial rationale (or lack thereof) for not using condoms, it is evident that his ‘fear factor’ has diminished from his earlier sexually active days. Having gone from doubling up the condom, to perceiving condoms as a hassle reveals an important transformation in his retention, if not also uptake, of the safe sex message. It is not that he has forgotten the safe sex message; rather, he has chosen reasonable risk as his modus operandi. Despite his avowal that he has “been taking major risks”, he is at a loss to explain why, other than what he calls stupidity. However, his sense of trust in others, coupled with his reluctance to forego the pleasure of barebacking, has permitted Patrick to rationalize barebacking as safe, especially in certain circumstances.

I don’t know. I just - I just kinda get to know the person a bit, and get a feeling for whether they’ve slept around a lot and - and I ask them whether or not they’re HIV positive or negative and, you know I can get a pretty good feel on whether or not I can trust them and - sometimes I don’t even have to ask questions. Like one of those guys - had never been with a guy before, so I kind of - really believed him.
One of the elements that makes this theme viable is the fact that information about safe sex and risk is more salient when it is received 'from someone deemed to be trustworthy'. In this case, Patrick deems the stranger trustworthy because he stated that he was HIV-negative, and Patrick felt that he was HIV-negative – he trusted his own judgment. On the surface, this appears to be the opposite of what arises out of theme one, where one tends not to trust one's own judgment; however, in reality, it may be more analogous than distinct. While Patrick does not exhibit (or mention) confidence in either himself or his partner(s), which would require conscious thought (as explained previously), his 'blind faith' trust is operationalized, on the flimsiest of pretexts – his sense of 'feeling' out his partner(s). In reality Patrick has no reason to trust either the casual sex partner or himself, since by his own admission, he considers himself 'stupid' for barebacking, and for trusting. False trust, and misplaced trust are fundamentally the same thing in the end – they both lead to faulty decision-making with respect to risk.

Patrick demonstrates how formal, institutionalized safe sex education can be a double edged sword. While as the youngest in the group, and by his own admission, the safe sex education he received in school translated into a MSM paradigm as well, he should be the most cognizant of the risks involved in barebacking. Yet he is perhaps the most lax of the group when it comes to using
condoms. His 'real' education, if one could call it that, has come from his experiences – his sexual encounters, most of which have been unsafe (in the traditional sense). The reinforcement that "I just kinda get to know the person a bit", and his impression of "whether they've slept around a lot" serves as his benchmark, rather than the more bureaucratized (and sanitized) school versions.

Conclusion

The question of 'knowing someone' first, as was stated by several of the participants, was a basic tenet of early HIV/AIDS education. The notion of 'knowing one's partner' is socially constructed as an embedded 'truth form' in both themes three and four. However, as previously argued, the notion of 'knowing' someone is problematic. As exemplified by Tim in theme three, we note many instances of relationships (both gay and straight) of long duration that break apart because one partner (or both) feel that they don't really 'know' the other, after all. However, the notion, as expressed by Patrick in theme four is a carryover from earlier HIV/AIDS education. The assumption that 'knowing someone' imparts knowledge about sexual scripts and risk decision-making is delusional – many people have become infected by their so-called monogamous sex partners, which clearly indicates that 'knowing' may be a form of false consciousness, and potentially lethal comfort.
Theme one deals with the ability to trust. “Falling in love, like the act of sex, is an act of risk and an act of trust.” (Gregor 1995: 334) Significant material and emotional capital is vulnerable. Can one’s partner be trusted with confidences and secrets? Will the relationship last, or will one’s heart be broken? Will it end up in boredom? These fears are substantial enough, but deeper fears lie beneath the surface. “At the deepest level, the experience of love may tap profound anxieties... fragmentation, disorganization, and dissolution of the self” (Pearson 1989: 44.). Alan typifies this apprehension, as evidenced by how he treats potential boyfriends, his specific lack of trust in himself, and his admission that it is most likely that he can never feel comfortable about his ability to make decisions about sexual risk, leading him to adhere to a more simplistic notion – ‘sex without condoms is taboo’. Therefore, especially for Alan, allowing himself to fall in love is, by nature, intrinsically bound up with risk-taking and taboo, and is not liable to happen.

The significance of this love/risk interplay cannot be overstated – if the pursuit of affection, approval, and attention are inextricably linked to risk (and therefore also to trust), the prospects for disassociating risky sexual behaviour from sexual expression, especially in the context of a love relationship, are dismal. Since risk is an ubiquitous and contingent component of love, and trust is the ameliorating factor that manages risk, then trust must also be considered an integral part of the relationship script. While this seems, on the surface, an obvious connection to
make, one must bear in mind how frequently the discussion group participants spoke of the differences between sex and love. Nonetheless, they are not wholly divergent issues – in actuality, they are part of the same emotional package, dressed up in different guises. Casual sex, for all it is touted to be, is, in the gay world (at least) a ritual form of courtship; and the desired outcome of courtship is the establishment of a lasting emotional attachment.

Overall, the ‘gay courtship’ dynamic is based in a ‘fuzzy logic’ (Möllering, 2001:413) of trust by means of a resolute belief that trust is ultimately ‘reasonable’. In other words, whether our bases for trust are more calculative or more intuitive, more abstract or more idiosyncratic, what matters ultimately is that they embody ‘good reasons’ for trust. However, there is no automatic logic connecting interpretation (good reasons) to a guaranteed favourable outcome.

At the core of the issue is the question, “Why then would anyone place himself in harm’s way with respect to potential infection, especially if the final desired outcome is the establishment of a long-term, loving (and sexual) bond?” As has been demonstrated, both through the voices of the participants, and the theoretical analyses of love and risk, it is precisely because of the fuzzy logic of love and affection that trust (and possibly love) does happen, and sexual risk is thus incurred. Moreover, in sexually active people, if risk is ultimately
omnipresent, it is not the issue of whether the presence or absence of risk is there, but, the degree of risk that is to be assumed.

As exemplified by theme two, and confirmed by Christian's internalized homophobia, the notion of multiple transgressions (gay, pedophilia, anti-Catholic behaviour) plays into the inability to trust oneself to 'behave' appropriately. Having already transgressed by enjoying pedophiliac sex, and by virtue of being gay, in and of itself, Christian has accepted and internalized a stigmatized, or spoiled identity. As the expression goes, "In for a penny, in for a pound"; as we have seen, many gay men have bareback sex, not despite its intrinsic risk, but precisely because of it. Consciously or subconsciously, barebacking is the embodiment of the sex/love/risk/taboo continuum. Even those who state that they didn't mean to have UAI (functional 'oopses'), i.e.: were too drunk, or had no condom available, or that their partner was 'so hot', are in reality expressing the same sense of merging — the heady intoxicant of a potential (stigmatized) relationship. Abandoning self-imposed boundaries and self-control makes possible the sense of merging. The social situation of the mutuality of pleasure promotes an even greater permeability of restrictions. At this juncture, risk, already subsumed to passion, is at best a secondary consideration.

As an adjunct to theme four, a new generation of gay men has chosen to depart from the institutional frameworks that older gays have developed and maintained
over the course of the past 20 years (occasioned by the occurrence of AIDS in Western society). In so doing, they have not, as one would suspect, developed new rules about social interaction; rather, they have developed a culture that shuns rule-making in favour of contingency — a post-modern, or in some parlance, a post-gay paradigm. Out of this contingent world emerges a plethora of new ways of interrogating sex, dating, relationships, risk and trust.

The participant discourses attest to the fact that, social marketing notwithstanding, there are few absolutes in their lives — whether it is with respect to the stability of early life in the family, the coming out process, the use of drugs and/or alcohol as mood enhancers, notions of risk, relationship dynamics, and so on. What is interesting to note is that despite living in this contingent arena, at no time did anyone, when asked a question, reply that they ‘didn’t know’ — they all believed that for themselves, there were answers to all questions, notwithstanding the fact that the answers themselves were dependent on other factors in their lives, or the lives of others. This speaks volumes about the utility of Lewis and Weigert’s (1985) assertions that trust is a functional alternative employed to acknowledge and manage complexity in one’s life, a reductionist methodology that renders the incalculable and the contingent manageable.

More often than not, the participants indicated a distrust of others, while professing a substantial degree of trust in their own decision-making processes.
This pervasive distrust syndrome is ameliorated by a either a confidence in their own perceived abilities to discern truth from falsehood, right from wrong, and moral from immoral, or an amplification of their own self-doubt. Thus, when faced with a situation that calls for trusting others, in some cases that trust is freely given, while in other cases it is withheld. The basis of withholding trust is a determination of the trustworthiness of the other – what Sztompka described as ‘reciprocal trust’. In all cases, the cardinal sin was not related to the partner’s sexual behaviour as much as it was to the emotive behaviour – the worst offense was to be “a liar not a cheater”.

As further support to theme four, especially with respect to the concept of trusting others for reliable information, David Good (2000) explains the subjects’ negative experiences of rule breaching (being lied to) as a function of “the role played by another’s reaction to one’s own action [not feeling that one can trust another person or institution], in confirming the validity of the prior experience on which that action was based”. Or, in plainer terms, ‘once burned, twice shy’. The consequences of not having a measure of predictability in one’s life are dire – Rutter et al (1980) postulated, on the basis of a number of experiments that “those who are more willing to trust other people are likely to be equally trustworthy in that they are less likely to lie, cheat, or steal. They are also less likely to be unhappy or maladjusted, and are typically more liked by their friends and colleagues” (from Good, 2000). On the other hand, if social marketing
messages, other social messages, or indeed the bearers or spokespersons of those messages are deemed unreliable, especially because of one’s own lived experiences, the clash between one’s own presumed honesty and the ‘other’s’ lack of honesty may leave a gap too wide to traverse.

With this in mind, it is understandable why some of the participants were less concerned with being infected with HIV and more concerned with the quality (honesty) of their encounters, regardless of the serostatus of their partner(s). And, while the issue of trust was frequently part of the discourse, it was generally accompanied by at least some reasons to distrust; quite often reasons that have been absorbed via social marketing messages, such as to use a condom all the time, since anyone could be a carrier of contagion, presenting the individual with a confused state of affairs with which to contend – a state of affairs redolent with contingency.

In one’s daily life, there is a series of events which demand that decisions be made, bringing about a wide assortment of consequences for one’s well-being. One could spend countless hours analyzing the costs and benefits of each situation in order to derive the maximum benefit from each, at the least psychic cost. However, in today’s sexualized HIV vectored gay world, time is also a valuable commodity. When HIV may, paradoxically, be just around the corner, time and the enjoyment of life is seen as being even more limited and precious;
the highly rational approach to risk-analysis calls for extensive self-reflection only under certain (and rare) circumstances. This is an example of the manner by which the contingencies surrounding trust, risk and intimacy found in theme three are managed. Often it is easier to 'go with the flow' of gay society, and to hoard one's sense of resolve and intellectual and emotional resources for those situations that absolutely demand their use.

The four themes relating to family and early socialization, internalized homophobia, the contingency and instability of a sexually vectored gay world and safe sex education point to several conclusions. First, trust and risk are social constructions that are individually interpreted based on prior experience, irrespective of formalized social marketing tools; second, early socialization in a heterosexist world contributes to the formation of generalized and specific risk-taking as one both discovers one's gay sexuality and as one acts out a gay script; third, for gay men in particular, quality of life in the here-and-now takes precedence over potentialities of the future, be they disease or premature death; and fourth, so-called community norms, especially with regard to sexual risk-taking, are ephemeral and lack general applicability to a gay population as a whole. In the final chapter, these conclusions will be elaborated, and the prospects for an effective behaviorally-based programme to halt the spread of HIV/AIDS will be examined.
CHAPTER 7 – CONCLUSION

Summing Up

Focusing on individuals, groups or communities, safer sex interventions in the past have attempted to change individual attitudes, beliefs, skills, and risk behaviors associated with HIV transmission as well as community and social conditions that encourage or at least fail to discourage risk behavior.

However, as of 1993, after approximately 10 years of social marketing programs, only 68.9 percent of the 818 gay and bisexual men surveyed in a national study (Myers et al, 1993) reported using condoms all the time for insertive anal intercourse; 71.7 percent reported using them for receptive anal intercourse. The reported reasons given for the non-use of condoms varied, but it appears that the researchers only looked at instrumental rationales (a lack of condoms, passion in the heat-of-the-moment, the belief that the partner was HIV-negative, and so on), avoiding any deeper meanings of sex, intimacy, trust, the significance of fluid exchange and other psychosocial variables that might have an impact on the decision not to use condoms for anal sex. By 2000, the figures and reported justifications had barely changed.

Clearly, we would never tell an HIV-negative monogamous heterosexual couple always to use condoms, “just in case …”, yet this remains the prevailing safer sex
message for gay men, suggesting that either gay men are intrinsically less capable of making their own reasonable decisions about condom use, or that there is ‘something different’ about homosexuality that requires stricter surveillance and increased state and civil intervention. On the other hand, we do need to adapt some forms of safer sex principles for gay men to accommodate the large numbers of men who do not consistently use condoms. We must also recognize that a significant number of men who believe their relationships to be monogamous are still being infected with HIV. If self-justification contributes causally to the occurrence of high-risk sex, we need to know if and how AIDS education might counter it. The difficulty lies with the fact that almost always, AIDS education is delivered at a time and place other than during sexual contact.

What is required is a merger of the discourses on trust, risk, and sex. To do this, we need to understand the meanings gay men and MSM ascribe to risk, particularly the risk of contracting HIV; to examine the relationship between the pleasure of sex and the rationality of desire; the importance of relationship quality as it pertains to trust in oneself and one’s partner; the linkages between beliefs and behaviours; and what, if any, social marketing interventions hold some promise with regard to changing the behaviour patterns and sexual scripts of people who choose to have unprotected anal intercourse.
As early as 1991, when the data for the ‘men’s survey’ (Myers et al, 1993) was collected, over 94% of gay men surveyed knew that anal sex without a condom was ‘very high risk’, yet almost 30% of the same respondents who practiced receptive anal intercourse did not consistently use a condom. Of this cohort, more than 28% indicated they did so because “the sex was so exciting”. For many gays and MSM, as evidenced by a number of this study’s participants, anal intercourse truly represents ‘real sex’, with other forms of sexual expression being a part of their sexual scripts, but not nearly as important as penetration. The importance of anal intercourse between men is not simply derivative of heterosexual penetrative sex. While heterosex has always been ‘normative’, and accepted by society, gay sex, especially anal penetration, historically has been demonized. For the receptive partner in anal intercourse, sex with a condom can be anticlimactic or unfulfilling, and for the insertive partner, the physical and emotional sensations that the use of a condom desensitizes can make him feel ‘cheated’ of the true carnal pleasure of sex.

In order to fit in with the community, especially for those gay men who are already community-involved, risk taking becomes an integral part of being gay – not only from a sexual perspective, but by simply assuming the risks associated with being ‘out’. It is not surprising then, that gay men have subliminally (and sometimes overtly) been coerced and conditioned by a homonegative society as well as gay society, to some extent, into being ‘risk takers’.
A meaningful sociological focus with respect to non-condom use among regular partners must examine the nature of regular and casual relationships, which may in turn provide an understanding of the different meanings gay men ascribe to condom-less sex. Implicated in this analysis is the contingent nature gay men ascribe to the constitution of risk — especially since purely epidemiological evidence comprises but a small percentage of the range of risk-types. Consequently, a majority of men who have condom-less anal intercourse with regular partners do not perceive their behavior to be risky, despite either not knowing their partner's HIV status, or whether their partner has had sex with other people during the course of the relationship. In the case of casual sex, it appears that 'knowing' one's partner takes on significant importance, notwithstanding the ephemerality of 'knowing', as we have seen. Frequently, either rudimentary or complex rules are negotiated that sanction sex outside of relationships, yet offer some semblance of sexual safety. Additionally, it should be noted that for those men who have sex with men, but do not self-identify as gay or queer, rule making plays an extremely important role in determining sexual scripts, both in their MSM and non-MSM statuses.

Much of the public HIV/AIDS prevention work has utilized various social marketing models. Social marketing programs have implicitly (and occasionally, explicitly) fostered the belief that gay sex is 'always' equivalent to contagion — a virological falsehood and a homophobic declaration. Generally, they do not
allow for much interpretation of 'safer' sex, nor do they usually allow the leeway for two HIV-positive men to have condom-less sex\textsuperscript{58}, let alone two HIV-negative men.

The earliest versions of public health campaigns pertaining to AIDS prevention frequently depended on a morbid fear of infection in order to persuade gay men to change their sexual behaviors, and in particular, to \textit{always} use condoms when having sex. The prevailing paradigm, the KAB (knowledge, attitude, behaviour) strategy, is based on a 'rational man' model – the hypothesis being that the dangers of condom-less sex, once conveyed, will be avoided, and replaced by prescribed safer sex behaviors. However, many ASO's that claim to have moved to 'community-based' strategies of HIV prevention by applying models of collective solidarity among gay men (Kayal, 1993), continue to produce KAB-type social marketing programmes. The supposed rationale behind the turn to collective solidarity is that this approach may have some value among gay men by amplifying their sense of empowerment, and by improving gay self-acceptance, which may in turn promote safer sex behaviors. Additionally, participation in the gay community has been shown to be associated with safer sex practices. However, community consultation is generally cursory, at best.

\textsuperscript{58} There is a continuing medical debate on whether or not one can be re-infected with different (and potentially drug-resistant) strains of HIV.
Constant condom use was, in the late 1970s and early to mid 1980s, a sensible reaction to a new medical disaster. The expectation was that this would be a temporary measure, until a cure for HIV/AIDS was found. However, notwithstanding new drug protocols that prolong life and improve the quality of life, the cure remains elusive. For many gay men what is now needed is a cultural adaptation about what appears to be a permanent way of life. "Marketing strategies often encourage men to consider sex acts as narrowly defined and circumscribed, requiring only a simple, discrete adjustment to be made safe, like an automobile with bad brakes" (Rofes, 1996:131) However, while gay men may comprehend that anal sex without a condom is generally unsafe, they may be unable or unwilling to consider their personal psychological relationship to risk.

Furthermore, as a society, we tend to see sexual behaviour patterns in many gay men that might suggest an egocentric view of society and themselves; the parallels between the risks gay men take, especially in their early coming out period, and youth in general, are clearly identifiable. However, since traditional information transition routes and forms of social reproduction open to young people are changing towards a less homogeneous and hegemonic standpoint, as has been demonstrated, it stands to reason that the same holds true for many gay men. Concurrently, and complimentary to this paradigm shift, the HBM [health belief model] proposes that health behaviour is located within individual (and not societal) rationalizations of risk. In short, risk-taking, for many, fulfils a need.
Health beliefs are also rooted in wider socio-economic structures in which people live their lives. In Ingham et al.'s study (1992), young people's decision-making about when to undertake safe sex was mediated by wider social and cultural understandings of sexual relationships in general. The concept of talking to their partners about previous sexual history, or asking them if they were HIV-positive was contrary to the social and personal norms of how sex was done. Apparent risk situations are frequently seen as safe because of sexual intimacy and trust embedded in close (and sometimes not-so-close) relationships. Risk and choice therefore, are seen to be mediated and negotiated through personal social relationships.

Generally, trusting others evokes positive actions towards others. Trust is liberating, trust mobilizes human agency; it releases creative, uninhibited, innovative, entrepreneurial activism toward other people (Luhmann, 1979:228). Additionally, being trusted by someone may be an argument for others to grant trust as well. Reciprocal trust develops most smoothly and acquires a self-enhancing capacity. Quite simply, trust breeds trust. It is easy to offer trust since one can expect trust to be returned. Social change is compatible with trust, providing that change proceeds gradually and in a constant direction.
However, in times of rapid and radical social change in society, as in a (perceived) crisis, instability undermines the existential fabric of social life. This general societal period of instability, brought about, in part by the AIDS crisis, though resulting in an increasing gay visibility, and greater recognition of gay rights, has also incited fundamentalist backlashes, both culturally and legislatively. In that case, there is no reason to expect reciprocal societal trust, predictive trust becomes difficult to assess, and suspicion and a tendency to withhold trust results. This becomes clear when one examines the sexual behaviour of gay men who have recently come out. As confirmed by the conversations with the study participants, in general, they initially feared the possibility of infection and, having absorbed ‘safe sex’ messages, usually insisted on condom use, at least until they became more acclimatized to their new life as a gay man, at which point, they moved from the rapid and often disconcerting coming out process into a more stable, less precarious life as a gay man. Their new-found confidence in their sexual identity provoked changes in their risk/trust analyses.

