Re-Defining Risk Behaviours among Gay Men: What Has Changed?

Joseph O'Shea

Department of Sociology

McGill University, Montreal

August, 2005

A Thesis submitted in partial fulfillment of the requirements of the degree of Doctor of Philosophy

@ Joseph O'Shea, 2005

Library and Archives Canada

Published Heritage Branch

395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque et Archives Canada

Direction du Patrimoine de l'édition

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence
ISBN: 978-0-494-25223-9
Our file Notre référence
ISBN: 978-0-494-25223-9

NOTICE:
The author has granted a non-exclusive license allowing Library and Archives Canada to reproduce, publish, archive, preserve, conserve, communicate to the public by telecommunication or on the Internet, loan, distribute and sell theses worldwide, for commercial or non-commercial purposes, in microform, paper, electronic and/or any other formats.

The author retains copyright ownership and moral rights in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

AVIS:
L'auteur a accordé une licence non exclusive permettant à la Bibliothèque et Archives Canada de reproduire, publier, archiver, sauvegarder, conserver, transmettre au public par télécommunication ou par l'Internet, prêter, distribuer et vendre des thèses partout dans le monde, à des fins commerciales ou autres, sur support microforme, papier, électronique et/ou autres formats.

L'auteur conserve la propriété du droit d'auteur et des droits moraux qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this thesis.

While these forms may be included in the document page count, their removal does not represent any loss of content from the thesis.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de cette thèse.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.

In Memory of Thomas and Mary O'Shea

ABSTRACT

Re-Defining Risk Behaviours among Gay Men: What Has Changed?

Joseph B.M.O'Shea

As we enter the third decade of a devastating worldwide epidemic, much has been done to stem the flow of HIV/AIDS, in particular within North American and Western European urban centres. Successful prevention campaigns in the 1980s had the immediate impact of lowering the rate of HIV infection among gay men, and anti-retroviral drug therapies in the mid-1990s have literally brought thousands of gay men back from the brink. However, by the middle to late 1990s, epidemiological and anecdotal evidence has strongly suggested that gay men have begun to move away from the safer sex orthodoxy of the 1980s.

Forty gay men ranging in age from 21 to 55 were interviewed for this study in order to determine if they have changed their approach to safer sex strategies implemented in the mid-1980s. In contrast to approaches to risk behaviour that emphasize the Health Belief Model, with its focus on the rational individual, this dissertation focused on the social contexts that shape gay men's decisions.

This study found a number of factors that influenced gay men's sexual choices, including age and the changing role of community. Younger gay men, those who have come of age during the 1990s, have taken a different approach to the AIDS epidemic. None of the younger participants in this study had lost anyone to HIV. Furthermore, they were now part of a group of men who no longer considers a HIV diagnosis to be immediately fatal. New medications have definitely shifted their approach to AIDS. Finally, this group of gay men no longer feels defined by a gay community like older gay

men interviewed for this study. They believe they are coming of age in a time and place where they have more choices in how they will define themselves as gay men. For older gay men, those who lost many lovers, friends, and acquaintances during the HIV epidemic, changes in gay men's sexual risk-taking are both surprising and inevitable. These men are dealing with issues of ageism, loss and lack of visibility in a changing gay community.

Although there are different age-related arguments for abandoning safer sex strategies, this study helps to explain why there is a definite shift in risk-taking behavior underway as we enter the third decade of HIV/AIDS. It suggests new challenges and approaches for AIDS service organizations to deal with a substantive change in gay men's sexual behaviour.

Résumé

Comme nous entrons dans la troisième décennie d'une épidémie dévastatrice mondiale, beaucoup d'effort a été déployé afin de contrôler l'invasion du VIH/SIDA, en particulier dans les grandes villes d'Amérique du nord et de l'Europe de l'est. Les campagnes de sensibilisation des années 80 ont eux un impact immédiat sur la réduction des cas d'infections au VIH dans la population d'hommes gais, et l'arrivée des thérapies anti-rétro virales dans le milieu des années 90 a littéralement sauvée des milliers d'hommes gais d'une mort certaine. Cependant, du milieu à la fin des années 90, une évidence épidémiologique et anecdotique a fortement suggérer que les hommes gais commençaient déjà à s'éloigner des pratiques sécuritaires orthodoxes des années 80.

Quarante hommes gais variant de 21 à 55 ans ont été interrogé pour cette étude afin de déterminer s'ils avaient adopté les pratiques sexuelles sécuritaires qu'ont leurs avaient enseignées au milieu des années 80. En contraste avec l'approche des comportements risqués dont l'emphase est basée surtout sur l'individu rationnel, cette thèse se penche plutôt sur l'aspect social qui conduit l'homme à ses décisions.

Cette étude a fait ressortir un nombre de facteurs qui ont influencé les pratiques sexuelles des hommes gais incluant l'age et la vision changeante de la communauté gaie. Les hommes gais plus jeunes, qui sont devenus sexuellement actifs durant les années 90, ont adopté une approche différente envers l'épidémie du VIH. Aucun des jeunes participants à cette étude a souffert la perte d'un être cher face au VIH. De plus, ils font partie d'un groupe d'homme qui ne considère plus un diagnostic VIH positif comme fatal à courte échéance. Les nouvelles thérapies ont modifié leurs visions du SIDA. Finalement, ce groupe d'hommes gais ne se sent plus limité à la communauté gaie

comme leurs confrères plus âgés qui ont été interrogé dans la même étude. Ils croient évolué dans une génération ou ils ont plus de choix face à la façon de se définir comme hommes gais. Pour les hommes gais plus âgés, ceux qui ont vécu la perte de plusieurs partenaires, amis et connaissances durant l'épidémie du VIH, le changement d'attitude face aux pratiques sexuelles non sécuritaires est surprenantes et inévitables. Ces hommes ont a faire face au problème du vieillissement, de la perte de visibilité dans une communauté gaie en pleine évolution.

Même si il existe plusieurs arguments reliés à l'age pour l'abandon des pratiques sexuelles sécuritaires, cette étude fait la lumière sur les nouvelles tendances dans les comportements à risques des hommes gais à l'aube de la troisième décennie du VIH/SIDA. L'étude suggère de nouveaux défis et approches aux organismes du VIH/SIDA afin de faire face aux changements de comportement sexuelles des hommes gais.

Acknowledgements

I want to express my sincere thanks to my dissertation supervisor, Suzanne Staggenborg. Her dedication and commitment to my project is one of the primary reasons that it has come to a successful conclusion. I would also like to acknowledge the other members of my committee, Prue Rains and Morton Weinfeld, whose direction and insight were most beneficial.

There are so many people who have assisted me during the last 18 years of my academic life: my parents, siblings (in particular my sister, Geraldine and her husband, Olivier), friends (my best friend Catherine Browning), colleagues (Avi, Carla and Ignacio) and especially the institutional support of McGill's Sociology department. Without their unflinching support, I would not now be at the end of my formal academic education. The academic, personal and economic assistance that has been provided to me over all these years has made this project realizable.

I would like to make mention of a few very special people. In particular, Sharon Barqueiro and all who worked with her to provide the support that all graduate students could not get by without. I dropped out of the PhD program in 1999 for personal reasons. However, Sharon continually pushed me to re-register and complete it. As a result of her constant persuasion and support, the thesis is now complete. I will never forget her dedication and support.

Moreover, this study would not have been a success without all those gay men who were willing to share the most personal parts of their lives with me. It was not always easy for them to divulge how they engaged in their sexual practices but their belief in this project has made it one in which I am very proud. Thank you from the bottom of my heart.

Lastly, I would like to acknowledge the most important support that I have been given over four years. My life partner Denis has been the most important person in making me thrive on a personal and academic level. His support makes the completion of this thesis one of the most gratifying experiences of my life. It would have been a significant personal achievement without his support, however, having him in my corner, makes it outstanding. Thank you from the bottom of my heart, for everything!!

Glossary

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community Based Organizations
CDC	Centres for Disease Control
HAART	Highly Active Antiretroviral Therapies
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
MSM	Men Who Have Sex with Men
PWA	Persons with AIDS
SMO	Social Movement Organizations
STD	Sexually Transmitted Diseases
YMSM	Young Men Who Have Sex with Men

Table of Contents

Abstract 3

Résumé 5

Acknowledgements 7

Glossary 8

Chapter 1: Introduction 12

A New Socio-Cultural Phenomenon 14
Main Issues 18
Research on Sexuality and Risk 21
Methods 24
The Role of Sociology 27
Plan of Dissertation 29

Chapter 2: The Sociology of Risk 31

The Health Belief Model 32
Cost/Benefit Approach 35
Social Action 36
The Culture of Risk 39
HIV/AIDS Literature 43
Community Organizations 44
Barebacking and Gay Identity 46
Conclusion 49

Chapter 3: Safer Sex Behaviour among Gay Men 51

The Early Days of HIV 52
The First Response: Safer Sex 53
Sustaining Safer Sex 57
Relapse Theory 61
Conclusion 64

Chapter 4: Does Age Matter? Young Gay Men and Sexual Risk **66**

AIDS and Intergenerational Relations **67**
Different Times, Different Choices **71**
Protease Inhibitors **74**
The Role of Community **77**
Young Gay Men: Other Explanations of Risk **86**
Social Nature of Sex **89**
From a Gay Community to a Global Community **92**
Conclusion **99**

Chapter 5: HIV Risk-Taking among Older Gay Men **102**

A Generation Touched by AIDS **103**
Ageism and Desirability **109**
Condom Fatigue **114**
Those "Magic" Pills **117**
Urban Gay Communities **119**
Conclusion **123**

Chapter 6: Barebacking: A New Socio-Cultural Phenomenon in the Gay Community? **126**

Barebacking: Its Origins and Meanings **127**
Internet Access to Risky Sex **128**
A New Name for Unsafe Sex **130**
The Multi-dimensional Nature of Barebacking **134**
New Strategies of Risk Reduction **138**
The Future? **141**
Conclusion **144**

Chapter 7: Conclusion **147**

Limitations of Study **150**
The Early Days of HIV **150**
HIV and Younger Gay Men **155**
The Sociology of Risk **157**
The Future of Safer Sex Strategies among Gay Men **158**
Future Research **160**

Appendix A: A Personal and Sociological Journey **163**

Being Young in the Post-Stonewall Generation **165**
Interesting Discoveries **171**
Conclusion **174**

Appendix B: Interview Results **178**

Appendix C: Ethics Committee Approval Forms **180**

Bibliography **181**

Chapter 1

Introduction

To give up on understanding sex is to surrender to ignorance, to despair of our own potential for thought and knowledge.

-Dean Hamer and Peter Copeland, *The Science of Desire* (1994)

More than two decades have passed since we first began to hear of a new sexually transmitted disease within gay male communities. Fear and death permeated these communities for the next ten years. During that time, a substantial number of gay men changed their sexual practices and developed innovative safer sex programs. With the introduction of protease inhibitors in the mid-1990s, gay men found new hope. These drugs were not a cure, but infected men could now live many years longer. AIDS (acquired immunodeficiency syndrome) became a chronic disease. Despite these medical advances, we find ourselves at an important crossroads in the AIDS crisis. Never before has there been so much promise: we know how to prevent the transmission of HIV (human immunodeficiency virus), and we have the means to do so. We have treatments for fighting both the virus and the opportunistic infections that ravage the bodies of those living with AIDS. However, people are still dying of AIDS, particularly in non-Western regions like Africa but also in advanced countries like Canada. In the United States and Canada, for example, HIV infection for men, women and youth in prison is still often a death sentence. Outside prison walls, people of colour, injection drug users, Aboriginal peoples, and poor people in general continue to be infected and to die at alarming rates.

Although HIV has permeated every corner of North America, affecting men, women, and children of all ages, races, ethnicities, and demographic categories, gay men

are still disproportionately affected, accounting for an estimated 42 percent of new HIV infections each year in North America (Centre for Disease Control, 2001b). Moreover, there were troubling signs by the end of the 1990s that rates of HIV infection were starting to accelerate, once again, in this population. Reports of upward trends began to appear in several metropolitan areas of North America (Calzavara et al., 2000; Ekstrand, Stall, Paul, Osmond & Coates, 1999; Kellogg, McFarland & Katz, 1999) and Europe (Dukers et al., 2001).

This alarming resurgence of HIV rates among gay men does not seem to be eliciting the same concern that appeared within the gay community at the beginning of the AIDS epidemic. Beginning in the mid-1980's, those trying to control the spread of HIV among gay males have counted on a variety of "facts" about AIDS to shift the way we think about and have sex. Because few gay men survived more than a year or two after an AIDS diagnosis, HIV-infection was considered lethal and anyone who tested positive would soon die.

Between 1989 and 1994 a tidal wave of deaths hit large North American urban centres, such as New York, San Francisco, Toronto and Montreal. Frequent funerals and memorial services clarified the fatal dangers gay men faced when taking risks with sex or needles. When a majority of men in the gay ghettos of San Francisco and New York were testing HIV-positive, AIDS groups constantly reminded gay men that half of their sex partners were likely to be infected, and instructed them to use condoms without fail.

However, since 1995, particularly with the appearance of new drug cocktails to fight HIV, there has been an important change in how gay men are approaching the epidemic. Epidemiological and sociological evidence since the mid-1990s are in

agreement that an important number of gay men are having unprotected sexual intercourse. The reasons are complex, but it is clear that some gay men are rejecting the safer sex strategies of an earlier time. Is it the result of new medications, safer sex fatigue, alcohol or drug use, age or a combination of factors? This research project will attempt to more fully explain why some gay men continue to risk infection.

A New Socio-Cultural Phenomenon

The success of early prevention/awareness campaigns significantly lowered the rate of HIV infection among gay men. Recently, however, as confirmed by recent studies by the Centers for Disease Control (Colfax, G.N. et al., 2002), rates of HIV infection among gay men in urban centres in North America and Western Europe have been increasing in the last several years. Even though unprotected anal sex has persisted throughout the epidemic, there seems to be a significant shift in the reasons why some gay men still engage in this high-risk behaviour. This is most evident within a small sub-population of the overall gay community that is now consciously, willfully, and proudly rejecting condoms. A small minority of HIV-positive men is choosing to have unprotected intercourse with other HIV-positive men and some HIV-negative men are also making this choice to have condom-free intercourse with HIV-positive men.

This new phenomenon, referred to as “raw”, “skin-to-skin”, or “bareback” sex, essentially refers to intentionally seeking out anal sex without a condom. Barebacking has become a new term in the lexicon of many gay men. The need to invent a new name for a sexual practice which has been around for ages suggests that there is a change in the way

some gay men view the safer sex culture that has dominated the gay male community for the past 15 years.

U.S. gay HIV-positive porn star and writer Scott O'Hara, who first coined the term barebacking, used it to refer specifically to unprotected anal sex. In a 1995 editorial entitled "Exit the Rubberman" in Steam, his journal devoted to sexual adventurism, O'Hara wrote: "I'm tired of using condoms, and I won't... and I don't feel the need to encourage negatives to stay negative" (gaytoday.badpuppy.com/garchive.viewpoint.051799vi.htm).

Since 1995, the barebacking phenomenon has found its greatest expression on the Internet. Dozens of websites are dedicated to the world of bareback sex, condomless intercourse and the free and gratuitous exchange of semen. They offer opportunities to meet and become actively involved. There are college types, middle-aged men, young men barely out of adolescence and mature gay men, all seeking condomless sex. Most of these sites are very emphatic about the expectations of the site and state that visitors are expected not to ask about HIV status or discuss condoms. The anonymity of these sites provides an ideal place to confess forbidden desires as well as find others who share them. Within the last few years, chat rooms, mailing lists and personal ads devoted to barebacking have allowed gay men to discuss, and act on, their desire for raw sex. Moreover, there is some evidence, not yet conclusive, that these sites may even be contributing to risky sexual practices (Mettey et al., 2003 and CDC, 2002).

A recent study by researchers at the US Centers for Disease Control (CDC) suggests that there is more than anecdotal evidence for this new socio-sexual phenomenon in the gay community. The researchers conducted a cross-sectional survey

of 554 Men Who Have Sex with Men (MSM) in the San Francisco Bay Area from July 2000 to February 2001. All were 18 or older, lived/worked in the Bay Area, and reported having had sex with a man in the previous twelve months. This report gives strong evidence that the practice of barebacking is becoming more common, specifically among gay and bisexual men. The researchers found that barebacking was practiced by gay and bisexual men regardless of race/ethnicity, education, income or sexual orientation identification. The study confirmed that those who did bareback wanted to experience greater physical stimulation and to feel more emotionally connected with a partner. The investigators also found that more than two-thirds of participants were familiar with the term barebacking. The median number of bareback partners in the previous 12 months was three. Of men familiar with the term and thus potentially familiar with the phenomenon of barebacking, 14% of gay and bisexual men who had heard of barebacking reported that they had unprotected sex at least once during the past two years. Furthermore, of those aware of the term, 22% of HIV-positive and 10% of HIV-negative men had barebacked. According to the authors, negative MSMs have internalized the idea that unprotected receptive anal sex is the highest risk and are avoiding it; and nearly two-thirds of the positive men bareback with positives (Colfax. et al., 2002).

Most who engage in barebacking do so with knowledge of the risks involved. However, there is also a small minority of these barebackers who intentionally seek out the disease from those willing to give it to them. These men seek out barebacking parties where condoms are not permitted. According to Rick Sowadsky's article, "Barebacking in the Gay Community" (May, 1999) there are the following types of barebacking

parties: All positive barebacking parties (where everyone at the party is HIV positive); all negative barebacking parties (where everyone is supposedly HIV negative); conversion parties (group sex parties where bug chasers allow themselves to get infected by gift givers); and Russian Roulette parties. These Russian Roulette parties include both positive and negative men. Negative men take their chances that they will be infected when having sex with the positive men there. Sowadsky (1999) also lists the terminology associated with barebacking parties.[1]

On November 20th, 2001, the CBC television program *Disclosure* presented a program entitled "Russian Roulette". They interviewed three men who practice unprotected sex. One of these men, Phil, is a successful accountant and the son of a minister. He is a bug chaser, someone who is purposefully looking to get infected. According to Phil, "It's ok if I become positive now... With the way the meds are, it would be 15 years, maybe 20, who knows? Then I can take control and decide my fate... It's [to become HIV-positive] what I want. I'll be happy and celebrate" (CBC Disclosure, Transcript, p.7).

The phenomenon of barebacking raises a number of interesting questions. Do these men find relief in finally knowing that they don't have to avoid getting infected anymore? Do they believe, as other barebackers do, that HIV is a chronic manageable disease? Is there also a generational difference between those who purposefully seek out HIV?

Many of these questions will be difficult to answer. However, there is urgency in developing sociological explanations for a new phenomenon which, even if practiced by

[1] Bug chasers are men looking to get themselves infected with HIV. Gift givers are men with HIV who are willing to infect bug chasers. The gift is HIV.

only a small minority of gay men, is threatening to undo much of safer sex philosophy of the last two decades. Epidemiological studies are giving us a picture of those involved in the practice of barebacking. They will not, however, give us the social and structural rationales behind this behavioural change among gay men. This is the importance of sociology.

Main Issues

Why do some gay men engage in unprotected anal sex? Is it a backlash to the safer sex messages of the 1980's and 1990's? Certainly, not all gay men who take risks with unprotected anal sex do it to become sero-converted. Some gay men use drugs and alcohol to reduce their inhibitions in social situations and are lax about condom use; theirs is not a deliberate choice to become HIV-infected. An even larger group of gay men intend to practice safer sex but are complacent and occasionally slip into engaging in anal sex without a condom. Finally, there are committed gay couples that agree to have negotiated safety--promising to use condoms with sex partners outside the main relationship. Negotiated safety is a calculated risk analysis that both HIV-positive and negative men use to decide what they believe about a partner's HIV status before making such decisions as whether to use condoms, to bottom or top in anal sex, or to restrict riskier behaviours to a limited number of partners (Halperin, 2000).

One important explanation for the increase in high-risk sexual behaviour is safer sex fatigue. For some young men in their twenties, the safer sex message of the 1980s and 1990s is no longer effective. It has been argued that in recent years younger gay men may be increasingly and disproportionately at risk of HIV infection. Several studies in the

U.S. have investigated unsafe sex among young gay men (Hays, Kegeles and Coates, 1990, 1991, 1992). Their studies reveal a correlation between younger age and greater 'sexual risk-taking' among gay men. Research suggests various contributing factors: younger men in the earlier stages of 'coming out' may not be fully gay-identified and therefore may not perceive themselves to be in a 'risk group'; negotiation of safer sex may be hampered by a lack of social skills caused by inexperience in interpersonal relationships; the young may have heightened feelings of invulnerability to risk; and younger men may perceive AIDS to be a problem of older gay men (Maxwell, 1998).

Another important explanation of the motivation behind decisions to engage in high-risk sex is that the threat of AIDS has declined with the use of protease inhibitors and combination therapies, a new class of drugs that has made remarkable progress in treating many people with AIDS (Elford, Bolding, Maguire, and Sherr, 2000; Katz et al., 2002; and DiClemente et al., 2002). These drugs have been very successful in reducing the symptoms and even the viral load of many Persons With Aids (PWAs). This reduction in the viral load has also led some HIV-positive men to believe that they are less infectious. This is true for some, but not all, and transmission is still possible even with low or undetectable counts. Moreover, these drugs would appear to some as a safety net; most gay men still don't want the disease, but they believe that if they get it, they will be able to keep it under control. Combination drug therapies have transformed the deadly disease in the minds of many HIV-negative gay men into something "manageable" or a "minor nuisance".

Many believe that AIDS has now become a chronic disease, manageable with an effective drug regimen. Many gay men who engage in risky sex have no pathological

intent to become infected. However, the possibilities offered by these new medications and the hope of a cure do reassure many gay men that they can continue to work and enjoy life in ways not even imaginable in the mid-1980s until the mid-1990s. Gay men, whether from a younger or an older generation, seem to be displaying similar attitudes towards the use of safer sex methods and the belief that new medications will prolong their biological lives and the quality of those lives. Most epidemiological studies and one-on-one interviews with gay men seem to confirm that the effectiveness of new medications is a precipitating factor in the abandonment of condoms, particularly in anal intercourse.

There is also a growing awareness within gay male communities that the safer sex message employed so successfully in the past must change to take on the new political, cultural and sexual realities of gay men's lives. The safer sex message of the early years targeted, for the most part, a homogenous gay male identity. However, the political and sexual changes of gay men's lives since the mid-1990s have necessitated a new approach to deal with these new realities. Gay men have multiple sexual and social identities and increased political inclusion within mainstream Canadian and American societies. These important changes will have a direct impact on how gay men will approach each other, their communities and society in general. It will also directly impact how they deal with the devastating presence of HIV.

Despite the social, sexual, and political changes that are being experienced by gay men, the vast majority of them, regardless of age, do believe in the safer sex philosophy developed in the late 1980s. Neither age group overtly seeks out HIV/AIDS, but both believe that the quality of their lives, even if they do become infected, has been greatly

enhanced. However, rationales for abandoning safer sex methods, either occasionally or intentionally, do differ for gay men in their 40s and 50s and those in their early 20s and 30s. For most gay men over fifty, particularly those who suffered the loss of a partner or many friends to HIV, decision-making about condom use is qualitatively different than for men of the post-epidemic era of AIDS. Loneliness, aging and a sense of loss are all important factors which can lead older gay men to abandon safer sex use. Moreover, the youth focus of the gay community can also make it particularly difficult for this generation of gay men. Advertisements within gay magazines or for specific gay-related parties rarely, if ever, acknowledge that there are gay men over 30. Younger gay men are coming out in a time when they are able to take advantage of the important changes that have occurred in gay men's lives since the late 1960s. Theirs is a time of greater openness, whether that is political, cultural or social. However, HIV/AIDS remains one the most significant health challenges for this younger generation of gay men, just as it was for their brothers in the 1980s and 1990s. There are new drug therapies and more health resources available than ever before. There is a greater understanding among the general public about how HIV is transmitted. The social stigma remains for many, but the world's understanding of this epidemic has grown exponentially since its early days in the 1980s. Despite all the new advances at all levels, gay men are still disproportionately affected.

Research on Sexuality and Risk

The findings of research on sexuality and risk behavior often seem contradictory. On the one hand, gay men are reported to have drastically changed their sexual behavior

through the adoption of safer sex strategies, which combine an affirmation of sexual choice with rational disease protection (Becker and Joseph, 1988; Stall, Coates, and Hoff, 1988; Catania et al., 1989; and Bolton et al., 1992b). On the other hand, men who have sex with men continue to have unprotected sex. Since the mid-1990s, some gay men have been using new rationales to explain their unsafe sex practices. The success of new medications to fight HIV and a backlash to the safer sex message of the last two decades has led, to a significant degree, to the practice of barebacking. However, there are also men who are willing to take occasional risks: those who use drugs and alcohol to lower their inhibitions, others who in "the heat of the moment" decides not to use a condom and men in relationships who decide to negotiate safety.

The traditional approaches of social and epidemiological research have persistently focused on those individual characteristics that are assumed to explain why people continue to take risks. This has led to the assumption that a person who continues to engage in high-risk behavior is disturbed. This, in turn, favored the adoption of preventive strategies that sanction social control and treatment. Another popular and pervasive theory considers promiscuity as the main cause of HIV transmission among gay men (Bolton, 1992a).

Underlying most theories of the prevention of HIV infection is the belief that high-risk behavior is the result of insufficient knowledge. According to others, prominence should be given to the role of alcohol or drugs. Both views have proven rather weak in explaining high-risk behavior among men who have sex with men because of their failure to take account of the social and cultural context in which sexuality and risk behavior

occurs (Bolton, 1992b). An important element of this context is the sexual encounter and its negotiated order (Davies and Weatherburn, 1991).

However, in Britain, the results of the Project SIGMA study (Davies et al., 1992) do not support the contention that young gay men are at greater risk of HIV infection through unsafe sexual behavior. The report, in regard to condom usage, says that despite an increased incidence of anal sex among younger gay men, they are more likely than older gay men to use a condom for both insertive and receptive anal intercourse. Finally, knowledge of HIV and safer sex among the younger men studied was found to be at least equivalent to that of older gay men.

Nevertheless, there may be a backlash among a younger gay male cohort to the safer-sex campaigns that were prevalent during the height of the HIV epidemic. Some gay men talk about never being able to have the sex they enjoy most. Others who have not known anything else in their sexual lives let their guards down to see whether skin-to-skin sex is as good as some make it out to be. An older generation of gay men that has lived through the epidemic may no longer see the need to protect themselves. For older gay men, as well as other age cohorts, the new medications will allow them to manage the disease. Furthermore, ageism also plays a role in why some older gay men may discard the condom, especially those who are single in their late 50s and 60s. The need for some physical attention can often outweigh any perceived or actual risks that may accompany their decisions.

The phenomenon of gay men who have decided to abandon condom use pushes us to understand the multiplicities of explanations and contexts that lead men to engage in unsafe sexual practices. Knowing the reasons and motivations behind this behavioural

change is crucial to our understanding of safer sex practices. Understanding the epidemiology of HIV/AIDS is not the focus of this dissertation. Trying to determine the multifaceted socio/sexual complexities that lead some gay men to 'risk it all' is the central focus of this study. This study's findings will hopefully lead us to a greater appreciation of the complexities of gay men's sexual lives.

Methods

The main research method for this dissertation was structured, open-ended interviews. Each interview combined a pre-established range of theoretically informed questions. However, open-ended questions left room for significant flexibility. Face-to-face interviews were done with 40 gay men ranging in age from 21 to 54. The interviews took place between June 2003 and May 2004. The interviewees were chosen through a snowball sampling procedure. The starting point for the interviewees was an initial series of friends and acquaintances. The interviewees were asked at the end of the interview if they could suggest any further informants for my study. In some cases, the informants provided email addresses in order to contact future participants. In other cases, the informants asked me if I could give a phone number in order for them to contact me about a possible interview. Interviews were conducted at my office at McGill University and at my home in Montreal.

The main goal of this study was to try and obtain a wide diversity of ages in order to explore the importance of this variable in determining how gay men engaged in sexual intercourse. I chose age as the dominant variable in this study because I believed that one's presence within the gay community and the unfolding HIV/AIDS epidemic would

act as important indicators in how they are dealing with this new socio/sexual phenomenon within the gay community.

As a result of this focus on age, I did not specifically seek out barebackers or to try and divide the sample between those who were HIV+ or HIV-. In the course of the interviews, 5 men self-identified as barebackers and 5 men self-identified as HIV+. When the informants identified themselves as barebackers or HIV+ the specific types of questions that were initially part of my questionnaire had to be modified. These individuals were not only asked about how their age and history in the gay community affected their decisions to have high-risk sex, but also how their status affected their sexual decision-making. Their responses dictated what follow-up questions would be more relevant in trying to get as much information about their process of negotiating safer sex practices.

In the initial process of drawing up the questions for these interviewees, there were some important concerns raised by the ethics committee. For instance, what if some of the gay men that were interviewed acknowledged that they were engaging in unprotected sex without advising their sexual partners? What would be my role as a researcher in such circumstances? I believed that it was not my role to become a moral or legal advisor for any type of personal information I received, no matter how disturbing it might be. I believe that acting in any other role but a researcher would jeopardize my credibility and neutrality in the research process. Despite these legitimate concerns raised by the ethics committee, I was never faced with any ethical dilemmas throughout the interview process.