Nicholas Luhmann (1979:78) suggests that self-confidence makes one more prone to take risks involved in trusting others. In *Sex, Gay Men and AIDS*, (Davies et al., 1993) the authors examined social perspectives on anal intercourse. Many men mentioned trust. Being able to trust the partner to stop, if asked, was
common. Trusting the insertive partner to use condoms properly and to check the condom frequently was also underscored.

In part, they conclude that if trust is accurately communicated, the trust is justified. Additionally, we have also learned that education, family life, school experiences, past personal history, personal experiences and moral sensitivity heighten or lessen one’s ability to trust.

Second, risk and trust are symbiotic, and typically tend to act in inverse relationship to each other; in other words, the greater the risk, the lower the trust. Yet, in terms of sexual risk-taking, this may not always be the case. In either circumstance, behaviour, risky or otherwise, must be positively associated with social relationships and specific conditions of sexual encounters. Clearly then, risk and risk-taking, trust and trust-giving must be recognized as not only contingent, but also as a negotiated and mediated method of social interaction.

In that trust relationships are fundamental to the stability of social and psychosocial interactions, they deserve centrality in the analysis of barebacking and sexual risk taking. As we can see in the case studies, the stories reveal several important meanings about life course moments, the coming-out process, sex education, trust and risk, definitions of sex, loneliness and isolation, and intimacy. These case studies have lead to four recurring themes:
THEME 1: There appears to be a direct relationship between family dysfunction and the capacity to trust and make reliable decisions concerning trust, sexual risk and partnership intimacy.

THEME 2: There appears to be a direct relationship between an early lack of trust in oneself and/or in gay men and the denial of one's sexuality, which impacts one's ability to trust other gay men and leads to sporadic and anonymous sexual risk-taking as one fully enters gay life.

THEME 3: The social meanings ascribed to notions of 'trust', 'risk' and 'intimacy' are contingent and unstable in the gay world; meaning that attempts to communicate MSM risk-avoidance health messages must acknowledge and account for ambiguity and multiple meanings in their communication objectives, strategies and messages.

THEME 4: Since safe sex education intrinsically concerns risk and trust, it is more salient when received in situ from someone deemed to be trustworthy, rather than in formal, bureaucratic settings or via mass audience appeals.

These recurrent themes help explain why social marketing efforts have, in the main, lost their potency, and address the manner by which we can envisage some possibilities of stemming the tide of new infections in the future. In addressing these related challenges, the proposals to follow are different, radical and sometimes costly. But not nearly as costly as the continued loss of life in what appears to be a 'runaway train' of contagion and infection.
HIV Optimism

As an adjunct to the initial HIV optimism studies cited in chapter 4, in April 2001, an email message was sent to 390 Vanguard participants soliciting their opinions on the recently documented increase in HIV incidence (Martindale, et al. 2002, unpublished). As of May 9, 2001, 65 responses (17%) were received. Three questions were posed to the group.

1. Why do you think there has been a recent increase in HIV infection among Vanguard Project participants and other gay and bisexual men in the Vancouver area?

2. In general, what do you think should be done about it?

3. Specifically, what tactics could health care providers and community-based organizations use to make their HIV prevention messages more effective?

The responses to the first question suggest that antiretroviral drug therapy has a major impact on risk decision making – 18 people (28%) cited the success of this therapy as the reason. The second most frequent response was the high prevalence of barebacking (15 responses: 23%). Interestingly, 8 responses dealt with social marketing issues: lack or absence of prevention campaigns (12%), and loss of impact of prevention campaigns/backlash against them (12%).

As to the second question, ‘what should be done about it?’, almost half (31 responses – 48%) proposed “increased awareness through education and the media”. Ten people suggested promoting fear-based messages, while five people
suggested avoiding fear-based messages. Six (9%) suggested community development.

Regarding the third question, 45 people made suggestions for new tactics. Of this group, 14 (31%) suggested outreach and condom distribution, and 12 (27%) suggested that the realities of living with HIV/AIDS be better publicized.

These data, along with the comments (not reported in this study) made it abundantly clear that a) there is a sore lack of trustworthy and reliable information upon which to base risk decisions, and b) current social marketing in Vancouver is both inadequate and unfocussed.

Safe Sex Fatigue

Alex Kellogg, reporting in the electronic version of *The Chronicle of Higher Education* (January 18, 2002), cites a national study of undergraduate sexual practices (*Archives of Sexual Behavior* – December 2001) that indicates that “condom use remains low among many college students, especially gay men”. In this study, “only 36 percent of gay men reported always using condoms, whereas 48 percent of heterosexuals reported always doing so”.

He interviewed a number of students and administrators, almost all of whom cited similar reasons for not using condoms: “A lot of them aren’t getting the messages or they’re not hearing the messages. It can’t be that ‘If you don’t do

384
this, you're going to die'. These kids don't care. They just don't buy that message at all.” (Ronni L. Sanlo – director of the LGBT Campus Resource Center at UCLA, Professor of Education); “College students make their decisions based on some kind of risk assessment” (Katie Stepp – peer sexuality advisor, University of Georgia); “For college-aged people today, AIDS and all this STD hype is theoretical. They don’t have the hands-on reality of people dying or of seeing the devastation caused by AIDS.” (David R. Pasquarlli – spokesperson for ACT UP) and “Their real value [peer sexuality educators] appears to be in the networking that they do with their friends and their peers one-on-one, sitting in informal situations and talking in an informed way about sexual-health issues.” (Gloria B. Varley – director, Peer Sexuality Educators Program, University of Georgia).

Apparently, conventional safe-sex messages have little relevance for a contemporary cohort of young gay men who have little direct experience with AIDS. They exhibit what Kellogg refers to as ‘safe sex fatigue’. As 22 year-old Benjamin Persky states in the article, “[I’m tired of] being told that gay equals AIDS equals death”. This comment sounds very similar to Martin’s comments with regard to his lack of fear about HIV/AIDS, and his disdain of aging.

HIV Prevention Intervention

While some recent data indicates that some educational interventions directed at reducing HIV risk behaviours have met with qualified success, nonetheless, HIV

385
risk behaviours are not often reduced by conventional interventions and most likely do not lessen risk behaviour on a sociodemographically random basis. In a study by Barbara Warner and Carl Leukefeld, (2001), the authors found that “the success of interventions may be related to participant characteristics. Identifying participant characteristics related to both intervention completion and reduction in risk behaviours may be useful for further developing explanatory models of health behavior and for targeting and customizing interventions”. [Italics added] (479). One of the significant findings of the study was that the “perceived chance of getting AIDS did not significantly reduce any of the risk behaviors” (Ibid.)

In their study, there was a statistically significant difference in both the completion rate of the intervention and in the risk behaviour modification. Demographically, they found that “respondents who were white, younger, male and homeless were significantly less likely to complete all three sessions of the intervention” (490), but at the same time, crack users and persons who exchanged sex for money were more likely to complete the intervention.60 While their intervention was based on the Health Belief Model, they note some inadequacies in the model. Typically, the model suggests that the perceived chances of contracting AIDS should be related to intended reductions in harmful behaviour. However, they only found one risk variable (out of six) that was

60 Their methodology section is silent on whether or not the participants were paid for their participation. This would have a major impact on completion rates. Typically, respondents in these categories (drug users, hustlers) are paid per visit.
significantly related to changes — the number of times alcohol or drugs were used with sex. More telling is the fact that the “the proportion of times that sex was unprotected was the only risk variable that did not decrease for the majority of respondents”. (487) Clearly, the efficacy of their three-part Health Belief Model intervention program failed to produce the desired result.

A more recent study (Rosser et al., 2002) had significantly different findings, notwithstanding some potentially serious limitations of geography, follow-up loss due to question placement, and a small sample size. Using control and seminar groups:

At the 12-month follow-up, the proportion of men in the control group who reported consistent condom use decreased 29%; the proportion of the intervention group increased 8% ($t = 2.546; p = 0.015$). (p. 66)

The men in the seminar groups may well have incorporated the health and sexual satisfaction messages into their sexual scripts, and consequently developed more integrated and complex decision-making practices surrounding safer sex and risk-taking. Assuming the validity of the study (despite its stated limitations, there is no reason to doubt its overall utility), this advancement in HIV/AIDS prevention reinforces the positions previously discussed with respect to targeting MSM through multiple forms of messages, socially and sexually appropriate to the heterogeneity of the population.
Risk Reduction (condom use), risk substitution (substituting lower risk behaviours for higher risk ones) and contextual modification (unprotected anal sex only within long-term seroconcordant relationships) are all necessary to discuss in an integrated approach to overall risk reduction. (Ibid.:68)

The authors conclude that what is required to overcome the ‘condom barrier’, as well as issues of trust and intimacy in relationships include a comprehensive approach to sexual health promotion; the normalizing of same-sex education in the schools and communities; and the development and testing of new interventions based on theoretically sound and culturally sensitive understandings. (Ibid: 69)

These themes are expounded further in the following section.

Social Support

*THEME 1: There appears to be a direct relationship between family dysfunction and the capacity to trust and make reliable decisions concerning trust, sexual risk and partnership intimacy.*

In a perfect world, there would be no poverty, alcoholism, sexual abuse, homophobia, bullying, dysfunctional families, abandonment or conflict. However, many, if not all of these conditions are found in the family history of many gay men. The family is a social resource relevant for trust in a number of ways: first, the family is crucial for the development of trusting impulses, or basic trustfulness. It functions as a site for everyday testing of especially private and trusting drives – it serves as a “springboard” for the “leaps of trust” (Sztompka,
1999: 130) in other spheres of life both in the present and in the future. Family support allows many young people to take ‘calculated risks’ with regard to educational choices, employment, dating and marriage, and most germane to this thesis, coming out. However, low social support, or the lack of early family trust building can have, and often does have, opposite effects – either taking ‘uncalculated risks’ or taking no risks at all. Martin and Tim are good examples of both aspects of this notion – Martin’s significant risk-taking and Tim’s noteworthy risk avoidance exemplify the yin and yang effects of the lack of early life social support and the lack of family trust, respectively.

As evidenced by high suicide ideation and suicide attempts, gay youth and gay men are significantly vulnerable to the pressures that low social support brings about. A recent survey of the Vanguard cohort and suicide is illustrative of this point.

Our analysis revealed that prior suicide attempts appear to be independently and positively associated with current low social support and also low self-esteem. Persons with low social support were two times more likely to attempt suicide, while those who had low or moderate self-esteem were nearly four times more likely to attempt suicide. (Botnick et al, 2002)

The level of suicide ideation among gay and bisexual men in the Vanguard cohort was also extremely high. Of the 345 young men in the study, 44% had considered and 19% had attempted suicide at least once. These findings are consistent with those of Garofolo et al. (1998) who found that more than one-
third of all gay and lesbian high school students surveyed had made a suicide attempt in the past twelve months. Similarly, Roesler (1972), and Jay and Young (1979) found that an unusually high level of suicide attempts occurred in gay youth. In the latter survey of 5000 homosexual men and women, 40% had considered suicide. Canadian research (Bagley & Ramsay, 1997) also appears to confirm this statistic. This information clearly speaks to personal and societal conflict, sexual/gender roles, and individual maturation.

Whether it occurs in the family, in the school or on the streets, gay and bisexual youth frequently confront heterosexism and homophobia in their day-to-day lives. The destructive binarism of homosexuality/heterosexuality, and its attendant negative and positive connotations, needs to be eradicated in favour of recognizing the necessity of normalizing all human relationships, regardless of whether or not cross-gender or same-gender affiliations are present, especially amongst youth. Furthermore, this process cannot begin in adolescence; it must begin as early as possible in childhood. If it does not develop naturally in the home environment, then it should be nurtured in the schools, in the gay and lesbian community, and in the media. Gay positive recognition is a line of egress from the psychological (and potentially behavioural) morass that is created by homophobia and heteronormativity. (Botnick, et al. 2002)
Unfortunately, there is a paucity of accumulated academic information concerning the paths of personal transformation and the effects of life events prior to and subsequent to the coming out process for gay men. While much concern is placed on childhood and its subsequent effects on the adult’s behaviours and attitudes (pace Freud and Piaget), not enough literature has been developed that studies adolescence or adulthood in its own right; in other words, as anything other than the inevitable product of early childhood experiences. Notwithstanding this gap in sociological literature, the importance of early and middle childhood experiences cannot be overlooked, not only for its influence on individual personality development (pace Erik Erikson and Daniel Levinson), but also because of its influence on identity formation and life choices (as opposed to life course experiences) in adolescence and adulthood. For many gay youth and adults alike, early socialization points the way not towards who they will become, but who they will not become. As evidenced by the majority of the personalities presented in this thesis, their adult mode of socialization is almost an inversion of their childhood experience. Christian, brought up in a close, loving family, claims to be distant and aloof with respect to friendships and relationships; Patrick, raised in abject poverty, with alcoholic parents on welfare, works for the Federal government and is totally independent, social and communicative. Martin, a self-admitted brat as a child, effeminate, a loud-mouth, and extremely low in self-esteem, has become highly socialized – eager to please, choosing his friends...
carefully and with confidence, and exhibiting high self-esteem. Josh, coming from a poor, struggling family that exhibited "a lot of discord", as an adult states that he "communicate[s] very honestly and openly", and maintains that being gay, for him, is "amazingly empowering".

These social transformations notwithstanding, there are vestiges of early dysfunctionality, as evidenced by their notions of trust (generally lack of trust in their own judgment). "I don't give people a chance" – Christian; "I've been taking major risks . . . I guess I'm stupid . . ." – Patrick; "In my normal self I do have sort of inhibitions when it comes to people" – Martin; "I rarely get to the point where I trust the person enough – even someone I love" – Alan. These dysfunctionalities have led the respondents to develop reasonable sexual trust/risk analyses on bases other than 'conventional' rationality. In general, their analyses are based on one of two elements – fear or the lack of fear. In the former case, the fear of being hurt, the fear of being lied to, and the fear of being perceived as something other than a 'real man' have imbued their social and sociosexual scripts with a coldness and avoidance of emotive relationships. Whether it be one-night stands, anonymous sex in public places, or jealousy/mistrust, they all practice trust avoidance – establishing for themselves social situations wherein they are not required to make choices and can allow events to unfold at the pace, and in the manner, of others' choosing. In the latter instance, the lack of fear has led some of the respondents to adopt a similar
attitude, but for different reasons. The laissez-faire attitude towards safer sex, the non-use of condoms, the acknowledgment that they may indeed contract HIV, may die young, and may possibly infect other people, become secondary to the fulfillment of personal gratification, the willingness to ‘go along’ with the crowd, and the intensity by which they live their lives.

We can therefore appreciate that weak or negative social support early in life has a bearing on how many gay men respond to the pressures of gay ideation, the process of coming out, and the ongoing process of being out. For many, the first step is to understand, implicitly or explicitly that to “choose” to be gay brings with it negative social consequences, both in terms of social acceptance and, for many, the purported inevitability of shame, stigma and possibly disease. Having made the decision to live as a gay man (although for many there is no alternative), the prophesy tends to come true – there are negative social consequences to being gay. To be sure, there are many positives as well, and most gay men would never want to go back into the closet; nonetheless, having been indoctrinated earlier in life into the belief that coming out (or living a gay life) is an unwise choice, and having had it proved (at least partially) correct, casts a pall on other decisions that need to be made, principally in the areas of trusting oneself to make wise decisions.

64 Proponents of the ‘nurture’ school of thought of social identity hold that being gay is a choice.
Additionally, as can be seen from the narratives, many of the individuals reported instances when they had made faulty decisions in trusting their partners to be monogamous and to practice safe sex. If that was not enough, they also chastised themselves for allowing themselves to be 'duped'; at the same time, acknowledging that their partner choices were, in the long run, poorly made. Their indulgence in casual sex escapades, with or without condoms, again suggests that their faith in their abilities to find their ‘soul’ mate is either futile or emotionally undesirable, underscoring the nature of their own lack of self-trust and judgment. Last, their fear or lack of fear of HIV/AIDS points to the fact that their self-trust capacity is limited; either, in the first instance, in their ability to discern safer from less safe sex, or in the latter instance, to understand the nature of how they can minimize their sexual risks and still have a loving, intimate, sexual relationship.

Internalized Homophobia

THEME 2: There appears to be a direct relationship between an early lack of trust in oneself and/or in gay men and the denial of one’s sexuality which impacts one’s ability to trust other gay men, and leads to sporadic and anonymous sexual risk-taking as one fully enters gay life.

Social networks or ‘connections’ are closely correlated with other forms of personal capital. (Sztompka, 1999:129) These can take the form of friendship circles, fellow sports team players, classmates and so on. These social networks help to advance trustfulness. Relations within these social networks are usually
permeated with trust, and often with returned or reciprocated trust. Thus, they foster the development of a generalized culture of trust, as one progresses through life-cycle stages. Additionally, they reinforce the feelings of groundedness, security, solidarity, community and potential support should support be needed. In this regard, the development of the propensity to trust, early on, has a bearing on the ability to trust later in life.

However, for most young gay (or questioning) people, social ostracism or being the brunt of the bully's wrath is a far more common occurrence. When one learns not to trust family or friends with secrets, an ethos of distrust develops.

Additionally, and unfortunately for the vast majority of the group participants, and many members of gay communities, among certain social groups family and friends are indicated by 42.7 percent and 35 percent respectively as the potential source of support in case of losses or other calamities, and among the occupational elites, only 28.7 percent and 27.7 percent. (Sztompka 1999:131)

Once this environment of trust or distrust emerges, it becomes a qualifier for subsequent cycles in the formation of trust/distrust (132), augmenting or altering the calculation of trust in later life.
In as much as the coming out process, or the being out process is concerned\textsuperscript{62}, it appears self-evident that the less one trusts others, as well as one’s own intuition as to what is safe and what is not safe to disclose, the more difficult it becomes to identify with other members of gay communities, much like Christian as a young man. What is mistrusted is usually feared; and fear is the root of homophobia. In this sense, at least, it then becomes expedient to deny or suppress outward manifestations of one’s gayness, opting instead for, at the barest minimum, ‘straight looking, straight acting’\textsuperscript{63}, and at the other end of the spectrum, acting out one’s supposed straightness by becoming a ‘gay basher’. Unfortunately, this latter scenario is by no means uncommon. Additionally, this absence (in whole or in part) of gay community attachment, and the lack of opportunity to become acculturated to the nuances of safe sex scripting, leaves the individual vulnerable to faulty (or nonexistent) risk analysis, which in turn requires a sort of ‘blind trust’ in others. Alternatively, it leads to an overabundance of misplaced trust in oneself that foreshadows the possibility of grave harm ensuing as a result of one’s sexual behaviour.

What develops are sporadic and non-emotive liaisons, in part because they appear to be emotionally safer, and in part because the alternative, an emotive relationship, is tainted with mistrust, which, in most instances, dooms it to failure.

\textsuperscript{62} Gay men are continually in the process of coming out – at least in the sense of meeting new people at school, work, leisure activities and in general social settings.

396
As several participants expressed, if they become too close to someone, they either push them away (Christian), or make life so miserable for them that their partners want to leave (Marty). What is left but casual sex with strangers or ‘soft strangers’?

Having then established that self-trust is difficult to develop after being socialized to mistrust oneself and others, and that this culture of mistrust leads one into sexual arenas that are heavily populated with one-night stands, short-lived relationships, and a marked lack of intimacy, it becomes evident that the social meanings ascribed to trust, risk and intimacy must somehow be different from what one considers the norm (at least in a heterosexual sense); in fact, they are more unstable and less definable in the gay world than they are in the straight world.

One of the major deficiencies in gay mens’ lives, and most importantly in young gay mens’ lives, is positive role models. Even though gay stereotypes are abundantly portrayed in the media, and to some extent, can be seen in everyday life, the paucity of ‘ordinary’ gay men to look up to is clearly problematic for younger gays. While heterosexual boys and adolescents have (or can have) many heroes with whom to identify (athletes, musicians, actors, politicians, fathers, uncles, to name a few), or failing that, organizations that provide role models (Big

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63 This is a common phrase found in personal ads in gay publications.
Brothers, Scouts or Cubs, Church Youth Groups), gay kids do not generally have the opportunity to relate to these types of social influences in ways that are meaningful and respectful of their difference. Should a gay (or even questioning) child or adolescent become involved in any of these organizations, they would quickly learn that they do not ‘fit’; either they are picked on for their ‘difference’, or in some instances, are not permitted to belong at all (e.g. the Boy Scouts).

The net result of this covert discrimination is a social distancing from most potential positive role models, and in some instances the adoption of inappropriate role models – many gay kids only see the twenty or thirty-something gym-going, alcohol imbibing, drug-using, party-going, sexually vectored gay men who are, perhaps in the minority, but clearly the most visible cadre of the community, and assume that this is what ‘gay’ is all about.

It is not hard, therefore, to understand why many gay kids, unable to relate to this behavioural type, retreat within themselves, and deny that they are gay – their experiences and sensibilities are not reflected in their own understanding of either their sexuality or their overall identity. This retreatist posture is compounded by a heteronormative world that conveys the message that they are not only different, but unacceptably so. As they mature, it is highly probable that one of two outcomes occur: either they adopt the stereotype for themselves, or reject it, and

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*A term coined by my friend Patrick Michell to represent people whom one knows, but not very well.*
with this rejection, many other aspects of ‘gay culture’. This accounts for both the ‘early adopters’ – adolescent gays who sneak into bars with fake ID (like Patrick), or ‘late bloomers’, like Christian, who repress their homosexuality until it is no longer possible or expedient to maintain the fiction.

In either case, the inability to relate to the more positive aspects of gay life and gay culture lead the younger (and sometimes older) people into a situation where they forego, to a great extent, a critical analysis of what kind of life they want for themselves, and instead accept others’ understandings and scripting of gay life. The lack of critical thought can, in turn, lead to sexual risk behaviour that is not cognitively chosen, but merely ‘a part of the scene’. If one’s perceptions of what it means to be gay is closely aligned with the sheer enjoyment of sex, and less aligned with culture, the controlling paradigm will be homosex and all that homosex supposedly entails, including frequency, meaning (or lack thereof) and generally, the absence of bonding.
Social Meanings

THEME 3: The social meanings ascribed to notions of 'trust', 'risk' and 'intimacy' are contingent and unstable in the gay world; meaning that attempts to communicate MSM risk-avoidance health messages must acknowledge and account for ambiguity and multiple meanings in their communication objectives, strategies and messages.

Michael Warner, in *The Trouble With Normal* (1999) writes that "The best historians of sexuality argue that almost everything about sex, including the idea of sexuality itself, depends on historical conditions, though perhaps at deep levels of consciousness that change slowly." (10) As proof he identifies several circumstances, among which is the notion that reciprocal romantic love, now taken as natural and normative, only came into being relatively late in our history. As well, some people feel more exposed in their sexuality than others. Heterosexuals can see an image of themselves, of their straightness, reproduced everywhere, from car commercials to mystery novels, and "although they often rebel against the resulting banality of their sexual lives, they also profit from the way they seem no more sexually noticeable than anyone else." (Ibid.:23) Gay people cannot see themselves presented in the media to the same degree, and when they are depicted as personalities or in roles, they are usually stereotyped in negative or unflattering ways.

Gayle Rubin (1984) asserts that people organize good sexuality and bad sexuality according to a series of hierarchies:
TABLE 7 - 1: HIERARCHY OF SEXUAL STIGMATIZATION

<table>
<thead>
<tr>
<th>Good, Normal, Natural</th>
<th>Bad, Abnormal, Unnatural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td>Homosexual</td>
</tr>
<tr>
<td>Married</td>
<td>Unmarried</td>
</tr>
<tr>
<td>Monogamous</td>
<td>Promiscuous</td>
</tr>
<tr>
<td>Procreative</td>
<td>Nonprocreative</td>
</tr>
<tr>
<td>Noncommercial</td>
<td>Commercial</td>
</tr>
<tr>
<td>In pairs</td>
<td>Alone or in groups</td>
</tr>
<tr>
<td>In a relationship (involved)</td>
<td>Casual</td>
</tr>
<tr>
<td>Same generation</td>
<td>Cross generational</td>
</tr>
<tr>
<td>In private</td>
<td>In public</td>
</tr>
<tr>
<td>No pornography</td>
<td>Pornography</td>
</tr>
<tr>
<td>Bodies only</td>
<td>With manufactured objects</td>
</tr>
<tr>
<td>Vanilla(^{65})</td>
<td>Sadomasochistic</td>
</tr>
</tbody>
</table>

It should be noted that these distinctions are not generally a ‘package deal’ – there is an inclination for people to mix a few from each column. However, the foremost consideration the separate distinctions have in common is the fact that each is a binary, and if one is on the wrong side of the hierarchy, one will be

\(^{65}\) Plain or ordinary, as in the ‘missionary position’.
stigmatized in a manner that may entail personal damage. (Warner, 1999:26) Yet, in examining these putative notions of normality and abnormality, it is evident that negative stereotypes, which are often assimilated before one even knows that one is homosexual, leads many gay men to internalize, and then act out a ‘self-fulfilling prophesy’. In turn, this typified or stereotypical behaviour, when exhibited by others, within a gay context, is inverted and is taken as ‘normal’. That is, Rubin’s “good, normal and natural” are seen as abnormal, and her “bad, abnormal and unnatural” are seen as the norm. In such a scenario, trusting someone who exhibits the behaviour listed in the second column is perceived as an accepted thing to do, in that the behaviours or traits represent, for many, their normative range of sexual scripts. Martin’s behaviour (or as he describes himself “Trashy Marty) is a prime example of Rubin’s typology of the ‘bad, abnormal, unnatural’ column characteristics.

Placing trust is always accompanied by risk. (Kollock, 1994, in Sztompka, 1999) This is because there is always the possibility that one’s trust will be broken, that some harmful action will arise out of trusting. Placing trust requires us to ‘bracket’ risk, suspending the possibility that the trust will be violated, or acting as if the risk is nonexistent, or at least minimal. However, there is a surplus of negative psychological experiences for gay men vis-à-vis straight society, making trust more difficult to execute. In essence, one is required to trust social institutions that have proven to be untrustworthy, and in fact, for most gay men,
the task of assuming risk is undertaken in the face of certain knowledge that one's trust, somehow, sometime, will be violated. Therefore, the prudent choice is not to trust, or at least to trust sparingly. The same does not hold true for heterosexuals, since they generally have less immediate reasons to mistrust their own social structures.

Reasonable trust, risk and intimacy, the three pillars of relationships, are compromised, for gay men, by this realization. There is always the possibility that the stigmatization of 'bad sex' will rear its head, whether in the community at large, the family, the workplace, or the myriad of social institutions with which one interacts on a continual basis. The culture of trust, therefore, must be moderated by contingency — "I will trust you only if . . ." certain conditions are met; one of which must be the earning of trust. Thus arises the proverbial conundrum: how does one prove one's trustworthiness without being given the opportunity to demonstrate it to begin with? The answer to that comes back to the notion of trust: if one is able to demonstrate, in small ways, that one is trustworthy, such as never lying, (or to be more positive — always being truthful) it is probable that trust can eventually be earned. However, as we have discovered, should one breach that trust, even once, the relationship (and possibly future relationships) can be permanently tainted.
To this end, gay men have learned not to trust even their own social institutions; moreover, many have also been conditioned to mistrust themselves. The two go hand-in-hand, in some instances. The prime example of this, as has been discussed previously, is the “100% safe, 100% of the time” social marketing message. Notwithstanding the fact that the message is homophobic (as Christian indicated — “straights don’t have to use condoms”) and sex-negative, at first, many men uncritically ‘bought into’ the idea. However, it soon became apparent that the dictum was impossible to observe; therefore, not only were gay men given a task that was doomed to failure, the objective was subjectified — they too were considered failures or transgressors — practitioners of ‘bad sex’, and what would inevitably follow was anger, shame, guilt, and most importantly, reasons to distrust both oneself and one’s social institutions (especially ASOs).

**Trusting Others**

*THEME 4: Since safe sex education intrinsically concerns risk and trust, it is more salient when received in situ from someone deemed to be trustworthy, rather than in formal, bureaucratic settings or via mass audience appeals.*

We have seen, both in the literature and first-hand from the study participants, the various levels of information uptake and subsequent operationalization of information regarding safe(r) sex. We have also seen how the information has been misunderstood, misapplied, and ignored. In the few instances where safer sex has been the *modus operandi*, at least more often then not, we have also come to realize that the impetus for such behaviour has come from fear-based
experience, such as Patrick’s misunderstanding that AIDS is inevitable if one is to have sex with a man, or Martin’s epigrams: AIDS = Ass Injected Death Sentence, and AIDS backwards = Stick Dick In Ass.

When one considers the miserable track record, of late, of ASOs with regard to developing and maintaining a climate of sexual safety in and for their constituencies, we come to realize that the overarching issues may be more structural and deeply ingrained than first imagined.

In the January 22, 2002 issue of *The Advocate*, Chris Bull reports on the controversy stirred up by renegade AIDS activists, David Pasquarelli and Michael Petrelis, questioning whether AIDS prevention programs can be fixed. He states that “there is little, if any consensus about how to reinvigorate prevention campaigns, which have begun to fall on deaf ears among many gay men”. While Petrelis and Pasquarelli are regarded by most people as being on the verge of ‘AIDS terrorists’ according to Bull, calmer voices have joined the debate, such as Tom Coates, the director of UCSF’s Center for AIDS Prevention Studies: “AIDS is just not the dreaded disease it once was in the gay community, and, perhaps, people are taking risks because they have other priorities, such as feeling loved, feeling desired, and getting laid.” Jeff Getty, a well-known San Francisco AIDS activist, while depicting Pasquarelli and Petrelis as “the Al Queda of

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66 University of California, San Francisco
AIDS” acknowledges the structural problem: “The problem is that we [the gay community] have no grassroots infrastructure because everyone has either returned to their ordinary lives or is working for AIDS service groups, which do not engage in street activism.” AIDS activism, in short, has become a victim of its own earlier successes, as well as the effectiveness of antiviral drug cocktails. By keeping the debilitating effects of AIDS at bay, or at least trading the symptoms of AIDS for the symptoms of HAART\textsuperscript{67}, new treatments have made the HIV-positive messengers of prevention look and feel healthier, rendering their personal stories of how AIDS has had an impact on their lives physically less drastic and more normalized.

Additionally, funding for AIDS education has been dramatically cut. For example, in November 2001, federal officials in San Francisco, one of the most gay friendly cities in North America, deemed ‘obscene’ two forums run by the Stop AIDS Project of San Francisco that sought to eroticize safer sex. Health and Human Services secretary Tommy Thompson then announced that HHS would scrutinize federal funding for all AIDS prevention campaigns. (Bull, 2002)

In short, innovative, locally based attempts at reinvigorating HIV/AIDS prevention work are, or at least run the risk of being censored, lending credence to Petrelis’ claim that AIDS prevention efforts aimed at gay men are thinly veiled attempts to quash sexual liberation. “The only thing I’m guilty of is wanting gay

\textsuperscript{67} Highly Active AntiRetroviral Treatment
men to be treated with respect. The AIDS prevention campaigns treat us like children by trying to scare us. One recent ad featured the line ‘Do You Give a Fuck?’ about AIDS. Well, yes I do, and I believe gay men do. But you are not going to appeal to gay men by using that kind of disrespectful language.” (Bull, 2002: 33)


Public health officials marveled at the massive changes in behavior of gay men in the early days of the epidemic. People didn’t stop having sex, but there was a real passion that went into saving lives and in bringing down the rate of infection. It seemed that AIDS was on its way to being eliminated, at least in the American gay community. Now we have to find new ways of making prevention relevant to gay men who have not lost so many of their friends. (Italics added) (in Bull, 2002)

The lack of trust in AIDS organizations, government departments and other social institutions has led to a vacuum in the gay community. Not only have protests and civil disobedience reappeared, much like the ACT UP tactics of the 1980s and 1990s (Pasquarelli and Petrelis are currently awaiting trial on charges of violating a restraining order and stalking the targets of their protests), but as Coates indicates, AIDS prevention work may have simply run its course, and may be, in effect, a dying social movement.
Andrew Barker (2001), former Man-to-Man Outreach Coordinator for AIDS Vancouver, observed that the organization had "a pretty good idea of many of the determinants of health that were contributing to the HIV vulnerability of gay men in Vancouver. These included: low self-esteem, drug and alcohol use/dependency, the advent of new HIV medications, the perceived invincibility of youth, shifting the HIV focus away from gay men, prevention fatigue, poverty, lack of role models, [the] lack of social supports and so on". (28) What Barker saw is indeed happening – the instrumental manifestations of a condition that began earlier in gay mens' socialization, reinforced by a community (in part) focused on pleasure and sexuality. He saw a community of men struggling with issues of trust, and succumbing to inordinate risks in the hopes of making the pain go away, or at least covering up the hurt with dysfunctional behaviour that felt momentarily good.

No doubt, there are problems of specificity and delivery on the one side and corporate or stakeholder pressures on the other. However, with the active involvement of many segments of the gay constituencies, who are, after all, the main stakeholders in harm reduction, message processing, as an important ingredient of the educative process, could resonate with certain segments of the community, thus deterring or discouraging high-risk sexual behaviour. In short, problems notwithstanding, there is no reason to give up. However, it is now clearly urgent that the gay community reconsider the crucial triad of sexual risk,
trust and intimacy, and return to the task of healing, possibly knowing it for the first time.

Social Policy Changes

It seems fairly obvious that if the familial dysfunctions identified in theme one were ameliorated, the issue of the lack of a ‘trusting culture’ would not be as significant a co-factor in the *laissez-faire* attitude that has formed around barebacking or any other risky psychosexual behaviours. It would then suggest that a long-term solution to the AIDS crisis requires some form of resolution to dysfunctionality in the family, the elimination of homophobia, and the provision of a nurturing atmosphere for people of all sexualities to express themselves and to develop their identities in a healthy and guiltless manner. Of course, this is not only unlikely to happen; rather, for some families, social pressures will always be present such that scapegoating, prejudice and discrimination will continue to be a part of the social scene.

However, there is a need to start somewhere, and perhaps the best place is in the second most influential social structure: the school system. Teachers are held in high regard (if not by students, then at least by many parents). In some jurisdictions, special secondary schools have been established specifically for gay and lesbian teens (most notably in Los Angeles and New York) who cannot cope with the mainstream school system. While this does not address social change in
the entire school system, it does provide those students an environment free of homophobia, self-hatred and a sense of ‘otherness’. While I personally do not advocate, on a wholesale basis, the ghettoization of queer youth, at the present time, for some at-risk students, it is a viable option that should be considered in many more school jurisdictions.

Yet, this too, does not fully address the fundamental problem. It seems apparent that what is required is a revamping of attitudes and beliefs starting in the earliest grades, and before the students can be taught social acceptance of all other people, the educators and school boards need to learn these lessons. To be sure, there are many impediments to this approach; most notable among them is a history of discrimination, intolerance and attempts at homogenization of difference. This is not to suggest that the situation is hopeless. Least probable is the possibility that education authorities and the governments that support them will change their mind-sets, and realize that they have been tolerating, if not actively promoting various forms of discrimination and hatred in their institutions. This is unlikely as long as these authorities either cling to fundamentalist religious beliefs, emulate parents who hold these beliefs, or adhere to the notion that adolescent sexuality is sinful, shameful or non-existent. However, if science does prove, conclusively, that homosexuality is genetically constructed and is not a choice that some people either consciously make or to which people inadvertently succumb, there is the more likely possibility that attitudes will
soften. (There is always the risk, however, that attitudes could harden, and some may seek a genetic 'cure'.)

However, one cannot pin one's hopes on an as yet to be discovered genetic 'truth'. If what is required is a framework of family relations that encourages (or at the very least accepts) difference as an acceptable model of interaction and if this framework is unlikely to be developed or adopted, then an alternative 'outlet' could be encouraged. One of the possibilities is to access and utilize social institutions outside of the home: religious institutions, youth's sports organizations, schools, libraries, playgrounds and other places where young people tend to congregate.

Additionally, while it may be difficult to influence some religious institutions to promote social/sexual diversity in and of itself, it could be feasible for them to address the overarching issue of discrimination in a more proactive way. For example, by actively encouraging youth to relate to people outside of their own social classes, or racial or ethnic groupings, through charitable works, field trips, and other forms of interactive contact, there is an opportunity to subliminally infuse young people with a culture of acceptance of difference. This could have two important consequences: for young people who are questioning their sexuality, the exposure to social and cultural forms other than what they are accustomed to would provide them with an expanded world-view, which in turn
could translate into an understanding that 'different' does not necessarily equate with 'bad' or 'deviant'. Second, for those young people who are more fixed in their social identities, and perhaps even threatened by the notion of difference, this type of exposure would broaden their horizons, and potentially allow them to relax their own learned notions of prejudice and discrimination.

Youth organizations, especially those that involve young people in team sports or other cooperative ventures also have the structural underpinnings to effect social change. More often than not, in today's society, younger people, especially boys, are introduced to homophobic attitudes by their peers and coaches. While it would be unacceptable to use racial epithets as either a form of encouragement or chastisement, homophobic statements and slurs are \textit{de rigueur} in the locker room and sports field. As indicated earlier, to be called a sissy, girl or fag is one of the most devastating insults a young boy might confront. Christian, for example, indicated that he was not comfortable demonstrating any aspects of his sexuality while in college, and in fact sublimated his sexuality into sports. When he did come out, he left the track team, deeming it no longer necessary.

While society has found that it has become imperative to reduce and ultimately eliminate parental and participant violence in youth sports (especially such team sports as hockey, baseball, basketball and football), little if anything has been done to educate professional or amateur coaches in the devastating effects of
sexually laden verbal abuse. Since most coaches are required to be certified by the various associations that support and promote sports leagues, it should become mandatory for potential coaches to also receive sensitivity training; those who fail to live up to the standards set by the associations should be censured or lose their coaching privileges. Additionally, coaches should be encouraged to pass this sensitivity training along to their charges, and to insist on a zero-tolerance policy with respect to these forms of harassment.

Public and school libraries are other potential sources of trust building for young people. Many libraries are either reluctant to shelve age-appropriate books on diversity, or are unable to fund such purchases. Second, many libraries have installed 'parental blocks' on their computers, so that certain key words (pornography, sex, and so on, including 'gay') prevent questioning or gay youth from accessing chat lines and information that might be of help to them. Third, many librarians are unschooled in dealing with young people who are in the throes of coming to grips with their sexual identities. Funding for educational programmes, a relaxation of censorship and easy access to information could go a long way towards providing many children with a sense of belonging that they otherwise would not experience. Rudimentary counseling skills could be offered to librarians (especially in the schools).
Critics of these approaches might justifiably argue that they circumvent parental rights with regard to what their children may and may not be exposed, and at what age. However, as a counter argument, it may be questioned that while as a society, we do not tolerate violence in the home, and routinely remove children from abusive situations, why then do we tolerate discrimination and hatred being taught to, or perpetrated upon young people? There are direct parallels between physical and emotional abuse, yet one appears to be treated as less important than the other.