The city of Montreal was chosen for its access to a well-established gay community residing in a specific geographical area. It is not necessarily essential for my study that there is a central location. However, gay resources, such as community centers, bathhouses and bars tend to be more concentrated in these areas. This provided more access to a greater number of possible candidates to interview.

The face-to-face nature of the interviews is more important than it might seem at first glance. There is a stigma within the established gay community towards men who engage willfully in unprotected sex. According to Mary Douglas (1992) members of the central community are generally in the habit of backing the agreed norms of behavior with a list of natural dangers that will blot out the whole (gay) community if deviance from accepted safer sex practices is ignored. Barebackers are considered to be individualists or fatalists. They do not see the same need to conform to the cultural demands of any particular group. An indirect result of this stigmatization is that many men are afraid to be open to their friends about their sexual practices. Face-to-face interviews provide an opportunity to build a rapport with gay men who may feel ostracized because of their sexual practices.

Barebacking as a sexual practice is relatively new. It is not, as previously stated, that unprotected anal intercourse did not continue during the last two decades of the AIDS epidemic; it did. The significance now is that other explanations are being put forward by those who actively engage in this practice. Even within the gay community itself, there are social prohibitions/stigmas attached to those who consciously engage in barebacking. The purpose of these interviews is not to make value judgments about the

barebackers and those who take occasional risks. It is to try and understand the social and/or cultural contexts that contribute to this phenomenon.

The Role of Sociology

What does sociology bring to this research project? More importantly, why is it important to use sociological concepts, hypotheses and conclusions in the study of sexual risk behaviours of gay men?

The science of AIDS, in particular biology, chemistry, and epidemiology, has told us much of the complexities of this life-threatening disease; how does it work in the body, how many people are infected and what treatments are most successful in its treatment. Research scientists have given us the tools to understand this disease. Science, most importantly, has given new life-sustaining medications, resulting in a quality of life for AIDS sufferers that most did not have in the early 1980s and 1990s. In other words, it has given them more time to live and to hope that a cure may come, soon. However, what these sciences lack is an understanding of why people engage in sexual risk behaviours.

Engaging in sexual intercourse is not an individual act, it is a social one. Two or more people decide whether or how this sexual act will take place. What goes into the decision-making process? This is where sociology is extremely important. It is here that we can study the social and structural variables that underlie any decision to engage in sexual intercourse. For example, consider the situation of older gay men.

Older gay men have some particular problems with regard to risk-taking. Gay men over forty have lived through some of the most difficult years of the last two decades. They have lost many friends and partners. They had a particularly strong bond with gay

communities and AIDS organizations (Achilles, 1967; D'Emilio, 2002; and Green, 2002). Their identity formation was concentrated in a subculture of bars and bathhouses. Within these institutions, gay men learned how to be gay, to become a community united by their sexual practices and, with the beginning of the AIDS pandemic, how to care about each other and how to fight hostile governments to gain access to good health care. An important number of these men were the founding members of AIDS organizations and relied on them for support, friendship and care.

For younger gay men, bars, bathhouses and sex parties are places to go for sex. A significant number of these men have their sexual identity affirmed within their biological families--unlike their older counterparts who experienced ostracism and rejection. Older gay men constructed their own families to find a positive confirmation for their lives. With the advancement of political, social and sexual rights for gay people from the late 1970s to the present, the building of a structured community to find positive gay-affirming roles and statuses is no longer as important. The positive changes taking place in Canada for gay men and lesbians will eventually contribute to a redefinition about the viability or necessity of a structured gay community.

This redefinition is particularly important for older gay men. Many older gay men who have survived the HIV/AIDS epidemic find themselves in difficult and challenging positions. The strong ties with the gay community are now weakened. The focus on youth in the gay village, in particular within the "party" culture, has left older men alone, and often lonely. AIDS and community service organizations continue to be available to gay men in need of medical, emotional, and psychological support. However, all other institutions within the gay community are centered on youth. Most of the discussion on

risk behaviours focuses on younger gay men. There is a definite lacuna of information on why survivors of the AIDS epidemic are also engaging in unprotected sexual intercourse.

This discussion underlines the importance of sociological variables in determining risk behaviours, not only among older gay men, but all social groupings who engage in risk behaviours. It is only by determining these sociological variables and their possible consequences that we will be able to get a more complete picture of gay men and their possible risk behaviours.

Plan of the Dissertation

The dissertation is organized as follows: Chapter 2 reviews the literature of risk sociology, in particular the Health Belief Model, the Cost/Benefit Approach and the Culture of Risk approach. This chapter will also include a discussion of HIV/AIDS literature as it relates to community organizations, and the relationship between barebacking and gay identity.

Chapter 3 provides a discussion of the historical development of safe sex behaviour from the early 1980s. This chapter outlines the early work of AIDS committees, and how by the early 1990s sociological and epidemiological evidence was providing clear evidence that some gay men had begun to change the safer sex philosophy which had dominated the early strategies on HIV prevention.

Chapter 4 examines the issue of age and generational differences concerning high-risk behaviour. This chapter focuses on young gay men. It examines how this cohort of gay men has grown up in a new social and political era. For many of these men AIDS has become less of a central concern, reflected by a greater acceptance of gay men and

lesbians in general, new HIV/AIDS medications and less stringent philosophies on safer sex awareness.

Chapter 5 looks at an older generation of gay men, men who came of age and sexual maturity during the most devastating years of the AIDS epidemic. It examines how they worked in the vanguard of the early preventative efforts to help their generation deal with HIV. It also discusses how the enormous loss and grief that followed in the aftermath of the epidemic has affected their approach to some of the new challenges facing gay men in the post-AIDS era.

Chapter 6 examines one the most current and salient issues facing a small group of gay men. It examines a small sub-population of the overall gay community that, since the mid-1990s, is now consciously, willfully, and proudly rejecting condoms. This chapter will examine some of the rationales that younger and older gay men use in deciding to abandon condom use.

Chapter 7 will give a summary of the main highlights of this study and what areas require further and immediate study.

Chapter 2

The Sociology of Risk

We shape the diseases that afflict us as much as they have shaped us.
-Lappe 1995, *Breaking Out*

Interest in the subject of risk has grown enormously. Estimates of risk in the health field have been driven by public health and epidemiological research. Research has been concerned with the measure of risk behaviors or exposure linked to particular disease outcomes, resulting in calculations of risk associated with frequency of exposure to the pathogen over time. These population-based studies have been translated through health education into individualized and prescriptive risk reduction. "At risk" individuals are advised to adopt health-enhancing lifestyles in which risk exposure is minimized. This redesignation of health as an exclusively individual responsibility, with no recognition of other factors associated with health and illness, has helped locate risk at the centre of public health discourse, and, in the field of sexual health, it has been instrumental in generating research with an individual and psychological focus (Hart and Boulton, 1995).

Sociologically informed theory and research has only recently offered direct criticism of the paradigm. The growing interest in risk behaviours/exposure can be found in many sociological studies of HIV/AIDS. Patton (1985), Treichler (1992), and Watney (1987) have all analyzed the public discourses on HIV/AIDS in terms that reflect Foucault's earlier linking of discourses and power (Foucault, 1980). Public discourses on AIDS have been linked to public agendas for the policing of sexuality, the punishment of victims and the surveillance of deviants (immigrants, gays and junkies).

Social scientific approaches to variations in risk behavior fall into three broad categories: 1) a health belief model that emphasizes the role of variable perceptions (perceptions of vulnerability to infection, perceptions of the seriousness of the health threat, etc.) in explanations of risk behavior (Davies, Hickson, Weatherburn and Hunt, 1993); 2) a cost/benefit approach that stresses the immediate rewards of risk behavior (intimacy, the possibility of having children) (Bloor, 1995); and 3) a culture of risk approach, first elaborated by the anthropologist Mary Douglas, which views variations in risk behaviors as stemming from different learned orientations to risk found in different subcultures (Bloor, 1995a).

The Health Belief Model

The health belief model (HBM) is one of several psychological approaches to the study of health behaviour. The HBM is a model of decision-making that attempts to predict whether or not people will accept medical intervention and treatment, and whether they will follow prevention recommendations such as attending regular screenings, not smoking or engaging in safer sex. It is based on two broad intersecting variables. The first is the individual's willingness, readiness or preparedness to make the potentially health improving change. Factors affecting this willingness may include knowledge of the illness, an assessment of its seriousness, and the cost involved in making the change. The second factor is the structural or external factors that aid or hinder change, such as financial cost and the availability of peer support (Davies, Hickson, Weatherburn and Hunt, 1993).

The HBM has been applied to a wide variety of health-related behaviour, and as such was an obvious model in trying to understand the move to safer sex. One of the best known HBM derivative models of safer sex is the AIDS Risk Reduction Model (Catania et al., 1990). This model proposes three stages of change: "1. Recognition and labeling of one's sexual behaviours as high risk for contracting HIV, 2. Making a commitment to reduce high-risk sexual contacts and increase low risk activities, and 3. Seeking and enacting strategies to obtain these goals" (p. 54). The model underlines a relationship between knowledge of attitudes towards and beliefs about AIDS, HIV and safer sex. The model also states that the desired outcome, safer sex practices, will occur only if the practitioners know about and have positive attitudes towards safer sex and also believe that safe sex will have the desired effect.

In the HBM, the individual is presented as a responsible, rational and free actor, motivated by the desire to live as long as possible in good health. This model is only pertinent if individuals have both real control over their lives and a feeling of control. Since knowledge, attitudes and beliefs are not always sufficient to predict behaviour change, researchers sought to find mediating factors that enhanced or impeded individuals' ability to act on their wishes. One important factor is the notion of self-efficacy (Bandura, 1977) or the internal locus of control (Rotter, 1966). The notion of self-efficacy derives from social learning theories (Seligman, 1975). It proposes that, based on the outcomes of individual action, especially those during childhood, people develop a sense of whether or not they are able to control what goes on around them. For example, a child who is praised and punished indiscriminately for what he or she does will perceive him/herself as being subject to the whims of fate. Alternatively, a child who

is praised for doing good and punished for doing bad will learn that outcomes are dependent on his or her actions, and consequently feel in control of the environment. In other words, those who have an internal locus of control think that they can act on the events affecting them. In contrast, individuals with an external locus of control think that external agents or uncontrollable circumstances are responsible for these events.

The ongoing popularity of this model can be at least partly explained by the fact that it focuses attention on processes which are relatively amenable to intervention: the provision of information, the fostering of positive attitudes towards safer sex and of negative attitudes towards unsafe behaviour, and the promulgation of the simple message that safer sex works. Despite the HBM's popularity, it suffers from some serious problems. One difficulty lies in the fallacious assumption that all sex in which HIV may be transmitted involves only one person, and, consequently, that this behaviour (unsafe sex) can be understood or accounted for by looking at one person alone (Davies et al., 1992). However, men who engage in unprotected anal intercourse do so as a result of an ongoing, explicit or implicit negotiation between at least two individuals.

The vast majority of articles on unsafe sex among gay men that use HBM analysis seek to elucidate the reasons why individuals continue to have unsafe sex. This approach fails because it focuses solely on the individual and therefore underestimates the influence of social ties on individual decisions. The HBM does not account adequately for the social, cultural, moral and political dimensions of risk, especially as they relate to health (Bloor, 1995a, 1995b; Gabe, 1995; Fee and Krieger, 1993; and Lupton, 1993).

Cost/Benefit Approach

An alternative approach emphasizes the situated rationality of risk behaviour by pointing to the contradictory social pressures on individuals and the immediate benefits that may accrue to risk-takers. This kind of approach is found in Luker's (1975) study of California women seeking repeated abortions. According to Luker, unwanted pregnancies result from contraceptive risk-taking behaviour that is the result of conscious decision-making. Contraceptive risk-taking is seen as a rational social process that is open to analysis and intervention. If contraceptive risk-taking decisions are based on what amounts to a cost-benefit analysis by the individual, then the costs and benefits, once outlined, can be changed by contraceptive programs that correspond more closely to the costs and benefits perceived by the individual. Luker believes that what appears to be ignorance or irrationality in these decisions can be seen as rational once one understands the costs, benefits and subjective probabilities within individuals' own social contexts/situations. Luker describes a range of shifting and cross-cutting desiderata that may influence reproductive decision-making:

> *In all heterosexual relationships (including those as brief as a single encounter), people are trying to manage a number of complex tasks--only one of which is not getting pregnant--and they are doing so in a social and cultural context that puts contradictory demands on them (1975 xi).*

A sociological study with a close affinity to Luker's work is Parsons's research on the reproductive behaviour of women at risk of bearing children with the genetic disorder Duchenne muscular dystrophy or DMD (Parsons, 1990; Parsons and Atkinson, 1992). The variation in reproductive risk behaviour among Parson's sample was not wholly

explicable by reference to differences between the women in the risks they ran of bearing a boy with DMD. Some women, advised by their clinicians that their child was at very low risk after amniocentesis, would terminate a male fetus; other women, advised after an amniocentesis they were at a higher risk, went ahead with their pregnancies. Such behaviour, which might be deemed irrational from a clinical perspective, was in fact the product of a situated rationality–a rationality rooted in the women's social situations. For some women, the wish to form a family was paramount in their lives. For other women, their previous experience of growing up with a brother who had DMD may have been a positive or negative experience, shaping their own family formation plans.

Bloor (1995a) and Rhodes (1995) promote the utility of situated rationality theories of risk that accommodate a plurality of other possible rationalities. Situated rationality theories allow movement beyond a unitary understanding of sex and instead suggest that sex can be seen as a repertoire of physical activities that potentially have a plethora of different meanings. These meanings inform both sexual decisions and sexual health decisions. Thus, this understanding explores sexual behaviour outside a purely 'health' perspective and illustrates the limitations of understanding sexual behaviour solely from this perspective. Models of decision-making should begin with some contextualizing of the sex in terms of its motivation (Ingham, Woodcock and Stenner, 1992), economic influences (Zalduondo and Bernard, 1995), power or sexual pleasure.

Social Action

Another view of risk behaviour casts it as social action, negotiated within a social environment. While research within this paradigm begins with the individual, it focuses

on investigating the meaning of the behaviour to that individual and its origins within social relationships. One of the most striking and consistent findings of behavioural research on gay men in both Great Britain and the USA is that high-risk sex is more frequently reported with someone described as a regular partner or lover (Hunt et al., 1992). An important approach to investigating the reasons for this has been to look at the nature of regular and non-regular relationships that might give unprotected intercourse different meanings in the two contexts. For example, in a study of 677 homosexually active men (MacLean et al., 1994), about half had had unprotected intercourse during the previous year. The majority of men who had had unprotected intercourse with non-regular partners perceived their behaviour as risky. The main difference between regular and non-regular relationships was the degree of emotional involvement the respondents reported. Three quarters of the men were in love with their regular partners and two thirds of the men were committed to an ongoing relationship. . By contrast, very few men reported emotional involvement with non-regular partners.

A study of bisexual men (Boulton et al., 1991, 1992) provides an example of research that looks at risk taking as social action. Sexual risk behaviour with male and female partners was investigated in a sample of 60 behaviorally bisexual men. Patterns of risk behaviour differed according to the sexual context in which the men lived. In particular, men who lived in a heterosexual context had quite consciously adopted the strategy of restricting themselves to safer sex with their male partners in order to continue unrestricted sexual activities with their female partners, among whom condom use was not expected and might require explanation. Perhaps the most significant feature of this study on risk is its attempt to link the behaviour of individual men to broader social

institutions, in this case the gay, bisexual and heterosexual communities. Patterns of values, norms and expectations within those communities both give meaning to sexual behaviour and constrain individual men's behavioural choices. They also mean that men and women linked to those communities have different likelihoods of exposure to HIV infection.

Approaches that focus exclusively on the individual are most often criticized by sociologists because of their implicit assumption of unrestricted volition in the populations studied. Behavioural choices, it is argued, are not freely made by individuals but are limited by the constraints of the situation and the resources available. Robinson and Davies (1991) used this approach in their study of two groups of male sex workers, "rent boys" and "call-men". This research on sex workers draws attention to the role of material resources, and the power relations that they give rise to in determining the outcome of sexual encounters in terms of safe and unsafe sex.

Robinson and Davies' study defined rent boys as young working class men who did not self-identify as gay, and sold sex on the streets of central London to willing customers. They were characterized as having few personal resources in terms of accommodations, secure income and non-sex related labour market skills. Call-men, on the other hand, worked as escorts and masseurs, either from their own homes or an agency. They could take clients home or travel to client's homes or hotel rooms. The call-men were of middle-class backgrounds and self-identified as gay.

Systematic differences between these two groups were observed in relation to risk behaviour that was in turn related to differing access to material resources. Anal intercourse rarely took place between call-men and their clients, but condoms were used

when it occurred. Penetrative sex is much more common among rent boys and condom use less frequent. Call-men had no need to find clients who would let them stay the night, and spent no more than an hour to an hour and a half with clients; rent boys were often looking for temporary accommodation, which could mean a night with a client. The call-men made a major distinction between sex at work and in their private lives, and were more likely to engage in unprotected intercourse with lovers and non-paying others in order to distinguish between activity with clients and friends. The rent boys had less scope for such distinctions and less control over the content of sexual encounters in different contexts (Hart and Boulton, 1995).

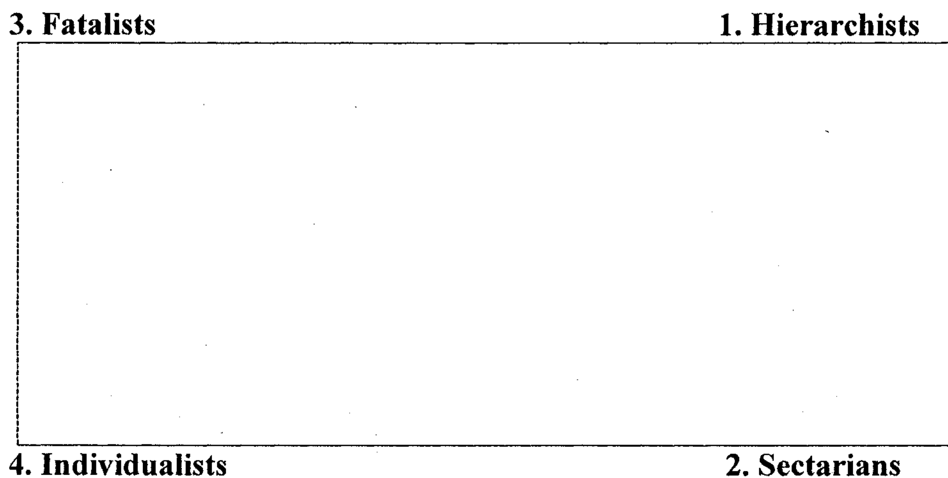
These studies demonstrate the heterogeneity of social experience evident within apparently homogeneous categories (sex work, street work), and this accords with sociological understanding of community dynamics, shared meanings and structural location. What these studies show is the central role of material resources in constraining individual choice regarding risk behaviours.

The Culture of Risk

The anthropologist Mary Douglas is a pre-eminent figure among those who see risk behavior as a culturally variable product. In a series of publications in the 1980's (Douglas 1985, 1992; Douglas and Widavsky, 1982) Douglas elaborated her 'grid-group' approach to risk behavior and in 1990 explicitly applied this approach to HIV-related risk behavior (Douglas and Calvez, 1990). Her argument is that variations in risk recognition, assessment and response are the product of local cultural variation and differential socialization in various subcultures and complex social institutions.

Variations in risk behavior can be represented schematically by their placement in a two-by-two table (see Table 1) whose two axes represent, respectively, the variable degree to which the individual is integrated into bounded groups ('group') and the variable degree to which those groups require adherence to particular rules of conduct ('grid'). In the resulting four-box table four different cultural orientations to risks can be distinguished: 1. Hierarchists (high grid and high group) whose risk behavior may be high or low, in close conformity with the prevailing norms of their social group; 2. Sectarians or egalitarians (low grid and high group) that identify strongly with their own group blame others for the emergence of hazards and are resistant to behavior change; 3. Fatalists (high grid and low group) who do not knowingly take risks but accept what is in store for them; and 4. Individualists (low grid and low group) who stress the benefits of risk- taking (Douglas, 1992; Bloor, 1995a).

Table 1: 'Grid-group' approach to risk behaviour



Douglas's own attempt to apply this analysis to HIV-related risk behavior (Douglas and Calvez, 1990) is less than satisfactory. In particular, there appear to be

difficulties with the differentiation of gay men from injecting drug users, and the characterization of injecting drug users as fatalists with low group integration contradicts 30 years of modern ethnographic research on drug subcultures from Becker's (1953) pioneering study of marijuana smokers onwards. Reports from large-scale studies of drug injectors have shown respondents to be following gay men in their dramatic reductions in risk behavior (Frischer et al., 1992), and ethnographic studies have shown that disapproval of casual needle-sharing in drug subcultures has similarities to the disapprobation of casual unsafe sex in gay subcultures (McKeganey and Bernard, 1992).

Particular problems with the grid-group analysis have been noted by Johnson (1987), notably the difficulty in allocating social groups unambiguously to one of the four basic cultural types. Most studies indicate considerable variability within social groups. More serious difficulties are raised by Bellaby (1990) who points to the static character of the model and its failure to account for the movement of individuals from one culture of risk to another. Bellaby suggests that a more dynamic and situated model is required. In some instances the normative expectations and cosmologies that people bring to the situation of risk may be a less important determinant of risk behavior than aspects of the situation itself. Risk-taking may follow less from learned orientations than from strategic relationships in the immediate risk situation.

Despite some difficulties within Douglas's culture of risk approach, The Royal Society study group stresses the paradigm-shifting importance of her work and that of her followers:

> The implications of this approach for risk assessment and perception are revolutionary. It implies that people select certain risks for attention to defend their preferred lifestyles and as a forensic resource to place

> blame on other groups . . . That is, what societies choose to call risky is largely determined by social and cultural factors, not nature (Royal Society, 1992: 112).

The HBM remains popular within the health care community because it focuses on processes that are relatively amenable to intervention. However, the model is flawed; with its focus on the individual as a rational, responsible and free actor, the HBM lacks any real social dimensions. It fails to recognize that all sexual intercourse, whether unprotected or not, involves negotiation between two or more individuals. Furthermore, this individualistic approach also fails to acknowledge that individual agency is limited by social structure. Young gay male street prostitutes, for example, are often faced with difficult decisions. Their lack of material resources, such as food, lodging and money, place them in situations that remove much of their freedom to choose a more beneficial course of action.

Beyond the HBM, there is a growing body of work that now tries to understand risk behaviours in terms of social, cultural, moral, and political dimensions. These factors are taken into account in a cost/benefit approach to risk behaviour. This approach is useful in trying to understand that there are contradictory social pressures on individuals. Equally important is the acknowledgement that community dynamics are an essential element to a more complete understanding of risk behaviour, especially among gay men. This is particularly evident in the solidification of certain norms and expectations in regard to unprotected intercourse over the last twenty years within the gay male community.

Douglas's 'culture of risk' is particularly beneficial in its attempt to understand risk behaviour as a culturally variable product; in other words, what societies or cultural groups decide to call risky is determined largely by social and cultural factors, not only by their biology. Her method is also important as a counterweight to social-psychological approaches like the HBM, which relegates the social and cultural dimensions of risk to the background in trying to evaluate risk-taking behaviours. However, this approach does not take into account individual movement within groups. This is an important failing, particularly when trying to understand those individuals who step out of these established groups. For barebackers, the norms and expectations within the larger gay male community do not restrict their behaviour; they challenge, in a very direct way, long held safer sex beliefs.

The culture of risk and cost/benefit approaches attempt to put forward a more comprehensive sociology of risk. Although each has specific shortcomings, they move our understanding of risk behaviours away from an individual-centered approach to health and illness. They offer, instead, the vital importance of the social within the sexual.

HIV/AIDS Literature

There is a growing body of work on the sociology of HIV/AIDS. Specifically, one finds a number of studies on social movements (Stockdill, 2003; Gould, 2000; Stoller, 1998; Cohen, 1998; Epstein, 1996; Deitcher, 1995; Arno and Feiden, 1992; Corea, 1992; Schneider, 1992; Crimp, 1990; Gamson 1989); gender (Goldstein and Manlowe, 1997;

Patton, 1994; Richardson, 1988; Kubler-Ross, 1987); community organizing (Altman, 1994; Ariss, 1994) and gay and lesbian identity (Roecker, 1998). This section will focus primarily on community organizing and identity issues and specifically on the development of AIDS organizations and their promotion of safer sex strategies.

Community Organizations

In many communities, the gay activists and community leaders who responded to the epidemic were those who had a strong sense of self-preservation for themselves as well as the overall gay community, and they adopted and promoted safer sex practices in response to their perceived risk. A number of these individuals had strong affiliations with their community-based organizations (CBOs) and AIDS service organizations (ASOs) (Cain, 1993, 1995, and 1997; Cohen and Hubert, 1997). During the initial period of the epidemic, the most effective response came from those CBOs that perceived a threat to their communities and designed programs to emphasize empowerment and self-efficacy. According to Valerie Lehr (1993) the affirmation of gay identity is the starting point for many organizations. She also argues that alliance formation is essential if AIDS is to be confronted effectively. Much of her argument concerns identity issues for AIDS-related organizations. However, she also stresses the dangers in focusing on identity formation: "identity politics emphasizes the formation of culture, which leads away from a focus on the strategies necessary to bring about change" (1993: 248).

The most complete summary of the role of community organizations is found in the work of Altman (1994). All of the organizations he studies are closely tied to the communities most affected by the AIDS epidemic. He argues that community groups are

human rights oriented and focused on 1) action against discrimination and 2) ensuring equal access to information, support and care (1994:18).

Over the stages of the epidemic, the strategies of community organizations tended to shift from reinforcing self-efficacy to providing networks for peers and applying social pressure for change. As these organizations grew, they encouraged a greater sense of community identification and contributed to peer networks where safer sex became the norm (Kippax et al., 1990). Often these initial ASOs evolved into major HIV prevention and care organizations.

Governments funded these organizations to provide HIV/AIDS prevention in recognition of their expertise and rapport within communities at risk and as a way of distancing themselves from directly recommending risk reduction methods such as condoms or clean needles (Cohen, 1992; O'Malley, 1992). These organizations tended to fill gaps left by the inadequate response by governments.

One important reason for the slow government response was the battle between moralists and pragmatists in the United States over the type of HIV prevention being promoted. Moralists tended to suggest the culpability of certain groups and advocated sexual abstinence, long-term fidelity and legal punishment for perceived abnormal behaviour. The pragmatists tended to offer risk-reduction techniques such as condom use and non-penetrative safer sex techniques (Clift and Sears, 1991; Kaplan, 1990; and Wellings, 1991). Other reasons for the inadequate response included institutionalized homophobia, lack of urgency, bureaucratic battling and the difficulty involved in confronting social taboos (Tomasinski, 1992; Shilts, 1987; King, 1994).

Barebacking and Gay Identity

Unplanned unsafe sex arises in a variety of circumstances: as a resolution to condoms and erectile difficulties, through momentary lapses and trade-offs, out of personal turmoil and depression, and as a byproduct of strategies of disclosure and intuiting safety (Adam, Husbands, Murray and Maxwell, 2005). But much more evident today than in the mid-1990s are those who have stopped safe sex altogether. O'Hara (1997), in his book Autopornography, talked of a recaptured sense of freedom in becoming HIV-positive in being able to return to a sexuality no longer constrained by the fear of infection. O'Hara was clear in the use of the term barebacking as referring to sex among HIV-positive only; he tattooed "HIV+" on his shoulder to warn all potential HIV-negative sexual partners of his status. Since that time, barebacking has become a more amorphous word, at times standing in for virtually any kind of unprotected sex, but often still retaining a sense of intentional condomless sex (Junge, 2002). The creation of a specific identity, not only around one's sexual orientation, but also around one's HIV status, practice and types would add another important dimension to the changing relationship between gay men and ASOs.

Identity is of core importance in the social movement literature on gay and lesbian organizations. Given its role in the formation of many organizations it is also important in the formation of coalitions or networks. A number of authors highlight the contribution of identity to the stability and longevity of SMOs (Valocchi, 1999; Clemens, 1996; and Stoecker, 1995). An important question is whether or not groups based on a particular identity are able to reach out to other populations and their organizations to form coalitions or create a network.

The early success of these ASO organizations' AIDS prevention campaigns had been their focus on sexual identity, particularly gay identity. Notions of the 'gay community' rely on a shared understanding of an identity and culture. In this way, gay identity has been central in prevention efforts, many of which focus on establishing a safer sex or condom culture. This strategy is dependent on the notion of a unitary gay identity. Indeed, HIV-prevention initiatives that have proven effective have been premised on just such community involvement (Kelly, St Lawrence and Diaz, 1991; Kelly et al., 1992).