Personal Empowerment

There is a scene in the movie “Good Will Hunting”, where Robin Williams, acting the part of a psychologist, tells Matt Damon, playing the hero of the story “It’s not your fault” over and over until Damon breaks down and begins to let his feelings overcome his resistance to appearing vulnerable. For the first time in the movie, Damon’s character cries. For many gay men, being told that it is not their fault, that the prevailing process of ‘blaming the victim’ is unfair and unreasonable, may go a long way towards healing, which in turn can permit a culture of trust to develop. Some men find healing in relationships, others in therapy, and yet others in reconciliations with family. These forms of dealing with the past could be fostered in gay constituencies through the increased availability of discussion groups, group therapy, and additional counseling resources. A rejuvenated sense of community could support such projects, and
encourage gay men to drop the tough guise and relate to themselves and one another in a more honest and healthful manner. In a sense, what is required is a holistic approach to gay mens' health; the fusion of medical, emotional, physical and psychic elements to foster and support a sense of wellness, rather than merely considering deviant behaviour as pathology.

This first theme (family and early socialization) is related to the second theme (internalized homophobia); in fact, the second theme flows out of the first. Not only does this early lack of trust in oneself manifest a continued lack of trust in one's own judgment, but also it converts itself into a lack of trust of others, especially other gay men who, like oneself are also presumed to be untrustworthy.

However, as with family and early socialization, there are some avenues of redress that are worth exploring. In the first instance, the lack of role models can be ameliorated by the formation of a gay version of Big Brothers – a form of mentorship. There are several rewards that this type of program could provide, both to the mentor and the 'acolyte'. Many gay men have not had the opportunity to be a father-figure to any child, and miss this form of social relationship. Yet, there can be lots of love, attention, and often, learning opportunities that are resources not being draw upon. On the other hand, for younger gays, the opportunity to have someone with whom to spend time, to learn about their social history, to share coming out experiences, to be introduced
to the wide variety of gay cultural forms, and to simply be oneself, could be like a gay oasis in a heterosexist world.

The main reason that this has not happened, at least in any appreciable way, is the fear that any cross generational liaison will be looked upon as pederastic. This is not an uncommon fear — gay men themselves, as well as parents of gay kids, legal authorities, educators and social organization leaders — are enormously concerned with the perceived potential for sexual abuse. However, the notion that permitting cross-generational bonding is tantamount to condoning pedophilia is insulting and homophobic. Gay men are not, in the main, child abusers. It is estimated that about 95% of pedophiles self-identify as heterosexual (Finkelhor, 1984); yet there remains a perception that gay equals child abuser.

In any event, theme two (internalized homophobia) suggests how gay men can internalize self-doubt and self-hatred to the point that when they do become sexually active, their inclinations toward intimacy and trusting are hobbled by their own fears and mistrust. The antidote is to provide both reasons to trust and the opportunities to trust, without fear of censure, or of being made to appear less than masculine (i.e.: homosexual = sissy) in the process.

On a smaller scale, and perhaps far more achievable in the shorter run, is a need to address, in smaller settings, current generations of younger and older gay men’s perceptions about their own adequacies and trust issues. It is, of course, not as
simplistic as effecting direct behaviour change, but it is possible with appropriate help. Earlier, it was indicated that peer counselors were vital in discussing safe sex practices. This is especially salient in most gay constituencies, in that there are, in many respects, organically produced opinion leaders who also have significant access to great numbers of people: disc jockeys, queer publication journalists, media personalities, and local heroes (drag queens, bookstore owners, bartenders, and the like). If they could be recruited and trained in peer counseling, they could form the first rank of peer educators. These people are viewed as trustworthy, making them obvious candidates for the promulgation of sex-positive, life-affirming, trust-building messages. They also can (and should) be in the front lines of the queer community in promoting overall gay mens’ health – not only with respect to HIV/AIDS, but the underlying conditions of mistrust and anomie, including body image, psychological problems, depression, and ageism, to name a few.

Second, a revival of community spirit, much like the state of affairs that was realized at the time of the onslaught of the AIDS pandemic could be fostered. An analogy for this can be seen in the game of ‘tug-of-war’: it takes one final mighty effort to win the game. If social marketing does have its place, the message that “we’re almost there” would seem more appropriate than the doom and gloom messages of the past. And the community is almost there – new and

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68 As opposed to institutionally produced leaders.
better drugs are being brought to market at an accelerated pace, various AIDS vaccines are being clinically tested, anti-viral lubricants (microbicides) are under investigation, and the homophobia that was endemic to current generations of gay men when they were young is less pervasive (although not in all places) than it used to be. There are reasons to be hopeful, and imbued with this more positive attitude, people can begin to heal themselves, or seek professional help in dealing with their trust and intimacy issues. If one begins the process of relearning how to trust oneself, trusting others should follow. No doubt this too is processual, but it is an extension of some of the remedies to the socialization issues of theme one. However, one of the main impediments to trusting others, especially in regards to sexual risk and intimacy, is the very real problem of whom to trust, and why they should be considered trustworthy. Closely aligned with this problem is the stigmatization of being HIV-positive – having to 'come out' to each sexual partner. A part of the resolution of this problem is to destigmatize seropositivity such that 'coming out' is no more traumatic than declaring one's preference for being a bottom or a top. When I wrote *Gay Community Survival in the New Millennium* (2000), I identified this stigmatization as a divisive element in gay society. A role of social marketing should be to address this community bifurcation, and reunite gay men on the basis of their other (and common) qualities. If seropositive gay men were not assumed to be 'prone to lying' about their status, the negotiation of safer sex could proceed with less mistrust,
seronegative gay men could have more faith that other gay men are telling the truth about potential risk; and barebacking, should it be a part of one's sexual script, could occur under safer conditions. Additionally, since many seropositive gay men already are involved in barebacking, the precedent has been set for serostatus disclosure. What needs to happen is the destigmatization of seropositivity itself, as well as the social conditions that militate against self-disclosure.

One of the problems associated with any forms of self-help, attitudinal or behavioural change, especially in the gay community, is the ephemeral nature of trust, risk and intimacy, all of which must be addressed if any progress in stemming the tide of new infections is to occur. Clearly, any broadly based social marketing programme can only hope to reach a small constituency of the committed and the potential adherents; and even then, their degree of uptake of the messages is dependent on their own standpoints. MSM risk-avoidance agendas need to acknowledge and account for all sorts of ambiguities and multiple meanings. This can be accomplished in two separate and distinct ways: by being absolutely blunt or by allowing the reader/listener/participant to draw their own conclusions.

There are, of course, difficulties with both approaches. In the first instance, one runs the risk of offending (as Petrelis indicated in Bull, 2002) some, if not most,
of the constituents. Sexually explicit messages do not suit everyone, nor does confrontational language. Additionally, there is always the possibility (as was seen in the San Francisco situation) that explicit material will be censored or banned altogether. On the other hand, there is a certain slippage if the audience is left to interpret messages to conform to their own sensibilities (much like Festinger's Cognitive Dissonance argument). People tend to hear what they want to hear, and if the message is not consonant with their beliefs, or presumed knowledge, there is a risk of losing them. For example, one is not likely to help an alcoholic who refuses to acknowledge that they have a problem, similarly, one is unlikely to help a gay man learn to trust, or reduce his risk, if he believes that he already has the situation under control.

Any attempts to instill more healthy self-beliefs in both individuals and community must therefore start from a basis of 'compassionate honesty' — a recognition of the multitude of problems that need to be addressed, an understanding of the etiology of these problems, and a sincere desire to help people help themselves. One must also acknowledge the fact that some people do not want, nor will they accept, help. Tough love may work for some, but others will reject it out-of-hand. To this end, programmes aimed at providing supportive environments for discussion and self-realization are central to this project. One of the most successful programmes, AA (Alcoholics Anonymous) recognizes that one need not be a nondrinker to attend meetings, people will fall
back into old established patterns, and that the point is to never give up trying. Their slogan, 'one day at a time', is most appropriate in this instance, because if one is to help people feel better about themselves, one must also accept the truth that not every day will be a good one. Community forums, discussion groups, seminars and retreats are reasonable and relatively cost-efficient ways to make this happen. What is required is a will to do this type of work, a strategy to implement such work, and a source of funding that will support the costs. Some ways in which this could happen might include the use of pre-existing community and private facilities (bars, community halls, schools, and private homes); peer educators (discussed earlier), and the endorsement and involvement of the gay media (at least for announcements of meetings, if not also editorials and news coverage). Getting a community to heal itself and its members is not a short-term task, nor are the results going to be uniform.

Social Marketing

This trust must also somehow be extended to the organizations that produce the programmes (whatever they may be). As indicated earlier, the various constituencies caught up in the AIDS industry are not deemed to be wholly acting for the benefit of the community. Without some manner of addressing their own lack of credibility, the reputation of the messenger may very well overshadow the message, deflating or eradicating what might otherwise be an important and potentially life-saving message.
The behavioural goals that social marketing messages advocate must be achievable. They must also be ‘baby steps’, in order to garner a ‘bank of trust’. Similar to “Just say no!” to drugs, ambiguous, totalizing and ultimately insulting messages are intrinsically more harmful than helpful. They become the brunt of a social joke, and are easily dismissed. For example, Randy Dotinga (PlanetOut.com, 2002) reports that a study published in the January 2002 issue of *Sexually Transmitted Diseases* (Peterman, T., et al.) calculated the odds of contracting HIV according to various sex acts:

Have sex with a stranger without asking about his HIV status, they say, and you’ll multiply your risk of getting infected by 43 times. Be a “bottom” with that man, without using protection, and face a one in 2,000 chance of getting infected.

Using this information, a social marketing message that suggests that one *asks* about serostatus before barebacking could reduce one’s odds of infection significantly. Or, another credible message could be constructed around ‘if you are a bottom, use a condom at least once this month – improve your chances of remaining uninfected’. Baby steps!

On a more macro level, the need to allow for multiple meanings of sex, as well as ambiguity in understandings of risk and one’s personal location on a risk continuum dictate a series of considerations that up to now have been lacking in social marketing communications. One must consider variations in educational levels, information uptake, ethnic and racial sensitivities, age, experience,
friendship networks and so on. Additionally, more ephemeral factors such as gay community attachment, prior history of community action against AIDS, the trustworthiness of the people in charge of the messages and their organizations, the community’s sexual culture and climate, and seroprevalence must be considered. Also of importance is where sex takes place and a myriad of other factors particular to the location, and the people involved. Most importantly, a community/constituency needs assessment is also required. What do the various constituencies need and want? What will they respond to? What will turn them off?

In a Vancouver-based study of capacity building sessions for those people working in gay men’s HIV prevention, Rick Marchand states:

Participants addressed many of the current prevention issues facing gay men and the community. They acknowledged that more work needed to be done in areas such as understanding the context of gay men’s sexual experiences; serodiscordant relationships; mental health needs; preparing gay men for making choices; life course events of gay men; street level harm reduction; knowledge on gay health issues; examining the cultural trends of HIV disclosure; Internet chat rooms; community preparedness about vaccines; among other issues. (sic) (Marchand, 2001: 3)

In other words, among HIV prevention workers, there was an acknowledgement of the multi-faceted dynamic they faced. HIV prevention is not, to them, a formulaic process – it is a highly complex series of interlaced and interdependent issues, all of which need to be addressed, if any one of them is to be unraveled.
It would seem that social marketing scare tactics are favoured by some people and condemned by others. In the Vanguard mini-survey (unpublished, 2002), 10 people advocated the use of fear-based social marketing and five people were opposed to such strategies (N=65). AIDS Vancouver has also discovered, through a number of recent focus groups (private correspondence with Phillip Banks, Gay Mens’ Health Programs (formerly Man-to-Man) Coordinator, January 22, 2002) that their constituency is also divided on the issue. The overarching point, according to the pro-fear-based supporters, is that the messages will not be lost in the plethora of other advertising material; they will stand out, and therefore attract the attention (and presumably alter the behaviour) of some people. On the other hand, the forces opposed to scare tactics suggest that this revisitation of earlier strategies carries social meanings that demean and degrade gay men, castigate them for non-observance of safer sex, and worsen their already poor self-esteem.

Both arguments have merit. Scare tactics may work, especially for a younger generation that has not been exposed to the campaigns of the 1980s and 1990’s. Also, some older gay men might ‘be brought to their senses’ by these messages, much like the nostalgia brought about by the reissuance of ‘golden oldies’ music. However, it is just as probable that many will either be turned off by the messages, or will simply ignore them.
On February 16, 2002, AIDS Vancouver launched its new social marketing campaign. The programme is informed by the prevailing notion of ‘HIV optimism’, discussed earlier the complacent attitude of many seronegative gay men toward the possibility of contracting HIV/AIDS, and their eventual need to take various medications. The media employed are billboards, several bus-shelter posters, pamphlets and a television commercial to be run as PSAs (public service announcements) — i.e.: not paid for, but dependent on the good will of the television stations. The cartoon/illustration type messages deal with three specific effects of the medication regime: depression, diarrhea, and body fat distribution. The tag line is “Cocktail or Condom?”

Catering to a middle-of-the-road strategy (not too menacing and not too soft), this campaign directs the attention of the constituency to some realities of the ‘drug cocktail’. Most seropositive gay men would agree that being HIV-positive and taking the drugs does produce these symptoms, so the message is truthful. However, it neither addresses the meanings of the behaviours that lead to infection (reasonable or for that matter unreasonable trust, risk and intimacy) nor does it support people who are HIV-positive; in fact, it further stigmatizes those who are currently on cocktails.

As stated, this new campaign fails to address the root causes of sexual risk. Apart from functional ‘oopses’, discussed earlier, those men who choose barebacking,
even occasionally, do so for reasons other than lack of information. The basic problem, which will not be easily overcome, is how to convince barebackers that there is merit in adhering to some form of a safer sex script some of the time, if not all of the time, given that many of them have been socially conditioned over many years to mistrust both their own judgment and that of others.

Furthermore, as has been noted, who delivers the message(s) is of critical importance. As Alex Kellogg (2002) reported (cited earlier in this chapter), peer sexuality educators appear to have more credibility than more formalized bureaucratic sources. Theme four, the relevance of the messenger, therefore, flows out of this need to communicate. Or as Marshall McLuhan wrote (1967) "The medium is the message".

So, while there is no single 'right' way to approach gay men's health programming, there are many wrong ways. The preceding chapters have described a host of issues that limit the ability to develop an effective strategy or strategies to address UAI and barebacking, and at the same time, this chapter has suggested opportunities to move forward with new, micro strategies that may ameliorate the 'second wave of infection'.

Limitations of the Study

It is important to note that this thesis has engaged an older paradigm, rational choice and moral panic, and exchanged it for a newer one, reasonable trust and sexual
risk. This paradigm shift has made way for a new understanding of both the centrality and contingency of individual cognitions, beliefs, fears and most especially meanings of trust, sexual risk and intimacy. From a sociological perspective, this shift moves away from instrumental rationality to explain (or predict) behaviour, to a notion of agency and contingency that may better serve to understand socially constructed meanings, at least among gay constituencies. It is a way in which social marketers, AIDS organizations, sociologists, and indeed, the gay community itself, may revisit the notion of harm reduction not just as a question of knowledge, attitudes and behaviour, but as an opportunity to examine the multitude of discrete and common factors that underlie sexual risk-taking, community development and behaviour change. 

Like most research ventures, this particular study also has its limitations. From the outset, my process was one of listening and recording, rather than interacting and intervening. As well, the value of the participant comments is limited by the need to distill 50 hours of tapes into a coherent and thematic collection of quotations and impressions. I do not suggest that these few participants represent the full range of gay communities that are effected or affected by HIV/AIDS, and in fact, since all of the participants were (and are to this day) 

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69 This shift in thinking about risky behaviour may also hold some promise for new or revised analyses of other social problems, such as eating disorders, alcoholism, drunk driving, and spousal battery, to name a few.
HIV-negative, they certainly do not reflect social meanings that HIV-positive individuals may have otherwise expressed.

However, I do contend that the best way to understand what meanings people ascribe to trust, risk and intimacy, is to ask them. The use of focus groups, not only in this dissertation, but in the broader community, could provide a wealth of previously untapped information that in turn could inform ‘knowledge makers’ and constituency members alike about the needs, commonalities and disjunctures of what it means to exercise reasonable trust and sexual risk in a sexually vectored society.

There is no magic potion that will set right the problems that have taken years to create. Gay men, for the most part, have never really trusted government and social institutions, and have even lost confidence in their own institutions, as well as in their peers. The life situations that the study participants describe, and the parallels that can be found in the lives of so many gay men, evoke a loose, uncertain and recomposing nature of experience and belief that ultimately informs sexual behaviour, through mediating processes of knowledge, self-reflection and observation. Many gay men make their choices in full awareness of the gravity of the potential outcome. The recurrent theme of reasonable trust – in oneself, in one’s partners, in medicine, and in a host of other intervening variables – pervades both the conscious and inner-most feelings that lead to the
implementation of sexual behaviours that include or exclude virological safety. It then seems logical to conclude that if the objective is to maximize virological safety and minimize the consequences of sexual risk-taking, one must specifically address the intervening variables, not merely the end result.
## APPENDIX 1

### GLOSSARY

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACT-UP</td>
<td>Highly controversial AIDS action group that uses confrontational demonstrations to press for changes in drug therapies, funding and so on.</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>Antiretroviral(s)</td>
<td>Class of drugs designed to reduce viral load (medical term)</td>
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<td>ASO</td>
<td>AIDS Service Organization</td>
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<tr>
<td>Bareback</td>
<td>anal intercourse without a condom (gay slang) (in context of this thesis, deliberate intent not to use condoms)</td>
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<tr>
<td>Bottom</td>
<td>anal receptive (see “Top”) (gay slang)</td>
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<tr>
<td>Closet</td>
<td>to be ‘in the closet’; to not disclose one’s homosexuality</td>
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<tr>
<td>Cocktail(s)</td>
<td>Combination of drugs to manage HIV or AIDS symptoms (see also HAART)</td>
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<tr>
<td>Come (coming) out</td>
<td>to voluntarily and openly aver one’s homosexuality</td>
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<tr>
<td>Cum</td>
<td>ejaculate, ejaculation</td>
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<tr>
<td>GCA</td>
<td>Gay Community Attachment</td>
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<td>GMHC</td>
<td>Gay Men’s Health Crisis, a New York AIDS service organization</td>
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<tr>
<td>GRID</td>
<td>Gay Related Immuno Deficiency (no longer used medical term for AIDS)</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>HAART</td>
<td>Highly Active Antiretroviral Therapy (acronym used mainly by medical / epidemiological professionals)</td>
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<td>HBM</td>
<td>Health Belief Model</td>
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<tr>
<td>Het</td>
<td>Heterosexual (gay slang)</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>Homosex</td>
<td>Sex between men (slang) (see MSM)</td>
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<tr>
<td>IDU</td>
<td>Injection drug user</td>
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<tr>
<td>Incidence</td>
<td>The number of new infections per year (medical term)</td>
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<tr>
<td>KAB</td>
<td>Knowledge, Attitude, Behaviour</td>
</tr>
<tr>
<td>KS</td>
<td>Kaposi's Sarcoma (a form of blood cancer that produces purple lesions)</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
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<tr>
<td>Negative</td>
<td>HIV-negative</td>
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<tr>
<td>NGCA</td>
<td>Not Gay Community Attached</td>
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<tr>
<td>Nomadic self-esteem</td>
<td>Self esteem that is situation-based rather than on the basis of overall self-perception</td>
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<tr>
<td>Outed</td>
<td>to come out involuntarily usually through the actions or words of others</td>
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<tr>
<td>PHM</td>
<td>Persuasive Health Message</td>
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<tr>
<td>Prevalence</td>
<td>The number of people living with HIV (medical term)</td>
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<tr>
<td>Positive</td>
<td>HIV-positive</td>
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<tr>
<td>PSA</td>
<td>Public Service Announcement</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>PWA</td>
<td>Person(s) With AIDS</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>Suck</td>
<td>Oral-genital stimulation</td>
</tr>
<tr>
<td>Top</td>
<td>Anal insertive (see “Bottom”) (gay slang)</td>
</tr>
<tr>
<td>Trick</td>
<td>Casual pickup; also street language for a prostitute’s customer</td>
</tr>
<tr>
<td>UAI</td>
<td>Unprotected Anal Intercourse (in this thesis, a manifestation of possible intent to use condoms, but not using them nonetheless)</td>
</tr>
<tr>
<td>Viral Load</td>
<td>Amount of HIV in the blood stream</td>
</tr>
</tbody>
</table>
APPENDIX 2