Community involvement is thought to be important because of the access it provides to informational resources (the gay press and safer sex information) and normative influences and social support. However, according to many authors and researchers, "gay sexual identity" is not a unitary or homogenous category (Gallagher and Wilson, 1987; Epstein 1990; Watney, 1994). It contains the same diversity that characterizes other groups defined by sexual-object choice, including heterosexuals, transsexuals and bisexuals.

With the advent of HIV/AIDS, new categories of sexual practices have emerged in gay communities. Sexual behaviours are now labeled "safe", "possibly safe', and "unsafe". Likewise, new identities based on serostatus ("positives" and "negatives") have emerged in these communities (Johnson, 1995; Odets, 1995). Furthermore, gay men are categorized in terms of sexual practices and sexual types. These sexual identities have created further divisions in gay communities. Conflicts arise from tensions both between the individual and the collective and between communities within the larger gay population. How does the gay male individual balance and negotiate his personal sense of

self and desire with his sense of social belonging to a group that brings with it other kinds of needs?

Weeks explains this paradox by noting that "sexual identity assumes fixity and uniformity while confirming the reality of unfixity, diversity and difference" (1995, p.88). When we express ourselves in terms of our sexual identity, it appears we belong to a distinct category with shared beliefs, behavioural norms, and sexual practices. In fact, individual differences as well as our various belongings and the social responsibilities attached to them pull us toward many sometimes conflicting trajectories (Yep, Lovaas, and Pagonis, 2002).

In response to HIV/AIDS, gays came together to apply political pressure for a faster and more humane medical response. Community standards for safe and safer sex were developed. The collective sense of unity, solidarity, and shared obligations was both enhanced by the emergence of the epidemic and made an effective response possible. This ability to collaborate to achieve important goals is clearly a valuable consequence of sexual identity. The choice of many individuals to contest community standards by engaging in barebacking is seen as a threat to the collectivity. Reflecting this sentiment in gay communities, Locke writes, "There are plenty of people who are going to hear about [barebacking]...and say, 'let the faggots die' " (1997, p.11).

Furthermore, Weeks indicates, "identities are deeply personal but tell us about multiple social belongings" (1995:90). An individual's passions and needs are experienced as powerful givens, uniquely experienced. These invented identities provide meaning to physical desires without directly proceeding from them. Such desires can be transformed, as has been consciously achieved in the case of the safer sex regimen (Yep,

Lovaas, and Pagonis, 2002). Choosing to maintain that regimen or to engage in barebacking is indeed a deeply personal and community issue. Ethnicity, age, and social class are among the significant intersections with sexual identity. People are continually engaged in creating and recreating their sexual identities against the backdrop of their own personal narratives.

Conclusion

The vast majority of health promotion programs, educational interventions and strategies during the AIDS epidemic tended to promote information and education as the foundation of behaviour change. These strategies were diffused through prominent peer or community leaders who acted as motivators for the implementation of healthy behaviours.

This strategy continues to inform much of contemporary health promotion work. It has been particularly important in the effectiveness of AIDS education programs since the mid-1980s. Recently, however, a more critical approach to health psychology has emerged (Radley, 1993, 1994, 1997; Brandt and Rozin, 1997). One of its central critiques relates to the fact that earlier models portray the individual as overly rational, and relatedly, take insufficient account of the complex psychosocial nature of choices facing individuals in relation to health related behaviours.

If we look carefully at how people behave and talk about health-related activities, such as having sex, it becomes apparent that they embody latent emotional, social, cultural and value-laden meanings that individuals and groups incorporate into their ways of thinking, which they are not necessarily aware of (Calnan, 1987; Nettleton, 1996 and

Crossley and Crossley, 1998).This is especially important as it relates to the issues of risk behaviour and gay men. Since most gay men understand how HIV is transmitted, sociological explanations are needed that can help us discover the social and cultural meanings that gay men use to justify this risky sexual behaviour. The next chapters of this dissertation will attempt a deeper explanation of the connections between gay men's sexual risk-taking and their social worlds.

Chapter 3

Safer Sex Behaviour among Gay men

Like other human beings, I desire the experience. I want to hold this man and kiss him. Is this wanting too much...? Can any straight person understand what it is like to want to make love but to be terrified that to do so means possible death?
-Larry Kramer, *Reports from the Holocaust* (1989)

I really don't know why I didn't use a condom. I know the risks of unsafe sex, but I did it anyways. I believed I would be okay.
-gay male, 22 years old, *Interview* (2003)

From the very beginning of the AIDS era, claims about the behavioural responses of gay men to the epidemic have been contested. Researchers carefully examined data describing trends of declining behavioural risk over time to determine whether behavioural risk was declining fast enough to stop the AIDS epidemic. A second, often contentious, debate focused on whether certain subpopulations of men, particularly young men, were characterized by greater levels of behavioural risk. Additional debates have been concerned with the way that substance abuse and HIV epidemics may intertwine among the gay male populations. More recently, researchers have debated the implications of rising levels of behavioural risk among gay male populations, along with the value of 'harm reduction' strategies such as 'negotiated safety'.

Much has changed in the debate concerning the appropriate behavioural changes of gay men in the last twenty years of the AIDS epidemic. The shifting nature of this debate necessitates an historical context to this complex social/sexual phenomenon. As a result, this chapter will present an historical overview of the changing nature of gay men's behavioural responses to the HIV/AIDS epidemic since the early 1980s.

The Early Days of HIV

By the early 1970s, the gay male community was experiencing, for the first time, a sexual, social, political and personal liberation that many had not thought possible a generation before. Sex was free, liberated, pleasurable, and erotic, and it was a time of sexual experimentation for gay men. It was a time for venereal diseases too, but no one seemed to mind as penicillin tended to take care of that loathsome little inconvenience (Shilts, 1987).

The initial euphoria of these early days of liberation would soon be dampened. By the early 1980s, a deadly infectious agent was lurking among the beds, bars, bathrooms, bookstores and bathhouses of major urban centres. Whispers were swirling through smoke-filled gay bars. Patrons exchanged tempered concerns about a new illness, an illness initially labelled "gay cancer". Was it real? With each hour, each day, more and more young gay men succumbed to the unforeseen modern-day plague. Some gay men believed the so-called cancer to be nothing more than a plot concocted by a homophobic society to suppress their newly found sexual liberation while other men began to sweat, especially at night, as their fevers soared and the once foreign but now all-too-familiar raised purple lesions of Kaposi's sarcoma ravaged their skin (Kramer 1989; Shilts 1987).

This crisis began with disbelief, from the condoms in the suitcase to the first Kaposi's sarcoma lesion on the ankle. The gay community was confused at a notion that even now seems incredible: that sex could cause cancer, and in time, death. As the magnitude of the epidemic was becoming fully realized, members of the gay community were horrified, angry, terrified and pathologically depressed. Over the next two decades

the gay community would move from denial and disbelief to fear, empowerment, action, sexualness, sexlessness, and fatigue (Hardy, 1999).

Early in the epidemic, even before the availability of HIV testing, the gay community had mobilized. Gay men, lesbians and their friends and supporters formed groups in order to provide sanity, hope and conviction in the midst of alarm. Once epidemiologists and other researchers had determined that AIDS was a sexually transmitted disease, a few prevention education programs received a funding boost. Gay pundits like playwright Larry Kramer in New York had already indicted "homosexual hypersexuality" and "exotic" sexual practices such as anal sex and rimming as the "cause" of AIDS. Soon Don Francis and others from the Centers for Disease Control (CDC) joined the gay muses as they warned their gay brethren to "sexually slow down" (Turner 1997, p. 4). A dark shadow was now covering a promising rainbow of possibilities.

The First Response: Safer Sex

The earliest safer sex advice for gay men was published in 1982. Two of these documents were produced by Bay Area Physicians for Human Rights, a group of lesbian and gay doctors who published a leaflet on *Kaposi's Sarcoma in Gay Men* and the fledgling Gay Men's Health Crisis (GMHC) in New York, which issued its first *Newsletter* and distributed a quarter of a million copies of their *Health Recommendation Brochure* to local gay bars in November and December 1982 (King, 1994).

These materials did not speculate on the relative safety of specific sex acts, but instead recommended three main types of behaviour modification: reducing the number

of different sexual partners; eliminating the exchange of body fluids during sex; and 'knowing your partners' by avoiding places characterized by sexual anonymity, such as bathhouses.

It was Richard Berkowitz and Michael Callen's *How to Have Sex in an Epidemic: One Approach* (1983) that pioneered the approach to safer sex that we recognize today. It was virtually the only safer sex publication that proposed a specific theory of what caused AIDS, on which its advice about specific sex acts were based. It also deduced a means by which gay men could continue to 'have sex in an epidemic' but take rational precautions to make that sex safer. They noted that

> because of the ridiculous and dangerous stereotype that being "passive" and getting fucked are somehow "unmanly", some gay men tend to be defensive about any warnings concerning the medical hazards of passivity. Remember that the issue is disease-not sex. The risk isn't getting fucked; the risk is getting exposed (p.21).

Berkowitz and Callen acknowledged that safer sex education should not be concerned primarily with deterring gay men from anal penetration, but instead with enabling gay men to make informed decisions about risk reduction.

This was a key distinction, and one which it is increasingly important to make. In the earliest years of the epidemic, when the cause of AIDS was still a matter of speculation and the idea that gay men should use condoms was little more than a joke,[2] safer sex guidelines first recommended reducing the number of one's sexual partners, and later, avoiding anal sex. The priority for HIV prevention was to provide the necessary information and support to help those who enjoy anal penetration to reduce the risk to

themselves and their partners. There were two possible approaches: either the correct use of condoms and lubricant, or to urge gay men to stop having anal sex (King 1994). This analysis has provided a model for safer sex campaigns ever since.

As Simon Watney (1994) has observed, "Since the earliest years of the epidemic, safer sex education among gay men has been most successful when rooted in the recognition that HIV is a community issue, requiring a community-based response." This does not mean simply that the individuals and groups best placed to undertake safer sex education for gay men are themselves gay. It reflects the fact that some aspect of gay identity leads gay men to feel that on varying levels they share interests, beliefs and values with their gay peers.

Risk reduction guidelines were modified over time as HIV was discovered and its routes of transmission clarified. According to King (1994),

> these guidelines first recommended reducing the number of one's sexual partners, and later, avoiding anal sex. It was soon established that anal sex was by far the most risky activity for HIV transmission, and that men who do not practice anal sex face at most a tiny risk of giving or getting HIV. The priority for HIV prevention must therefore be to provide the necessary information and support to help those who enjoy fucking to reduce the risk to themselves and their partners. There are two possible approaches to this: either the correct use of appropriate condoms and lubricant can be encouraged, or those men can be urged to stop having anal sex (p.88-9).

Safer sex, specifically condom use, became the established community norm within gay social networks throughout much of the industrialized world. This peer endorsement of safer sex, reinforced by educational interventions by groups recognized as a part of that

---

[2] However, from the late 1970s gay men who were 'super-carriers' of hepatitis B were recommended always to wear condoms for anal sex. The prevention of hepatitis B transmission was never seen as a community-wide gay health concern, unlike the prevention of HIV.

community and by the gay press, played a key role in helping gay men put factual information about safer sex into practice. Contrary to popular wisdom, this unprecedented mass behaviour change owed little or nothing to the actions of governments or others outside the gay community, or to HIV antibody testing, or to the application of theory-based health education models. Rather, it was founded upon gay men's sense of shared interests and responsibilities for each other, and upon individual and collective determination to overcome this epidemic (Patton, 1990; King, 1994).

The successes of these early preventative programs were even more compelling when one considers the political and cultural beliefs that had to be challenged. In the early to mid-1980s, generally conservative social mores, petty politics, and calcified religious beliefs continued to stifle efforts to obtain outside assistance for programs to enact behavioural change. Ideologically conservative politicians within North America, arguing that such prevention programs would foster promiscuity and promote a "homosexual lifestyle", effectively blocked government-funded HIV prevention programs or diluted them with severe content prescriptions (Bayer, 1989).

When the HIV/AIDS epidemic began in the early 1980s, Canadian governments and policymakers were not able to overcome a long history of discrimination and deal with the gay and lesbian communities in an accepting and responsible manner (Canadian HIV/AIDS Legal Network, March 1999). As a result, most gay men, with the help of some adventurous and progressive community organizations, were left to cope on their own and to find ways to change their behaviours. For some, this meant reducing their number of sexual partners. For others, it meant abstinence, at least temporarily, while other gay men began to use condoms for the first time (Martin 1986).

Once public health HIV prevention campaigns did kick off in the mid- to late 1980s, they were primarily based upon social marketing theory and upon traditional public health models such as the Health Belief Model, the theory of reasoned action, and other similar knowledge-based approaches (Levinton, 1989; Martin, 1986; Valdiserri et al., 1989; and Williams, 1986). Earlier programs leaned toward promoting abstinence and reducing the number of sexual partners but also touted the use of condoms. How much or how little these programs actually accomplished in prompting behavioural change is a matter of debate (Gold, 1993).

Nonetheless, whatever the "real" cause of the behaviour change--whether through public health education, self-motivation, personal experience, word-of-mouth, or all of the above--North American gay men, on the whole, did change their behaviour and condom use became for the most part widespread (Becker and Joseph, 1988; Joseph et al., 1987a, 1987b; Martin 1986; McCusker et al., 1989; McKusick et al., 1985., McKusick et al., 1990; Stall, Coates, and Hoff, 1988 and Valdiserri et al., 1989).

Sustaining Safer Sex

Many gay communities around the world have been justly congratulated on their unprecedented and extensive adoption of safer sex. It is held up as evidence that responsible behaviour change in response to the threat of AIDS was indeed possible. However, a number of reports from both clinics and cohort studies describe evidence of continuing and increasing levels of unsafe sex among gay men (Colfax et al, 2002). Although the rate of HIV seroconversion has decreased among gay men as a whole, in one study of 479 men in four cities, 47 percent of the gay respondents reported

unprotected anal intercourse in the previous six months (Kelly et al., 1991). Similar findings abound in the AIDS-prevention literature, with multiple studies sounding the alarm that gay men are returning to unsafe sex (Adib et al., 1991, Ekstrand and Coates, 1990; McCusker et al., 1992 and Stall et al., 1990).

Outside the medical literature, Michael Rooney's *Gay Men: Sustaining Safer Sex?* (1991) was an important first work that documented these new behavioural changes among gay men. Researchers responded by constructing theories to explain why some gay men might still be practicing unsafe sexual activities and defining subgroups of the gay and bisexual population in which unsafe sex might be particularly likely.

The article that first prompted the new attention to unsafe sex among gay men was published in *Morbidity and Mortality Weekly Reports* (MMWR), the bulletin of the US Centers for Disease Control (CDC). In November 1989, Dr. Handsfield and colleagues reported that the incidence of gonorrhea among gay or bisexual men attending sexually transmitted disease (STD) clinics had fallen from 720 cases in 1982 to 27 cases in 1988. However, during the first nine months of 1989, 71 cases were seen. There was no significant difference between the age and race of the men with gonorrhea in 1989 than earlier cases (Handsfield et al., 1989). During 1990, similar data were presented from STD clinics in the Netherlands and Victoria, Australia. In Amsterdam, cases of gonorrhea among gay men increased in 1989 after seven years of consistent decline. The number of cases of early syphilis among gay or bisexual men more than doubled in 1989 compared with the previous year (van den Hoek et al., 1990).

The San Francisco AIDS Behavioral Research Project continues to be one of the largest and most influential studies of gay men's sexual behaviour. An analysis presented

at the VI International Conference on AIDS in San Francisco in 1990 stated that 69 percent of high risk sex that occurred during a 1-month study period in 1988 "could be characterized as a relapse", in that the participants had previously reported the adoption of safer sex (King 1994, p. 139). In this analysis, high risk sex was considered to be any anal sex with a casual partner, regardless of condom use, or anal sex without a condom within a relationship. Out of 535 men, 256 had had unprotected anal sex during the preceding year, of whom 46 percent were in mutually monogamous relationships, 18 percent in non-monogamous relationships and 35 percent had no primary relationship. Further analysis revealed that:

> Men in monogamous relationships are more likely to report having unprotected sex as a result of being in love and having the same HIV antibody status as their partner than men without primary relationships. Men without primary relationships are more likely to report having unprotected sex as a result of being sexually aroused or due to a combination of sex and alcohol or drug use or a lack of condoms at the time that sex occurred than are men in monogamous relationships (Stall et al., 1990).

Studies that were conducted during the 1990s found similar findings of a relapse in gay men's attitudes and subsequent behaviour regarding safer sex practices. For example:

- Forty-three percent of a sample of 99 gay men from three West Coast cities reported engaging in unprotected anal sexual intercourse over the previous six months (Hays, Kegeles & Coates, 1990).
- Thirty-nine percent of a cohort of HIV-positive gay and bisexual men from a Midwestern city reported engaging in unprotected anal intercourse over the previous 3 months (Kalichman et al., 1997).
- In a study of 75 committed gay male couples of opposite HIV status (HIV-positive and HIV-negative), researchers found that in 50 (67%) of the couples, one or both partners reported having participated in sex outside the relationship (Wagner, Remien, & Carballo-Dieguez, 1998).

How do we explain these findings? Why, after two decades of successful HIV prevention, have gay men's attitudes and behaviours changed in relationship to safer sex practices? Many researchers and AIDS service organizations (ASOs) hypothesized that "HIV optimism" and "prevention fatigue" were motives for the new "laxness" on safer sex practice, by imputing motives to gay men based on the fact that epidemiological rates began to rise about the same time that the protease inhibitors were introduced in the mid-1990s (Adam, Husbands, Murray, and Maxwell, 2003).

According to researchers Joseph P. Stokes and John L. Peterson (1998) gay men, like their heterosexual counterparts, practice unsafe sex because it demonstrates emotional commitment. One participant in their study remarked:

> I was so in love with this young man and so desperate to be loved and have a sense of belonging that I was willing to forego the condom just to gain this man's love and acceptance... I was willing to contract this deadly disease just to prove my love to this young man or just to have him-for us to become one (p. 288).

During childhood, many gay men come to recognize that it is hard for them to bond or fit in with other guys. "That difference", Signorile (1997) observed, "often keeps them excluded from the typical kind of macho, heterosexual teenage camaraderie and bonding" (p. 138). Once they begin hanging out in the gay sexual world, these men vow never to be left out by the crowd, which in their minds consists of super-attractive, highly sexualized gay men. One man told Stokes and Peterson that if he has low self-esteem, he wants a sexual experience "at any cost. I would do whatever it takes to ensure that I continue to have a sexual experience" (p.288).

Gay men face extraordinary pressure, resulting from both societal prejudices and the realization that the cost of a fulfilling sexual encounter may be HIV infection. Unsafe

sexual practices hold a powerful attraction, as D.J. McKirnan and his colleagues (1996) note:

> For a given individual, sexuality may become associated with physical settings such as bars, clubs, baths, or "cruise" areas, certain partners, or ancillary behaviours such as substance use. These stimuli may come to elicit not only sexual arousal, but the anxiety, negative effect, and aversive cognitive restraint that accompany awareness of HIV risk. If the person learns to be cognitively disengaged in response to the stimulus, he receives powerful rewards both from sexual satisfaction, and from the lowering of anxiety over HIV (p. 662).

In other words, unsafe sex provides an escape or at least the illusion of escape from HIV risk, making life exciting and desirable. There is clear and compelling epidemiological and sociological evidence that men's safer sex practices have changed during the AIDS epidemic. Most AIDS activists and researchers are quite categorical in their belief that the safer sex messages were initially successful (Davies and Project Sigma, 1992). However, have gay men 'relapsed' into unsafe sexual practices or are there other explanations that can explain this shift?

'Relapse' Theory

Many behavioural scientists have come to describe a series of factors that they have described as 'relapse'. They identify the following recurrent themes as evidence of a qualitative change in gay men's sexual practices: 1) a number of clinic-based studies suggest that younger men may be particularly likely to practice unsafe sex; 2) there is clear evidence of an association between regular relationships and unprotected anal sex; and 3) differences may exist between men who have consistently practiced unsafe sex and men who revert to unprotected sex after a period of safer behaviour. The latter may

also be divided into those who usually have safer sex but may occasionally 'lapse' into unsafe sex, and those who consciously and rationally choose to have unprotected anal sex in particular situations (King, 1994).

Graham Hart and colleagues suggest that the term 'relapse' first appeared in presentations at the VI International Conference on AIDS in San Francisco in 1990, at which findings such as those from the AIDS Behavioural Research Project and the Chicago MACS cohort were presented (Hart, 1992). British researchers such as Hart and the Project Sigma team have taken a leading role in challenging the patterns of thought and interpretation from which the notion of 'relapse' is derived (Davis and Project Sigma, 1992; Davies, Hickson, Westerburn and Hunt, 1993). Linguistically, 'relapse' is used to describe the recurrence of the signs and symptoms of a disease, such as cancer or the opportunistic infections of AIDS itself. As Hart describes it:

> Relapse is therefore a term used frequently in medicine...in the treatment of alcohol and drug dependency. Outside medicine, the term relapse is more clearly pejorative, and refers to backsliding, or slinking back to an unacceptable position. Relapse, then, is concerned with a return to bad behaviour or state of being (1992: 279-280).

The close association between the concept of relapse and addiction models might well lead to the conclusion that providing 12-step programmes like those developed by Alcoholics Anonymous in the 1940s would be an appropriate assistance for gay men who are perceived as being relapsers, or at risk of relapsing. Indeed, relapse theory has emerged alongside the growing popularity in North America and Australia of 'sex addiction' and 'sex compulsivity' movements, which do use the 12-step method (Herman, 1988; Carr, 1990; and Syzmanski, 1992).

More importantly, according to Hart, proponents of relapse theory may be actively obscuring the true nature of the phenomenon. As Project Sigma points out, use of the term 'relapse'

> suggests that gay and bisexual men are unable to maintain the patterns of safer sexual behaviour for which they have been widely praised. They are, the term asserts, falling victim again to their urges, unable to resist a damned good fuck in the interests of their individual safety and the greater good (1992: 279-280).

According to Hart (1992) this implies two particularly misleading suggestions: first, that unsafe sexual behaviour is the result of individual factors such as ignorance, complacency, poor social skills, and loss of control, particularly due to drug or alcohol use, rather than the actions of two or more individuals; and second, that making the choice to practice unprotected anal sex is necessarily always wrong and therefore to be actively discouraged by AIDS educators. The reality for most gay men is that, despite evidence (Colfax et al, 2002) of resurgent HIV transmission, HIV prevention strategies have been a success story over the last twenty years. It is also clear that after twenty years of HIV, gay men are changing their behaviours based on important developments within the scientific community and within their own relationships. According to Adam, Husbands, Murray and Maxwell

> the voices of men making practical decisions in everyday life show how often situations of vulnerability to HIV infections are the consequence of following, not deviating from social prescriptions, of attempting to acquit oneself as a good and caring person not a bad or irresponsible one, and of trying to communicate love and commitment not sexual carelessness. Unsafe practices are often less a question of lack of knowledge, attitude, or the disabling of reason, than a complex deployment of signs and interactions that must be addressed if HIV transmission is to be affected. They are embedded in what Michel Foucault

> (1988) refers to as "practices of the self". While there is perhaps a "natural" and "common-sensical" quest among human beings to discover "bad" origins for "bad" effects, it is clear that "good" behaviour and "good" people are implicated in exposure to HIV transmission (2003: 30).

Furthermore, the assumption that the increasing levels of STD markers (gonorrhea, syphilis, Hepatitis C, genital Herpes, and Chlamydia) (Pozniak, 2003; Whittington et al., 2002; Brighton and Hove, 2000) or the direct evidence of increasing unsafe sex and HIV infection among gay men (Colfax et al., 2002) are due to an inability to sustain behaviour change also threatens to obscure the need for continuing basic safer sex education. This seems to be particularly evident among younger gay men, men who have come of age sexually after the introduction of HIV medication.

Conclusion

It is quite evident that during the 1980s gay men modified their sexual behaviour in response to the emergence of AIDS, and that these modifications--reducing the number of sexual partners and the practice of anal sex and using condoms for anal sex--had a dramatic effect on rates of transmission of HIV. Although in the gay centres of North America seroprevalence had already reached high levels before the existence of HIV was even suspected, in subsequent years new infections were markedly reduced. The key element in this successful response is evident: gay men reduced their practice of unprotected anal sex, the practice epidemiological studies quickly showed to be implicated in nearly all cases of HIV transmission between gay men (King, 1994).

There has certainly not been a complete reversal of the successes in HIV educational programs over the last two decades. However, it is clear that a certain

proportion of the gay male population is taking more risks in their sexual activities. Men who have not experienced the great personal losses of their gay peers cannot comprehend with the same intensity the importance of being vigilant in their sexual relations with other men. According to one of my young informants:

> I really don't think about HIV very often. When I have sex with guys my age it does not occur to me that they might be sick. It mostly the older guys who are sick, isn't it? Anyway, there are meds now; things are different for young guys like me (gay male, 24 years old, Interview 2003).

Those who have suffered loss are sometimes confused and angry that this younger generation of gay men does not uphold the long held beliefs that constituted the safer sex mantra of the last twenty years. As a former volunteer in a local AIDS organization put it:

> I often wonder where the change in attitude came about. When I was a younger man, in my late 20s or so, everybody I knew practiced safer sex. I worked as a volunteer for a few years [in an AIDS organization] and the only thing we were told to do and the only realistic message to protect us was that unprotected sex equals death. It was before the new meds and advances in science. We did the best we could under very difficult circumstances. Now we hear about men having anal sex without condoms. It seems hard to believe sometimes. Even older guys like me seem to be having unprotected sex as well. Maybe already being HIV positive makes a change for guys. Maybe its safer sex fatigue, maybe loneliness etc. I have no real answer but some changes are definitely happening in the sex lives of some gay men (gay male, 44 years old, Interview 2003).

These quotes highlight some important differences between a younger and an older cohort of gay men. Chapters 4 and 5 will investigate the generational differences between these two groups of gay men.

Chapter 4

Does Age Matter? Young Gay Men and Sexual Risk

I don't like having sex with older guys. I prefer younger guys. I think it is less risky to have sex with guys my age. I am so sure that guys my age are negative. I know that some young guys are sick but I feel there is much less chance. So many of the older men are sick. I just don't want to take a chance.

-gay male, 26 years old, *Interview* (2004)

A whole new generation of gay men who were not exposed to the safer sex prevention campaigns of the 1980s came out in the 1990s. Mass media coverage of AIDS within the gay community also diminished over the years, giving the impression to some younger gay men that the disease is predominantly relevant to an older generation. Coverage of the ravages of AIDS from the mid-1980s to the early years of the 1990s was a constant reminder of the horrors of AIDS, and of its ever-present danger. Since the onset of protease inhibitors in the 1990s, however, coverage of AIDS has slacked off dramatically. According to a Health Poll Report conducted by the Kaiser Family foundation between October 3-5, 2003 one of the main questions raised about media coverage of HIV/AIDS in recent years is whether there has been media fatigue in covering the story (Brodie, Hamel, et al. March/April, 2004). Based on this study, some might argue that such fatigue did in fact occur, as evidenced not only by a decline in the total number of stories over time, but also by the decreased reporting on the domestic epidemic.[3] This decline coincided with a change in the nature of the HIV/AIDS epidemic in the U.S. from an absolute death sentence to a chronic disease that more people live with and manage day to day. When the media, both mainstream and gay, has reported on AIDS, it has been

focused almost as a "manageable" illness. The drug regimens, the side effects of the drugs and the failure of the drugs—as well as the spread of drug resistant strains—all seem to have been played as a sort of sidebar, as minor stories to the larger story of AIDS being under control.

However, accumulating research shows alarmingly high HIV and STD prevalence rates among young gay men and high rates of sexual risk-taking, suggesting that young gay men are helping to create a new wave of the AIDS epidemic (Valleroy et al., 1996; Lemp et al., 1994; CDC, 1998, and Remafedi, 1994, 1998). This chapter will attempt to identify several possible explanations of this change in risk-taking behaviour.

AIDS and Intergenerational Relations

Since the late 1980s, HIV-related risk among younger gay men has increasingly become a topic of debate and controversy. A generational divide was emerging within urban gay male communities (Rofes, 1996), distinguished not only by age but by relationship to the onset of the AIDS epidemic. Younger men, who had come out after the epidemic began, by 1985 had embarked on the early stages of community development. The devastation of AIDS had slowed this process with the primary focus being on education and protection from HIV infection. Younger gay men wanted to start rebuilding around an image of gay men and their sexuality that was not necessarily directly connected to the HIV epidemic. This movement of gay men could be found between 1985 and 1990 making connections, redefining identities, and inventing new social venues and cultural semiotics (Rofes, 1996).

---

[3] The authors found a peak amount of media coverage of HIV/AIDS in 1987, when an average of 600

During these same years, the men who had constituted gay male cultures of the 1970s were watching the social and sexual worlds they had constructed fall to pieces; many were sick, dying or experiencing deep emotional and psychological reactions to the epidemic. By 1985, many gay men over the age of thirty were facing decimation beyond their wildest dreams. The following participant remembered this time with clarity:

> I just couldn't believe how many of my friends died during this horrible time. I worked as a volunteer during that time. I saw so much sickness and loss. I just don't understand how quickly we [the gay community] have forgotten. Now guys, even acquaintances of my age group, are having unprotected sex in bathhouses and sex parties. Maybe the new meds and party drugs are responsible for the change. It is hard for me to understand. For me, I find it is potentially very sad (gay male, 47 years old, Interview 2004).