Sample Criteria

Sample Group Methodology
Criteria for Live Subjects from the Vanguard Project:
“Getting to Know Me”

Starting with those members reporting in JUNE, and going backward 3 more months (May, April, March), please identify by tracking number, people with the following criteria:

A: FROM BASELINE

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>QUANTITY</th>
<th>QUALIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>&gt;4</td>
<td>In often + usually + always</td>
</tr>
<tr>
<td>23</td>
<td>&lt;6</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>&gt; 14</td>
<td>In often + usually + always</td>
</tr>
<tr>
<td>42</td>
<td>&gt;1</td>
<td>Yes</td>
</tr>
<tr>
<td>45</td>
<td>Any</td>
<td>Fuck w/o condom in sometimes + often + usually + always</td>
</tr>
<tr>
<td>46</td>
<td>Any</td>
<td>Fuck w/o condom in sometimes + often + usually + always</td>
</tr>
<tr>
<td>52</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Yes</td>
<td>W/o condom (any incident)</td>
</tr>
<tr>
<td>71</td>
<td>&lt;2</td>
<td>Yes to anything other than tobacco and/or alcohol</td>
</tr>
</tbody>
</table>

B: FROM FOLLOW-UP (latest wave that they did)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E7</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>E13</td>
<td>Any</td>
<td>Fuck w/o condom in sometimes + often + usually + always</td>
</tr>
<tr>
<td>E14</td>
<td>Any</td>
<td>Get fucked w/o condom in sometimes + often + usually + always</td>
</tr>
<tr>
<td>E20</td>
<td>&gt;1</td>
<td>Yes</td>
</tr>
<tr>
<td>E21</td>
<td>&gt;1</td>
<td>Yes</td>
</tr>
<tr>
<td>E24</td>
<td>Yes</td>
<td>Fucking and getting fucked w/o condom</td>
</tr>
<tr>
<td>Ki</td>
<td>&lt;2</td>
<td>Yes to anything other than tobacco and/or alcohol</td>
</tr>
<tr>
<td>K2—K6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N9</td>
<td>1 Quart.</td>
<td>SEE CODING SHEET—if necessary go to 1st &amp; 2nd quartile</td>
</tr>
<tr>
<td>N10</td>
<td>&lt;6</td>
<td></td>
</tr>
<tr>
<td>N12</td>
<td>&gt;4</td>
<td>In often + usually + always</td>
</tr>
<tr>
<td>N13</td>
<td>&gt; 14</td>
<td>In often + usually + always</td>
</tr>
</tbody>
</table>

NOTE: Please, if possible, sort in rank order as to how many of the criteria they match. Thanks.
To: Michael Botnick  
University of British Columbia,  
Department of Anthropology and Sociology,

Yes, your project interests me. Please call me to arrange a time to get together.

From: ________________________________ (Your Name)  
______________________________ (Your Address)  
_________________________ (Day Phone #) ____________ (Evening Phone #)  
________________________________ (email address)

Please don't leave a message for me □  
Please call me during the day □, evening □, or any time □.
APPENDIX 3

Vanguard Questionnaires
A. PERSONAL INFORMATION

NOTE: First we need some personal information, for research purposes only. This info will be kept strictly confidential.

1. When were you born?
   - month __________ day ______ year ______

2. How long have you been living in the Lower Mainland?
   - ______ years

3. If you have not always lived in the Lower Mainland, where was the last place you lived before arriving here?
   - City or town: ____________________
   - Province, territory or state: ___________
   - Country (if not Canada): ___________

4. What kind of housing do you live in right now?
   - Apartments or condominium
   - Single detached house
   - Student residence or dorm
   - Hotel or rooming-house
   - Shelter/hostel (e.g. YMCA, Salvation Army)
   - Squat
   - No fixed address
   - Other (please specify): ____________________

NOTE: The next question will allow us to compare responses from different areas of the Lower Mainland. This information will NOT be used to identify you.

5. What are the first three digits of your postal code?
   - ________
   - I'm not sure.
   - If not sure, name your neighbourhood: ____________________

B. FAMILY BACKGROUND

NOTE: The following questions are being asked to allow us to compare data from men of different ethnocultural groups. We recognize that ethnicity is a sensitive issue and we appreciate your cooperation.

7. Were you born in Canada?
   - Yes: If yes, in which province or territory?
   - ____________________
   - What city or town?
   - ____________________
   - No: If no, in what country were you born?
   - ____________________

8. In what country was your mother born?
   - ____________________
   - I'm not sure

9. In what country was your father born?
   - ____________________
   - I'm not sure

10. How would you describe yourself?
    - Aboriginal, Native or First Nations
    - Inuit
    - Métis
    - Asian (Chinese, Vietnamese, Japanese, etc.)
    - South Asian (Indian, Pakistani, Sri Lankan)
    - Black
    - Caucasian/White
    - Hispanic/Latino
    - Jewish
    - Middle Eastern
    - Other (please specify): ____________________

11. What part(s) of the world does your family come from?
    - Africa
    - Asia or Southeast Asia (e.g. China, Vietnam, Japan)
    - South Asia (e.g. India, Pakistan, Sri Lanka)
    - Britain or Western Europe
    - Canada or USA
    - Caribbean
    - Central America
    - South America
    - Eastern Europe or Russia
    - Middle East
    - Pacific Islands
    - Other (please specify): ____________________

Printed: June 24, 1997
Vanguard Project Baseline Questionnaire: Revised
Page 2 of 13.
12. What is your religious or spiritual background? (ie. What was the religious environment in which you were raised?)
□ No religion
□ Aboriginal/Native
□ Bahá’í
□ Buddhism
□ Christianity (please specify)
□ Roman Catholic
□ Protestant (eg. Anglican, United, etc.)
□ Other:
□ Hinduism
□ Islam (please specify)
□ Sunni
□ Shia
□ Ismaili
□ Other:
□ Judaism
□ Shintoism
□ Sikhism
□ Taoism
□ Unitarianism
□ Other: (specify)

Check all that apply.

13. What is your first language or “mother tongue”?  

14. How many years have you completed in elementary or high school?
□ K □ 1 □ 2 □ 3 □ 4 □ 5 □ 6
□ 7 □ 8 □ 9 □ 10 □ 11 □ 12 □ 13
□ Never went to school → go to question 17.

15. How many years of post-secondary education have you completed? (eg. university, college, institute of technology, CEGEP, trade school)
□ Less than 1 year
□ None
□ High school diploma
□ Trades certificate
□ University degree (eg. B.A., B.Sc.)
□ Post-graduate degree (eg. M.A., Ph.D.)
□ Community college certificate
□ (eg. CEGEP, institute of technology)
□ Other (please specify):

16. What certificates, diplomas or degrees have you received?
□ None
□ High school diploma
□ Trades certificate
□ University degree (eg. B.A., B.Sc.)
□ Post-graduate degree (eg. M.A., Ph.D.)
□ Community college certificate
□ (eg. CEGEP, institute of technology)
□ Other (please specify):

17. Do you currently have a paying job?
□ Yes: If yes, do you work...
□ Full-time
□ Part-time/casual
□ Self-employed
□ No: If no, are you...
□ Unemployed but available for work
□ Temporarily unavailable for work (eg. sick leave)
□ Unable to work and have never worked
□ Currently permanently unable to work
□ Student
□ Other (please specify):

How many hours per week do you work? 
Please describe your current occupation:

18. Do you receive money from:
□ Provincial income assistance (welfare)
□ Unemployment Insurance (UI)
□ Canada Pension Plan (CPP)
□ Savings or borrowing
□ Pensions
□ Employment insurance
□ Long-term disability insurance
□ Other legal sources of income
□ Non-legal or illegal sources
□ None of the above

19. How much money did you make last year? (include wages, salaries, and net self employment earnings, before deduction)
□ Under $5,000
□ $5,000 - $9,999
□ $10,000 - $14,999
□ $15,000 - $19,999
□ $20,000 - $24,999
□ $25,000 - $29,999
□ $30,000 - $34,999
□ $35,000 - $39,999
□ $40,000 - $44,999
□ $45,000 - $49,999
□ $50,000 or more.
□ $25,000 - $29,999
□ I'm not sure.

20. How would you rate your current physical health?
□ Excellent
□ Good
□ Very good
□ Fair
□ Poor
□ I'm not sure.

21. Compared to one year ago, how would you rate your physical health now?
□ Much better now than one year ago
□ Somewhat better now
□ The same as one year ago
□ Much worse now than one year ago
□ Somewhat worse now
22. **IN THE PAST WEEK**, how often have you...

<table>
<thead>
<tr>
<th>Problem Description</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt you just couldn’t get going?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt sad?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had trouble getting to sleep or staying asleep?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt that everything was an effort?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt lonely?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt you couldn’t get out of a rut or couldn’t shake off the blues?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had trouble keeping your mind on what you’re doing?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23. How many people in the Lower Mainland do you currently know who can provide you with personal support or friendship? (ie. in day-to-day living or times of crisis)

Total Number: __________

24. How many of these people are...

<table>
<thead>
<tr>
<th>Type of Support</th>
<th>Number of Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family members or relatives?</td>
<td></td>
</tr>
<tr>
<td>Friends or neighbors?</td>
<td></td>
</tr>
<tr>
<td>Co-workers or classmates?</td>
<td></td>
</tr>
<tr>
<td>Health care providers?</td>
<td></td>
</tr>
<tr>
<td>Counselors or therapists?</td>
<td></td>
</tr>
<tr>
<td>Priests, rabbis, or ministers?</td>
<td></td>
</tr>
<tr>
<td>Other? (Specify)</td>
<td></td>
</tr>
</tbody>
</table>

25. **IN THE PAST YEAR**, how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th>Problem Description</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not having a close companion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not having enough free time to do the things you want</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not having enough money to do the things you want</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not having enough responsibilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not having someone who shows concern for your problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Side effects of medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling too controlled by others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not having enough money to get by on</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not having enough money for medical treatment or prescriptions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not having enough close friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with partner or ex-partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not being able to get somewhere because of lack of transport</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Printed: June 24, 1997
Vanguard Project Baseline Questionnaire: Revised
We are defining "SEX" as: Any type of sexual intercourse - including anal, vaginal and oral sex - for which you gave CONSENT. [This does NOT include any type of non-consensual sexual activity that you were FORCED or COERCED into. For the following questions, please consider only sexual intercourse where you gave CONSENT.]

26. Who do you currently have sex with?
- I don't have sex.
- Only men.
- Mostly men but sometimes women.
- Both men and women equally.
- Mostly women but sometimes men.
- Only women.

27. Have you ever had sex with a woman?
- No ☐ [If no, go directly to question #33.]
- Yes ☑ If yes, continue with questions #28 through #32.

28. How old were you the first time you willingly had sex with a woman?
I was _____ years old.

29. How old were you when you willingly began to have sex on a regular basis with a woman? (At least once a month, but not necessarily with the same woman.)
I was _____ years old.

30. IN THE PAST YEAR, how many different women have you had sex with?
- None ☐
- One ☐
- 2 to 5 ☐
- 6 to 19 ☐
- Can you give a more exact number? ______

31. IN YOUR LIFETIME, how many different women have you had sex with?
- Fewer than 5 ☐
- 6 to 19 ☐
- 20 to 99 ☐
- 100 or more ☐
- Can you give a more exact number? ______

32. When was the most recent time you had sex with a woman?
- Less than one week ago ☐
- Between a week and a month ago ☐
- Between one and 12 months ago ☐
- Between one and five years ago ☐
- More than five years ago ☐
- I'm not sure ☐

33. Have you ever had sex with a man?
- No ☐ [If no, go directly to question #55.]
- Yes ☑ If yes, continue with questions #34 through #55.

34. How old were you the first time you willingly had sex with a man?
I was _____ years old.

35. How old were you when you willingly began to have sex on a regular basis with a man? (At least once a month, but not necessarily with the same man.)
I was _____ years old.

36. IN THE PAST YEAR, how many different men have you had sex with?
- None ☐
- 20 to 49 ☐
- 50 to 99 ☐
- 100 or more ☐
- 6 to 19 ☐
- Can you give a more exact number? ______

37. IN YOUR LIFETIME, how many different men have you had sex with?
- Fewer than 5 ☐
- 6 to 19 ☐
- 20 to 99 ☐
- 100 or more ☐
- Can you give a more exact number? ______

38. When was the most recent time you had sex with a man?
- Less than one week ago ☐
- Between a week and a month ago ☐
- Between one and 12 months ago ☐
- Between one and five years ago ☐
- More than five years ago ☐
- I'm not sure ☐
39. Have you had more or fewer male sex partners in the past year than you had in the year before last?
- I’ve had more male sex partners this year.
- This year I’ve had about the same number of male sex partners as I had last year.
- I’ve had fewer male sex partners this year.

**NOTE:**
The next question is about the places you had sex with male sex partners since your last visit.

40. IN THE PAST YEAR, where did you have sex with your male sex partner(s)?

<table>
<thead>
<tr>
<th>Location</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>At your home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At his home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At private sex parties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In hotels or resorts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In bathhouses or sex clubs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In bars or nightclubs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In peep shows or sex shops</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In public parks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In public washrooms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In other public places</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**NOTE:**
The remaining questions in this section ask you to give separate answers for regular and casual partners.

"REGULAR PARTNERS" are guys you have sex with on a regular basis, AT LEAST ONCE A MONTH.

"CASUAL PARTNERS" are any guys you have sex with LESS THAN ONCE PER MONTH (including one-nighters).

41. IN THE PAST YEAR, have you had regular male sex partner(s)?
- No
- Yes ➔ If yes, how many different regular partners?

42. IN THE PAST YEAR, have you had casual male sex partner(s)?
- No
- Yes ➔ If yes, how many different casual partners?

If yes to either question #41 or #42, please turn the page.
43. SUCKING [his penis in your mouth]:

**IN THE PAST YEAR, when you had sex, how often did you...**

- suck with a condom
- suck without a condom, but without getting cum in your mouth
- suck without a condom, and getting cum in your mouth

**Regular Partner(s) | Casual Partner(s)**

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>never</td>
<td>N</td>
<td>S</td>
<td>Q</td>
<td>U</td>
<td>A</td>
</tr>
<tr>
<td>sometimes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>under 30%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>over 70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>always</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A</td>
</tr>
<tr>
<td>not sure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

44. GETTING SUCKED [your penis in his mouth]:

**IN THE PAST YEAR, when you had sex, how often did you...**

- get sucked wearing a condom
- get sucked without a condom, but without cumming in his mouth
- get sucked without a condom, and cumming in his mouth

**Regular Partner(s) | Casual Partner(s)**

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>never</td>
<td>N</td>
<td>S</td>
<td>Q</td>
<td>U</td>
<td>A</td>
<td>?</td>
</tr>
<tr>
<td>sometimes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>under 30%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>over 70%</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>always</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A</td>
</tr>
<tr>
<td>not sure</td>
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</table>

45. FUCKING [your penis in his anus]:

**IN THE PAST YEAR, when you had sex, how often did you...**

- fuck with a condom, with him cumming inside you
- fuck with a condom, with him pulling out before cumming
- fuck without a condom, with him cumming inside you
- fuck without a condom, and pull out before cumming

**Regular Partner(s) | Casual Partner(s)**

<table>
<thead>
<tr>
<th>Frequency</th>
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<td>not sure</td>
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</tbody>
</table>

46. GETTING FUCKED [his penis in your anus]:

**IN THE PAST YEAR, when you had sex, how often did you...**

- get fucked with a condom, with him cumming inside you
- get fucked with a condom, with him pulling out before cumming
- get fucked without a condom, with him cumming inside you
- get fucked without a condom, and pull out before cumming

**Regular Partner(s) | Casual Partner(s)**

<table>
<thead>
<tr>
<th>Frequency</th>
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</table>

47. RIMMING [your tongue in his anus]:

**IN THE PAST YEAR, when you had sex, how often did you...**

- rim with a dental dam or other barrier
- rim without a dental dam or other barrier

**Regular Partner(s) | Casual Partner(s)**

<table>
<thead>
<tr>
<th>Frequency</th>
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</thead>
<tbody>
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<td>not sure</td>
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</table>

48. GETTING RIMMED [his tongue in your anus]:

**IN THE PAST YEAR, when you had sex, how often did you...**

- get rimmed with a dental dam or other barrier
- get rimmed without a dental dam or other barrier

**Regular Partner(s) | Casual Partner(s)**

<table>
<thead>
<tr>
<th>Frequency</th>
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<tbody>
<tr>
<td>never</td>
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<td>not sure</td>
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</tbody>
</table>

49. FISTING [your hand or fist in his anus]:

**IN THE PAST YEAR, when you had sex, how often did you...**

- fist with a glove or other barrier
- fist without a glove or other barrier

**Regular Partner(s) | Casual Partner(s)**

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>never</td>
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<tr>
<td>not sure</td>
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</tr>
</tbody>
</table>

50. GETTING FISTED [his hand or fist in your anus]:

**IN THE PAST YEAR, when you had sex, how often did you...**

- get fisted with a glove or other barrier
- get fisted without a glove or other barrier

**Regular Partner(s) | Casual Partner(s)**

<table>
<thead>
<tr>
<th>Frequency</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>never</td>
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<td>A</td>
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<td>sometimes</td>
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<td>under 30%</td>
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<td>not sure</td>
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</tbody>
</table>

51. HAND JOBS [jerking off; mutual masturbation]:

**IN THE PAST YEAR, when you had sex, how often did you...**

- jerk him off without getting his cum on your penis or in your anus
- jerk him off and get his cum on your penis or in your anus

**Regular Partner(s) | Casual Partner(s)**

<table>
<thead>
<tr>
<th>Frequency</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>never</td>
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<td>Q</td>
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<td>?</td>
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<td>sometimes</td>
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<tr>
<td>always</td>
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<td>not sure</td>
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</tbody>
</table>
**NOTE:**
For the questions on this page, please give SEPARATE answers for REGULAR and CASUAL partners.

52. **IN THE PAST YEAR, have you been fucked** without condoms, even once?

- No  
- Yes

If yes, please complete the following chart:
Which of the following best describe your reason(s) for not using condoms when getting fucked?

<table>
<thead>
<tr>
<th>Reason(s)</th>
<th>Regular Partner(s)</th>
<th>Casual Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are (or were) in a long-term relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We are (or were) in a monogamous relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The condom broke or slipped off.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We didn’t have a condom at the time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>He talks me into it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At the time I just didn’t care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The sex was better without a condom.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>He made me do it or threatened me if I didn’t.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We are (or were) both HIV-negative.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

53. **IN THE PAST YEAR, have you fucked another guy** without condoms, even once?

- No  
- Yes

If yes, please complete the following chart:
Which of the following best describe your reason(s) for not using condoms when fucking?

<table>
<thead>
<tr>
<th>Reason(s)</th>
<th>Regular Partner(s)</th>
<th>Casual Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are (or were) in a long-term relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We are (or were) in a monogamous relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The condom broke or slipped off.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We didn’t have a condom at the time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At the time I just didn’t care.</td>
<td></td>
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<tr>
<td>He made me do it or threatened me if I didn’t.</td>
<td></td>
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<tr>
<td>We are (or were) both HIV-negative.</td>
<td></td>
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<tr>
<td>Other (please specify):</td>
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</tr>
</tbody>
</table>

54. **IN THE PAST YEAR, have you had sex with a man who you knew was HIV+ at the time you had sex with him?**

- No  
- Yes

If yes, please complete the following chart:
**IN THE PAST YEAR, how many times** have you done the following with him (or with them)?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Regular HIV+ Partner(s)</th>
<th>Casual HIV+ Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fucking (your penis in his anus)</td>
<td></td>
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</tr>
<tr>
<td>* with a condom, and cumming inside him</td>
<td></td>
<td></td>
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<tr>
<td>* with a condom, and pulling out before cumming</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* without a condom, and cumming inside him</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* without a condom, and pulling out before cumming</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting fucked (his penis in your anus)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* with a condom, and cumming inside you</td>
<td></td>
<td></td>
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<tr>
<td>* with a condom, and pulling out before cumming</td>
<td></td>
<td></td>
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<tr>
<td>* without a condom, and cumming inside you</td>
<td></td>
<td></td>
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<tr>
<td>* without a condom, and pulling out before cumming</td>
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</tbody>
</table>
55. IN THE PAST YEAR, have you had sex outside of British Columbia with someone you were not traveling with?