Over 10,000 gay men had been diagnosed with this frightening new syndrome and tens of thousands more were infected with HIV and feared for their lives (Centers for Disease Control, 1986). Even more men had lost lovers, companions, neighbors, coworkers and entire social networks. The expectations they had for themselves and for the gay community in the 1970s at best had been interrupted; more likely dreams were being ripped to pieces. Profound changes in sexuality appeared, including dysfunction, sexual anorexia, or sex addiction (Odets, 1995, pp. 23-39).

This same period (the mid-1980s) was undoubtedly troubling for young gay men attempting to emerge from the closet and enter community life amid the reappearance of linkages between a sexual identity and deviant, even lethal, behaviour. The experiences of teenagers and men in their early twenties coming out amid this twisted connection between illness and sexual identity have yet to be fully documented. By the late 1980s, an assortment of new publications, organizations and cultures emerged out of the networks

---

stories per month appeared. By 2002, that number had declined to fewer than 200 stories a month.

of young self-defined queers. Adopting distinctive styles, music, activism, and icons, gay men created venues and identities which provided new ways to grapple with core issues: gender, power, social organization, sexuality and AIDS (Rofes, 1996). As one observer notes, both younger and older gay men changed:

> As the decade came to a close and the epidemic showed no signs of ending, both populations, [younger and older gay men], experienced internal shifts in the ways they framed identity, constituted desire, and occupied the queer public sphere. A resurgence of sexual activity slowly became evident among both of these gay male populations (King 1994).

By 1990, men of these two distinct generations were feeling a shared resurgence of libido. In urban centres, younger men had successfully established their own commercial venues: dance clubs, sex clubs, gyms, coffee shops, and backroom bars. For all of their attempts to separate themselves politically and culturally from the preexisting gay community, these younger gay men placed sex at the centre of their communal culture, as urban gay men had done a generation earlier. According to one interviewee:

> I really didn't see myself as part of the earlier AIDS era. We wanted to have fun, wanted to express our sexual identity, [we were] tired of all the stories of death. Expressing myself by having sex should not be associated with death. I really didn't see myself associated with this older group of gay males. I wanted to put sex back into how I expressed my self as a gay man (gay male, 31 years old, Interview 2004).

Jay Paul and colleagues (1995) describe a "generation gap" between these two populations of gay men:

> Historical changes in the gay community as a consequence of the AIDS epidemic have contributed to a "generation gap" between older and younger gay men. Every generation feels the need to assert its independence from previous generations, yet the highly threatening nature of AIDS may

> have intensified the younger generation's motivation to separate themselves from their gay elders (Paul et al., 1995: pp. 347-396).

As the younger generation's new cultural venues became institutionalized, there were signs that the previous gay generation was entering a period of sexual revival. Men who had stayed away from commercial sex establishments for years found themselves revisiting old haunts. Some men began participating in parties, dance clubs and other venues dominated by the younger generation of gay men. By 1995, *New York* magazine could report on the revived sex culture of Manhattan:

> The change in attitude is clearly visible around the city. The return of vintage seventies promiscuity has sparked a small boom in theatres, dance clubs, bars, and a variety of other venues that have back rooms and private cubicles for sex... A Chelsea club called Zone DK has been checked more than nineteen times over the past year and a half and during virtually every visit, inspectors saw customers having unprotected oral sex....At a joint called Jay's Hangout in the West Village, inspectors reported both oral and anal sex (Horowitz, 1995).

Social discourse about sexual issues, which had seemed frozen in a state of moral conservatism in the mid-1980s, began to thaw. Studies of gay men's sexual activity began to show a steady upswing at the close of the 1980s; more men had started to have more sex with more partners compared to the deadliest days of the HIV epidemic. At the same time, these surveys revealed that more men appeared to be engaging in what had become known as "high-risk" activity (Ekstrand and Coates, 1990).

Older gay men who never enjoyed anal sex and those who have been fully able to alter their sexual activities to ensure safety are often among those dumbstruck when they hear about the surge in new infections (Stall, Barrett, Bye et al., 1992; Hays, Keegles, and Coates, 1990; and Kelly, St. Lawrence, Brasfield, Stevenson, Diaz and Hauth, 1990). If

one's sexual behaviour has changed to deal with the new realities of sexual risk, it may be natural to expect others to change their behaviour as well. Gay men who cannot grasp the complex factors which motivate men to have unprotected sex can be firm and furious in their indictments. According to this young gay man, times have changed and there are new realities:

> I would not argue with the fact that gay men during the 1980s and 1990s had to endure very difficult years of death and suffering. However, I think it is not unreasonable to imagine that the epidemic has changed. More gay men are living longer, healthier lives. As a result, I believe that those who work on behalf of gay men as they deal with these new realities should be more tolerant. Berating and insulting a new generation of gay men because they do not necessarily uphold the safer sex philosophy of the 1980s is not helpful either in the short term or long term (gay male, 31 years old, Interview 2004

The level of outrage and self-righteousness may suggest an intense identification with the men they judge. It is also quite ironic that this moral rigidity is similar in many respects to that of the 1980s from the larger community, which was so categorically criticized by gay activists and community leaders during the early days of the HIV epidemic.

Different Times, Different Choices

Is it possible for men to make anything resembling an authentic choice to be anally penetrated without a condom in the middle of this epidemic? For those who value life above all else, it may be impossible to resist pathologizing men who maintain different priorities in the middle of an epidemic: a value system which privileges pleasure

or unfettered abandon. Hence many make sense of the newly infected by insisting they are driven by low self-esteem, a death wish, or some kind of addiction (e.g. alcohol, drugs, or sex). However, many young gay interviewees in this study disagreed with the idea that to engage in unprotected anal sex is necessarily related to a pathology of some kind. This quote illustrates the views of young gay men in this study:

> I am tired of hearing that if we don't wear a condom we must have some psychological problem, we must drink too much, take party drugs… I have made some mistakes, didn't use a condom. I discussed it with the person I had sex with and felt confident that it was ok. I know that it is not a smart thing to do, but I made a rational decision, not based on being drunk or being high. I understand that it is a risk, but I am not crazy. I don't want to get HIV, but sometimes I slip up (gay male, 27 years old, Interview 2003).

This interviewee also expresses the view that not all unsafe sex is necessarily pathological in nature:

> I cannot believe some of the comments I hear from some of my gay friends. During the AIDS epidemic, death was a near certainty for most gay men who had unprotected sex. However, times have changed. I don't think it is reasonable to expect us to go one living in the same era of twenty years ago. I know that there is still no cure for AIDS. Most of my friends are well aware of that. Sometimes I think that safer sex messages don't actually reflect the new realities. I plan on never getting infected, but, despite my best efforts, I know that it could happen. Except for monogamy, no sexual practice with other guys is completely safe. Condoms can break too (gay male 23 years old, Interview 2004).

Another informant explains how situations shape behaviour:

> I really don't know why I had sex with him without a condom. He didn't want to wear a condom, said he didn't like the feeling of it. Wanted a more natural feeling. I know people who are HIV, know about safer sex practices. I never thought I would not use a condom. My own father is

> HIV and still it did not stop me from doing it [not using a condom]. I liked this guy; he was very cute, nice body. I don't use alcohol or drugs and did not want to become HIV, but somehow the situation happened. I really don't know why, but it happened nonetheless (gay man, 21 years, Interview 2003).

Fundamental distinctions in the ways gay men, young or old, conceptualize life in the epidemic are rarely acknowledged or discussed, yet may be an important source of the varied responses to risk and safety. Even though there is little doubt that the overall gay community is not homogenous in nature, most prevention strategies seem to assume there is only one effective strategy to prevent HIV infection. Most strategies do not necessarily presume that younger or older gay men or those who are HIV- or HIV+ think differently when it comes to using safer sex methods. There is increasing evidence that sexual risk behaviour occurs in HIV+ men. Studies among patients attending venereal disease clinics in France (Meyer et al., 1994) and in England (Catchpole et al., 1996) have reached concurring conclusions. These studies showed that among these patients there was a proportion, particularly high among gay and bisexual men, who knew that they were seropositive, yet had recently contracted an acute sexually transmissible disease. Moreover, two-thirds of those in Paris and one half of those in England were aware that they were infected.

There are a number of factors which are specific to people who know they are HIV-positive. These factors are related to the specific situation of HIV-positive people. According to Schiltz and Sandfort (2000):

> their psychological functioning will be affected by their positive serostatus, subsequently affecting their sexual expression. Another issue that is specific to HIV-positive people is whether or not they disclose their serostatus to a potential partner. Finally, there are motives for practicing

> safe sex, which are specific to HIV-positive persons (p.1579).

It seems quite clear that, among gay men who distinguish themselves by their health status, an all-inclusive strategy by those who promote safer sex practices is no longer effective. From the early days of the epidemic, any form of unprotected sex was carried a serious risk for developing HIV and eventually AIDS (King, 1994). However, it is clear that not all forms of unprotected sex carry risk for HIV infection. This is most apparent for those men are in monogamous relationships and who are aware of their own and their partner's HIV negative antibody status. In the absence of other infections or ill health, there is no reason why gay men should not engage in unsafe sex.

Gay men of all age groups make decisions that are affected by their HIV status, which subsequently affects their sexual expression. The reality is that many HIV+ men make decisions about their sexual practices with a new set of priorities. HIV+ men in particular are no longer necessarily condemned by their status to a shortened life. In the last decade medical science has put into the hands of many HIV+ gay men new alternatives and strategies.

Protease Inhibitors: Are They Changing The Safer Sex Debate?

These new realities are particularly important for a younger cohort of gay men. The safer sex strategies developed in the late 1980s are being redefined. One crucial factor in that redefinition is the effectiveness of protease inhibitors. Among my informants, both older and younger gay men were in agreement as to the effectiveness of these drugs and what it could mean for shifting sexual risk strategies. Among several

younger male participants in this study, the relevance of these new medications cannot be underestimated. As this young gay man put:

> I am well aware that the new drug therapies on the market are giving so many people a second chance. I realize they are not a cure and that there can be many nasty side effects. But if I were to become infected with HIV, I know that my life would not necessarily end in six months. I usually wear a condom when I am having sex with another guy. It is at least good to know that if I were to take a chance [not using a condom] with someone it would not necessarily mean that my life is over. I am not looking to get infected, but at least there is hope now that was not there twenty years ago (gay male, 27 years old, Interview 2003).

Another participant expressed it in this way:

> I believe that the development of HIV meds has had an important impact on whether or not I decide to have protected sex with men. I usually discuss wearing a condom or not with the person I am planning to have sex with, and sometimes I am convinced that it is not always a risk. However, sometimes I am embarrassed to suggest wearing condoms because it is like suggesting that they might have HIV or a STD. I really am not part of a group of men looking to get infected. However, I do accept the risk that not all times that I have sex is going to be completely safe. I know that is certainly not a realistic way of having sexual relations. I do understand that at least if I do get infected, my life is not necessarily terminated in 3 months. So in that way, I guess, knowing meds are available makes me less careful at times (gay male, 24 years old, Interview 2003).

One interviewee suggested that this optimism about medications should be tempered by another reality that is often less discussed: the long term effects of medications.

> I have a few friends who tell me that they take risks in their sexual encounters. I think that they often forget that although medications are definitely helping those that are sick to remain healthy, they often do not understand the full consequences of these drugs. For a long time so many ads

> for new drugs would show these buffed men, attractive and healthy. However, the bottom line is that we will not always look like that after many years on these drugs. I believe that the drug companies were giving us a false image of what it meant to be on drugs. I know that these drugs are almost miraculous for some, but let's remember that many sick men cannot even use these drugs and others that do have so many terrible side effects. I good friend of mine even stopped taking his drugs because of what they were doing to him. There is no doubt that these drugs are life sustaining, but I think a lot of young guys don't understand the full picture (gay male, 36 years old, Interview 2003).

Despite the drawbacks of the new medications, most literature on risk factors identifies the powerful influence that they have on gay men in decisions as to sexual risk taking. The images of death that surrounded HIV/AIDS for so many years have been replaced by another set of images: that of happy and healthy men pursuing their sexual and social lives in the most optimal conditions. Whether or not that is the actual reality of many gay men on medications is of course debatable. However, there is no doubt that science has had a powerful effect in the lives of so many gay men.

Interestingly, in the early years of the AIDS epidemic, many ACOS and gay activists pushed governments and pharmaceuticals to fast track new drugs for gay men dying by the thousands. According to D'Emilio (2002):

> AIDS unleashed vitally new constructive energy. Within a few years, gays and lesbians had built a nationwide infrastructure of organizations that provided health care and social services, assisted in scientific research, spearheaded prevention campaigns and engaged in spirited public advocacy to combat the epidemic and the discrimination entwined with it (p.86).

The irony is that this success has contributed in its own way to a redefinition of safer sex strategies for gay men living through the third decade of this deadly epidemic. At the

same time that these new medical and political developments are greeted with joy and relief by many who are infected and affected by HIV, it is exactly these new drugs which are pushing gay men to revisit how they have sex.

The Role of Community

Many young gay men in this study have stated quite clearly that they no longer see themselves attached to a single homogenous gay male community. The political, social and cultural changes within the gay community have definitely put many gay men in a position where they feel less attached to one specific standard of same–sex behaviour. In other words, other choices are being made by gay men that do not always reflect a consensus that was developed at the beginning of the epidemic. It is quite clear that these changes have had an important impact on the choices younger gay men make in their sexual practices.

Gay men today are coming out of the closet with greater ease than any gay man in his 40s or 50s. Attachment to gay community organizations, bars and saunas or to a particular geographical area is not as strong or as necessary to the formation of a gay identity as it was for an earlier cohort of gay men. According to Hooker 1967 [1961], the "gay bar" was central among the public institutions of homosexual social life:

> Because most homosexuals make every effort to conceal their homosexuality at work, and from heterosexuals, the community activities are largely leisure time or recreational activities. The most important of these community gathering places is the "gay bar"... but there are also steam baths catering almost exclusively to homosexuals, "gay" streets, parks, public toilets, beaches, gyms, coffee houses and restaurants. Newsstands, bookstores, record shops, clothing stores, barber shops, grocery stores, and launderettes may become preferred establishments for

> service or for a rendezvous, but they are secondary in importance (p.173).

An essay by Nancy Achilles (1967) explores the institutional centrality of the gay bars of the early 1960s in greater depth. The most important service of gay bars, she comments, consisted of:

> The provision of a setting in which social interaction may occur; without such a place to congregate, the group would cease to be a group... Articulating with various commercial and political institutions of the larger society, the bar may obtain legitimate and illegitimate goods and services for its clientele. As each bar develops a "personality" of its own and becomes an institution in its own right, it fulfills more specialized and nonsocial functions. A particular bar, for example, may serve as a loan office, restaurant, message reception centre, telephone exchange, and so forth... The bar is the homosexual equivalent of the USO or the youth club (pp. 230-31).

Achilles (1967) and Hooker (1967 [1961]) make it clear how important specific institutions were for gay men in the 1960s. They underscore the important social interactions that took take place in the early days of community building. These places were safe harbors from homophobic institutions like family and workplaces. They were also the places where gay men began to build a set of institutions which would contribute to the construction of an identity which would liberate them from the oppressiveness of a heterosexually-dominated society.

Despite the ongoing importance of a specific urban gay culture to gay men of all ages (Green 2002), younger gay men's social identities are no longer defined by their participation in or with a specific community of gay men. Political changes such as the inclusion of sexual orientation as a protected right under the Charter, pension and health

benefits and the recent adoption of same-sex marriage have placed gay men within the same protection as all other Canadians. Gay men, whether single or coupled, are increasingly part of the political, cultural and social mainstream of Canadian life. Their social identities will no longer be exclusively formed within a territorially or socially constructed space; they will be developed within all the formal institutions that have excluded them in the past, such as family, church and government. Although gay space will continue to be important to the development of a gay sexual identity, it will increasingly be only one of many places where their personal, social and sexual development will unfold.

I would hypothesize that gay men from the 1960s, 1970s and 1980s viewed their relationships within gay communities as a defining characteristic of their identities. It is not that these men did not view themselves as having identities or social roles outside their community relationships. However, it was within these geographical communities that being gay was intricately associated with the social and sexual dimension of one's identity (Altman, 1976; D'Emilio, 1983; and 1992). Bars and bathhouses were the place where gay men could congregate to feel safe, secure and liberated. The relationships formed within these institutions would eventually constitute the foundations of gay communities. It was in these establishments that families of origin were being replaced by families of sexual identity. The emotional and psychological bonds formed in these early days of gay communities would eventually have a decisive role in the political, cultural, social and sexual definitions of what it meant to be gay (Green 2002). As the following participant noted, being gay in the 1970s meant:

> that there was little or no understanding of the complexities of our lives. Most people viewed us as sexual deviants,

> fixated on sex with no discussion other than who we slept with. Society could not imagine us in long term committed relationships, having children, being responsible citizens. When the AIDS epidemic hit the only people who actually cared about our suffering or dying was our own community. As a result, our relationship with our own often became the most salient relationship that we had. They became our friends, helpers, and mourners. They were the only people, with some important exceptions, that thought we were worth fighting for. Today's younger gay generation are certainly viewed with greater acceptance by mainstream society. They see us as more than people defined by our sexual relations (gay male, 51 years old, Interview 2003).

The following participant concurs with this view on the early days of gay community formation. For this participant, these places were crucial to his survival.

> Unless you were young gay men in the early 1970s, you would have no idea how important these bars and gay friendly restaurants were to us. Many of us, including many of my friends, were generally stigmatized from the greater human community. Everyone thought we were weird, strange, predators, homos, fags and lots of other crude names. Very few people cared whether we lost our jobs, our apartments or got beaten up for being different. So when many of my friends and partners began dying of what many called a gay cancer, there was really no one to help us. There were a few courageous people who cared if we lived or died. However, when people imagine us as nothing less than a half human, we had to turn to our own people to save our lives. Personally, I don't think I would have survived if I had not been involved with the men in these AIDS communities. Everything, even today, for me, is shaped by these early communities. I know that many gay men in 2003 cannot understand the importance of those days. But believe me when I tell you that I am not sure if I would still be around without them (gay male, 54 years old, Interview 2003).

These interviews suggest that one cannot overestimate the influential role of these community organizations for a marginalized population. Gay men's socialization was taking place in a heterosexually-dominated set of institutions: families, governments

and churches. These institutions did not recognize the validity of gay men's feelings, behaviours and sexuality. With the appearance of local gay bars, clubs, and bathhouses within urban metropolises, another set of identity-forming institutions were giving gay men a new and positive way to explain and define themselves (Bailey 1999). It was the first time that they came to a more complete understanding of who they were as gay men. Much of their identity construction was formulated during this time and in these institutions. A group of marginalized men was finding a new place and a new reality.

During these early days, however, gay male communities and organizations did not have to deal with the growing complexities of gay men's lives that are present today as a result of a whole new set of political, sexual and social freedoms. Moreover, nothing added to the complexities of gay men lives more than AIDS. All these changes had an important effect on shifting strategies of sexual risk between an older and a younger cohort of gay men. This is how one young gay man put it:

> There is no doubt that the struggles of older gay men have made my life easier. Their fight against AIDS and discrimination against gays in general has made my life a lot less difficult. I appreciate what they have done. But, I am more than a person who has sex with other men. I play sports, go to university, volunteer in several organizations. I don't feel it is necessary for me to listen to AIDS groups or gay community organizations in order to determine how to life my life or have sex. As I have said, I do appreciate their efforts on my behalf, but I can make my own choices, whether about sex or other things (gay man, 26 years old, Interview 2003).

Another informant agrees with the former interviewee regarding the past efforts of an older cohort of gay men, but he is tired of listening to messages about safer sex, drugs, and AIDS.

> I don't think anyone of my generation really underestimates what older gay guys did for us in terms of rights. But I am tired of being identified with AIDS. There is more to life than the gay village, rave parties and safer sex messages. There is often an assumption that all gay men are nothing but sexual objects. But my life is more than that, by a long shot. I am a proud gay man, open to my family and friends. I don't hide my orientation to anyone. I know that I am the beneficiary of other people's efforts on my behalf. However, I know that prevention strategies work, that drugs can make me more susceptible to engaging in unsafe sex practices. But I also have so many other things to focus on in my life. I think we need to focus on developing more complete life strategies that tie us to the whole human community (gay man, 27 years old, Interview 2004).

I would not argue that the new openness enjoyed by gay men means that they are less inclined to practice safer sex. However, we should remember that most, if not all, ACOs and CBOs during the early days of the epidemic focused almost exclusively on the technical aspect of sex. Very few programs addressed HIV prevention in a larger context.

One of the primary reasons for this focus on the technical aspect of sex on the part of ACOs was that "in the early to mid-1980s, generally conservative social mores, petty politics and calcified religious beliefs stifled efforts to obtain outside assistance for programs to enact behavioural change" (Turner, 1997: 5). As a result, most gay men, with the help of some adventurous and progressive community organizations, were left to cope on their own. For some, this meant seeking refuge in a monogamous relationship. For others, it meant reducing their number of sexual partners. For a small group, it meant abstinence, at least temporarily, while other gay men began to use condoms for the first time (Martin, 1986). Once HIV prevention campaigns did kick off in the mid to late-1980s, they were primarily based on social marketing theory and upon traditional public health models such as the Health Belief Model, and other similar knowledge-based

approaches (Levinton, 1989; Valdiserri et al. 1989 and Williams, 1986). It does not necessarily mean that these early efforts at HIV prevention did not see gay men beyond the sexual act, but the need to save lives was urgent. As the comments of some of the younger participants in this study demonstrate, however, we can no longer afford to avoid discussing the multiple complexities surrounding the choices that gay men are making in this new era of AIDS. According to Alan Sinfield:

> Gay men should look with more subtlety at safer-sex messages and at the psychology of the condom. But, in the final analysis, if an informed person chooses to put him--or herself at risk--as with substance abuse, from saturated fats through alcohol and tobacco to heroin-we have to allow that he or she may have some serious reasons (1998: 94).

Recent research with British teenagers has shown a decreasing awareness of HIV and AIDS (Forrest and Kanabus, 2004). There is also evidence that even where they [young gay men] are otherwise well-informed about HIV and STDs, young people do not believe that they are vulnerable to contracting them (World Health Organization, 2003). According to the following participant:

> Prevention programs must include the new realities of HIV+ men having unprotected sex with other HIV+ men and HIV- having unprotected sex with HIV+ men They are exempting very important information from the lives a new generation of gay men. Although many within leadership positions of gay male AIDS organizations object strenuously to these choices, they [unsafe sexual practices] are becoming a significant part of how men are having sex and cannot be avoided. Even if I do not personally understand why some of the gay men I know are making these choices, we have to become more welcoming to those who many feel are putting gay men's lives at risk. We should provide the information and not judge (gay male, 24 years old, Interview 2003).

The redefinition of community and safer sex among a younger generation of gay men is definitely having an impact on the choices that gay men are making today. A specific community identity which shaped the sexual, cultural and political choices for a generation of gay men is no longer as evident or necessary. Gay men's social and sexual socialization takes place within a larger, global community. Gay bars and bathhouses are still important venues for socializing with other gay men, but not necessarily important in shaping their identity as a gay man. With the advent of HIV in the early 1980s, gay men learned how to protect themselves. However, new medical realities, such as anti-retroviral drugs, are instigating new approaches to safer sex education. For most gay men, the safer sex mantra still remains vital to the survival of gay male communities. However, new realities are shifting our approaches to this epidemic. Some gay men now define themselves as HIV+, HIV-, or barebackers, to state just a few. One HIV+ participant put it this way:

> As a middle aged gay man who has been HIV+ for 5 years, I have made some important changes in how I approach my sexual activities with other gay men. I am not in a relationship, I am healthy, at least my doctor tells me I should live for a long time. There is no doubt that meds have changed the quality of my life. As a result, I love to have sex as long as I can. I hate using condoms and as a result I try and have sex with other positive guys who don't like to wear condoms. I will use condoms if guys won't have sex without them. However, I prefer to have sex with men who are also positive. I know that if a lot of my friends knew this [not wearing condoms] they would be disappointed with me. However, it is my life and I am going to live it the way I want to. I never lie about my status if I am asked (gay male, 48 years old, Interview 2004).

Another participant takes a more critical approach to those who condemn gay men for not following the 'always condoms' approach:

> I find it hard to believe that some of the same people who tell all gay men to use a condom all the time have always worn a condom. I am HIV+ and single. I certainly do not wear condoms all the time. I find that wearing condoms all the time is a pain. It takes away from that natural feeling from skin to skin. I want to share everything with the man I am with. I don't make a big deal about it if they want to wear a condom. I always tell my potential sex partner my status, which is certainly something that not all gay men do. I would prefer not to wear one but I prefer to have sex than not to have it. If I am having sex with another positive man and they also don't want to wear a condom, I do not see who it is hurting. I have been told by a few guys that I am putting the whole gay community at risk. As far as I am concerned, that is a lot of bullshit. Who are they to tell me how to live my life? My life is already shortened by HIV. I am not going to live until 80 unless there is a cure. So why shouldn't I do what I want. Anyways, I know that are many risks by not wearing condoms. However, I am willing to live with them and if other guys who have sex with me are also willing to do live with the same risks, then who are we hurting? I am going to continue to have sex the way I want. Things have changed for gay men and I don't believe that I have to sex the way everyone does (gay male, 29 years old, Interview 2003).

It seems quite clear that the strategies implemented in the early days of the epidemic are not as easy to apply to a generation of gay men who actually define themselves not only by their sexuality but by their illness. In the early days of the HIV epidemic there was really only one safer sex strategy: one should use condoms at all times. There really were no other solutions. Men who developed full-blown AIDS died within weeks and months. There was no time to imagine how a group of HIV survivors might eventually redefine their sexual practices. But with the introduction of protease inhibitors in the mid -1990s, this is exactly what began to happen. For the first time in ten years men could imagine living longer lives, returning to work and maybe even having sex again. This is exactly what has happened. As a number participants in this study have

acknowledged, one's HIV status is equally important in determining whether or not or how to have sex with other men. The section will examine some of these important issues.

Young Gay Men: Other Explanations of Risk

Prevention strategies have, almost exclusively, emerged from public health behaviourist approaches to education. The current attempts to explain unprotected sex often occur within limited frameworks for understanding the ways desires are constituted. Some look for environmental factors that cause a man to take risks and blame bathhouses, sex clubs, drug and alcohol use, prostitution and the gay ghetto. Sometimes, as the following informant explains, there is no explicit reason for not practicing safer sex methods. Moreover, he reflects the on the context in which this powerful sexual drive exists.

> Sometimes I just try and forget that I have to use condoms. I find myself in situations, in particular in saunas, where I just let myself go. In the back of my mind I am aware that wearing condoms will prevent AIDS and other nasty diseases. Boy, it is difficult sometimes. My friends tell me sometimes of their experiences in saunas, where they just take a chance, and trust the person they are with. I often cannot understand why they do these things, but then I find myself equally tempted as well. There seems something more natural without condoms. I know that sounds crazy, but that is how I feel sometimes (gay male, 30 years old, Interview 2003).

Many AIDS educators insist that if individuals are reasonably intelligent, informed about safer sex, and provided with condoms, they will use them 100 percent of the time; when men violate these expectations, they insist they "haven't got the message," or "lack common sense" (Rofes, 1996). This interviewee disagrees:

> Why do a certain number of AIDS professionals believe that we cannot make rational judgments about sex? I know the possible consequences of condomless sex, but we are not children. Times have changed. Why can't they see they there are other choices to make. I am in an open relationship with my boyfriend. When we decided to have sex for the first time, we wore condoms. When the relationship progressed, we both got tested. We were both negative. As a result, we have decided to not use condoms anymore. I know that when we have sex outside our relationship there is always the possibility that a mistake can be made. However, in the heterosexual community many men and women who are supposed to be in monogamous relationships have extramarital relationships. Are these so-called 'closed' relationships any safer than ours? At least in our relationship we don't deny that we have sex with other men. Do AIDS educators think that our relationship is somehow any more dangerous? I know they are trying to prevent more AIDS in the community, but there are other choices than condoms all the time (gay male, 32 years old, Interview 2004).