☐ No ☑ Yes  If yes, did you fuck or get fucked without a condom while outside of BC?

☐ No ☑ Yes  If yes, please complete the following chart, indicating how many different sex partners you fucked or got fucked by without condoms in each location.

<table>
<thead>
<tr>
<th>Province or Territory</th>
<th>City/County</th>
<th>Country</th>
<th>Number of different sex partners</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
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(If you need more space, please continue on the back of this page.)

I: PAID SEX

This section is about PAID SEX. We are defining paid sex as: "Sex exchanged for money, drugs, goods, clothing, shelter or protection.

56. IN YOUR LIFETIME, have you ever been paid for sex?

☐ No ☑ Yes  If yes, continue with questions #57 through #60.

57. How recently?

☐ Less than one week ago
☐ Between a week and a month ago
☐ Between one and 12 months ago
☐ Between one and five years ago
☐ More than five years ago
☐ I'm not sure

58. With men or women?

☐ Men
☐ Women
☐ Both men and women

59. If the sex involved fucking, were condoms used?

☐ Always
☐ Usually [over 70% of the time]
☐ Often [30%-70% of the time]
☐ Sometimes [under 30% of the time]
☐ Never

60. Have you ever been paid MORE to have sex WITHOUT a condom?

☐ Yes
☐ No

61. IN YOUR LIFETIME, have you ever paid someone else for sex?

☐ No ☑ Yes  If yes, continue with questions #62 through #64.

62. How recently?

☐ Less than one week ago
☐ Between a week and a month ago
☐ Between one and 12 months ago
☐ Between one and five years ago
☐ More than five years ago
☐ I'm not sure

63. With men or women?

☐ Men
☐ Women
☐ Both men and women

64. If the sex involved fucking, were condoms used?

☐ Always
☐ Usually [over 70% of the time]
☐ Often [30%-70% of the time]
☐ Sometimes [under 30% of the time]
☐ Never
☐ Not applicable
The next section is about NON-CONSENSUAL SEX.

We are defining non-consensual sex as:

"Any type of sexual activity that you were FORCED or COERCED into against your will (including childhood sexual abuse, molestation, rape and sexual assault)."

We recognize that these may be difficult questions for you to answer, and we thank you for your cooperation.

65. Have you ever been forced or coerced to have sex against your will?
- No
- Yes ➡ If yes, please continue with questions #66 and #67:

66. At what age did this happen to you?
- When I was a child [under 12 years old]
- When I was a youth [12 to 17 years old]
- As an adult [18 or over]
- I'm not sure.
- I prefer not to answer.

67. Who did this to you?
- Male relative(s)
- Female relative(s)
- Male(s) known to me or my family
- Female(s) known to me or my family
- Male stranger(s)
- Female stranger(s)
- Male date(s) or boyfriend(s)
- Female date(s) or girlfriend(s)
- Sex trade client(s) ("johns")
- My pimp(s)
- I'm not sure.
- Other: ______________________
- I prefer not to answer.

68. Have you ever stayed in any of the following institutions?
- Orphanage: ☐ yes ☐ no ☐ not applicable
- Boarding school: ☐ yes ☐ no ☐ not applicable
- Group home: ☐ yes ☐ no ☐ not applicable
- Detention centre: ☐ yes ☐ no ☐ not applicable
- Jail or Prison: ☐ yes ☐ no ☐ not applicable
- Detox centre: ☐ yes ☐ no ☐ not applicable
- Residential rehab: ☐ yes ☐ no ☐ not applicable
- Psychiatric ward: ☐ yes ☐ no ☐ not applicable

If yes to any of these, please continue with questions #69 and #70:

69. Did you ever willingly have sex within any of these institution?
- Orphanage: ☐ yes ☐ no ☐ not applicable
- Boarding school: ☐ yes ☐ no ☐ not applicable
- Group home: ☐ yes ☐ no ☐ not applicable
- Detention centre: ☐ yes ☐ no ☐ not applicable
- Jail or Prison: ☐ yes ☐ no ☐ not applicable
- Detox centre: ☐ yes ☐ no ☐ not applicable
- Residential rehab: ☐ yes ☐ no ☐ not applicable
- Psychiatric ward: ☐ yes ☐ no ☐ not applicable

70. Were you ever forced or coerced to have sex against your will within any of these institution?
- Orphanage: ☐ yes ☐ no ☐ not applicable
- Boarding school: ☐ yes ☐ no ☐ not applicable
- Group home: ☐ yes ☐ no ☐ not applicable
- Detention centre: ☐ yes ☐ no ☐ not applicable
- Jail or Prison: ☐ yes ☐ no ☐ not applicable
- Detox centre: ☐ yes ☐ no ☐ not applicable
- Residential rehab: ☐ yes ☐ no ☐ not applicable
- Psychiatric ward: ☐ yes ☐ no ☐ not applicable

---

If you have been sexually abused, the following agencies can provide you with support and/or referrals:

- Vancouver Society for Male Survivors of Sexual Abuse: 682-6482
- Incest and Sexual Abuse Counselling (Vancouver): 874-2938 (ext. 143)
- Incest and Sexual Abuse Counselling (Richmond): 244-9319
- SAFER Suicide Prevention Counselling: 879-9251
- Crisis Centre Hotline: 872-3312

Printed: June 26, 1997
71. IN THE PAST YEAR, have you used any of the following substances:

<table>
<thead>
<tr>
<th>Substance</th>
<th>What Kind or How?</th>
<th>How Often or How Much?</th>
<th>Date Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td></td>
<td>(Number smoked; not number of packs.)</td>
<td>month:</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td>(Number of drinks; not ounces.)</td>
<td>month:</td>
</tr>
<tr>
<td>Poppers</td>
<td></td>
<td>(Number of &quot;sniffs&quot;; not bottles.)</td>
<td>month:</td>
</tr>
<tr>
<td>Hot or hash (marijuana)</td>
<td></td>
<td>(Number of times used; not grams.)</td>
<td>month:</td>
</tr>
<tr>
<td>Cocaine, crack</td>
<td></td>
<td>(Number of times used; not grams.)</td>
<td>month:</td>
</tr>
<tr>
<td>Speed</td>
<td></td>
<td>(Number of times used; not grams.)</td>
<td>month:</td>
</tr>
<tr>
<td>Acid</td>
<td></td>
<td>(Number of times used.)</td>
<td>month:</td>
</tr>
<tr>
<td>Junk or Snack</td>
<td></td>
<td>(Number of times used; not grams.)</td>
<td>month:</td>
</tr>
<tr>
<td>Inhalants, glue</td>
<td></td>
<td>(Number of times used.)</td>
<td>month:</td>
</tr>
<tr>
<td>Ice</td>
<td></td>
<td>(Number of times used; not grams.)</td>
<td>month:</td>
</tr>
<tr>
<td>Ecstasy,MDMA</td>
<td></td>
<td>(Number of hits or doses.)</td>
<td>month:</td>
</tr>
<tr>
<td>Steroids</td>
<td></td>
<td>(Number of times used.)</td>
<td>month:</td>
</tr>
<tr>
<td>Other recreational drugs</td>
<td>(please specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: We are asking these questions for research purposes only. Your answers will be kept strictly confidential.
NOTE:
For the questions on this page, please consider ONLY drugs that were NOT prescribed by a doctor.

72. IN THE PAST YEAR, have you injected drugs?

☐ No  ☑ Yes If yes, please continue with questions #73 and #74:

73. How often did or do you shoot up?

☐ less than once a month
☐ one to three times a month
☐ once a week
☐ two or three times a week
☐ once a day
☐ two or three times a day
☐ four to six times a day
☐ more than six times a day
☐ I'm not sure

If you have stopped shooting up, when did you quit?

month: __________
year: __________

74. IN THE PAST YEAR, did you use a rig that had already been used by someone else?

☐ No  ☑ Yes If yes, please continue with questions #75 through #78:

75. How often did you use a rig that had already been used by someone else?

☐ Always
☐ Usually [over 70% of the time]
☐ Often [30% - 70% of the time]
☐ Sometimes [under 30% of the time]
☐ Never

76. Who had used these rigs before you?

☐ A sex partner
☐ A relative
☐ A close friend
☐ An acquaintance
☐ A stranger
☐ Someone in a shooting gallery
☐ A fellow inmate
☐ A dealer
☐ Other (specify): __________
☐ I'm not sure.

77. How often did you clean the rig before using it?

☐ Always
☐ Usually [over 70% of the time]
☐ Often [30% - 70% of the time]
☐ Sometimes [under 30% of the time]
☐ Never

78. What did you usually use to clean it?

☐ Cold water
☐ Hot water
☐ Boiling water
☐ Bleach
☐ Alcohol
☐ Other (specify): __________
☐ I'm not sure.

Want $20?

There's a new study for people who CURRENTLY inject drugs. If you qualify, you can get $20 for completing their questionnaire, which takes about an hour. Call the VIDUS Project office at 685-6355 for more information.
79. Do you have any tattoos?
- No
- Yes

80. **How many** tattoos do you have?

81. When did you get your **first** tattoo?
   - month: __________________
   - year: __________________

82. When did you get your **last** tattoo?
   - month: __________________
   - year: __________________

83. **Where** did you get your tattoos?
   - At a tattoo parlour
   - At a professional’s home
   - At a non-professional’s home
   - In jail, prison or detention
   - Other (specify): __________________

84. Was **clean** (sterilized) equipment used to pierce your skin?
   - Yes
   - No
   - Sometimes
   - I’m not sure

85. Do you have any body piercings?
   (eg. earrings, nipple rings, etc.)
   - No
   - Yes

86. **How many** piercings do you have?

87. When did you get your **first** piercing?
   - month: __________________
   - year: __________________

88. When did you get your **last** piercing?
   - month: __________________
   - year: __________________

89. **Where** did you get your piercings?
   - At a piercing studio
   - At a professional’s home
   - At a non-professional’s home
   - In jail, prison or detention
   - Other (specify): __________________

90. Was **clean** (sterilized) equipment used to pierce your skin?
   - Yes
   - No
   - Sometimes
   - I’m not sure

You have now completed the questionnaire.
Thank you very much!
**A: PERSONAL INFORMATION**

A1. What is today's date?

<table>
<thead>
<tr>
<th>month</th>
<th>day</th>
<th>year</th>
</tr>
</thead>
</table>

A2. Have you signed the consent form included with this questionnaire?

- [ ] Yes
- [ ] No
- [ ] Not sure

**NOTE:**
First we need to confirm some personal information. This info will be kept strictly confidential.

A2. Have you signed the consent form included with this questionnaire?

- [ ] Yes
- [ ] No
- [ ] Not sure

A3. When were you born?

<table>
<thead>
<tr>
<th>month</th>
<th>day</th>
<th>year</th>
</tr>
</thead>
</table>

A4. Are you still living in the Lower Mainland?

- [ ] Yes
- [ ] No: If no, where are you living?

1. City or town: ____________________________________________
2. Province, territory or state: _____________________________
3. Country (if not Canada): ________________________________

How long have you lived there? ____________

**NOTE:**
"SINCE YOUR LAST VISIT" means since you last completed a Vanguard Project questionnaire, about a year ago.

A5. Since your last visit, how many cities or towns have you lived in?

- [ ] just one
- [ ] ______ cities/towns

A6. Since your last visit, what kind of housing have you lived in the most?

- [ ] Apartment or condominium
- [ ] Single detached house
- [ ] Student residence or dorm
- [ ] Hotel or rooming-house
- [ ] Shelter/hostel (eg. YMCA, Salvation Army)
- [ ] Squat
- [ ] No fixed address
- [ ] Other (specify): __________________________

A7. Since your last visit, how many places have you lived in?

- [ ] just one
- [ ] ______ places

A8. Since your last visit, what is the longest period of time you lived at one of these places?

- [ ] the whole time
- [ ] ______ months

**NOTE:**
"SINCE YOUR LAST VISIT" means since the last time you completed a Vanguard Project questionnaire, about a year ago.

A9. What are the first three digits of your postal code?

[ ] [ ] [ ]

- [ ] I'm not sure.

If not sure, name your neighborhood: ____________________________

A10. What is your current marital status?

- [ ] Single and never married
- [ ] Married and living with wife
- [ ] Common-law (male partner)
- [ ] Divorced from female partner
- [ ] Divorced from male partner
- [ ] Separated from female partner
- [ ] Separated from male partner
- [ ] Widowed (female partner died)
- [ ] Widowed (male partner died)

A11. What is your current relationship status?

- [ ] Not involved with anyone
- [ ] Living with female partner
- [ ] Living with male partner
- [ ] Involved with a woman but not living with her
- [ ] Involved with a man but not living with him

A12. Since your last visit, have you been in school?

- [ ] No
- [ ] Yes

A13. How many years of high school or post-secondary education have you now completed?

- [ ] High school: ________ years
- [ ] Post-secondary: ________ years

A14. Since your last visit, have you received any certificates, diplomas or degrees?

- [ ] None
- [ ] High school diploma
- [ ] Trades certificate
- [ ] University degree (eg. B.A., B.Sc.)
- [ ] Post-graduate degree (eg. M.A., Ph.D.)
- [ ] Community college certificate (eg. CEGEP, Institute of technology)
- [ ] Other (specify): __________________________
B1. SINCE YOUR LAST VISIT, have you had a paying job?

- Yes: If yes, did you work...
  - Full-time
  - Part-time/casual
  - Self-employed

How many hours per week did you work? _____

Please describe your occupation: ________________________________

- No: If no, were you...
  - Unemployed but available for work
  - Temporarily unavailable for work (e.g. sick leave)
  - Currently permanently unable to work
  - Student
  - Other (specify): ________________________________

**NOTE:**

The next question is NOT an attempt to identify illegal activities. Your confidentiality is assured.

B2. SINCE YOUR LAST VISIT, did you receive money from:

- Provincial income assistance (welfare)
- Handicapped status
- Employable status
- Unemployable status
- I'm not sure of my status
- Employment Insurance (EI or UIC)
- Canada Pension Plan (CPP)
- Savings or borrowing
- Drug trafficking
- Sex trade/prostitution
- Student loans or grants
- Long-term disability insurance
- Other legal sources of income
- Other (specify): ________________________________

C1. SINCE YOUR LAST VISIT, have you had any of the following symptoms that lasted for at least 3 DAYS IN A ROW?

(Do not include any symptoms that you have all the time)

- Fever
- Night sweats
- Swollen glands or lymph nodes
- Sore throat
- Mouth Sores
- Body Rash
- Sore muscles or joints (for no reason)
- Nausea
- Vomiting
- Diarrhea
- Headache (not from a hangover)
- Light hurting eyes
- Stiff neck (not from exercise or injury)
- Fatigue
- Other (specify): ________________________________

C2. Have you had any of the symptoms listed above IN THE LAST TWO WEEKS?

- No
- Yes

C3. Have you EVER had any of these sexually transmitted diseases (STDs)?

- Chlamydia, Non-Specific Urethritis or Non-Gonococcal Urethritis (NGU)
- Gonorrhoea (‘the clap’)
- Syphilis
- Genital or rectal herpes
- Genital or rectal warts
- Unknown STD
- Other (specify): ________________________________

C4. Have you had any of the STDs listed above SINCE YOUR LAST VISIT?

- No
- Yes: If yes, which one(s): ________________________________

**NOTE:**

'SINCE YOUR LAST VISIT' means since the last time you completed a Vanguard Project questionnaire, about a year ago...

Printed: October 16, 1998

Vanguard Project Follow-up Questionnaire, Wave #4
C. PHYSICAL HEALTH (continued)

C5. Have you EVER had Hepatitis? (also known as jaundice)
- No
- Unsure
- Yes: If yes, which type(s)?
  - Hep A
  - Hep B
  - Hep C
  - Unsure

A VACCINE is a shot which protects against a specific disease.
The vaccine for Hepatitis A became available free of charge for gay and bisexual men in Vancouver in late 1997.

C6. Have you received the Hepatitis A vaccine?
- Unsure
- Yes: If yes, when _______ (year)
  - One
  - Two
  - Unsure
- No: If no, is there a reason why not?
  - I've already had hep A.
  - I didn't know about the vaccine.
  - I think I'm at low risk for hepatitis.
  - I don't like getting shots.
  - It's too expensive.
  - I don't know/no reason.
  - Worried about vaccine's safety.
  - Other (specify): __________________________

C7. Have you received the Hepatitis B vaccine (a series of three shots)?
- Unsure
- Yes: If yes, when _______ (year)
  - One
  - Two
  - Three
  - Unsure
- No: If no, is there a reason why not?
  - I've already had hep B.
  - I'm a carrier for hep B.
  - I didn't know about the vaccine.
  - I think I'm at low risk for hepatitis.
  - I don't like getting shots.
  - It's too expensive.
  - I don't know/no reason.
  - Worried about vaccine's safety.
  - Other (specify): __________________________

NOTE: If you haven't been vaccinated for Hep A or Hep B, you can get the shots for free at medical clinics or from your doctor.

D. GENERAL SEXUAL HISTORY

D1. SINCE YOUR LAST VISIT, have you had sex with men, women, and/or transgendered people?
- Only men.
- Mostly men but sometimes women.
- Both men and women equally.
- Mostly women but sometimes men.
- Only women.
- Transgendered people.
- I haven't had sex since my last visit.
  - If you haven't had sex since your last visit, go to question #F1.

D2. SINCE YOUR LAST VISIT, how many women have you had sex with?
- None: If none, go to question #D4.
- One
- 2 to 5
- 6 to 19
- 20 to 49
- 50 to 99
- 100 or more
  - Can you give a more exact number?

D3. When was the MOST RECENT time you had sex with a woman?
- Less than one week ago
- Between one week and a month ago
- Between one and 12 months ago
- Between one and five years ago
- More than five years ago
  - Check one only.

D4. SINCE YOUR LAST VISIT, how many men have you had sex with?
- None: If none, go to question #F1.
- One
- 2 to 5
- 6 to 19
- 20 to 49
- 50 to 99
- 100 or more
  - Can you give a more exact number?

D5. When was the MOST RECENT time you had sex with a man?
- Less than one week ago
- Between one week and a month ago
- Between one and 12 months ago
- Between one and five years ago
- More than five years ago
  - Check one only.
E1. SINCE YOUR LAST VISIT, where did you have sex with your male sex partner(s)?

Use this percentage scale as a guide:

- Never
- Sometimes (under 30% of the time)
- Often (30% - 70% of the time)
- Usually (over 70% of the time)
- Always

- At your home
- At his home
- At private sex parties
- In hotels or resorts
- In bathhouses or sex clubs
- In bars or nightclubs
- In peep shows or sex shops
- In public parks or beaches
- In public washrooms
- In other public places
- In cars or other vehicles
- Other (specify):

E2. SINCE YOUR LAST VISIT, have you had regular male sex partner(s)?

- No: 
- Yes:

E3. SINCE YOUR LAST VISIT, how many regular partners have you had?

- just one
- or: _____ partners

E4. How many of these regular partners are over 30 years of age?

- none of them
- some of them
- about half of them
- most of them
- all of them

Can you give a more exact number? _____

E5. HOW OFTEN do you discuss using condoms with your REGULAR male partner(s)?

- Always
- Usually (over 70% of the time)
- Often (30% - 70% of the time)
- Sometimes (under 30% of the time)
- Never
- Not applicable

E6. SINCE YOUR LAST VISIT, have you had casual male sex partner(s)?