Richard Rodriguez has written, "To grow up homosexual is to live with secrets and within secrets" (1992, 30). These days many young gay men may live with a very specific secret: sexual desires and activities are sources of great comfort and pleasure that may be needed now more than before the epidemic. During the worst days of the HIV epidemic any exchange of fluid during sexual intercourse was considered deadly except within a strictly monogamous relationship. However, for many HIV+ and HIV- gay men, the sharing of semen is extremely important to their relationships. It is the seminal moment of their sexual intercourse. For many, it is a return to the way many gay men had sex before the epidemic; to a time where the sharing of semen is no longer necessarily deadly. While treated as exchangeable and expendable by many prevention campaigns, specific acts in fact provide considerable meaning and value to young gay men's lives and identities. The following men relate that their intimacy is greatly enhanced by not

wearing condoms. They told me that they believe the way they have sex brings considerable meaning to their lives. This participant put it in these words:

> I just can't imagine not sharing everything with the person I have sex with. For so long, semen as being seen as deadly, and of course it was. We have been told that the sharing of fluids is really not necessary; that it is something we will have to forget about. I just can't buy that. Nothing brings me closer together with the man I am with than the mutual sharing of our fluids. We have been told how unnatural and deadly it is for so long. As a HIV+ man who only has sex with other positive men, this sharing is the most important thing in my sexual act. I know how that may sound to you and to others, that we are hurting the man we are with or the whole community. I just think that is a whole lot of nonsense. They [HIV educators] have made the sharing of fluids so taboo, but it to me it has a lot of meaning. It is a natural part of sex that has been denied to us for so long (gay male, 35 years old, Interview 2004).

For the following participant, we have taken something so natural and loving and made any discussion of it a betrayal of the gay community.

> I know that what I am about to say is certainly a minority view in the gay community. However, I think it is hypocritical in the extreme to pretend that something so natural and beautiful cannot be spoken of unless it is in coded language. As a young man who is growing up in the days of new treatments and discussions about AIDS, I just don't believe that things have to remain the same as they were in the bad days of certain death by HIV. Do we really believe by keeping this discussion on barebacking or the sharing of fluids behind closed doors is somehow going to make it go away? By pushing this discussion underground we are almost assuring that it will continue and that many will not understand the consequences. When I have sex with other men I tell them my status, which is positive, and if another positive guy wants to mutually share fluid, then it makes me very happy. I don't share fluids with men who don't want to. However, I think so much of this discussion has marginalized men who do like to share fluids that we have only made the problem worse. As a young man, I believe that we can have a reasonable discussion about this

> issue that it does not have to remain a secret anymore (gay man, 28 years old, Interview 2004).

For some young gay men not using condoms is bound up with trust or love. Research has also shown that young people, including young gay men, can see taking risks as valuable. For some it feels like an important part of learning to make decisions for themselves (Wight et al., 1998). It is also the case that being too worried about risks associated with sex can also make them feel fatalistic about the outcomes of their behaviour (van der Velde and van der Pilgt, 1991).

Social Nature of Sex

It would be difficult to say with absolute certainty what processes, whether social, political, sexual or psychological determine young gay men's decisions to engage in high-risk sexual intercourse. However, as the last set of interviewees suggest, one important component seems to be the reestablishment of sex in the lives of gay men. During the deadly days of HIV/AIDS the high value placed on sexual expression diminished with each death. Prior to the epidemic, sexual expression for gay men was becoming a predominant and open part of gay men's lives (Altman, 1982; Bronski, 1998; Duberman, 1999; Rimmerman, 2002). After AIDS, for close to a decade, sex, even within gay communities, had lost much of its excitement and wonder. It was pushed backed into the closet as HIV robbed thousands of men of their lives.

The interviews of younger gay men in this study underscore one important element of all gay men's sexual practices; that is, despite what many health education strategies seem to suggest, these practices are social in nature. It is not simply a set of individual choices. Too many other variables determine the choice of having sexual

relations. Most prevention programs have been based on the traditional health belief model that was discussed earlier in this study. In other words, if we have the information about risk and access to an alternative, reasonable people will choose the less risky alternative. However, prevention of HIV is not just an individual decision. Any sex involving risk happens with someone else—whether that relationship lasts ten minutes, two years or a lifetime. While most of us may identify with a particular sex practice, the reality is that sex is relational, and most of us change what we do depending on whom we are with. Admitting that sex is relational means admitting that one does not have full power over this decision.

Most explanations of unprotected sexual intercourse are often complex- a rich web of social and cultural relations that constitute human activity. This complexity is underscored by R.W. Connell and colleagues in a series of articles linking postmodern theory about sex and desire with HIV prevention for gay men. They offer innovative and pragmatic approaches to understanding sexual behaviour. Decrying medical and public health's stranglehold on HIV education, they write:

> Sexuality must be understood as inherently social, not merely as a biological-phenomenon-with-a-social-context. Many social relationships are in considerable part constituted by sexuality, forming networks and institutions that, like all other forms of social structuring, are dynamic in historical time. Such evolving patterns of social relationships form the crucially important contexts of particular sexual practices (Connell et al., 1990, p. 129).

The sexual practices of young gay men in this study give us a clear indication that their decisions to have unprotected sex are not just a biological act. In some cases, they discuss how they are going to proceed, other times it is a spur of the moment decision. Many participants interviewed for this study acknowledged their health status before they

engaged in sexual relations, but this was not always the case. They also believed that the safer sex methods of an earlier time are still relevant, but should be modified.
Many young men suggested that it is simply not enough to suggest that if they do not have protected sexual intercourse that somehow they have slipped or relapsed. In other words, if they disregard it on occasion they must be drug-impaired or self-destructive. For many of these of participants this discussion of relapse ignores the fact that sex is about desire, relationships and our sense of self. If a man wants to have sex without a barrier to be more intimate with his partner, this cannot be dismissed as irrational. Confronted with such dismissals, many gay men are turned off to prevention strategies.

My interviewees also suggested that equating death with unsafe sex is not realistic. Many young gay men in this study believe that there are alternatives. They believe that if one has a committed relationship, and has HIV testing done, then there is no reason why condoms cannot be abandoned. They understand that HIV/AIDS is incurable, even though drug cocktails do prolong, and add quality, to an infected person's life. This young participant puts it this way:

> Is the only alternative to wear condoms all the time? Does that mean my lover and I have to always have protected sex? Is there no other way? We decided that we would be in a committed relationship and that we would not wear condoms. I know that there is a risk but we think it is a rational decision. Do they ever ask straight couples if they wear condoms when they live together? Why is it unreasonable that gay men should not be doing the same? There was a time when it was definitely unsafe not to wear condoms all the time. But times have changed. We [my partner and I] do not enjoy the feel of condoms and since we are together in a relationship, see no need to use them. I think those who work in AIDS organizations should realize that we are not all the same. We have different needs and we are in different times (gay male, 33 years old, Interview 2003).

The following quote reflects the same idea, in a more direct way:

> Sometimes I would like to tell those people who put together messages for gay men to fuck off. Who are they to tell me how to have sex? The guys I have sex with, I tell them my status, which is HIV+. After that it is up to them to decide if they want to have sex with me or not [with or without a condom]. I am not there to make decisions for them. Most men will not even tell you their status, and a lot of them don't get tested regularly, and often are not 100% sure. I can bet that the overwhelming number of men who attend saunas or sex parties never discuss their status. The last thing I need in my life is a bunch of sex police to tell me how to have sex with another guy. It just gets me so fucking mad sometimes when I hear people talk about the fact that gay men are irresponsible when it comes to having sex. Am I to assume that there are no STDs and AIDS cases among other segments of the population? We make mistakes sometimes, but I cannot believe this only applies to gay men (gay male, 28 years old, Interview 2004).

There is definitely an important shift underway for younger gay men. Their realities cannot be separated from the important social, political and medical changes in which they find themselves. On the medical front, those with HIV are living longer, more productive lives. Furthermore, political changes are helping to remove the stigma of being a gay Canadian. Gay men and women are increasingly part of the larger Canadian family. These changes are relatively new, but they will definitely shape how gay people live their lives. The next section will examine some of these important changes.

From a Gay Community to a Global Community: Important Political and Social Changes

These interviews of men under forty suggest that there are factors which may determine their approach to safer sex approaches. One important factor is that many young gay men in this study do not identify with a homogenous gay identity as defined

by community organizations and leaders and regarding safer sex messages or other related issues.

> I do not think all the community leaders understand that things have fundamentally changed for a post-epidemic generation. I identify myself not only as gay, but also as a son, partner and student. My focus is no longer, at least not exclusively anyways, on the sexual part of my identity. I know that I can say that because of the fundamental changes that have occurred within the gay community. So, I generally accept the idea that some of my social status is defined by the gay community, but certainly not all of it (gay male, 33 years old, Interview 2003).

Among today's gay youth, attachments to core gay organizations or communities are not so essential. For an older cohort of gay men, these organizations and communities were often the only places they could seek help, support, and care. They gave gay men the only "family" that some of them ever had. They relied heavily on the services provided by these organizations. Many gay men still live in more predominantly gay geographical urban areas. However, these areas are becoming more difficult to define. Many gay men also find themselves outside these "ghettos". They believe that these areas are important, but not necessarily essential for living an openly gay life in a large urban centre.

Today's generation, although not completely unattached from these organizations and geographical spaces, can find help in many government organizations, in the health care system, and even among their own families. In Canada, significant progress has been made in achieving legal equality and social acceptance. This is most immediately evidenced by the extension by the state of legislated human rights protections in response to dogged activism by lesbians, gays and bisexuals and by the legal recognition of same-sex relationships and marriage (Warner, 2002). According to a May 2001 Environics Research Group Survey (www. religioustolerance.org/hom_poll4.htm), it would appear

that the percentage of Canadians who approve of human rights protections for gays and lesbians has more than doubled in only five years (see Table 1). Much of the change seems to be due to persons who had no opinion in 1996 having made up their mind in favour of gays and lesbians.

Table 1. Poll Results of May 2001 Environics Research Group Survey[4]:

Year	Approve	Disapprove	No Opinion/Response
1996	22%	48%	27%
1999	34%	34%	29%
2001	44%	37%	16%

This growing level of social acceptance for the legal, political and social rights of gays and lesbians has made it easier for a larger number of young gay men to live with their families, unconnected to a gay world except when they are having sex. Many others, though they live on their own, are more attached to a loose network of friends or bar buddies than to a structured gay community. Some gay men I spoke with did not want to be associated with a gay ghetto or AIDS organizations. They felt that these places were necessary for an older generation to develop their gay identity, but that they have other choices today. According to one interviewee:

> I like going to the gay village. It is a lot of fun. There are a lot of bars and restaurants that really make you feel comfortable. However, I really don't want to live my life around the corner from a gay bar or sauna. I just want to live in other areas of the city where I can meet not only gay men. It is nice every now and then to go out, but my life does not centre around gay men all the time. I feel very comfortable in all areas of this city [Montreal]. I don't feel

[4] This poll was carried out between April 5-April 24 2001. 2,035 Adult Canadians were interviewed.

> I have to restrict my gay identity to one part of town. Younger gay men like me have other choices. I just don't feel any particular attachment to the older generation of gay men. Their issues were so different from mine. I don't want my existence to only be associated with bars, saunas, sex parties and AIDS (gay male, 31 years old, Interview 2003).

The openness of many young gay men's lives today allows them to make choices that are beyond the gay community. Their identity is not only sexual; it is social, political and cultural. Many do not want to be judged by one set of community standards as it pertains to their gay identity or sexual practices. One of my interviewees explained that, while he certainly believes that early ASOs and CBOs played an integral role in saving our lives and making us proud to be gay men, things have changed and it is time that it was reflected in these organizations:

> It made a lot of sense that during the worst days of the epidemic, that we did have important institutions working for us. Most other agencies and governments did not seem to care if we died or not. If it was not for their love and support, we would not have achieved the level of success we have currently have in the larger society. I would never want to say that AIDS organizations are completely irrelevant, or that community workers did not do a lot for us. However, it is time to see that things have changed a lot for gay men and that they should change along with it. It is mostly true that unprotected anal intercourse did lead almost certainly to death a decade or more ago. But this is just not the case anymore. Not all unprotected sex necessarily leads to HIV. More gay men than ever live in committed relationships. Their sexual acts or no more or no less safe than other couples, whether they are straight or gay (gay male, 35 years old, Interview 2003).

The interviews conducted with younger gay men highlight some important differences between an older and younger generation of gay men. It seems that younger gay men's perceptions of the safer sex practices of the late 1980's have definitely shifted in importance. There seemed to be no lack of understanding about how one becomes HIV

infected. Furthermore, all interviewees were quite clear that although HIV is now a chronic disease, there is still no cure.

Gay men coming into early adulthood and engaging in sexual practices by the mid-1990s faced new challenges and opportunities. A significant number of gay men growing up then and now can do so with a relative ease not experienced by an earlier generation. This ability to have pride in one's self produced a generation of men who were not afraid to pronounce their sexuality to the world, and more importantly, to discuss openly issues of sex in positive ways. This does not mean that some gay men are not still facing difficult times in being open with their sexuality. However, most images of gay men on TV, in magazines, and movies are beginning to be much more positive than they once were. They show gay men in healthy, stable lives and relationships. There seems little doubt that these positive advances are beneficial to the psychological, emotional and social well being of gay males in general. One young gay man put it this way:

> I feel so much luckier than some of the gay men that preceded me. They did not have the same rights that I have now. I am open to my family, and can pretty much discuss with them what I want. It is still not easy being gay, but I certainly feel that I am protected a lot more. For example, I think it would be very hard for my company to fire me just because I'm gay or had AIDS. That is very different than a few decades ago. I really don't know anybody with AIDS, at least nobody who has told me. I am aware of the safer sex issues. If I did become infected, I think my life would be somewhat easier. At least I would have a chance, which is what an older generation of gay men did not have. But I do believe this healthier discussion of gay men lives, not just as sexual beings, is going to be very helpful to me to avoid some of the mistakes that were made in the past by others. At least, I hope so. But nothing is 100% sure in life, is it? (gay male, 21 years old, Interview 2004)

As this interviewee has suggested, there is a more open discussion about sexuality in general, within families and in society as a whole. This openness, I would suggest, does not necessarily lead to more risk-taking in one's sexual behaviour. One could argue that, in many ways, the establishment of full political and social rights acts as a positive reinforcement in the choices men make about the use of safer sex strategies. It also provides them with more opportunities to have long-term relationships rather than just casual sex. Moreover, it focuses on the full human development of gay men, not just one based on who they have sex with. These developments have led to a significant movement in the establishment of full political and parental rights for a growing number of gays and lesbians and their families. One interviewee put it this way:

> I guess I may be one of the lucky ones because I can discuss anything about my sexuality with friends and family. AIDS and HIV are still important issues for gay men. However, the discrimination faced by an earlier generation of gay me is not something that I can relate to (gay male, 23 years old, Interview 2004).

Moreover, one could hypothesize that a fuller and more honest discussion of issues pertaining to sex among gay men can only lead to more positive changes in gay men's sexual lives. There would be less of a need to keep their sexual nature buried in backrooms and saunas. However, this era of openness has not lessened younger gay men's risk-taking behaviour. Young men who have sex with men (YMSM) are at a high risk for HIV and other sexually transmitted diseases. There is still an ongoing social stigma to a gay identity, which often leads young gay men to conceal their same-sex sexual behaviour.

Although we have seen significant changes in gay men's sexual practices, they still have a higher proportion of those who are HIV-infected than among any other social

grouping. In Canada, for example, MSM account for 70.9% of positive HIV test reports among adult males since testing began in 1985 (Health Canada, April 2003). In particular, young gay males seem to be more at risk than their older gay counterparts. This is supported by a United Kingdom study that found about 25% of all HIV diagnoses have been in young gay men under the age of 29 (HPA Communicable Disease Surveillance Centre, April, 2003). According to this interviewee:

> There is certainly more freedom for young men my age today. We have a lot of advantages. However, this does not seem to detract some of my friends around my age from taking risks that could lead to HIV. I thought that this openness would make us less susceptible to taking sexual risks. I thought we had learned from so many AIDS deaths in the last twenty years. Sex just seems to be such a complicated thing for a lot of people. I know that some of my friends who told me they had unprotected sex with strangers had often taken party drugs and alcohol. There are a lot of young gay males who attend these parties and take a lot of drugs and then go to the bathhouse and have sex. Whether the guy they are having sex with has a condom or not, is probably not their greatest concern, especially if they are stoned (gay male, 29 years old, Interview 2003).

As this young man points out, more open discussions, in public or in private settings, of gay men's lives do not always lead to healthier choices. Many young gay men have access to information that many did not have at the beginning of the epidemic. This, however, has not completely lessened the risks that some young gay men take in their sexual practices. Some younger gay men find it difficult and embarrassing to raise the issue of using condoms in some circumstances and to negotiate using them. For some gay men asking a partner to wear a condom can feel like they are suggesting that they might have HIV or another sexually transmitted disease. Men can find themselves in circumstances where they feel less cautious about protecting themselves and their

partners than they usually do. Research with gay men on their sexual experiences on holiday showed that a small number took risks they would not usually take at home because they thought that there was less risk of meeting someone with HIV. There were more opportunities to have sex with new partners, and that they felt under less pressure to have safe sex (Clift and Forrest, 1999).

Conclusion

From the interviews, it is clear that younger gay men do realize that they are living in a different time of AIDS. AIDS is still a terminal disease but many view the development of new medications as a positive development. It has made HIV/AIDS a chronic disease for most, if not all, gay men. Many younger gay men believe that if they do become infected, they will live longer, healthier lives than earlier AIDS victims.

Another important discussion among these younger gay men was the role of an established gay community for the development of a positive gay identity and how they approach their sexual practices in third decade of the HIV epidemic. A number of participants did acknowledge the role of an older cohort of gay men in the development of a positive gay identity and HIV safer sex strategies. For many gay men who came of age in the pre-AIDS era, the only safe places that could be found were in a geographically-defined urban area. It was within these urban spaces that many gay men were able to define themselves socially and sexually as gay men. They were a haven from the social, political and cultural repressiveness of mainstream society. It is also where many gay men would learn about an epidemic that would change their lives. They took it upon themselves to build a set of organizations to care for "their" families. They

developed a series of strategies that would lead to wholesale behavioural change among gay men. These AIDS organizations have shaped the safer sex debate since the early 1980s. But the success of new medications in the 1990s has definitely affected how a new generation of gay men approaches this debate.

These younger gay men are also part of a new gay awareness in society in general. Many young men do not believe that a territorially-defined gay community plays such a definitional role in their identity and sexual practices. They see themselves in a broader, global context. The entertainment complexes of gay communities are still important to them but they feel their lives are defined within larger institutional practices like family and government. In terms of sexual practices, they believe that HIV is still an important reality. However, much has changed since the deadly years of the epidemic. The one size-fits-all safe sex strategy must come to terms with the social, medical and political changes that are now underway.

However, all these newly acquired rights and statuses have allowed younger gay men to evade the reality of AIDS. Many young gay men are still engaging in unprotected intercourse. Their rationales are in some ways no different than earlier generations: loneliness, homophobia, drugs, alcohol, etc. There seems little doubt that this generation will escape the extreme ravages of the earlier epidemic. Furthermore, new advances in science are making lives for many HIV-infected men more manageable. Whether or not new attitudes toward sexual risk-taking will lead to ever-increasing numbers of younger gay men being infected is still uncertain. What does seem to be happening is that the earlier prevention messages are not always being applied. It is difficult to say how

extensive the change in behaviour is, but there are some important changes underway in how gay men practice sex.

Do these changes in sexual risk-taking only apply to a generation of gay men who never knew loss and suffering? Chapter 5 will examine this issue and its potential relationship to any significant changes in overall sexual practices within gay male communities.

Chapter 5

HIV Risk-Taking among Older Gay Men

So many of my friends are HIV+. I can't believe that so many young guys are not using condoms. All those sites dedicated to barebacking. I am really surprised after so many deaths that people want to get infected. Guys my age went through such hell. I just don't understand.

-gay male, 51 years old, *Interview* (2004)

One might find it difficult to understand why gay men over forty, survivors of the deadly epidemic, would engage in high-risk sex. These men, who lost hundreds of acquaintances and friends, were in the vanguard of early prevention efforts. Many helped to establish some of the earliest HIV support organizations. Why then, would these same men engage in unprotected anal intercourse? What rationales could explain lapses in their private safe-sex regimens?

A study published in 2003 shows that there is indeed good reason to be concerned about risky behaviour among older gay men. The study was conducted between November 1996 and February 1998 in four urban centres--San Francisco, Los Angeles, New York and Chicago. Approximately 17 percent of the respondents were 50 or older. The data suggest that the overall rate of HIV among older gay men (50 years or older) is at a very high level (13 percent). The highest prevalence rates were found among men in their 50s (19 percent) and 3 percent for men in their 60s. No men in their 70s were HIV-positive. HIV prevalence rates for older urban gay men were only slightly lower than for the overall urban gay male population and are on a par with the prevalence levels in sub-Saharan Africa (Dolcini, Catania, Stall, and Pollack, 2003).

Despite these alarming numbers, however, most of the data and the attention have been devoted to gay youth as a population particularly vulnerable to HIV transmission

(Remis, Alary, and Otis, 2000; Strathdee, Martindale, Cornelisse, et al., 2000). To date, much of the existing literature on older gay men has been of an exploratory nature (Vacha, 1985; Lee, 1989; Berger, 1996; Grossman, D'Augelli and Hershberger, 2000).Although the literature provides useful insights into some social and psychological aspects of older homosexually active men's lives, there is a conspicuous lack of detail about their sexual relations and practices. The stereotype of the older gay man has been one of disengagement from the gay community, loneliness, rejection, depression and unhappiness (Bennett & Thompson, 1980; Berger, 1980; Berger and Kelly, 1986 Friend, 1987 and Wotherspoon, 1986). Their sexual practices have not been given the same attention as those of their younger counterparts. As the interviews in my study will demonstrate, this has been a serious omission; factors such as loneliness and depression can contribute to older gay men's decisions to take sexual risks.

A Generation Touched by AIDS: Loneliness, Loss and Survival

The experiences of the men over forty in my research project are shaped not only by age but also by a particular socio-historical circumstance. Sometimes referred to as the "Stonewall generation" for their initiation of the "out and proud" phase of the gay movement, these men are now living in the third decade of the AIDS epidemic, including the early years of public panic, the death of many of their peers, and years of ineffective treatment. This interviewee suggested that:

> Many men of my generation do have a different approach to HIV/AIDS. We couldn't believe that after getting some new freedoms that we would now die because we had sex they way we wanted to. I find it hard to understand why some young men today seem to be so easily abandoning condoms. I lost so many friends and lovers that it makes me

> sad that the younger generation do not seem to understand. I don't want to judge them because being gay is still difficult. I hope they will be careful. I am HIV and I can tell you that there is nothing great about it (gay male, 49 years, Interview 2004).

The following participant put it in the following words:

> When I was a young man in the late 1980s everything about having sex with men was being demeaned. Bathhouses and bars were being closed. Surviving more than a year or two after a diagnosis with HIV was quite exceptional. I do not understand how some of my younger friends are not being as careful as we were. However, I think that, although we don't always understand everything about what is going on today, we have to admit that changes are taking place. I just hope that some of my friends understand the terrible consequences they take when they decide to make other choices (gay male, 47 years old, Interview 2003).

The deaths of so many young men during this time brought about a prolonged sense of bereavement and immanent mortality within the gay community. It became a central theme of a good deal of gay fiction in the 1980s and 1990s (Nelson, 1992; Murphy and Poirier, 1993) and has been documented by researchers (Mayne, T. et al., 1998; Springer and Lease, 2000). Alongside these factors, widowhood, isolation and insecurity were recurring themes in stories of the men in the Toronto study, a series of interviews and focus groups among gay and bisexual men over forty commissioned by the AIDS Committee of Toronto (Murray, J. and Adam, B.D., 2001). The following interviewee collaborates these views:

> I lost my partner in 2001. We had been together for 10 years. I am now 52 years old. How in the hell does one get over that kind of loss? My friends tell me to go out and meet someone new. Do you know how fucking hard it is to meet someone when you are over 50 and do not look like Tom Cruise? Most times I just stay home and watch a movie or something. Who needs the kind of rejection that one can get from younger guys? I feel so all alone. The

> only place I can get some sexual gratification is a sauna. I don't feel I am in any position to tell a guy that I won't have sex unless a condom is involved. Loneliness often pushes me into decisions I would not make at any other time, especially when it comes to sex (gay male, 52 years old, Interview 2003).

This theme was reflected in many of the interviews for this study. Men over forty, almost exclusively, seemed to confirm to a substantial degree the findings of the Toronto study. When asked what particular reason(s) they believed led them to engage in unsafe sex, there emerged a widespread consensus that a sense of social devaluation often sets the stage for the "trade-off" (Adam, Sears and Schellenberg, 2000) of sexual safety for emotional and sexual needs. According to this participant:

> I am thrilled when a younger man gives me attention. How can it be that that a young virile man wants an out-of-shape guy like me in my late 40s? This excitement often makes me forget about using condoms, especially if that's what would please him. If the choice is between having sex without a condom or no sex, then I usually take a chance. It is no fun being lonely… and old (gay male, 48 years old, Interview 2003).

This view was also echoed in the following interview:

> I think it is important for many to know that growing old in society in general is not really easy. I believe that it is particularly important within the gay community. I remember when I was a young gay man how important it was to be young. Everything about having sex or promoting parties was centered on the images of buffed young men. Now that I am in my 50s I can see how much value is placed on older gay men, not much from what I can see. Now that I am single I find it very hard to meet anyone because of my age. I hate going to bathhouses for sex, but I do. I have often been asked to have sex without protection. I can honestly say that I have been tempted. I guess that is what can happen when you are lonely (gay male, 50 years old, Interview 2003).

It seems clear from these interviews that older gay men's decisions about sexual activities are different from those of the younger cohort. The issues that separate them are not always the same, but when it comes to a discussion of age, older gay men give us an important insight into some rarely discussed rationales for abandoning protection during sexual intercourse.

Many of these older gay men have lost partners to AIDS. In addition to this loss, age bias makes it more difficult to find new friends and potential partners. Finally, the social networks that sustained these men during the epidemic are now significantly weaker. This combination of factors influences how older gay men decide on the level of risk in their sexual encounters. It is poignantly expressed in the following quote.

> I often cannot imagine that my partner is dead. We were together for many years. It is very difficult to try and get back into dating and having sexual relations again. When you're in your early 50s, and not in great physical shape, many younger men find this unattractive. I often go to the sauna to have sex. When guys want to have sex with me, they sometimes don't want to wear condoms. Even though I know it is not the right thing to do, I have had sex without condoms just because a cute guy found me attractive. I feel so stupid after, but I am so lonely, and want the physical attention so bad, I just did it. Man, I wish I were not alone, it is so hard (gay male, 52 years old, Interview 2004).

Explaining differences between age cohorts of gay men is complicated. Both groups, younger and older gay men, are aware of the risks involved in having unprotected intercourse. The safer sex programs of the past two decades have been successful, despite criticisms from inside and outside AIDS organizations. Yet it seems that many gay men are not heeding the message that was so central to the original successes in early HIV prevention programs. The following interviewee wonders why so much has changed so quickly despite the fact that gay men are still getting infected and dying from HIV.

> I have to say that I really don't understand what is going on out there in the gay community. It is like we have found a cure for AIDS. I am completely aware of what new medications are doing for so many of my friends with HIV. However, unless I was not informed of a cure, there isn't one. Anyone who knows anyone on meds knows that it is not as pleasant as ads in gay magazines and pharmaceuticals lead you to believe. Many of my friends are suffering from debilitating bouts of diarrhea or nausea, depression and crippling pain in their back, hands and feet. I know I may be the minority in this discussion, but I sincerely believe that our complacency in the gay community is continuing to kill us. Certainly not killing us as it used to in the days before drugs, but we are dying and that to me is the real problem that we have to face (gay male, 36 years old, Interview 2004).

This participant puts the same sentiment in equally strong words.

> I keep hearing that times have changed, that we are now going to live longer, healthier lives than we did before these powerful drugs came on the market. It seems like too many of us have forgotten what has happened in the past. I know I haven't. Do any of these people who believe that we have entered a new era of HIV remember anything about the dying and suffering of all our gay brothers? Have we completely lost our minds? There is no cure, end of story. And as far as those famous meds are concerned, do any of these guys who are having unprotected intercourse really know what it means to be on these meds? I hope they never have to (gay male, 49 years old, Interview 2004).

While an immense amount of research focuses on the question of what kinds of people fail to practice safe sex, HIV prevention programs must be able to communicate in order to be effective. HIV prevention relies on the assumption that everyone wants to live a long life. The failure of this assumption among many street youth and injection drug users has hampered conventional HIV prevention messages, and it is an assumption that should not always be taken for granted among gay men. Depression and loneliness do enter into situations of vulnerability to unsafe sex practices. How we imagine our future

years and what meaning we give to them is an important assessment that gay men make when risk-taking is assessed. Among older gay men that have suffered much loss, personal and social, their own individual stories and particular social contexts are often crucial in determining the level of risk taking behaviour. One interviewee sums up this argument quite succinctly:

> There really is probably no excuse for abandoning condoms when having sex, no rational excuse anyways. However, anyone who has lived through the enormous personal loss of many dear friends and lovers sees life in a much different way, at least I do. So much of my social life disappeared with those lovely men. I feel so alone and cut off from a new generation of gay men. I just don't have much in common with them. I try to get back out into the community, but I find it so unlike what I used to know. Now when I want to have sexual contact, I am left with little choice but saunas and chat lines. I have had unprotected sex in saunas, not often, but I have. Loneliness can be a real killer (gay male, 52 years old, Interview 2004).

For younger gay men, the level of personal and social loss is not a mitigating factor. There are other issues, however, including coming out, acceptance, the invulnerability of youth and new medications. This young gay man puts it in the following way:

> I have not lost any friends to AIDS. I guess at 23 years of age, I am a little young yet to have lost anyone. However, I have not found it easy to be accepted as a gay man by my family. I hear a lot about how much easier it is supposed to be for my generation, but I have not found it to be so. I go out to parties, do some drugs at the big rave parties. Sometimes I go to sex parties after the rave. I know I am probably at greater risk on drugs when it comes to having sex. It just looks more natural without a condom. When you get lost in the moment, condoms are the last thing that comes to mind, for me anyways. I do wear condoms sometimes, but it depends on the young guy I might be with (gay male, 23 years old, Interview 2003).

My interviews with older gay men suggest how complex it is to have sex; there seem to be no absolutes. Younger gay men who have unprotected sex do it because they are young, feel invulnerable, do a lot of drugs and alcohol, and are dissatisfied with how we talk about AIDS in the 21st century. For older gay men, some of whom are the survivors of the early days of the AIDS epidemic, there are often new issues which have not been central to discussions among gay men. For the first time in many years gay men have the chance to live longer lives. With that often come issues such as age, loss and vulnerability. These factors have been underestimated but are legitimate in trying to understand how older gay men find themselves in the third decade of HIV.

Ageism and Desirability in the Gay Male Community

Among the most important issues raised by older gay respondents in this study is a strong concern with age and appearance. Most participants highlight the importance of their physiques, youthful appearance and overall sexual attractiveness. These concerns with appearance and sexual competition are not unique to gay men in this study, but have been identified by other researchers of urban gay culture (Levine 1992; Fitzgerald, 1986). Most gay men in this study find that their physical appearance constitutes an important part of their social status and social exchange. They believe that their sexual and relational marketability is intimately linked with their external appearance. According to the following participant:

> Do you ever see an unfit or overweight man in a gay magazine? Don't they all look perfect? How in the hell does one compete with that look? I just think that growing older in the gay community puts a lot of pressure on older gay men. So little is understood or written about the life experiences of our lives; how we feel, how we have sexual

> relations, how we cope with the loss of so many friends. We are supposed to not make the same mistakes that our friends made back in the 1980s and 90s. However, it is not easy to always be rational when one is alone and been without companionship for many years. Just let me tell you, it's tough to grow old when everything about your community is focused on perfect faces, hair and tight butts (gay male, 51 years old, Interview 2003).

Another participant reflects on how age can lead to feelings of discouragement and disillusionment. He acknowledges that

> Older gay men are up against a lot of challenges that a newer generation of men do not face. I know that getting old in our "youth" culture is not just a problem for gay men. It is difficult for many, in particular, women. However, I find that the ongoing tragedy of HIV has complicated our lives. Many of us no longer have the relationships that once centered our lives. I feel so torn at times. I know that unprotected sex is potentially, if not, ultimately deadly. But as a single gay man in his late 40s I cannot tell you how tempted I am to abandon everything I was taught over the last twenty years of the epidemic. I have found myself so completely discouraged sometimes that I have taken what I like to call a 'calculated' decision to have unprotected anal intercourse. I know that people reading this might think how stupid that sounds. It sounds kind of crazy to me too, but I am just trying to survive emotionally and psychologically as an older gay men. Fuck, it can be tough (gay male, 49 years old, Interview 2004).

An important conclusion of Gary Dowsett's study (1996: 148) of Australian gay men was that "to have one's sexual desire acknowledged by other men was important to all the older men in his study. He believes that this issue must rate as one on which modern gay communities are failing in their challenge to more general sexual conventions". The loss of attractiveness and of sexuality with age was described as an

essential dread by one of his participants and also acknowledged in this study. One of my interviewees described it in the following way:

> Being over fifty in the gay community is not an easy thing to deal with. Younger men fixate on orgasms. Men my age just don't have as many as they used too. Other things, like touching or hugging, are also important. We are judged by our sexual performance, body type, and especially, age. When those things change, we feel neglected and abandoned by a gay community that views youth as the ultimate factor. There is just such a greater chance of being alone as we age. I guess I never have imagined myself over 50 and alone. What a pain! (gay male, 51 years old, Interview 2003).

Another interviewee strongly emphasized the feeling of physical and sexual change and its relationship to loneliness:

> I wonder if anyone can imagine what it is like to be sick and old in the gay community. Let me tell you a little bit about what it is like. First of all, I have been HIV+ for many years. When I was first diagnosed in the mid-1990s I felt that my life was over. My partner left me soon after. He was just too afraid, he said, about what might happen to him if we continued to have sex. I guess I can't blame him. I might have made the same decision if I were him. It has been almost ten years since I have had a serious relationship with anyone. I have had lots of sex but that is not the same thing as a relationship. As soon as guys find out my status they can't run fast enough. I tell them I am on meds and I am doing well, but they just don't seem to care. I try and only have sex with other positive guys but I am sure that over the years I have had sex with guys who are negative. Now that I am in late forties, having sex with anyone is just becoming impossible. The medications I am on have nasty side effects which means that I am not always well enough to have sex. These drugs may have saved my life, but they have left me with physical marks that turn guys off and you can be sure they know what they mean. You can hide your status when you are first on meds but the longer you are on them, the signs begin to appear. We may be alive, but the cost can be quite high. For me, it has made [me] angry and lonely. So when the opportunity comes to have sex, I don't say much and don't have too

> many philosophical discussions on the ethics of how to have sex safely (gay male, 48 years old, Interview 2004).

Other participants in this study struggle with the effects of many years of medications, in particular the appearance of facial and upper dorsal (hunchback) lipodystrophy. On interviewee expresses it in this way:

> I remember many of my friends who died in the late 1980s. They died before the so-called miracle drug therapies of the mid-1990s appeared. For most of us on meds today the worst side effects like Kaposi's sarcoma are not an issue. I remember so many of my friends being rejected because of those tell tale marks of AIDS. Today, many of us who have been on meds for a long time have some form of facial lipodystrophy-deep pock marks on our face. Believe me; people can pick out some of us quite easily. I am sure that people assume that I have HIV and refuse to have sex with me. As a result, I often have sex with other HIV+ men. I find it less complicated. We don't tend to discuss safer sex issues that much and we generally just understand each other better. I know that I am not as desirable as I used to be to other gay men. I also know that it is not solely because I am sick. I have no doubt my age has a great deal to do with it. I also am very much aware that I will not be around in twenty years from now so I intend to have as much sex as I can while I am still able can (gay male, 52 years old, Interview 2003).

Another older participant put it in the following words:

> I remember one time when I was about to have sex with a guy I met online. We met at a local bar in the gay village. I remember thinking before I met him what he would think, not so much about my age but what he would think about my facial appearance. I have been on a series of meds for many years and it is beginning to take a toll. We met, and it didn't take long for me to figure out that even though we did not discuss health status, he decided that I was HIV+ and that was the end of any get together. I guess it could have been my age but I have no doubt my facial appearance was the determining factor. It is just something I will have to live with. It hurts to be rejected; it hurts a lot (gay male, 47 years old, Interview 2003).

Age and the long term damage done to HIV patients after many years of taking medications is becoming increasingly important in the lives of older gay men. Prior to the introduction of triple therapies in the mid-1990s, many gay men did not live long enough for any age considerations to be so important. There is certainly no denying that these medications brought many gay men literally back from death. However, the downside for many older gay men in this study is how the ultimate success of these pills has lessened their desirability. The physical and psychological effects of these medications are the important issues that many men living with HIV today must face. They have survived the initial diagnosis, but many of the long term issues surrounding long term survivors have yet to be analyzed in any significant way.

Ultimately, HIV is more than a chronic disease; it is a deadly one. Several men in this study described a sense of immanent loss, and some felt an urgency to exploit their desirability while they could. One older participant who has been on HIV medication for many years explains his rationales for taken "negotiated" or "calculated" risks with other male sex partners. He says:

> Look, no matter what anyone tells us about how successful these so-called "magic" pills are; we are going to die. I hate to be blunt, but it is the reality that I face. I am not pretending that my quality of life has not been enhanced by popping 10 pills, three times a day. But let us not bury our heads in the sand. Death is around the corner for me and many of my friends. I hear how some younger gay men think that so much has changed for the better. It would be denying that reality completely for me not to agree. But let's get serious: we don't all do well on these drugs; some of us can't tolerate them at all. I am planning to live my life to the best of my ability. Ten years ago I probably would not be doing some of the sexual activities I am doing now, like having unprotected sex with other HIV+ guys. However, my shortened life and age make my considerations change. It is not something that I am proud

> of. But the reality of my illness, its physical and psychological ramifications, certainly have altered my approach to life (gay male, 49 years old, Interview 2004)

In light of these interviews with older gay men, it is important to recall that much of the literature about the rationales of gay men for failure to practice safer sex practices is based upon studies of young gay men. The rationales include: (1) condom fatigue, (2) treatment optimism, and (3) alcohol, drugs, etc. and (4) inserter vulnerability (Colfax et al., 2002). The next section of this study will address the issue of condom fatigue. This discussion will attempt to understand whether or not one of the important determinants for younger gay's men participation in unsafe sex practices, condom fatigue, is also an important rationale for an older generation of gay men.

Condom Fatigue

While HIV prevention research has long demonstrated that negative attitudes towards condoms are associated with less use of them, there is much less research literature on why condoms may be held in low regard by some men, but not others. This study did show an age-related dimension regarding condom usage. Men under forty wanted to have the feeling of "natural" intercourse. Many of these men grew up in the middle of the epidemic and did not, or have not, had the experience of condom-free intercourse. Those men over forty, in greater numbers, have enjoyed penetrative sex without condoms. Men over forty espouse different reasons for abandoning condom use. They report a declining ability to have and sustain an erection as they age, and they found that condoms exacerbated their inability (also reported in Imrie et al., 2002 and Richters, Hendry, Crawford & Kippax, 2003).

Several interviews reflect this view about condom use. One interviewee put it the following way:

> I find that having an erection is not as important as the whole body experience, and that's okay with me. However, my partner does not like the fact that I don't have an erection when we have sex. He doesn't think I am having a good time if I am not as hard as him. Sometimes I don't use a condom because I think it might help me have an erection (gay male, 46 years old, Interview 2003).

Another said:

> I'm a bottom [insertee in penetrative sex], so I don't really care all that much if I get an erection or not. But, when I go to sex parties, people often remark that I am not getting hard, they think there must be something wrong. I tell them I am having a good time, but other guys see erections as the ultimate reflection of having a good time. Young guys think that erections are the ultimate sign. I often take off my condom if I think it would help in getting an erection (gay male, 50 years old, Interview 2004).

In this study, older gay men have articulated a range of ways in which age has directly or indirectly affected their sexual choices. These men certainly acknowledge their concerns over negotiating safer sex against the backdrop of strong sexual desire. Some older gay men acknowledge that they enjoy sex without the constraints of associated with condom use. The following participant put it this way:

> I can remember so vividly when nobody, or at least very few people that I knew, ever discussed using condoms. Being gay and having sex with men in bathhouses or saunas in the late 1970s was a time when sex was fun and really uninhibited. It just felt so good to have sex that seemed so natural. I knew that not wearing condoms could involve getting herpes or other STDs. It could be embarrassing to have to discuss it with your doctor, but it wasn't deadly. The feel of having your skin in someone else's without a rubber felt so perfect. I can understand younger gay men not wanting to wear a condom. I wear them more often today, but I really hate them. People try

> and tell me that it really makes no difference. I don't believe that that is true. When you have experienced anal intercourse most of your life without a condom, it is certainly hard to want to change it. I know that today not wearing a condom is more dangerous than ever before. However, I can't deny that when I don't wear one it is so much better (gay male, 45 years old, Interview 2003).

This view was also supported by a young participant. He acknowledged that, with the reality of AIDS, not wearing a condom seems suicidal to most people. He puts it in the following way:

> I have read many stories and seen many porn movies from the era before AIDS. I have also seen porn movies made today that show men having sex without condoms. I know that there is definitely a risk involved. But I can imagine how good it must feel not to have to wear protection. I have had sex a few times without condoms and it is just the best. It feels so damn good. When I compare it when I wear a condom, there is just no comparison. I know that there are many events in gay men's lives that have changed significantly since AIDS have become part of our lives. But in some ways I envy gay men from an earlier generation who did not have to worry about dying when they had unprotected sex. I know some of my young gay friends who refuse to wear condoms. They tell me they just want to forget about what not wearing condoms mean. Just as older gay men are tired of condoms, some younger gay men feel exactly the same. I know I do (gay male, 21 years old, Interview 2003).

Gay men in this study reflect some important changes based on the reality of their age and their illness. These two interviewees reveal that important changes are taking place in the sexual lives of both older and younger men as it relates to condom use. Younger gay men, especially those who came of age by the mid-1990s, have certainly seen a shift in the dialogue around safer sex practices. For them, the issue of wearing a condom is a matter of a more "natural" feeling. For an older cohort, it is the ability to sustain an

erection. Although there are different reasons for abandoning the use of condoms, a central practice of safer sex strategies, this is one area where one can find common ground.

Those "Magic" Pills

Of the participants over forty in this study, most agree that the new drug cocktails do play some role in their decision-making about safe or unsafe sex. These participants also agree that age bias and its accompanying loneliness is an important determinant of their behaviour (Murray, J. and Adam, B.D., 2001). This interviewee suggests that

> new AIDS drugs are possibly one reason for some people. I have seen, among my HIV positive friends, what cocktail treatments can do for them. I have a really good friend who was basically near the end of his life. Most of us were sure that he wouldn't make it when we seen him in hospital. Then within a few months of being prescribed new meds by his doctor, there was a remarkable change. He went back to work six months later and was having sex again, something he had not done in almost a year. I can certainly see how gay men's lives have undergone an important shift. As an important as these new AIDS drugs are, I am not sure if they would make me more susceptible to have unprotected sex. Just not sure at all (gay male, 49 years old, Interview 2004).

Another participant concurs with this statement but believes that loneliness can often be the deciding factor:

> Getting old in the gay community is tough. Everybody, in magazines, gay TV shows like Will and Grace [NBC sitcom] are young and beautiful. How does someone like me compete with that? I know that wearing condoms in all sexual activities is important. But when you are single and over 50, it is increasingly difficult to find a companion. I found myself in a bathhouse one time being cruised by a young, attractive man. He wanted to have sex with me, without condoms. I can tell you it really felt good to be

> asked. I insisted on protection, but he didn't want to. I can tell you, that when you have been alone and lonely for months and years, it is hard to say no to such an offer even when you know the possible outcome [of having unprotected intercourse] (gay male, 51 years old, Interview 2004).

There seems little doubt that older gay men's decisions to have unprotected sexual intercourse have changed since the introduction of new medications in the mid-1990s. This is certainly one area where younger and older gay men tend to agree. The explanations for unsafe sex among younger gay men are complex and multifaceted (Kegeles et al., 1999 and Strathdee et al., 1998). Adolescence and young adulthood are often characterized by experimentation and exploration of sexuality and drug use. For some young men, individual factors that can lead to unsafe sex include feeling invulnerable to HIV; having high levels of optimism about HIV antiviral medications; perceiving that unsafe sex is more enjoyable than safer sex and using alcohol and other drugs (Choi et al., 1999). Middle-aged gay men also face challenges but they are qualitatively different than their younger cohorts. According to Doug Haldeman

> middle-aged gay men face tremendous challenges because we grew up in such a youth-oriented gay culture. Thirty-five is seen as old, and 50 is ancient! That's a blow to our narcissism. Not only are we not the pretty things when we walk into the bar, we're the age of the parents of the pretty things (DeAngelis, 2002, p. 3).

However, what ever those reasons are, the discovery of these so-called "miracle" pills seems to be one area where there is much agreement. Although there is much agreement on the role of medications in discussions of safer sex, other rationales are more complicated. One factor of potential importance is the gay community. Does the

community have any relationship to how gay men define themselves and ultimately how might that lead to decisions about how they have sex?

Urban Gay Communities

Intergenerational issues between gay men raise some interesting and troubling questions. For gay men over forty, a sense of connection with a well-established gay community, a personal history of volunteering and the idea that this social network would support them in ageing and sickness, separates them from the post-epidemic era. Moreover, according to Green (2002):

> Urban gay centers provide powerful social resources to repair the psychological damage associated with homophobic families and communities, and to develop a positive gay self-concept. Moreover, urban gay centers offer extensive opportunities for the formation of homosexual friendships and dyads (2002: 82).

This view is reflected in the following interview:

> I remember being gay in the late 1970s. I really didn't know any gay people. I lived in a small rural town and found it very difficult to talk with anyone about what was going on in my life. I heard from some former high school friends that there was a gay bar in the city. I finally took my first steps into gay life when I opened those doors. It was unbelievable. I was so psyched, so nervous. I had no idea what to expect. However, after that first experience, I couldn't wait for the weekends. They were people just like me and I could relate so easily to that. Finally, I could talk to people who understood me without giving them my life history. It was so liberating. It was in this downtown urban centre of bars and restaurants that I developed the first real friendships of my life. I often think back to those days. So many of the people I knew are now dead. I often long to have those days back although I know that it is not going to happen. I know that a lot of gay men still go out to bars and

> clubs but I don't think it is for the same reasons as many as my friends did (gay male, 50 years old, Interview 2004).

The following participant put it this way:

> Everything I know about being a gay man was learned in the bars, clubs, saunas and restaurants of downtown Montreal. These places and people help me to identify myself as a gay man. I learned what it meant to be a whole gay man. Not just someone who happened to sleep with other men. They gave me companionship, friendship, support at the most difficult time(s) in my life. I know much has changed and much has been lost to us as gay people, but I will never forget the excitement and joy that these gay places brought us. And it was never more important than when those tragic days hit us so hard. I am alive in no small part because of what I learned during those days among my real family, my friends, and my lovers. No matter what may be changing in the discussion about AIDS these days, I think that it is important not to forget the role of these people and organizations. I know that I never will (gay male, 49 years old, Interview 2003).

These men identify the important role these gay urban centres played in their social and sexual development. The hometowns and families of these participants made these bars and clubs an essential refuge from homophobia and misunderstanding. For Green (2002), migration to urban gay centres initiates a powerful turning point in the development of sexual identity, psychological repair and the sexual career. Nonetheless, gay men's experience of urban gay ghettos is not monolithic but, rather, mediated by individual and sociological variables, including age.

It is not that a younger generation of gay men does not appreciate the role of these organizations in their own personal and sexual development, but the issues confronting younger gay men are different. Most, if not all, of the younger gay males interviewed for this study did not lose anyone in the epidemic and have no history of involvement as a

volunteer in a community organization. When asked whether his generation of gay males approached HIV issues differently, one interviewee responded in the following way:

> I find it hard to become involved in HIV as a health issue. I know how serious it is. I know how to protect myself. There are meds now that help people with AIDS. Things are getting better for them and for gay people. All my gay friends are healthy. I don't know anyone who is HIV. I have other issues that concern me. It's not that I don't care; it's just that I am a young gay male who wants to have fun and enjoy myself (gay male, 23 years old, Interview 2003).

These ideas are also supported by the following participant.

> It is not that I am not unaware of the issues surrounding AIDS. As I mentioned to you earlier, my own father is HIV. However, that alone is not enough for me to be continually thinking about HIV. I guess if my father gets sicker then I will probably find that this issue will become more real to me. I don't live with my father and I don't see the everyday battles he probably has with the meds and other related problems. My father has a very positive view about his long term future and I find that I am not living his reality every day. My father often suggests to me that I should volunteer in local AIDS committees. However, none of my friends do, so I guess I have just become disinterested. I just want to be sure that you know that I am well aware of all the issues surrounding HIV more than most. But not growing up in the worst of the AIDS epidemic has given me a different perspective (gay male, 21 years old, Interview 2003).

This discussion on gay communities and their institutions gives us an important insight into how some gay men make decisions about their sexual practices. I do not think that having or not having a strong attachment to a central, defining community makes one more or less inclined to engage in unprotected sexual practices. However, I would strongly argue that the experiences of these older gay men and their attachment to a strong gay male community cannot be disregarded. Much, if not all, of what it meant to be a gay man in the early days of sexual, social and political liberation was defined in

relationship to those communities and their institutions. They learned what it meant to be a gay man, how to have sex and, with the AIDS crisis, how to care for themselves. According to D'Emilio (2002)

> gay men and lesbians motivated by Stonewall[5] and the protest movements of the 1960s left an important legacy, one in which the notions of coming out as the key to change and pride as a stance toward one's sexual identity were central.... The fight against AIDS had startling effects. It brought many more gays and lesbians out of the closet... it led to renewed cooperation among lesbians and gay men (D'Emilio, pp. 83-86).

The construction of their identity by the gay movement and the AIDS movement was no doubt important to the decisions that they would make in their sexual and social lives. I do not believe that the identity formation of the early days is the only important tool that is used by older gay men when they are making decisions to engage in sexual activity. How one has sex is far too complicated to be explained by one variable. However, identity formation within the early days of the gay movement influences how older gay men are redefining their sexual behaviours. D'Emilio expands on these issues of sexuality and gay liberation during the late 1960s and 1970s in New York. He believes that gay liberation

> taught--and it was a most welcome lesson--that it was okay to feel good about our particular brand of sexuality. It created a movement out of sexual desire, an intensified sense of brotherhood that added an erotic charge to almost any encounter with another gay man. For participants like myself, it also made gay life even denser. Now we were gay not only when we went looking for sex, but during those endless hours when we were activists as well.... But, by and large, my friends and I moved in a social world in which sexual expression figured differently than it had in

[5] A police raid on Stonewall Inn in New York City on Friday, June 27th, 1969 that led to a series of demonstrations and conversations that would give birth to the modern gay movement.

> years past, both quantitatively and qualitatively. Quantitatively, because the opportunities were multiplying, and qualitatively, because we felt much freer, because our sexual desires were now enmeshed in a community we were creating and were suffused by an ideology that associated sex with liberation (2002, pp. 203-205).

The sexual practices that older gay men had become accustomed to, in particular condomless sexual intercourse, during the early days of gay community and identity formation had socialized them to decouple sexuality and emotional intimacy. But when AIDS became associated with sexual practices in the mid-1980s, many men of this generation had to rework their sexual socialization and achieve a balance between sexual desire and the safer sex movement developed in the advent of HIV/AIDS.

Conclusion

Gay men over forty are men who have survived an era of sickness and death often completely unimaginable to their younger gay brothers. There is little doubt that their position in a pre-AIDS era has determined how they would approach the new realities of HIV. Many of these men are survivors of the first wave of death and suffering in the gay male community, and as a result many of their decisions must be seen in that context.

Several participants in this study were incredulous that gay men are having unprotected anal intercourse simply because there are some new wonder drugs. However, others believe that we cannot ignore how a new generation of gay men and even some of their own age cohorts are viewing safer sex differently. Many of these older participants believe that the message of safer sex must include strategies that move the discussion of sex beyond its technical elements

For some participants issues such as age, loneliness, loss and vulnerability must not be overlooked. Much of the discussion about safer sex focuses on the concerns of a new generation of gay men. Very little discussion centres on the factors that precipitate older gay men to abandon decades of safer sex. Many who analyze these issues might imagine that the survivors of HIV would be a group of gay men who would not consider unprotected sex an option under any circumstances. However, the reality is that older gay men are putting themselves at risk for infection or re-infection. The difference is that the calculated decisions they make are not informed in the same ways as younger gay men. Vulnerability, loss, ageism and the side effects of medications are determinants in the decision-making process. For men who are already HIV+, it is a combination of all these factors. For those who remain healthy, party drugs, alcohol, safer sex fatigue and new medications are factors that could be decisive in their sexual risk-taking practices.

One important point to mention is that all the older men interviewed for this study believe that they make their sexual choices with as much information as possible. Those men interviewed in this study do not have any desire to get infected or to infect others. They consider the risks involved and make calculated decisions based on their situations and their potential sexual partners.

The focus of the next chapter is on what many HIV/ AIDS activists and health care workers consider to be a growing threat to the success of safer sex strategies: the practice of barebacking. Many of the men interviewed about barebacking, whether younger or older, believe that their decision to have unprotected sexual intercourse is not as dangerous as many in the gay and medical communities would like us to believe. They

also believe that a narrow focus on reducing HIV infections is no longer sufficient in motivating gay men to alter their sexual practices.

Chapter 6

Barebacking: A New Socio-Cultural Phenomenon in the Gay Male Community?

Every Thursday through Sunday night in San Francisco's Castro district, someone named Marshall uses his house to host a party for other gay men who share a similar sexual interest: no condoms. Admission is $8, and after I pay, Marshall hands me a piece of paper. "This is a bareback party", the house rules read. "It is assumed that all guests are HIV+ or have made the decision to attend this kind of party. Therefore there will be no discussion of status, illness or medicine".

-Michael Scarce, *A Ride on the Wild Side* (1999)

Beyond the general acknowledgement that unsafe sex practices continued throughout the AIDS epidemic, there is a growing, albeit controversial, consensus that for many years some gay men have been purposely engaging in unprotected anal intercourse.

While the issue of unprotected anal sex has always been a concern within the gay male community (Martin et al., 1989), recent media attention capitalizing on the sound bit allure of the term "barebacking" could potentially create a self-fulfilling media prophecy. Why has unprotected anal sex, a concern throughout the epidemic, suddenly become so popular? What is the role of the Internet in popularizing or contributing to high-risk sex? Is it related to safer sex fatigue? Do alcohol and drug use increase the probability of high-risk sexual activity? What about the role of new medications (antiretroviral drugs)? What does it tell us about the role of gay men in HIV prevention as we enter the third decade of the epidemic?

Barebacking: Its Origins and Meanings

The late writer and porn star Scott O'Hara was the first to lead the barebacking charge. In a 1995 editorial titled *"Exit the Rubberman",* in *Steam,* his journal devoted to sex in public spaces, O'Hara (1995) wrote:

> I'm tired of using condoms, and I won't... and I don't feel
> the need to encourage negatives to stay negative".

As O'Hara and other HIV positive men restated their positions in such magazines as *POZ* and *The Advocate*, there was a sense that they were mining a long-buried, pre-AIDS memory, the sharing of semen, and reclaiming its rich symbolic meanings. These anti-condom statements were more than enough to frustrate, infuriate and sadden the majority of older gay men who fought so hard to reduce infection rates while burying their loved ones.

In September 1997 the debate moved from the gay press into full public view with a piece in *Newsweek* called "*A Deadly Dance"* (Peyser, 1997). Soon, former Miss America Kate Shindle was commenting, speculating in a February 1998 *Advocate* commentary *"Barebacking? Brainless!"* (Shindle,1998), that funding for AIDS prevention would dry up if government agencies took notice of gay men's supposed disregard for public health.

Since its public naming over three years ago, barebacking, also called raw or skin-to-skin sex, has been simultaneously condemned and sensationalized by the media. The debate is stuck between two hyperpolarized camps, with anti-barebackers screaming, *"Dangerous sex fiends",* while barebackers counter with *"Condom Nazis"* (Scarce, 1998). Meanwhile, a new sexual subculture has emerged, organized around the no-condoms creed (Gendin, 1999; and Kirby, 1999). Driven underground, this community

flourishes in private houses and especially on the Internet (CDC, 2002), where its members can fantasize, experiment and connect with others, free from the stigma attached to openly soliciting unsafe sex.

Internet Access to Risky Sex

The same accessibility and anonymity that makes the Internet so popular also makes it dangerous to sex-seeking users, with the potential of multiplying the probability of high-risk sexual contact. This potential was highlighted in several studies that suggested a possible link between the Web sites and higher rates of sexually transmitted diseases and HIV (Benotsch, Kalichman, and Cage, 2002; McFarlane, Bull, and Rietmeijer, 2000; and Mettey, et al., 2003).

McFarlane et al. (2000) attempted to determine if the use of the Internet to solicit sex partners should be considered a potential risk factor for STD/HIV. They surveyed 856 people who sought HIV testing at the Denver Public Health HIV Consulting and Testing Site in Colorado. Seventy-eight percent of the clients were white, sixty-nine percent were men, sixty-five percent were heterosexual and eighty-four percent were between 20 and 50 years old. They found that among this group, seeking sex partners via the Internet was a relatively common practice. The researchers compared online sex seekers with those who did not seek sex on the Internet.

> Online seekers were more likely to have had a previous STD than offline clients, thus increasing their risk of STDs or HIV. Online seekers had a greater numbers of partners than offline clients but were more likely to have used a condom during their last sex act.

They conclude that, among this group of people, the Internet clearly has had a role in the solicitation of risky sex partners. Thus, seeking sex on the Internet may be a potential risk factor for STD/HIV. This was confirmed by Mettey's et al. study (2003), which concluded that among men who have sex with men (MSM) those using the Internet to seek sex partners may have modestly elevated risks for acquiring or transmitting STDs.

For many men who consider themselves to be sexual adventurers, the Internet offers an alternative to bathhouses or sex clubs. The anonymity of the net provides a non-stigmatized zone for those who seek out barebacking and/or high-risk sexual activity. This is also the case for people who engage in other practices like anorexia and seek out non-mainstream social movements. By increasing the realm of possibilities and eventual contacts, the net also acts as a community for those who have intentionally abandoned the safer sex philosophy. Several interviewees made these points about the Internet and community development around barebacking.