- No: 
- Yes:

E7. SINCE YOUR LAST VISIT, how many casual partners have you had?

- just one
- or: _____ partners

E8. How many of these casual partners are over 30 years of age?

- none of them
- some of them
- about half of them
- most of them
- all of them

Can you give a more exact number? _____

E9. HOW OFTEN do you discuss using condoms with your CASUAL male partner(s)?

- Always
- Usually (over 70% of the time)
- Often (30% - 70% of the time)
- Sometimes (under 30% of the time)
- Never
- Not applicable
**E: SEX WITH MEN (continued)**

For the questions on this page, please give SEPARATE answers for REGULAR partners (men you have sex with AT LEAST once a month) & CASUAL partners (men you have sex with LESS THAN once a month).

<table>
<thead>
<tr>
<th>Use the scale as a guide.</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = never</td>
</tr>
</tbody>
</table>

**E10. SUCKING [his penis in your mouth]:**

<table>
<thead>
<tr>
<th>SINCE YOUR LAST VISIT: when you had sex, how often did you...</th>
<th>REGULAR Partner(s)</th>
<th>CASUAL Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>...suck with a condom</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...suck without a condom, but without getting cum in your mouth</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...suck without a condom, and getting cum in your mouth</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
</tbody>
</table>

**E11. GETTING SUCKED [your penis in his mouth]:**

<table>
<thead>
<tr>
<th>SINCE YOUR LAST VISIT: when you had sex, how often did you...</th>
<th>REGULAR Partner(s)</th>
<th>CASUAL Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>...get sucked wearing a condom</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...get sucked without a condom, but without cumming in his mouth</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...get sucked without a condom, and cumming in his mouth</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
</tbody>
</table>

**E12. FUCKING [your penis in his anus]:**

<table>
<thead>
<tr>
<th>SINCE YOUR LAST VISIT: when you had sex, how often did you...</th>
<th>REGULAR Partner(s)</th>
<th>CASUAL Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>...fuck with a condom, and cum inside him</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...fuck with a condom, and pull out before cumming</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...fuck without a condom, and cum inside him</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...fuck without a condom, and pull out before cumming</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
</tbody>
</table>

**E13. GETTING FUCKED [his penis in your anus]:**

<table>
<thead>
<tr>
<th>SINCE YOUR LAST VISIT: when you had sex, how often did you...</th>
<th>REGULAR Partner(s)</th>
<th>CASUAL Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>...get fucked with a condom, with him cumming inside you</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...get fucked with a condom, with him pulling out before cumming</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...get fucked without a condom, with him cumming inside you</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...get fucked without a condom, with him pulling out before cumming</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
</tbody>
</table>

**E14. RIMMING [your tongue in his anus]:**

<table>
<thead>
<tr>
<th>SINCE YOUR LAST VISIT: when you had sex, how often did you...</th>
<th>REGULAR Partner(s)</th>
<th>CASUAL Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>...rim with a dental dam or other barrier</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...rim without a dental dam or other barrier</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
</tbody>
</table>

**E15. GETTING RIMMED [his tongue in your anus]:**

<table>
<thead>
<tr>
<th>SINCE YOUR LAST VISIT: when you had sex, how often did you...</th>
<th>REGULAR Partner(s)</th>
<th>CASUAL Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>...get rimmed with a dental dam or other barrier</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...get rimmed without a dental dam or other barrier</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
</tbody>
</table>

**E16. FISTING [your hand or fist in his anus]:**

<table>
<thead>
<tr>
<th>SINCE YOUR LAST VISIT: when you had sex, how often did you...</th>
<th>REGULAR Partner(s)</th>
<th>CASUAL Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>...fist with a glove or other barrier</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...fist without a glove or other barrier</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
</tbody>
</table>

**E17. GETTING FISTED [his hand or fist in your anus]:**

<table>
<thead>
<tr>
<th>SINCE YOUR LAST VISIT: when you had sex, how often did you...</th>
<th>REGULAR Partner(s)</th>
<th>CASUAL Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>...get fist with a glove or other barrier</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...get fist without a glove or other barrier</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
</tbody>
</table>

**E18. HAND JOBS [jerking off; mutual masturbation]:**

<table>
<thead>
<tr>
<th>SINCE YOUR LAST VISIT: when you had sex, how often did you...</th>
<th>REGULAR Partner(s)</th>
<th>CASUAL Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>...jerk him off without getting his cum on your penis or in your anus</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
<tr>
<td>...jerk him off and get his cum on your penis or in your anus</td>
<td>NSOUA</td>
<td>NSOUA</td>
</tr>
</tbody>
</table>
E19. SINCE YOUR LAST VISIT, have you been fucked without condoms, even once?

- No: If no, go to question #E20.
- Yes: If yes, how many times?

If yes, please complete the following chart:

<table>
<thead>
<tr>
<th>Reasons for not using condoms when getting fucked</th>
<th>Regular Partner(s)</th>
<th>Casual Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We are (or were) in a long-term relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• We are (or were) in a monogamous relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• It was more intimate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• We got carried away</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The condom broke or slipped off</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• We didn't have a condom at the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• It feels better without a condom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At the time I just didn't care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The sex was too hot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• He talked me into it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• I was drunk or stoned at the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• We are (or were) both HIV-negative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• We are both HIV-positive (HIV+)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• I wanted to try it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• He threatened to leave me if I didn't</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• He made me do it/He threatened me if I didn't</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• I don't know/No reason</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E20. SINCE YOUR LAST VISIT, have you fucked another guy without condoms, even once?

- No: If no, go to question #E21.
- Yes: If yes, how many times?

If yes, please complete the following chart:

<table>
<thead>
<tr>
<th>Reasons for not using condoms when fucking</th>
<th>Regular Partner(s)</th>
<th>Casual Partner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We are (or were) in a long-term relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• We are (or were) in a monogamous relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• It was more intimate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• We got carried away</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The condom broke or slipped off</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• We didn't have a condom at the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• It feels better without a condom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At the time I just didn't care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The sex was too hot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• He talked me into it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• I was drunk or stoned at the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• We are (or were) both HIV-negative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• We are both HIV-positive (HIV+)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• I wanted to try it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• He threatened to leave me if I didn't</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• He made me do it/He threatened me if I didn't</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• I don't know/No reason</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
E21. THE LAST TIME you fucked another guy, did you use a condom?
- No
- Yes
- Not applicable

NOTE:
If you have sex with guys for money, please INCLUDE this in your answers to the questions on this page.

E22. THE LAST TIME you got fucked by a man, did he use a condom?
- No
- Yes
- Not applicable

For the remaining questions on this page, please give SEPARATE answers for REGULAR and CASUAL partners.

E23. SINCE YOUR LAST VISIT, have you had sex with a man who you knew was HIV+ at the time you had sex with him?
- No
- Not sure
- Yes: If yes, how many times?
  If yes, please complete the following chart:

| SINCE YOUR LAST VISIT, how many times have you done the following with him (or with them)? | How many times since last visit?
---|---|
| + with a condom, and cumming inside him | |
| + without a condom, and cumming inside him | |
| + with a condom, and pulling out before cumming | |
| + without a condom, and cumming inside you | |
| + with a condom, and cumming outside you | |
| + without a condom, and cumming outside you | |

E24. SINCE YOUR LAST VISIT, were any of your male sex partners people who inject drugs?
- No
- Not sure
- Yes: If yes, how many people?
  Number of REGULAR Partner(s) _______ Number of CASUAL Partner(s) _______

E25. SINCE YOUR LAST VISIT, have you had sex outside of British Columbia with someone you were not travelling with?
- No: If no, go to question #F1.
- Yes: If yes, did you fuck or get fucked without a condom while outside of BC?
  - No: If no, go to question #F1.
  - Yes: If yes, please complete the following chart, indicating how many different sex partners you fucked or got fucked by without condoms in each location.

| Province | Number of different sex partners |
---|---|
| City/Urban | | |
| Rural | | |
| Other | | |

(If you need more space, please continue on the back of this page.)
F: PAID SEX

2. DEFINITION: We are defining "PAID SEX" as: "Sex exchanged for money, drugs, goods, clothing, shelter or protection."

F1. Have you EVER been paid for sex by men or women?
   • No: If no, go to question #F8.
   • Yes

F2. THE FIRST TIME you were paid for sex, how old were you?
   I was ________ years old when paid by a man.
   I was ________ years old when paid by a woman.

F3. HOW RECENTLY have you been paid for sex?
   By men By women
   • Less than one week ago
   • Between a week and a month ago
   • Between one and 12 months ago
   • Between one and five years ago
   • More than five years ago

F4. SINCE YOUR LAST VISIT, have you been paid for sex by men or women?
   • No: If no, go to question #F8.
   • Yes: If yes, who has paid you?
     • Men
     • Women
     • Both

F5. SINCE YOUR LAST VISIT, how many times have you been paid for sex?
   • None: If none, go to question #F8.
   • Only once
   • 2 to 9 times
   • 10 to 49 times
   • 50 to 99 times
   • 100 or more times
   • Can you give a more exact number? ________

F6. If the sex involved fucking, were condoms used?
   Men Women
   • Always
   • Usually [over 70% of the time]
   • Often [30% - 70% of the time]
   • Sometimes [under 30% of the time]
   • Never
   • Not applicable

F7. SINCE YOUR LAST VISIT, have you been paid more to have sex without a condom?
   • Yes
   • No

F8. Have you EVER paid a man or woman for sex?
   • No: If no, go to question #G1.
   • Yes: If yes, who?
     • Men
     • Women
     • Both

F9. HOW RECENTLY have you paid someone else for sex?
   Men Women
   • Less than one week ago
   • Between a week and a month ago
   • Between one and five years ago
   • More than five years ago

F10. SINCE YOUR LAST VISIT, have you paid someone else (man or woman) for sex?
    • No: If no, go to question #G1.
    • Yes: If yes, who?
      • Men
      • Women
      • Both

F11. If the sex involved fucking, were condoms used?
    Men Women
    • Always
    • Usually [over 70% of the time]
    • Often [30% - 70% of the time]
    • Sometimes [under 30% of the time]
    • Never
    • Not applicable

Note: "SINCE YOUR LAST VISIT" means since the last time you completed a Vanguard Project questionnaire, about a year ago.

We are defining "NON-CONSENSUAL SEX" as:

"Any type of sexual activity that you were FORCED or COERCED into against your will (including childhood sexual abuse, molestation, rape and sexual assault)."

We recognize that these may be difficult questions for you to answer, and we thank you for your cooperation.

G1. Have you EVER been forced or coerced to have sex against your will?

☐ No: If no go to question #H1.
☐ Yes:

- NOTE:

The next questions are about the FIRST TIME someone forced or coerced you to have sex against your will.

G2. The FIRST TIME this happened, how old were you?

I was about ________ years old.

G3. The FIRST TIME this happened, how old was the other person(s)?

They were about ________ years old.

G4. The FIRST TIME this happened, who did this to you?

☐ Father
☐ Step-father
☐ Brother
☐ Step-brother
☐ Other male relative(s)
☐ Mother
☐ Step-mother
☐ Sister
☐ Step-sister
☐ Other female relative(s)
☐ Regular male partner(s)
☐ Casual male partner(s) or date(s)
☐ Female date(s) or girlfriend(s)
☐ Male(s) known to me or my family
☐ Female(s) known to me or my family
☐ Male stranger(s)
☐ Female stranger(s)
☐ I'm not sure.
☐ Other (specify): __________________________

- NOTE:

Some people use coercion, manipulation or pressure to force others to have sex against their will and some people use physical force or violence. The next question is about the use of PHYSICAL FORCE or violence. It is not meant to invalidate or trivialize experiences in which physical force was not used.

G5. The FIRST TIME someone forced you to have sex against your will, was physical force or violence used against you?

☐ No
☐ Yes, some physical force
☐ Yes, extreme physical force

G6. The FIRST TIME this happened, what took place against your will?

☐ I was kissed or touched against my will
☐ I was forced to kiss or touch someone else
☐ I was masturbated/jerked off against my will
☐ I was forced to jerk off someone else
☐ I was sucked off against my will
☐ I was forced to suck or lick someone else
☐ I was fucked against my will
☐ I was forced to fuck someone else
☐ I was forced to watch a sex act
☐ Other (specify): __________________________

G7. How many people have forced or coerced you into having sex against your will?

☐ One person only
☐ More than one person

- Can you give a more exact number? ________

G8. How many different times have you been forced or coerced into having sex against your will?

☐ One time only: If once, go to #G14.
☐ More than one time

- Can you give a more exact number? ________
G: NON-CONSENSUAL SEX

* NOTE:*
The following questions are about the MOST RECENT TIME someone forced or coerced you to have sex against your will.

G9. The MOST RECENT time this happened, how old were you?

I was about _____ years old.

G10. The MOST RECENT time this happened, about how old was the other person(s)?

They were about _____ years old.

G11. The MOST RECENT time this happened, who did this to you?

- Father
- Step-father
- Brother
- Step-brother
- Other male relative(s)
- Mother
- Step-mother
- Sister
- Step-sister
- Other female relative(s)
- Regular male partner(s)
- Casual male partner(s) or date(s)
- Female date(s) or girlfriend(s)
- Male(s) known to me or my family
- Male stranger(s)
- Female stranger(s)
- I'm not sure
- Other (specify): ______________________

G12. The MOST RECENT time someone forced you to have sex against your will, was physical force or violence used against you?

- No
- Yes, some physical force
- Yes, extreme physical force

G13. The MOST RECENT time this happened, what took place against your will?

- I was kissed or touched against my will
- I was forced to kiss or touch someone else
- I was masturbated/jerked off against my will

Check all that apply:
- I was sucked off against my will
- I was forced to suck or lick someone else
- I was fucked against my will
- I was forced to fuck someone else
- I was forced to watch a sex act
- Other (specify): ______________________

G14. Have you EVER told anyone about this experience before now?

- No:
- Yes: If yes, who?

Check all that apply:
- Counsellor
- Crisis hotline or Bash line
- Doctor/nurse
- Family members
- Fellow sex trade worker
- Friend(s)
- Partner
- Social worker
- Police
- Support group
- Other (specify): ______________________

G15. How supportive have the people you told about this experience been?

- Not at all supportive
- Somewhat supportive
- Very supportive
- Not applicable

G16. Have you EVER received any counselling that dealt with sexual abuse issues?

- No
- Yes: If yes, are you CURRENTLY receiving such counselling?

- No
- Yes

Want to talk to someone about it?

If you have been sexually abused, the following agencies can provide you with support and/or referrals:

- BC Society for Male Survivors of Sexual Abuse: 682-6482
- Incest and Sexual Abuse Counselling (Vancouver): 874-2938 (ext. 143)
- Incest and Sexual Abuse Counselling (Richmond): 244-9319
- SAFER (Suicide Prevention Counselling): 879-9251
- Crisis Centre Hotline: 872-3311

Note: "SINCE YOUR LAST VISIT" means since the last time you completed a Vanguard Project questionnaire, about a year ago.

Printed: October 16, 1998
Vanguard Project Follow-up Questionnaire: Wave #4
Page 11 of 19
H: PHYSICAL ABUSE

**NOTE:**
The following questions concern PHYSICAL ABUSE in relationships, which is also called "domestic violence." We recognize that these may be difficult questions for you to answer, and we thank you for your cooperation.

H1. Have you EVER been physically abused (i.e. hit or assaulted) by a boyfriend, girlfriend, sexual partner or date? (Do not include sex trade clients in this section.)
- **No:** If no, go to question #H6.
- **Yes**

H2. The FIRST TIME this happened, who did this to you?
- Regular male partner(s)
- Casual male partner(s) or date(s)
- Regular female partner(s)
- Casual female partners) or date(s)
- Other (specify):
  - Check all that apply.

H3. When was the MOST RECENT time this happened?
- Less than one year ago
- Between one and two years ago
- Between two and five years ago
- More than five years ago

H4. Have you EVER told anyone about this experience(s) before now?
- **No**
- **Yes:** If yes, who?
  - Counsellor
  - Crisis hotline
  - Doctor/nurse
  - Family members
  - Fellow sex trade worker/"co-worker"
  - Friend(s)
  - Partner
  - Social worker
  - Support group
  - Other (specify):
    - Check all that apply.

H5. Have you EVER required medical attention as a result of such abuse (i.e. did you see a doctor or nurse or go to the hospital after being assaulted?)
- **No**
- **Yes:** If yes, did you tell the doctor or nurse that you were assaulted by a boyfriend, girlfriend, sexual partner or date?
  - **No**
  - **Yes**

H6. Have you EVER been gay bashed?
- **Yes**
- **No:** If no, go to question #H6.

H7. When was the MOST RECENT TIME you were gay bashed?
- Less than one year ago
- Between one and two years ago
- Between two and five years ago
- More than five years ago

---

J: INSTITUTIONALIZATION

J1. SINCE YOUR LAST VISIT, have you stayed in any of the following institutions?
- Boarding school: **yes** | **no**
- Group home: **yes** | **no**
- Detention centre: **yes** | **no**
- Jail or Prison: **yes** | **no**
- Detox centre: **yes** | **no**
- Residential rehab: **yes** | **no**
- Psychiatric ward: **yes** | **no**

If no to all of these, go to question #K1.
If yes to any of these, please continue with questions #J2 and #J3:

J2. SINCE YOUR LAST VISIT, did you willingly have sex within any of these institutions?
- Boarding school: **yes** | **no** | **not applicable**
- Group home: **yes** | **no** | **not applicable**
- Detention centre: **yes** | **no** | **not applicable**
- Jail or Prison: **yes** | **no** | **not applicable**
- Detox centre: **yes** | **no** | **not applicable**
- Residential rehab: **yes** | **no** | **not applicable**
- Psychiatric ward: **yes** | **no** | **not applicable**

J3. SINCE YOUR LAST VISIT, were you forced or coerced to have sex against your will within any of these institutions?
- Boarding school: **yes** | **no** | **not applicable**
- Group home: **yes** | **no** | **not applicable**
- Detention centre: **yes** | **no** | **not applicable**
- Jail or Prison: **yes** | **no** | **not applicable**
- Detox centre: **yes** | **no** | **not applicable**
- Residential rehab: **yes** | **no** | **not applicable**
- Psychiatric ward: **yes** | **no** | **not applicable**

---

Note: "SINCE YOUR LAST VISIT" means since the last time you completed a Vanguard Project questionnaire, about a year ago.
K1. SINCE YOUR LAST VISIT, have you used any of the following substances:

<table>
<thead>
<tr>
<th>Substance</th>
<th>Yes</th>
<th>No</th>
<th>Yes or No</th>
<th>Select one only:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
<td></td>
<td>(Number smoked; not number of packs.)</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td>(Number of drinks; not ounces.)</td>
</tr>
<tr>
<td>Peppers</td>
<td></td>
<td></td>
<td></td>
<td>(Number of &quot;sniffs&quot;; not bottles.)</td>
</tr>
<tr>
<td>Pot or hash</td>
<td></td>
<td></td>
<td></td>
<td>(Number of times used; not grams.)</td>
</tr>
<tr>
<td>Coke</td>
<td></td>
<td></td>
<td></td>
<td>(Number of times or hits; not grams.)</td>
</tr>
<tr>
<td>Crack (crack/cocaine)</td>
<td></td>
<td></td>
<td></td>
<td>(Number of times used; not grams.)</td>
</tr>
<tr>
<td>Speed</td>
<td></td>
<td></td>
<td></td>
<td>(Number of hits; not grams.)</td>
</tr>
<tr>
<td>Acid (LSD)</td>
<td></td>
<td></td>
<td></td>
<td>(Number of hits)</td>
</tr>
<tr>
<td>Junk or Smack (heroin/opiates)</td>
<td></td>
<td></td>
<td></td>
<td>(Number of hits; not grams.)</td>
</tr>
<tr>
<td>Crystal meth (crank/oric)</td>
<td></td>
<td></td>
<td></td>
<td>(Number of times used; not grams.)</td>
</tr>
<tr>
<td>Ecstasy (MDMA)</td>
<td></td>
<td></td>
<td></td>
<td>(Number of hits or doses)</td>
</tr>
<tr>
<td>Special K (khat/ketamine)</td>
<td></td>
<td></td>
<td></td>
<td>(Number of times used.)</td>
</tr>
<tr>
<td>GHB (Gamma-hydroxybuturate)</td>
<td></td>
<td></td>
<td></td>
<td>(Number of times used.)</td>
</tr>
</tbody>
</table>

*Other recreational drugs (specify):*
K2. Have you EVER felt you ought to cut down on your drinking?
   □ Yes  □ No

K3. Have people EVER annoyed you by criticizing your drinking?
   □ Yes  □ No

K4. Have you EVER felt bad or guilty about your drinking?
   □ Yes  □ No

K5. Have you EVER had a drink first thing in the morning to steady your nerves, to get rid of a hangover, or as an “eye-opener”?
   □ Yes  □ No

K6. Have you EVER considered yourself to have a drinking problem or to be an excessive drinker?
   □ Yes, during the time since my last visit  □ Yes, before my last visit  □ No, never

K7. Have you EVER had any kind of alcohol or other drug treatment?
   □ No:  □ Yes: If yes, what kind?
   □ Detox/Youth detox  □ Recovery house
   □ Treatment centre  □ Spiritual healer
   □ Counsellor  □ Alcoholics Anonymous (AA)
   □ Narotics/Cocaine Anonymous (NA/CA)  □ Methadone program
   □ Other (specify): ____________________

K8. Are you CURRENTLY enrolled in any kind of alcohol or drug treatment?
   □ No:  □ Yes: If yes, what kind?
   □ Detox/Youth detox  □ Recovery house
   □ Treatment centre  □ Spiritual healer
   □ Counsellor  □ Alcoholics Anonymous (AA)
   □ Narcotics/Cocaine Anonymous (NA/CA)  □ Methadone program
   □ Other (specify): ____________________

K9. SINCE YOUR LAST VISIT, have you used any of the following drugs either DURING sex or within two hours BEFORE sex?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Never</th>
<th>Sometimes (under 10% of the time)</th>
<th>Often (10% - 70% of the time)</th>
<th>Usually (over 70% of the time)</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poppers (nitrite inhalants)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pot or hash (marijuana)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coke (cocaine)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Crack (crack cocaine)</td>
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<tr>
<td>Speed</td>
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<tr>
<td>Acid (LSD)</td>
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<tr>
<td>Junk or Smack (heroin/opiates)</td>
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<tr>
<td>Ice (crystal meth)</td>
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<tr>
<td>Ecstasy (MDMA)</td>
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<td>Special K (kats/ketamine)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>GHB (gamma-hydroxybuturate)</td>
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<td></td>
<td></td>
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<tr>
<td>Other drugs (specify):</td>
<td></td>
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</tr>
</tbody>
</table>

Note: "SINCE YOUR LAST VISIT" means since the last time you completed a Vanguard Project questionnaire, about a year ago or...