> For me, the Internet makes me feel like I am not alone out there. I like to talk to people who enjoy sex without condoms. However, I know that among the general gay population my views are still controversial. I remember one time on a local gay chat line when one guy told me that I was fucking crazy, why was I trying to kill myself and other gay men. From that time on I only go to websites where my feelings about sex are more accepted (gay male, 29 years old, Interview 2003).

Another gay male, who actively engages in sex without condoms, echoed these comments:

> I wish people would leave me alone. I know what I am doing when I decide to have unsafe sex. I am so tired of people and organizations telling people like me that we have some type of sickness. I don't! I hate sex with condoms and want to have sex that way with other guys

> who feel the same way. Are we to believe that other guys during the epidemic were not having sex without condoms? Give me a break! The only difference now is that we are being honest about it. Thank God for the Internet! I know it is not always the best way to get the kind of sex you want, but at least I am not being judged (gay male, 31 years old, Interview 2003).

It is certainly too early to tell if there is a causal relationship between online access and higher levels of risky sex. More studies will have to be done in order to make any concrete determinations about that relationship. However, one thing does seem clear. The Internet is clearly creating a community of risk takers who feel disenfranchised from the central community of gay leaders and HIV educators. This feeling of disenfranchisement from HIV educators was echoed in a workshop presented at the August 1998 National Lesbian and Gay Health Conference by Michael Scarce and Tony Valenzuela entitled *Reducing the Risk of Doing It Raw: Strategies for Barebacking Harm Education* (Young, 2005). Their presentation focused on how health providers and activists could assist barebackers in reducing their risk of acquiring HIV. They

> believe that AIDS prevention efforts have written off barebackers, demonizing them as the poster boys of unsafe sex. We want to move past moral judgments of bareback sex.

It is precisely this moral judgment and its related stigma that many barebackers feel when they declare that they are into bare sex. On the Internet, morality is barely audible.

A New Name for Unsafe Sex

For years, public health experts told HIV positive men to err on the side of caution by using condoms even with others who are also HIV positive, though the scientific jury on reinfection was still out. However, a number of recent reports from medical journals

show that patients with HIV can be reinfected with the AIDS virus. A recent study and an accompanying editorial published September 5, 2002, in the New England Journal Medicine cast doubt on the widely held assumption among HIV+ persons that they cannot be reinfected. The "HIV-1-Superinfection" study

> documents the case of a 38-year old HIV positive man who became infected with a second strain of the AIDS virus. He acquired the first strain of HIV-primarily found in Southeast Asia-in 1998. For 28 months, the man had only that strain of the virus and was treated with a four-drug regimen which ended because of drug toxicity. The man later traveled to Brazil and had unprotected sex. Three months after the treatment ended and three weeks after the unprotected sex, the man was "superinfected"-or re-infected with a second strain of HIV that is "endemic" to Brazil (Wolfe, 2002).

Despite this confirmation, Jack Summerside, head of Living Well with HIV services at the UK's Terrence Higgins Trust, believes that the issue of reinfection is complex. He does acknowledge that this study suggests the possibility that people with HIV can risk subsequent reinfection with different strains of HIV. But he added:

> There appear to be very specific circumstances where this has been demonstrated. These include whether or not the individual is taking anti-HIV treatment, and the degree of difference of HIV sub-type between partners. It would be misleading to translate these into overly simplistic health information for people with HIV regarding condom use with HIV positive partners (BBC News, Sept. 5, 2002).

While many HIVers have complied--condom use was viewed in the late 1980s and early 1990s as a virtual communal duty--many others have not. They seem unwilling to abandon an act of such fundamental importance as skin-to-skin sex for an as-yet-unproved harm.

The barebacking phenomenon can be seen as a reaction to prevention efforts, which have failed to adequately address the complex meanings of sexual behaviour in relation to the divergent identities that have developed around HIV serostatus. Moreover, prevention campaigns have not adequately addressed the different needs of negative and positive men. Odets, an HIV activist, argues that HIV prevention campaigns have been simplistic at best, and patronizingly absolutist at their worst. Gay men have been told to wear condoms "every time", as if such behaviours are sustainable over a lifetime. But what if one is already positive or does not care either way? Naturally, people find ways to rationalize behaviours that put their health at risk, whether that risk is fatty foods, smoking or unprotected sex (Odets, 1995). This view is echoed by an interviewee in this study:

> Even though I know that using condoms is the best way to prevent STDs and HIV, I don't think it is realistic to keep the same messages that are so old. I think it would be better to reflect the new realities of young guys like me. Many friends my age also believe it is time to change our views on safer sex. Instead of condemning everyone for not using a condom, I think it is time to acknowledge that some gay men are having sex without condoms, for reasons that they consider legitimate even if AIDS groups may not think so (gay male, 24 years old, Interview 2004).

Ironically, the attention focused on anal sex as a risk activity has given it even more symbolic meaning as an act of profound intimacy or even rebellion. This problem is only compounded when the target population is one that already sees its identity as a community tied to a recently acquired sexual liberation. Gay men have traditionally been at the vanguard of sexual liberation and experimentation with new forms of human relationships. This view is reflected by the following interviewee; although not in

agreement with barebacking as a sexual practice, he says that we must look at it in the context of gay men's sexual history:

> I get so tired of people condemning gay sex, especially when it comes from people in the gay community itself. I don't think that barebacking is a safe thing. I certainly don't plan on doing it myself. But to say that all gay men who consciously decide to not use condoms are harming me and all gay men, I think this is an exaggeration. I think that AIDS organizations should try and understand why some gay men do not want to use condoms. Just saying no sexual intercourse without condoms, ever, is just not going to work. That is what I think, anyway (gay male, 39 years old, Interview 2003).

Another interviewee put it this way:

> Sex is not just about how to put on a condom. It is far more complicated than that. We have to think about all the social, psychological, cultural and emotional reasons why some gay men decide to not use condoms. However, for over 20 years, safer sex education has focused on the technical aspects of safer sex. We are not uni-dimensional beings. We make decisions about sex in a variety of ways. If it was just about putting on condoms to diminish the risk of getting HIV, then it would not be much of a discussion. However, things have evolved over the last 20 years of the epidemic, and no doubt our feelings about sex have also changed along with it (gay male, 33 years old, Interview 2003).

This experimentation has always existed under the threat of sanction from powerful institutions such as the police, the church, schools, and the family. Barebacking can thus be seen as merely the latest in a long line of challenges by gay men to the sexual status quo, and the institutions that support it. But what makes this challenge different?

It seems clear that, despite the limited research on this new sexual code, there is a clear distinction between the tendency of gay men to "slip" into unsafe sex practices and the intentionality of barebackers (Gauthier and Forsyth, 1999; Goodroad et al., 2000).

The premeditated, eroticized and intentional decision to engage in unprotected anal sex seems to be the clear demarcation point. While intentions for unprotected sex appear to be at the core of gay men's understanding of barebacking, however, it is less clear how these intentions emerge or how they drive men towards unprotected behaviour. It is precisely this dilemma that makes the challenge multifaceted and difficult.

The Multi-dimensional Nature of Barebacking

Investigations of the psychological, behavioural, and sociological motivations of any individual or group of individuals engaged in sexual intercourse are extremely complicated. There are very few concrete answers. However, any attempt to understand these motivations must not only focus on the individual and his/her behavior. There must be an understanding of the social within the sexual (Bloor, 1995a, 1995b; Douglas 1985, 1992; Douglas and Widavsky, 1982; Fee and Krieger, 1993; Gabe, 1995 and Lupton, 1993). Despite the limited data on this social/sexual phenomenon within the gay male, some preliminary hypotheses can be suggested.

Barebacking has only recently been considered in the academic literature (Drescher et al. 2002; Gauthier and Forsyth, 1999; Goodroad et al. 2000; Suarez and Miller, 2001 and Yep et al., 2002). This limited research points to historical, sociological, behavioural and psychological factors which all, directly and/or indirectly, affected gay men's decisions about whether or not to engage in unprotected intercourse. Furthermore, it seems evident that it is more than condom-less sex. Men who engage in barebacking seem to have some motivations that separate them from those who simply slip up or take

occasional risks. In one of the interviews for this study, this intentionality was clearly identified:

> I have heard about bare sex. When I was younger none of my friends, at least I don't think so, would ever have anal sex without a condom. Of course, sex is a complicated thing. Maybe they were not using condoms all the time. I know that I didn't wear a condom 100% of the time. Now, at least it seems to me, that there is a difference between guys like me who made a mistake sometimes and those who go onto web sites and want to meet guys only for bareback sex. Guys on these sites always talk about how much better it feels without a condom, that it is more pleasurable. Sometimes I see guys who look for only positive guys and guys who only want negative. I grew up during the epidemic and all we heard from AIDS groups was to wear a condom all the time. I even worked as a volunteer in an AIDS committee. Nowadays, with new meds especially, that fear seems to be gone. I try and wear condoms all the time, but nobody is perfect. But I do feel that there is a change in sexual behaviour out there [in the gay community] (gay male, 48 years old, Interview 2004).

This interviewee clearly noted that growing up in the era of AIDS has had an impact on his behaviour. Most of the literature would agree that there was a substantial impact on men of older cohorts as it relates to safe sex practice. But even for this participant, there seems to be a change in how men relate to the mantra of "Always condoms, All the time".

Another possible explanation for this important behavioural change among gay men is "that unsafe sex practices incorporate a symbolic meaning of rebellion and transgression" (Crossley, 2002: 56). The significance of unprotected anal sex among gay men, according to Odets, is that it "has real significance aside from its anatomical convenience" because it incorporates strong 'interpersonal and psychological meaning'

(Odets, 1995: 1989). And again, Rofes claims that unsafe gay sex is all about identity and 'survival strategies' which 'makes living satisfying and worthwhile' (Rofes, 1998: 225).

What does this mean? According to Crossley (2002), gay men feel attached to certain risky sexual practices because they provide a psychological feeling of rebellion against dominant social values, which, in turn, creates a sense of freedom, independence and protest. These explanations came up, although in a limited way, in a couple of interviews, specifically the sense of independence and freedom from twenty years of regulated behaviour that was demanded from gay communities in response to government-directed health initiatives for gay men. According to this interviewee:

> I remember so very well the years immediately preceding the AIDS epidemic. It was a time of sexual liberation that was really unknown to gay men. We were free to love and have sex in a more uninhibited and psychologically freeing way. I grew up in a conservative religious family that did not allow any discussion of sex, period! Can you imagine what it meant to finally be free to have intimacy with whom we wanted to? However, sadly, this did not last very long. Along came AIDS and with it our sexual freedom. Things changed over night. And they have not been the same since. Although I believe, to some degree, some gay men are trying to recapture those times, and as a result may be placing themselves at greater risk. Even though I do not agree with it [barebacking], I can somehow understand why some men do it (gay male, 52 years, Interview 2004).

One young gay man interviewed for this study took a similar approach:

> I cannot imagine what it was like in the late 1970s and early 1980s, before HIV/AIDS became such a central concern to my life and many of my friends. That kind of sexual freedom for a generation of gay men must have been sensational. I grew up in a generation where being a gay man and having sexual relationships is no longer as difficult. So, in that sense, I cannot relate to it. But despite our new found freedom, we are not as free to engage in sexual activity the way we might want to. The sense of

> sexual independence that became so important to us has changed, at least for my lifetime (gay man, 33 years, Interview 2003).

These interviews raise a larger point, suggesting how such acts as barebacking stand in defiance of more general societal prohibitions against 'bad sex' and homosexuality (Odets, 1995). One might argue that certain sexual activities constitute an affront to the conventions of 'normal', 'responsible', 'respectable' society. By explicitly engaging in such 'irresponsible' practices, culminating in unprotected sex and the intentional transmission of HIV infection, gay men engage in acts which rebelliously deny the values of mainstream culture, thus asserting their own psychological independence and autonomy.

Indeed, it is in this sense that some academics have argued that barebacking is simply an extension of the gay liberation movement:

> Gay men have traditionally been at the vanguard of sexual liberation and experimentation with new forms of sexual relationships. This experimentation has always existed under the threat of sanction from powerful institutions such as the police, the church, schools and the family. Barebacking can thus be seen as merely the latest in a long line of challenges by gay men to the sexual status quo and the institutions which support it ... Attempts to 'manage desire ... tend to produce 'transgressive desire', a fetishizing of certain acts because they are dangerous, stigmatized and emotionally charged (Mallinger, 1999).

This view is certainly a limited view within academia and the gay community. I did not find this analysis among the gay men I interviewed for this study. None of the men I interviewed for this study were barebackers in the sense that they engaged in willful, careless sexual intercourse to become infected or to infect their sexual partners. There were, however, some discussions about barebacking as a reaction to a uni-dimensional

approach to safer sex in general. In particular, a significant number of men in this study believe safer sex strategies have failed to keep up with many of the social and political changes that have transpired within the gay community over the last twenty years.

New Strategies of Risk Reduction

Although there is no evidence that the majority or even a significant minority of gay men are involved, it does seem that a group of gay men are literally engaging in unsafe sex behaviour that is putting them at risk for HIV/AIDS.

Many men in this study made it quite clear that they have made choices other than wearing condoms one hundred percent of the time. They believe that there are risk reduction strategies that are available to them, especially those in long-term committed relationships. Here is one example from the interviews:

> I would just like to say that my boyfriend and I have a long term relationship. We sometimes have a third person over for sex on a casual basis. However, we only play together, and we engage in no sexual activity that would put us at danger of HIV or STDs. I know this may be unusual, but we are safe, and are hurting no one. It [casual sex] does not happen very often, but we enjoy it and feel that it is ok for us (gay male, 32 years, Interview 2004).

For them, there is certainly a range of behaviours in between barebacking, a deliberate attempt to avoid condoms and those men who wear condoms without fail.

The ability to consistently negotiate and implement safe sex procedures hinges on a high degree of rationality precisely under conditions when individuals tend to be the least rational--in the throes of sexual excitation (Turner, 1997). Drugs, alcohol and a high degree of sexual attraction all serve to further diminish one's rationality during sexual

interactions. To the extent that drug and alcohol use are coupled with sexual opportunism and institutionalized within gay male culture, repeated lapses in protected intercourse with primary and secondary partners is not surprising (Green, 2002).

Among some of the gay men in this study who spoke about their difficulties with employing safer sex strategies, some experienced a momentary slip from condom use, while others incorporated unprotected anal intercourse into their sexual repertoires on a regular basis. The following participant explains his lapse in this way:

> My boyfriend and I often go out to nightclubs, sex parties and circuit parties. We have been together for four years and for that time we were monogamous. However, now we have decided to have sex with other guys. Our intention is always to have protected sex, but drugs, alcohol and the excitement of the moment has led both to forget about wearing condoms. Most of the guys we have sex with are also drinking or are doing drugs and so none of us really thinking about or talking about using condoms. We figure that if they don't talk about it, they are probably positive like us. We don't go to these parties with the intention of not using condoms but circumstances sometimes lead us to make that decision not to protect ourselves or others (gay male, 37 years old, Interview 2004).

Much of what the following participant discusses reflects the view that lapses are often a momentary decision. In other words, they are not planned that way. They "just happen".

> I am a single man who really enjoys sex. I just can't imagine not having sex with all the men I want. I do often discuss how my potential sex partner and I will have sex but often the moment is so sexually powerful that I just forget about it. I know about condoms, know how to use them, but the sexual energy I feel when I meet a really sexy guy puts me in a state of mind whether condoms is the last thing on my mind. Sexual attraction with all its energy makes me do some stupid things. I know it but if I am also having some drinks and doing some pot, the last thing on my mind is condoms and lube. I just want to fuck and they don't object. I just want to do it. As I mentioned, I think, when I go out to the bars or clubs my intentions are to play

> safe. But my best intentions are not always carried out (gay male, 23 years old, Interview 2003).

As the previous participants have suggested in their interviews, barebacking during their sexual experiences was generally unanticipated. Sexual attraction, drugs and alcohol were precipitating factors. However not all experiences with unprotected anal intercourse are unanticipated. For a few participants in this study, it was quite clear from their interviews that having sex without a condom was their main goal. The first participant put it in the following words:

> I guess what I am about to tell you would make a lot of people reading this think that I am crazy or worse. I am sure they think that somehow I may be contributing to a new HIV epidemic. However, I really don't think I am. All the guys I have sex with know my status. I just refuse to wear a condom. It just seems like the most unnatural thing to do. When I was young in the late 1970s, it [not wearing condoms] was also the most natural thing to do. When I see a lot of HIV+ men today at the sex parties that I go to I think how much it resembles how so many of us [gay men] had sex in the 1970s. Sex was to be enjoyed, not feared. So much about who I am and how I have sex was formed in those days. I was 26 years old when AIDS became a central part of my life. At the time I didn't think I would get sick. What young person thinks about dying in their 20s? I know that I sure didn't. I became very sick around 1995 and fortunately for me modern science has me still going strong. As I mentioned at the beginning of this interview, I know how crazy all this may seem to a lot of people. But coming-of-age before the AIDS crisis still defines so much about how I have sex (gay male, 50 years old, Interview 2004).

The sexual socialization of another participant is also an important rationale:

> So you want to know why I don't like wearing condoms. Well, that is not always easy to answer. I guess that growing up in the middle of the AIDS crisis should have told me enough about suffering and dying. We were the guys who were dying big time. There didn't seem like much hope for any of us. I often think that all the tragedies

> of the time should be enough to make me think very different about how I have sex today. However, except for a brief period during the height of safer sex promotion, or what I would like to call 'the time of the sex police', I have rarely returned to wearing condoms. I never fail to identify myself as a HIV+ man. I cannot tell you that new meds did not play a role in my return to condom less sex, because I am sure it did. I know that as a HIV+ man my time is definitely limited regardless of these meds. I was raised during a time when having natural sex [without a condom] was the only real way to have sex. Nothing since those early days has really changed my mind that it is still not the best way for two gay men to have sex (gay male, 55 years old, Interview 2003).

These interviews suggest that men who periodically or intentionally abstain from using condoms use a multiplicity of rationales. For some it is simply a question of spontaneity, for others it is the use of party drugs and alcohol. The last two quotes offer an explanation that is quite different. These two participants made it clear in their interviews that having unprotected sex is a choice based on their sexual socialization. They were raised in a generation where gay sex came out of the closet so to speak. Their sexual practices were formed during a time when having unprotected intercourse was 'the' way of having sex. There is no doubt that these men understand the consequences of HIV since they are both positive. Despite or perhaps because of this reality they intend to continue to pursue unprotected consensual sex with their potential sex partners. Is this approach contributing to a new generation of HIV+ men? Are we in danger of starting a new phase of the epidemic at the beginning of the 21st century?

The Future?

The literature has documented small but significant upward trends in unprotected anal intercourse among sexually active gay men (Ekstrand et al., 2000; Dodds et al., 2000;

Stoite et al., 2001 and Hogg et al., 2001). A significant amount of this increase has coincided with the wide-spread introduction of highly active antiretroviral therapies (HAART). The logic underpinning the association was that new HIV treatments engendered optimism among gay men about the quality of life and life expectancy of those infected with HIV. Moreover, the suggestion was that gay men's fear of becoming HIV or of infecting others had been reduced, which in turn led to more unprotected anal intercourse. This HIV optimism thesis has subsequently been supported by empirical social research that suggests that HIV optimism was at least one factor associated with recent increases in unprotected anal intercourse in Australia (Van de Ven et al., 2000).

A second view is that the increase in unprotected sexual intercourse is related to gay men's adoption of increasingly sophisticated strategies of risk reduction. This understanding emerged out of qualitative in-depth interviews with gay men in Brisbane and Sydney (Rosengarten et al., 2000). The narratives revealed that some gay men adopted a range of HIV risk reduction strategies based upon the 'clinical markers' of viral load and HIV testing. The strategies include:

- Negative men being insertive only with casual and regular partners.
- Positive men being receptive only with casual and regular partners.
- HIV positive men engaging in unprotected anal intercourse with partners of unknown or different HIV status on the basis of having a low or undetectable viral load.
- Positive men engaging in unprotected intercourse with other positive men.

The extent to which these strategies are being employed is not yet well understood. A study by Davidovich, de Wit, and Stroebe (2000) of 435 Dutch men in

steady gay relationships and found that, while 12 percent of these men negotiated safer sex with partners, 10 percent of the men who negotiated safety did not follow through as negotiated (i.e., they had unprotected sex with casual partners), heightening the risk for HIV transmission during unprotected anal intercourse within the steady relationship. A further associated risk with the use of negotiated safety is that it requires partners to present for HIV testing. Although testing is anonymous, and readily available, it still poses a great deal of fear for those who undergo testing. In short, some people do not wish to know their HIV status. Secondly, and perhaps more importantly, negotiated safety requires partners to be open and trusting about their sexual behaviour outside the relationship. Many partnerships find it difficult talking about these issues, which is the ultimate barrier in making negotiated safety work (MESMEN Project). Recent quantitative analyses have shown that men who disclose their HIV status to casual partners are far more likely to engage in unprotected anal intercourse than men who did not disclose, and that some unprotected casual intercourse is exclusively between HIV positive men (Prestage et al., 2001).

The available evidence suggests that the recent increases in unprotected sexual intercourse do not constitute a wholesale abandonment of safer sex by many of those engaging in unprotected casual anal intercourse. This evidence raises the possibility that some of the recent increases in unprotected anal intercourse may be accounted for by gay men adopting risk reduction strategies, in a similar vein to the adoption of negotiated safety strategies a decade or so ago. These negotiated risk strategies are significantly different from those employed in casual encounters. For one thing, negotiated safety is grounded in regular relationships whereas the other risk reduction strategies are grounded

in both casual and regular encounters. At the level of casual encounters this has more profound complications in terms of trust and being able to negotiate with one's partner. Most importantly, negotiated safety involves partners known to be of the same serostatus whereas the other risk reduction strategies sometimes involve partners of different HIV status (Smith and Van de Ven, 2001). However, it is not at all clear how effective the negotiated safety strategy is for reducing the possibility of HIV infection. Turner (1997) believes that the ability to consistently negotiate and implement safer sex procedures hinges on a high degree of rationality precisely under the conditions when individuals tend to be the least rational—in the throes of sexual excitation. Furthermore, Green (2002) argues:

> Drugs, alcohol and a high degree of sexual attraction all serve to further diminish one's rationality during sexual attractions. To the extent that drugs and alcohol use are coupled with sexual opportunism and institutionalized within the urban gay system of homosociality, repeated lapses in protected intercourse with primary and secondary partners is not surprising (pp.115-116)

The similarities between negotiated safety and other risk reduction strategies are overshadowed by the differences. Risk reduction strategies may not reach a threshold of safety that would admit them into the realm of 'safer sex'.

Conclusion

It might be easy to dismiss these strategies but there is an important reason why discussion should not be foreclosed around alternatives like negotiated safety or negotiated risk. Many men in this study have made decisions, based on personal, emotional, psychological and social rationales, which do not always follow the course

that has been laid for gay men over the last twenty years by AIDS organizations. These men are fully aware that HIV is still present, in significant numbers, within the gay male community. However, many promotion and prevention efforts continue to be based on psychological models (Health Belief Model) that espouse information and education as the foundation of behaviour change.

Efforts at health promotion not only ignore, but often deny, the complex psychological, interpersonal and psychosocial issues that have arisen as a result of the AIDS epidemic and are manifested in various forms of sexual behaviour (Odets, 1995). They support the vision that gay sex is without human meaning, overdetermining gay men as sexual beings and undermining the complexity of sexual behaviour. Such meanings must be understood if health promotion is to have any impact on such behaviours. As Mallinger argues, 'we need to move beyond latex education to the real, messy complexities of sex education' (1999: 3). The failure to do so may actually have created the potential for the barebacking phenomenon which has emerged as a reaction to prevention efforts failing to address adequately the complex meanings of sexual behaviour.

During the AIDS epidemic, most health promotion programs, educational interventions and strategies promoted information and education as the foundation of behaviour change. These strategies were diffused through AIDS community leaders and organizations who acted as motivators for the implementation of healthy behaviours (Kramer, 1989). This strategy continues to inform much of contemporary health promotion work. However, there has been the recent emergence of a more critical health psychology (Radley, 1993, 1994, 1997; Brandt and Rozin, 1997). One of its central

critiques relates to the fact that such models produce an image of the individual as overly rational, and relatedly, one which takes insufficient account of the complex psychosocial nature of choices facing individuals in relation to health related behaviours.

If we look carefully at how people conduct and talk about health-related activities, such as having sex, it becomes apparent that they embody latent emotional, social, cultural and value-laden meanings that individuals and groups incorporate into their ways of thinking and that they are not necessarily aware of (Calnan, 1987; Nettleton, 1996 and Crossley and Crossley, 1998).This is especially important as it relates to the issues of risk behaviour and gay men. Since most gay men understand how HIV is transmitted, sociological explanations are needed that can help us discover the social and cultural meanings that gay men use to justify this risky sexual behaviour.

Chapter 7

Conclusion

AIDS was first recognized in gay men in large urban centres in 1981, and since then it has become a defining force in gay men's lives. In Western countries and their urban centres, gay men still comprise the largest group, in absolute numbers, of people living with AIDS and HIV infection.

The effects of HIV/AIDS on the lives of individual gay men are as diverse as the men themselves. Many gay men have faced the prospect of declining health and early death and grieved the loss of partners and friends; still others have come to the point of sexual maturation amidst fears and uncertainties about HIV transmission. HIV has further stigmatized gay men who were already regarded by society as outsiders, but HIV has also galvanized many gay communities, as gay men and lesbians formed health, mental health, and political agencies to ensure that they received necessary health care and support and that their individual human rights were respected.

Gay men have coped with the AIDS epidemic in remarkable and various ways. Some have thrived, and some have become depressed. Some have been gripped by fear, while others have met the challenges and pushed for equal rights and models of care that respect their sexual orientation. The fight for political and human rights legislation in Canada even preceded the AIDS epidemic[6] and would eventually see the gay and lesbian community in Canada becoming the fourth country in the world to legalize same sex marriage.[7]

---

[6] See Miriam Smith's Lesbian and Gay Rights in Canada (1999) for a more complete discussion.
[7] Bill C-38, giving same-sex couples the legal right to marry in Canada, was passed on July 21st, 2005.

Much of the social science and epidemiological literature on the subject of AIDS congratulated gay communities in the late 1980s for their unprecedented and extensive adoption of safer sex strategies. This has been seen by many health care providers, ACOS and CBOS as evidence that responsible behaviour change in response to the unfolding drama of HIV/AIDS was indeed possible. Since the late 1980s, however, the focus on the elements of success in gay men's behavioural modifications has shifted, as a number of reports from both clinics and cohorts described evidence of continuing and increasing levels of unsafe sex among gay men. Researchers responded by constructing theories to explain why some gay men might still be practising unsafe sexual activities, and defining subgroups of the gay male population in which unsafe sex might be particularly likely.

A new paradigm was established, characterized by the view that what was occurring could be accurately described as 'relapse' or 'slippage' (King, 1994, p.135), as gay men were apparently unable to maintain safer sex practices, perhaps due to the effects of alcohol or drug use. However, as noted earlier in this study, Hart and a group of British researchers working on Project Sigma believe that this interpretation of gay men's sexual behaviours ignores the social context of unsafe sexual behaviour by focusing on individual factors such as ignorance and loss of control and that making a choice to engage in unprotected sexual intercourse is always wrong (Hart, 1992). This discourse on the relapse approach sheds little (if any) light on the true range of very practical considerations that are likely to be the most influential factors in determining why some gay men have unprotected anal sex: it is exactly these factors, social and cultural, which have been the focus of this research project.

This research project attempted to understand why, after so much success in trying to understand the threat of AIDS and protecting a generation of gay men from one of the worst health epidemics of the century, there seems to be an important qualitative change in how some gay men are approaching HIV/AIDS. In other words, in the face of a disease that does not yet or may not have a cure for the foreseeable future, what has moved an important number of gay men to reject a tried and true success strategy?

The stories told in this study reflected the views of gay men ranging from their early twenties to their early fifties. Their views speak to the generational differences of the gay experience. Many grew up in the worst days and years of a deadly epidemic. Others, although knowledgeable about HIV and its potential consequences, have never had to face the isolation, stigma, suffering and death associated with a positive HIV test. Views about safer sex strategies and options differed across age groups. A number of older and younger gay men in this study did acknowledge that they engaged in unprotected sexual intercourse. Although safer sex fatigue and new medications were advanced as reasons for taking sexual risks, other, more age-related, factors like personal loss and ageism separated these two groups of gay men.

The scientific, historical and sociological evidence has recorded that gay men have succeeded in changing their sexual practices in the advent of a deadly health epidemic. What also seems clear is that an important number of gay men are making decisions to abandon this safer sex strategy. This study attempted to discover what, if any, generational differences there were between an older and younger cohort of gay men as it related to their safer sex practices.