**I: INJECTION DRUG USE**

**NOTE:**
For the questions on this page, please consider ONLY drugs that were NOT prescribed by a doctor.

**L1. Have you EVER injected drugs?**
- No: [ ]
- Yes: [ ]

**L2. How old were you the FIRST TIME you injected drugs?**
I was about ______ years old

**L3. When was the LAST TIME you injected drugs?**
- Today: [ ]
- 1 to 3 days ago: [ ]
- 4 to 6 days ago: [ ]
- 1 to 2 weeks ago: [ ]
- Between 2 weeks and 1 month ago: [ ]
- 1 to 3 months ago: [ ]
- 3 to 6 months ago: [ ]
- Between 6 months and my last visit: [ ]
- Before my last visit: [ ]

**L4. SINCE YOUR LAST VISIT, how often do you inject drugs?**
- less than once a month: [ ]
- one to three times a month: [ ]
- once a week: [ ]
- two or three times a week: [ ]
- once a day: [ ]
- two or three times a day: [ ]
- four to six times a day: [ ]
- more than six times a day: [ ]
- I'm not sure: [ ]
- I quit: [ ]

**L5. SINCE YOUR LAST VISIT, how often have you used a rig that had already been used by someone else?**
- Always: [ ]
- Usually: [over 70% of the time]: [ ]
- Often: [30% - 70% of the time]: [ ]
- Sometimes: [under 30% of the time]: [ ]
- Never: [ ]

**L6. SINCE YOUR LAST VISIT, how often have you given or lent a rig that you had already used to someone else?**
- Always: [ ]
- Usually: [over 70% of the time]: [ ]
- Often: [30% - 70% of the time]: [ ]
- Sometimes: [under 30% of the time]: [ ]
- Never: [ ]

**NOTE:**
The following questions are about HIV testing and HIV test results. Your responses will be kept totally confidential.

**M1. HOW OFTEN do you get tested for HIV?**
- every three months: [ ]
- every three to six months: [ ]
- twice a year: [ ]
- once a year: [ ]
- less than once a year: [ ]
- not applicable: [ ]
- Other (specify): ____________________

**M2. When was your last HIV test?**

date (month/year) [ ]

**M3. The LAST TIME you were tested for HIV, what led you to be tested?**
- I just wanted to know: [ ]
- I get tested regularly: [ ]
- I felt ill: [ ]
- I thought I had been exposed to HIV: [ ]
- I knew someone who tested HIV+: [ ]
- I was advised to by a doctor or nurse: [ ]
- I was asked to by a sex partner: [ ]
- I was asked to by a friend or family member: [ ]
- I was entering into a new relationship: [ ]
- I applied for private insurance: [ ]
- I tried to donate blood: [ ]
- I was part of a research study (eg. Vanguard): [ ]
- I was in the hospital: [ ]
- Other (specify): ____________________

**M4. How many people do you personally know (or have known) who are HIV+?**
- None: [ ]
- 20 to 49: [ ]
- 50 to 99: [ ]
- 100 or more: [ ]
- 2 to 5: [ ]
- 6 to 19: [ ]

Can you give a more exact number? ___________

**M5. What was the result of your last HIV test?**
- Negative (i.e. non-reactive): [ ]
- Indeterminate: [ ]
- Not sure: [ ]
- I didn't return for the results: [ ]
- Positive: [ ]

If HIV+, go to question #N1.

**M6. SINCE YOUR LAST VISIT, how likely do you think it is that you've been infected with HIV?**
- Usually: [over 70% of the time]: [ ]
- Not at all possible: [ ]
- Not very likely: [ ]
- Possibly infected: [ ]
- Probable infected: [ ]
- Almost certainly infected: [ ]
N1. I consider myself to be:

- straight
t- gay (homosexual)
- bisexual
ttransgender
- none of the above
- other (specify):

N2. Have you EVER told anyone that you are gay or bisexual, or that you are sexually attracted to men?

- Yes
- No
- Unsure

N3. How old were you the FIRST TIME you "came out" to anyone? (i.e. the first time you told someone you were gay or bisexual, or that you were sexually attracted to men)

I was _______ years old

N4. How many people know that you are gay, bisexual, or sexually attracted to men?

- No one
- One or two people
- Fewer than half the people I know
- About half the people I know
- More than half the people I know
- Almost everyone I know
- Absolutely everyone I know
- Can you give a more exact number?

N5. Who is aware that you are gay, bisexual or sexually attracted to men?

- male friends
- female friends
- female sex partners
- parents
- siblings (i.e. brothers & sisters)
- other relatives
- employer(s)
- co-worker(s)
- counsellor or therapist
- doctor
- nurse/clinic staff
- other (specify):
- other (specify):

N6. How comfortable do you feel with your sexual orientation?

- totally comfortable
- somewhat comfortable
- not very comfortable
- not at all comfortable

N7. Have you EVER seriously thought about committing suicide?

- No
- Yes: If yes, have you EVER attempted suicide?
- No
- Yes: If yes, when was MOST RECENT time?

N8. Have you EVER been told by a doctor, counsellor or psychiatrist you have a mood disorder or mental disability, such as depression, schizophrenia or manic-depression (bi-polar disorder)?

- No
- Yes: If yes, specify:

N9. SINCE YOUR LAST VISIT, how have you felt about yourself?

- On the whole I am satisfied with myself
- At times I think I am no good at all
- I feel that I have a number of good qualities
- I am able to do things as well as most other people
- I feel that I do not have much to be proud of
- I certainly feel useless at times
- I feel that I am a person of worth
- I usually do not feel respect for myself
- All in all, I am inclined to feel that I am a failure
- I take a positive attitude toward myself

Note: SINCE YOUR LAST VISIT means since the last time you completed a Vanguard Project questionnaire, about a year ago.
**N: SOCIAL SUPPORT & SOCIAL ISSUES (continued)**

N10. How many people in the Lower Mainland (or in the city you now live in) do you CURRENTLY know who can provide you with personal support or friendship? (i.e. in day-to-day living or times of crisis)

<table>
<thead>
<tr>
<th>Total Number:</th>
</tr>
</thead>
</table>

N11. How many of these people are...

<table>
<thead>
<tr>
<th>partners, ex-partners or lovers?</th>
</tr>
</thead>
<tbody>
<tr>
<td>family members or relatives?</td>
</tr>
<tr>
<td>friends or neighbors?</td>
</tr>
<tr>
<td>co-workers or classmates?</td>
</tr>
<tr>
<td>health care providers?</td>
</tr>
<tr>
<td>counselors or therapists?</td>
</tr>
<tr>
<td>ministers, priests, or rabbis?</td>
</tr>
<tr>
<td>other (specify):</td>
</tr>
</tbody>
</table>

| other (specify): |

**NOTE:**
The questions on this page are used to compare different social issues, and together they provide an overall picture of a person's social support. They are intentionally repetitive and have been previously validated, which is why we can't edit them to make them shorter. Thank you for your cooperation in completing this page.

N12. IN THE PAST WEEK, how often have you...

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>...felt you just couldn't get going?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>...felt sad?</td>
<td></td>
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<tr>
<td>...had trouble getting to sleep or staying asleep?</td>
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<tr>
<td>...felt that everything was an effort?</td>
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<tr>
<td>...felt lonely?</td>
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<tr>
<td>...felt you couldn't get out of a rut or couldn't shake off the blues?</td>
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<tr>
<td>...had trouble keeping your mind on what you're doing?</td>
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</tbody>
</table>

N13. SINCE YOUR LAST VISIT, how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Having problems managing money</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Not having a close companion</td>
<td></td>
<td></td>
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<tr>
<td>• Having too many responsibilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Not having people you can depend on</td>
<td></td>
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<tr>
<td>• Having too many demands on your time</td>
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<tr>
<td>• Not having a satisfactory sex life</td>
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<tr>
<td>• Having problems communicating with others</td>
<td></td>
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<tr>
<td>• Not seeing enough of people you feel close to</td>
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<tr>
<td>• Deciding on how to spend money</td>
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<tr>
<td>• Not having enough responsibilities</td>
<td></td>
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<tr>
<td>• Not having someone who shows concern for your problems</td>
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<tr>
<td>• Not having enough free time</td>
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<tr>
<td>• Not having enough money to do the things you want</td>
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<tr>
<td>• Side effects of medication</td>
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<tr>
<td>• Not having a satisfying job</td>
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<tr>
<td>• Feeling too controlled by others</td>
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<tr>
<td>• Not having enough money to get by on</td>
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<tr>
<td>• Not having enough money for medical treatment or prescriptions</td>
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<tr>
<td>• Not having enough close friends</td>
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<tr>
<td>• Problems with partner or ex-partner</td>
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<tr>
<td>• Not having someone who shows you love and affection</td>
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<tr>
<td>• Feeling too dependent on others</td>
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<tr>
<td>• Other people interfere with things you do</td>
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<tr>
<td>• Problems with family or relatives</td>
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<tr>
<td>• Not having someone who understands your problems</td>
<td></td>
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<tr>
<td>• Having too much time on your hands</td>
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<tr>
<td>• Conflicts with people who are close to you</td>
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<tr>
<td>• Not being able to get somewhere because of lack of transport</td>
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</tbody>
</table>
P1. SINCE YOUR LAST VISIT, have you been admitted to hospital overnight or longer?
- No
- Unsure
- Yes: If yes, how many times?
  - Only once
  - 2 to 4 times
  - 5 times or more
  - Unsure

P2. SINCE YOUR LAST VISIT, have you seen or talked to any of the following alternative or complementary health care providers about your physical, emotional, or mental health?
- Acupuncturist:
- Chinese herbalist:
- Other herbalists:
- Holistic practitioner:
- Homeopath:
- Naturopath:
- Chiropractor:
- Religious/spiritual healer:
- Traditional Aboriginal healer:
- Other (specify):
- Other (specify):
- Other (specify):

P3. SINCE YOUR LAST VISIT, have you used any of the following dietary supplements, herbal or medicinal remedies, or other complementary therapies for your physical, emotional, or mental health?

**Dietary supplements:**
- Boost™ or Ensure™: 
- Blue-green algae:
- Diet pills/weight loss therapy:
- Protein supplements (e.g., Creatine):
- Steroids:
- Vitamins/minerals (including Zinc):
- Other (specify):
- Other (specify):

**Herbal/medicinal therapies:**
- Herbs (Echinacea, St. John’s Wort):
- Chinese herbs:
- Homeopathy:
- Other (specify):
- Other (specify):

**Other complementary therapies:**
- Acupuncture or acupressure:
- Healing/therapeutic touch:
- Massage therapy:
- Meditation:
- Other (specify):
- Other (specify):

P4. Approximately how much money do you spend on complementary therapies per month (such as the items listed in question P3)?
- I spend no money on them
- Less than $50 per month
- $50 to $99 per month
- $100 to $199 per month
- $200 or more per month
- I'm not sure.

P5. SINCE YOUR LAST VISIT, how many times did you receive medical attention or care from the following health care providers or services?

<table>
<thead>
<tr>
<th>Provider/Service</th>
<th>Once</th>
<th>2 to 4 times</th>
<th>5 times or more</th>
<th>Never</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family doctor/regular physician</td>
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<tr>
<td>Surgeon, allergist, or other specialist</td>
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<tr>
<td>Nurse/ street nurse</td>
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<tr>
<td>Dentist or orthodontist</td>
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<tr>
<td>Chiropractor</td>
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<tr>
<td>Physiotherapist</td>
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<tr>
<td>Drop-in clinic</td>
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<tr>
<td>Hospital emergency</td>
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<tr>
<td>Police detox/ detox</td>
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<tr>
<td>Other (specify)</td>
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</tbody>
</table>
Q: MISCELLANEOUS

Q1. How would you rate your CURRENT physical health?

- Excellent
- Very good
- Good
- Fair
- Poor

Q2. COMPARED TO YOUR LAST VISIT, how would you rate your physical health NOW?

- Much better now than last time
- Somewhat better now
- About the same as last time
- Somewhat worse now
- Much worse now than last time

Q3. Have you been circumcised?

- No
- Unsure
- Yes

Q4. Considering the new treatments for HIV, how worried are you now about contracting HIV?

- Much less worried
- Less worried
- Equally worried
- More worried
- Much more worried
- Not applicable - I'm already HIV+.

Q5. Have you ever used a "female condom" when having sex with a man?

- Yes
- No
- Unsure

Q6. How much time did it take you to complete this questionnaire?

- less than half an hour
- about half an hour
- between 30 and 60 minutes
- about an hour
- more than an hour

Q7. Did anyone help you complete this questionnaire?

- Yes
- No

Q8. If an HIV vaccine were tested in Canada on people who don't have HIV, would you be interested in participating in a study to see if it works?

- Yes, absolutely
- I probably would
- I don’t know
- I probably would not
- No, I certainly would not
- Not applicable (already HIV+)

Q9. If you have any comments on this year's questionnaire or the project in general, please include them either here or in the margins in the appropriate sections. Continue on the back of this page if necessary. Thank you for your input!

Q10. Were there specific sections of this year's questionnaire that you had trouble understanding or completing? Are there pages that could be better laid-out?

You have now completed the questionnaire.
Thank you very much!
APPENDIX 4

Interview Schedule
INTERVIEW SCHEDULE
UBC/VANGUARD DISCUSSION GROUP
PRELIMINARY INTERVIEW

ID# ______________________

______________

READ:
Thank you for volunteering to be a possible candidate in a new and we hope instructive
discussion group. Before we begin, I want to assure you that anything that you may say today will
be held in the strictest confidence I have assigned you a code number, and only that code
number will appear on the tape. At this point, your real identity will only be known to me and to
Bill Coleman.

Also, before we begin, we are obligated to get your written consent to be interviewed. Could you
please read this consent form, and if you agree, sign the bottom of the form.

WAIT FOR CONSENT TO BE SIGNED - PROVIDE COPY TO INTERVIEWEE

START TAPE

"Interview with (insert above code number) on (date) at (location)."

I realize that many of these questions are very personal and sometimes difficult to answer. Please
try to answer them as honestly and directly as possible. Again, I assure you that your answers will
be kept confidential.

1. Are you currently under the care of a psychiatrist, psychologist or any other mental
   health professional?
   □ No   □ Yes. If yes terminate the interview as follows:

   Thank you for coming out— however, we would not
   wish to interfere in any way with the therapy that you are
currently undergoing. Unfortunately, this disqualifies
   you from being in the project, at this time. We are sorry
   that you may have been inconvenienced in any way.
   (NOTE; THE ORIGINAL LETTER SPECIFIED “NOT
   UNDER ANY PSYCHIATRIC CARE AT THIS
   TIME”) STOP TAPE

2. If you could imagine your life, as it is now, on a scale from 1 to 10, 1 being very low (or
   awful), and 10 being very high (or wonderful), how would you rate your overall life
   satisfaction?

   _______________ Why do you feel that way? What makes up your life
   satisfactions and dissatisfactions?
3. Is there a time in your life when you didn’t feel this way? How old were you at that time, and what was happening in your life? (PROBE — every life-cycle period)

4. While we’re talking about when you were younger, can you remember at what age you realized that you were “different” from other boys? Was there anything specific that might have happened, or that you thought of; or saw or heard? How did you feel about yourself at that time? Are there any specific behaviours or incidents that illustrate how you felt? Can you elaborate on that?

5. Turning now to the subject of sex, and specifically sex with men, at what age do you recall first hearing about safe sex, or safer sex? From whom, or how did you hear of it? Do you remember what your first impressions were? (PROBE)
6. As you probably know, very few people are able to state that they have NEVER have had unsafe (or potentially less safe) sex. However, it is not totally unknown. Thinking back on your sex life to date, has there ever been a period of time when you only had safe sex? When was that? Why did you have only safe sex at that time? At what point (if at all) did that change for you? Why? (PROBE - THIS IS VERY IMPORTANT)

7. In the past 12 months, about how many times have you had sex with a man? How would you define “sex” — that is, what activities, come to mind that ‘count’ as sex? Of those times, about what percentage of the time do you feel that you had ‘safe sex’?

8. This is a hard question to answer, I know. But let’s give it a try. Sometimes you have safe sex and sometimes you don’t. (or: You never have safe sex.). How do you decide whether or not to use condoms for anal sex? Or for oral sex? (PROBE)
9. What do you think would change your mind about using condoms ALL OF THE TIME? Is there anything you can think of that would make you decide to ONLY have safe sex? (PAUSE & WAIT FOR RESPONSE) Why is that?

10. As you know, we are interviewing potential candidates for a discussion group about sex, our lives, and how we each make decisions about risk-taking. Do you have any questions for me about the process, why we’re taping the interviews and discussions, or anything else, for that matter?

Thank you very much for your cooperation. We will be getting back to you as soon as we can about who will be in the group. Since we can only take 15 people, all the eligible candidates’ numbers will be put in a hat and we will make a random draw. So, if you’re not chosen, it doesn’t mean that we didn’t feel that you would work well in the group - it literally is “the luck of the draw”. Are you ok with that?

STOP TAPE

Name: ____________________________

Best way to contact: ____________________________ home phone
______________________________ work phone
______________________________ e-mail
______________________________ other contact
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485


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497


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499


500