Limitations of Study

In retrospect this study did have any number of important limitations. In seems quite clear that focusing the study predominantly on age and not on variables such as income, education or even ethnicity have limited the amount of analysis that is incorporated in this study. For example, do gay men of different ethnic communities in Montreal have the same strategies and histories towards safer sex than the 40 white gay men that I interviewed? Furthermore, although most literature on risk behaviours find no significant differences as it relates to income and education, it would have been interesting to have a wider set of explanatory variables than age to try and determine such a complex socio/sexual phenomenon that is now part of a small subset of gay men in Montreal.

The Early Days of HIV: HIV and Older Gay Men

Gay men who came to an age of sexual maturity at the height of the AIDS epidemic were being faced with an unprecedented level of illness and death. At a time when many gay men were experiencing the first decades of political and sexual liberation, they were also discovering that this new found sexual expression could be ultimately deadly. Moreover, the lack of political will on the part of all levels of governments to fight this epidemic made this a particularly lonely time for infected and affected gay male populations in large urban centres to be seeking action on behalf of a social group. However, as J. D'Emilio (2002) argues in his book, The World Turned, the inaction by governments led to a revitalization of the gay movement by building a set of institutions and associations that would act on behalf of gay men in the political, social and medical arenas. The advent of AIDS, although deadly, regenerated a community

spirit that would move eventually move beyond this epidemic, to secure a greater array of rights for all gay men.

Gay men, by definition, during this historical period, were excluded from many of the social-structural life paths that have always been afforded to heterosexual men. The inability to marry, to adopt children, to be gay-identified throughout much of one's social position and to lead a fully open and sexually integrated existence, had potentially powerful effects on the shaping of sexual practices and erotic norms (Green, 2002).

Many gay men, denied the formal social structures of the heterosexual community, reached out to more hospitable centres, primarily urban. It was within these urban centres that gay men were able to initiate new sexual and social options. Men who were living within strictly closeted identities were given the opportunity to create a more stable, positive identity. This identity was formed on the street, within bars and bathhouses and overlapping institutions. Gay men were part of an urban gay system of homosociability which promoted a commercialized sexual identity constituted by sexual opportunism and bachelorhood (Adam, 1987; Warner, 1993).

These institutions had a profound impact on the lives of an earlier generation of gay men precisely because they were excluded from the institutionalized rites of passage that define heterosexual adulthood in the society. Gay bars, bathhouses and nightclubs provided the optimal conditions for sexual exploration and the construction of a positive sexual identity. Much of the positiveness of this time would soon change, however. Just as many gay men were constructing an individual and collective identity as gay men, HIV would enter into these gay communities and institutions and forever change how their life stories would unfold.

An entire generation of gay men would be now be defined, both internally and externally, by the discourses of HIV/AIDS and safer sex. The messages of safer sex saturated the gay community through health clinics and gay-oriented periodicals. Initially the messages were confused on questions such as whether kissing or oral sex was considered as dangerous as anal sex. These discussions fundamentally changed what it meant to be a gay male. Monogamy became a life-or-death issue for gay male couples. For the first time, gay men had to learn how to use condoms, not as a prophylactic to prevent pregnancy or even the annoyance of an STD, but to prevent death. Gay men had to adapt quickly to this new reality, mostly without the help of local or national health centres.

This general unwillingness of established health organizations to help stem the increasing level of death in the gay male community mobilized many within this community to take on the issue of HIV/AIDS. They built AIDS Community Organizations (ACOs) and Community Based Organizations (CBOs) which would eventually become the vanguards in this political and medical struggle. These associations cared for infected gay men and their partners on a personal, psychological, emotional and medical level. They developed some of the first safer sex strategies for gay men. They pushed national governments and their respective health agencies to take this crisis more seriously.

These ACOs fought homophobia and heterosexism which many gay activists believed to be contributing factors to the inertia of governments in the face of this epidemic. They built a series of health service organizations with which gay men could seek comfort, medical help, financial assistance and housing. These became the identity

markers for a generation of gay men affected and infected by HIV. These organizations strengthened the gay male identity and reenergized gay activists after many years of death, disease and suffering (D'Emilio, 2002).

These gay-identified institutions certainly pushed the health of gay men to the forefront of many countries' agendas. Within North America, and in particular, Canada, these institutions expanded a struggle for political and legal recognition; issues such as same-sex benefits, marriage, pension benefits and hate crime legislation would begin to dominate the political agenda (Warner, 2002).

There is no doubt that this generation of gay men put AIDS on the front burner of health issues of the last two decades. They built structures and institutions which are still working on behalf of gay men. However, many gay men of this generation did not live to see the achievements of their gay brothers. Many, especially those in the early struggles to save gay men's lives, would probably not imagine the changes that have taken place, specifically as they relate to AIDS.

In my interviews with members of the generation who survived the first deadly wave of HIV/AIDS I found some concern about how a younger generation of gay men is not following the same safer sex strategies there were such an important part of their lives. Most of these older gay men are struggling to understand how things have changed since the early days of the epidemic. They acknowledge, for the most part, that not all gay men identify themselves solely as survivors of an epidemic or as sexual beings.

Not only have the social and cultural definitions of what it means to be gay changed, but those who are infected by the HIV virus are no longer given an immediate death sentence. AIDS, in the view of many, can now be defined as a chronic,

manageable disease. As a result of this redefinition, younger gay men are no longer as frightened by the earlier scourge of AIDS. New medications have shifted how a new generation of men view HIV.

Despite these concerns, older gay men have also begun to re-examine how they see and react to HIV. I had assumed that most still held on to the belief in a safer sex philosophy developed during the early days of the epidemic. However, this was not exactly the case. For many of these men, age could be a double-edged sword. Yes, they were definitely aware that having unprotected sex could still be deadly; medications are available, but there is no vaccine or cure. Death is inevitable. Many of the men I interviewed had lost at least one partner and many friends. It is exactly this reality of loss that has placed this generation in a vulnerable position.

Personal loss, isolation and ageism are important psycho-social variables that have influenced decisions that some of these men have made to occasionally abandon a lifetime of safer sex protection. Except for the help and comfort provided by community organizations, many men in their 40s and 50s feel isolated from a gay culture that is fixated on age, rave parties and drugs. They do not feel that they are represented within the dialogue of a new generation of gay men. The focus of bars, magazines and saunas is on youth. Age is a defining characteristic and it is reflected in the popular gay media to such a degree that many men do not see their images in the larger context of the gay community.

HIV and Younger Gay Men

Many younger gay men in this study made it quite clear that we must now view gay men and their sexual behaviour in a different light. The important changes that have enveloped this generation of gay men have also led to a redefinition of their sexual practices. A number of interviewees suggest quite strongly that AIDS prevention programs of the last decade may find themselves irrelevant in the next few years, if that has not already happened. It was one thing to expect gay men to practice safer sex one hundred percent of time in the context of the 1980s and 1990s, when many expected this sacrifice of sexual pleasure to last only a short period of time. It is quite another thing to maintain similar expectations in 2005, when becoming infected does not necessarily mean a swift and difficult death.

Since 1996 many men have made remarkable recoveries thanks to combination therapies, yet there is also an expectation that this information remain compartmentalized, separated from the information men factor into social and sexual strategies. Keeping and maintaining a narrow focus on reducing infections, as opposed to placing this strategy in a context of general overall health promotion, could encourage a single-mindedness that easily shifts into moralizing and subtle coercion.

An earlier generation of gay men made it quite clear that they were not interested in having the government in their bedrooms or bathhouses; younger gay men share this sentiment but are also not interested in having the "prevention police" in their own community. They declare that sex is their own choice, not the community's. Many have now disavowed the notion of safer sex as an ideology imposed on them by others in response to a crisis that has passed. In this sense, they also reject the more established

gay male community which brought them this era of safer sex ideology. Many younger participants believe it is no longer realistic to assume that all gay men are part of a homogenous gay identity of the 1970s and 1980s. For many, being gay cannot only be defined solely in the sexual relations they have with other gay men. Younger gay men's experience is fragmented. Although they find enjoyment, friendship and potential sex partners within a geographically established gay village, their own self-definition is more global in nature. As Green (2002) elucidates quite clearly, gay men of the first decade of AIDS constructed their identity within the parameters of a distinct set of institutions, bars, clubs, and bathhouses. Although younger men still use these institutions, they are not necessarily definitional in nature.

It seems quite clear from sociological and epidemiological evidence that many men have never adopted safer sex practices. Even during the darkest days of the epidemic a lot of men were in denial. Except for some rudimentary discussions, the media had hardly covered it. Not all gay men read or had access to the gay press. Many gay men just did not believe they would become infected. It did not seem so risky to have anal sex without condoms, particularly if it was only once in a while.

Younger gay men in this study have definitely been influenced by a new attitude. From new medications to safer sex fatigue, to party drugs and alcohol, to a media that downplays the sheer certainty of death, younger gay men are not as consumed by the topic of AIDS as was a generation of gay men living and surviving through this epidemic. Many younger gay men said they often make up their minds about safer sex in the heat of the moment. They spoke of calculated and negotiated decisions. They spoke of the fluidity of their decisions to use or not use condoms. It often depended on their partners.

There are grey areas in the debate about whether or not to use condoms all the time. These changes in gay men's relationship to safer sex have also elicited a wide range of opinions. For many gay men, any retreat from the message that saved tens of thousands of gay men's lives, is just suicidal. However, as we enter the third decade of AIDS, it seems that many gay men are retreating from this proposition because it is not realistic. Many gay men interviewed for this study believe that it is no longer possible to ignore the reality of the gay street for a new generation of gay men. There are simply too many profound changes in the social, cultural and sexual lives of gay men to avoid confronting how gay men are having sexual intercourse. It would simply be too easy to dismiss these men as irrational, ignorant or misinformed.

The Sociology of Risk

An important theoretical position of this dissertation was to ascertain whether or not most health educational models are applicable in the light of changes among gay men's health behaviour strategies. Most of these models, in particular the Health Belief Model (Davies, Hickson, Weatherburn and Hunt, 1993), promote the rationality of the individual actor. However, if we look carefully at how people conduct and talk about health-related activities, such as having sex, one cannot deny the emotional, social, psychological, cultural and value-laden meanings that individuals and groups incorporate into their ways of thinking and having sexual relations.

Gay men in this study, whether older or younger, make decisions to have unprotected sexual relations as a result of a series of negotiations between at least two individuals. Most of the men in this study continue to engage in safer sex strategies that

were first designed in the mid-1980s. However, many men, whether HIV+ or HIV-, make decisions to have unprotected intercourse based on any number of variables, including their serostatus, their age, and new medications. None of these decisions are made without the consent of their sexual partner. As a result, models of behavioural change that rely too heavily on the individual actor are ineffective, since they are based on the fallacious assumption that all sex in which HIV may be transmitted involves only one person, and, consequently, that this behaviour (unsafe sex) can be understood or accounted for by looking at one person alone (Davies et al., 1992).

The Future of Safer Sex Strategies among Gay Men

Gay men's desire to have unprotected sex has been simultaneously condemned and sensationalized by the media. This is often done in the name of ratings, readers and revenue. Gay community leaders seem to direct gay men's focus onto discussions about monogamy, morality, gay marriage and post-AIDS logic. Unfortunately, this often closes down any important discussions or dialogues on the real lives of gay men. Although AIDS service organizations are finally beginning to discuss the issue of barebacking, they too often focus their energies only on issues of treatment advocacy and funding.

Men who have sex with other men are definitely re-evaluating their options. They are making different choices. Sometimes these choices offend many within and outside the gay community. Gay men are asking different questions than those that saturated the community prior to the development of protease inhibitors. For example, what does it mean to have an undetectable viral load? Could it mean that gay men might not necessarily have to wrap themselves up in latex for the rest of their lives? What about

reinfection? If potential sex partners are made aware of their partner's HIV+ status and still decline a condom, what are the possible consequences?

Public HIV prevention messages have, until recently, been one-dimensional in nature. Early messages like "Use a condom every time. Every time" simply does not reflect or represent the sex lives of men who have sex with men. Many men in this study concurred with this reality. They felt that many ad campaigns of ACOs were unrealistic if one considers all the changes that have transpired in recent years. How then do we acknowledge the power and complexity of sexual relations and still reduce risk in the face of a disease that requires life-sustaining medications and redefinitions of what it means to be a gay man in the third decade of AIDS?

Because many gay men are claiming that the "one-size-fits-all" model of the early days of the HIV/AIDS epidemic is no longer realistic, it is now possible for gay men to reassess their options openly. When certain sexual acts, such as unprotected anal intercourse, are pushed back into the closet, we are denying reality. Unprotected intercourse is happening, and shaming people out of their behaviour will fail.

It seems quite clear from the interviews in this study that there must be an acknowledgement that an important number of gay men are having unprotected intercourse. They also agree that besides the choices that are made by gay men to engage in these risk sexual behaviours, HIV/AIDS education programs must take into account of the changes that are ongoing in the gay community. For many, post-AIDS prevention programs must relinquish any perception of moralizing. The facts on the ground are changing and as a result gay male communities and AIDS organizations are no longer operating under emergency conditions. However, these communities and organizations

are not always speaking the same language. This is very problematic since gay men are still having unprotected sex.

The key seems to be that one must accept that every act of unprotected anal intercourse involves risk. In some cases, the risk is so small that most would agree that it can be discounted, as with a couple that has been monogamous since their last HIV negative tests, or a couple in which neither partner has ever had penetrative sex. In other cases, where partners are of unknown status, the same encounter can be extremely risky. Between these extremes, however, are a range of situations where the state of affairs is less clear cut and where many men make most of their decisions most of the time. The impact of HIV/AIDS on gay men is undergoing an important qualitative and quantitative shift and organizations committed to gay men's health must be open to how this redefinition of the impact of HIV is challenging the orthodoxy of safer sex. New solutions and ideas are going to be needed to stem any further increase in the levels of STDs and HIV infections among gay men.

Future Research

It is quite clear to most researchers of the HIV/AIDS epidemic over the last twenty years that gay men have been successful in changing their sexual behaviour to reduce the level of infections. Furthermore, most studies, whether sociological or epidemiological, are stating that the introduction of anti-retroviral drugs is changing the quality of those who are HIV+. Although these two developments are extremely significant, the latter development is changing the former. This is very disconcerting. The

most important implication of such a change is that an apparently significant number[8] of gay men are changing their sexual practices because of these new medications.

In the public imagination, AIDS has moved from a category of being a terrifying mystery epidemic, to what is now commonly understood as merely a chronic disease, and, therefore, less pressing. As a result, it is getting increasingly difficult for AIDS organizations and health care providers to reach a new generation of gay men and keep an older generation of men using condoms. Slogans like *"Condoms every time"* must be replaced by conversations. There is no single narrative that can contain all of our experiences of desire, of sex, of relationships, of HIV.

The era of slogans and latex education must be replaced by the real, messy complexities of sex education. We often approach safer sex like it is something we just have to do on our own. That is partly true, but it is not just the mind that is involved. Sex, safer or not, happens with someone else--whether that relationship lasts ten minutes, five years, or a lifetime. While some of us may identify with one particular sex practice, the reality is that most of us change what we do depending on whom we are with.

I believe that further studies must focus on this divide between the reality of most gay men's lives and prevention programs that do not always seem to concur with that reality. AIDS must be accepted as a long term challenge. AIDS organizations must be freed from the pressure to condemn every incident of unprotected sex or feel personally responsible for every new infection. Incidents of unsafe sex should not be seen as shameful or as a badge of courage. New prevention programs must take the morality out of these discussions. Specific sex acts should be neither romanticized nor demonized.

---

[8] There is no absolute or accurate number of how many gay men are abandoning safer sex in the light of new medications men who decide to abandon condoms.

Finally, I would argue that further research must also be conducted on older gay men, a group of men who have been left out of a lot of the research about unprotected sex or barebacking. Survivors of this generation, as this study has shown, may be less likely to engage in unprotected intercourse, but it unrealistic to believe that none do so. Although there may be similarities between the factors that lead men to have unprotected sex, there are definitely other issues that concern older gay men that must be more carefully studied and evaluated such as ageism, loss, and vulnerability.

Appendix A

A Personal and Sociological Journey

As a 49 year old gay man, who has experienced the loss of many friends during this devastating epidemic, this dissertation has taken on a great deal of personal as well as sociological importance for me. When I first began the research, I realized how much of the material I read and studies I analyzed were very similar to ideas that I had and experiences that I had already lived, such as safer sex fatigue, loneliness, and ageism.

I believe it is important to recognize one's prejudices and assumptions and how they might affect one's observations and conclusions. It is not always possible or desirable to separate one's life from the issues one has decided to study. Part of the reason I attempted this research was that I thought being gay would make me an insider with access to knowledge that may not necessarily be available to all researchers who would attempt this topic. I realized as the study unfolded that it is very difficult to separate oneself from the actual research itself. I believe that my own experiences, coupled with the information that I was able to obtain from the participants in this study, will hopefully give readers and other researchers a deeper, personal understanding of a complex social/sexual issue.

I grew up as an openly gay man in the early years of the AIDS epidemic. At that time I was living in Ottawa (1984-1994) and attending the University of Ottawa. It was a difficult time, particularly since so much about being a gay man was becoming dangerous, even deadly. During the early days of the epidemic I really was not personally concerned with my health. I was in a monogamous love affair. Having sexual relations outside the relationship was taboo for both of us. As a result we did not always wear

condoms during our sexual relations. There were times when we discussed condom use, but it really did not become an important part of our conversations.

At the same time, I was hired by the Students Federation of the University of Ottawa to put together a policy statement on AIDS for the student body. We hoped that this would influence the administration of the university to institute a similar policy. In the early 1990s I was taken on as a volunteer by the AIDS Committee of Ottawa. I became a 'buddy' for a young HIV+ gay male. I spent a number of months with him, taking care of his personal needs: listening, doing laundry, picking up groceries etc. Mostly, I was there to listen to him, to provide comfort and support. I became personally involved in his life. We would eventually become good friends.

In addition, I was actively involved in AIDS work. I attended lectures and AIDS walks, and volunteered where I could. As I look back on this time, I often ask myself how, knowing so much about HIV, knowing and caring for HIV positive men and attending funerals, I would later find myself ignoring the most basic rules of HIV protection. Acknowledging this is not easy. I helped to draw up policies for AIDS prevention, helped to mourn those who lost friends and partners to HIV, and still, in many instances I took what I believe to be unnecessary and careless risks in my sexual practices. However, I believe that my own behaviour gives me some important insight into how gay men, knowledgeable about HIV, abandon safer sex practices.

As I listened to many participants in this study, I often, at the completion of the interview, could see myself in their situations. There often seemed to be a parallel analysis going on: the explanation of the participant and my own. It is a difficult process to try and understand why you potentially take serious risks with your life and those

around you. Actually, it is sometimes beyond a person's own psychological capacity to understand such a complex issue. However, being in similar situations to the participant(s) does open the door to a more complete analysis. It certainly does not mean that one has to engage in the same types of socio/sexual encounters to be able to give an appropriate analysis of a particular situation. There is, though, little doubt that my own personal experiences in similar contexts have made the analysis in this dissertation more complete.

Being Young in the Post-Stonewall Generation: My Own Journey

Youth springs eternal. One is at the cusp of important and exciting emotional, psychological and sexual awakenings. It is hard to imagine that we will ever get old. Very little seems beyond our reach. Regardless of the generation of whom we speak, it does not seem possible to imagine suffering and death.

Growing up as a gay man in 2005 is certainly, for many, an easier experience than what my peers and I faced. There were very few men of my generation who had the opportunity or courage to present our families and friends with the acknowledgement that we were gay, or as many labelled us, queer (today considered in a more positive light), faggot, sissy and many other emotionally scarring terms.

Despite advances in cultural, political and social rights, living openly as a gay man can often be psychologically and emotionally draining. Most parents, with the rarest of exceptions, expect that their children will be heterosexual, that they will have children and, hopefully, even grandchildren. Nothing would have made my parents happier than if I had married and had children of my own. In my own thinking, I considered myself

fortunate to have three brothers and a sister. There was at least a strong probability that one of them would get married and produce the required offspring!

At this point I would like to make something perfectly clear. My late parents, whom I loved and admired, were no different from millions of other parents of gay men and lesbians. They were socialized to raise their children as their parents had done. The very terms gay and lesbian were alien to them. When my parents became aware of the fact that their son was gay, nothing really changed. Nobody would discuss it with me. It was certainly a taboo subject in a Roman Catholic family who believes that homosexuality is a sin.

My family and I lived in a very small community with close neighbours who knew practically everything about everybody else's life. The overwhelming majority of these families also shared the same religious faith, and with the rarest of exceptions, considered homosexuality a sin. Having a gay son or daughter was considered to be a failure on the part of parents. Since very little within this closely knit community was not known, the revelation of this reality brought shame and sadness. The one thing that I did recognize later in my adult life was how psychologically and emotionally difficult it must have been for my parents to have a gay son. I am sure there was much pain for them when they had to explain why their son was still not married. Why was their second oldest son not like all their other children? When I reached my late 20s and early 30s, my parents just didn't ask anymore if I was dating a woman, or if I would get married. They came to a quiet and dignified acceptance of this reality in their life. It was difficult for all of us involved in these personal transformations. Most importantly, for me, the door to my childhood home was always open.

I recognize that for many gay men of my generation things were much more difficult. Many were disinherited. Some were thrown out of their homes and could never return home. There was much pain, and this pain, for some, remains today. Today's generation of gay men certainly have access to a wider set of institutions that can make their 'coming out' easier. Even their parents have organizations that they can turn to, a place where they can be understood, and a place where they discover they are not alone. Despite all this, the process of becoming a fully open gay man in the 21st century is not obstacle-free.

Many young gay men still find themselves in situations similar to what I remember. The one I recall most vividly is my high school, a very difficult experience for me and for young gay men of all generations. High schools are hostile environments for gay, lesbian and bisexual youth (Canadian Public Health Association, 1998; Flynn Saulnier, 1998). Discussion of gay and lesbian sexuality has been extremely slow to enter the curricula of Canadian schools; when it does, such discussion often faces opposition from religious organizations associated with the political right (McKay, 1998). Such hostility ranges from verbal abuse to physical violence.

Gay youth struggle to fit into the social atmosphere of high schools. Many cannot get answers in high school to all the questions they have about their awakening sexuality. Many have little or no contact with the gay community in their area. Many live in small, rural communities with no resources for gay teens. Many find themselves lonely, depressed and cut off from their gay peers.

The emotional, psychological and physiological changes that adolescents undergo are, at times, traumatic. This is the case even when you have family, friends, and other

social institutions that can actually understand and empathize with you. However, the experience of being on the margins, on the outside of mainstream beliefs about sexuality and sexual orientation, renders many gay youth helpless. The consequences are severe:

- Many lesbian, gay and bisexual adolescents drop out of school because of harassment, harassment that is often allowed and in some cases encouraged by teachers or staff (Flynn Saulnier, 1998; and Dempsey, 1994).

- Many gay adolescents become street-involved and homeless.

- Suicide rates and attempted suicide rates are high among gay students (Coalition for Lesbian and Gay Rights in Ontario, 1997; and Hellquist, 1996).

- Internalized homophobia, shame and low self-esteem are common (Canadian Public Health Association, 1998; Kaufman and Raphael, 1996 and Otis et al., 1999).

These issues for gay youth are indeed troubling. In my own personal experience as a young gay man, in a Roman Catholic public school in the early 1970s, the school environment was unrelentingly harsh. Nobody understood you. No social institution, family, friends, peers or the church, would or could do anything on your behalf. Even if they could help, you were not going to bring up the topic in the first place.

What did all this mean for me and for a generation of gay youth who went through their adolescence being invisible? One immediate consequence was lack of any knowledge of sexuality. What about sexually transmitted diseases? How did one have sexual relations with a man? Where did you go to meet other men? One would hear on the street where to find a gay bar but what not to expect when you arrived.

One's knowledge of this world most often came from first-hand experience. In my case, nobody ever told me what I should expect. How should I behave? Unfortunately, without any prior sexual education, I put myself at risk. The risk factor was high for a

young gay man raised in a religious family who believed homosexuality was a sin. No discussion on sex ever took place in my home or school. This, combined with loneliness and isolation, put me at a very high risk for STDs. As a result, during the early days of my "coming out" I did pick up a number of STDs. Luckily, none of them were life threatening.

These events took place three decades ago. In some important ways the risk factors that young gay men face are still with us. As I interviewed gay men in their 20s and early 30s I discovered that the issues they faced were somewhat similar to those I faced in my youth. I recognize that the world they grew up in was different than my own. They indeed have a wider range of freedoms and possibilities. However, one cannot ignore the fact that, despite these changes, many young gay men are dropping out of high school, suicide rates are very high, and low self-esteem still accompanies the realities of being gay.

Young men today know how HIV happens. They know the consequences. However, other mitigating factors are influencing their sexual relations with other men. The academic literature has identified safer sex fatigue, new medications, and party drugs as important factors in their sexual decision-making. Information and technological revolutions are giving these men the tools to become aware of HIV/AIDS in a way that was impossible for my own generation.

In the interviews with some of these young men I recognized many issues that I confronted many years before, even before HIV/AIDS. Being on the outside looking in, never fitting in, always having to explain what others never have to, places an added psychological weight on their shoulders. Why you are not married (in a traditional

marriage) yet? Are you planning on having children? Most family members, and friends, cannot imagine that your life will not be the same as theirs.

Despite the newfound freedoms, many young gay men still are not "out" to their family and friends. Much, if not all, of their social and personal life is hidden from view. Some drift away from their families to larger urban centres. Those who do not make it drift on to the street. On the street one may find freedom but one also finds oneself more vulnerable to abuse and disease.

Trying to understand why this generation of young gay men are still at risk to HIV is complex. One would think that the times we live in have made it easier to be gay. All the young gay men I interviewed were certainly aware of AIDS and how it is transmitted. They did not know anyone personally who had died from AIDS but they certainly knew that it is still with us.

In many ways, however, their generation is similar to the post-Stonewall generation that I experienced. They want a return to the sexually open days following Stonewall and preceding 1982. The days, months and years after Stonewall liberated many gay men from social and sexual repression. The sad days after the discovery of HIV left many men frightened to enjoy sex the way they knew it. Many gay men were criticized for their voracious sexual appetites. The bright rainbow of sexual freedom was fading and has only recently begun to reinsert itself in the centrality of gay men's lives. This, along with an era of greater political and social freedom, has forced many gay men, whether older or younger, to reconsider issues that had been dormant for many years. In particular, how do gay men have sex in the light of these new freedoms?

This return of sex to the centrality of many gay men's lives is pushing the discussion of sexuality to new areas of concern that could not have been imagined during the deadly days of the HIV/AIDS epidemic. In a myriad of ways, today's youth views sex differently. Having sex with other men is not deadly. New medications have changed the face of AIDS. New clubs are opening up. In Europe, especially, backroom sex is back with a vengeance. Gay men want to forget about AIDS. Yes, they understand that it is ever present, but it is qualitatively and quantitatively different from the early days of the epidemic.

I believe that this young generation of gay men do have reason to see things differently. In many ways, AIDS is different. However, the reasons that men engage in high risk sexual activities are in some ways no different than my own. Alcohol, drugs safer sex fatigue and new medications act as important motivations in a young gay man's decision to have unprotected sex. Knowledge about HIV itself is not always sufficient to protect these men from taking a calculated or negotiated risk.

Finally, it is important to state that this group of gay men is not homogeneous. Any educational strategy that tries to incorporate all gay youth into one social grouping is a mistake. Gay men have multiple identities and often complex personal realities. The closer we come to designing strategies to encompass these complexities, the better placed we will be to handle the issues for a new generation of gay men.

Interesting Discoveries

It seemed clear to me as I was conducting the study that men in their 40s and 50s, like me, were indeed taking risks in their personal sexual encounters. As the early

chapters of the dissertation highlight, there are significantly more studies that examine the risky sexual practices among young gay men than older gay men. Studies which acknowledge, and try to understand, the levels of high risk sex among men over 40 are extremely limited.

However, I never really doubted that older gay men do take risks in their sexual practices. I was one of those men. In my own adventures at sex parties and bathhouses I met many older men who abandoned condoms, many of whom had no trouble relinquishing the safer sex mantra in return for some physical and sexual attention. As I look back at this time, in the writing of this dissertation, it never occurred to me how complicated it was to try and explain why an older cohort of men engaged in unprotected anal intercourse.

As I went through my own self-evaluation I realized that these older men's histories within the larger gay community could act as a double-edged sword. Yes, these men were more aware than most of the enormous sacrifices that have been paid by men of their generation. They, and many of their peers, were on the frontlines of HIV prevention. They formed the backbone of the central community message of safer sex: '*Unsafe sex=death*'.

As the survivors of this deadly time in our collective gay history, however, many do not feel as attached to the central institutions of gay life, like bars, bathhouses and circuit parties. Many who have lost lovers and friends find themselves isolated, and alone, in a community that puts the accent on youth. From the bar culture to magazines to saunas, youth is the drawing card. When was the last time that you saw a gay man in his

sixties as the main image in a gay magazine, in an ad for a major community event? This isolation has its consequences.

I do not believe that there is a direct link between older gay men's isolation from the larger community and an increase in riskier sexual practices. However, I do believe that this isolation leads to loneliness. This, combined with ageism, personal loss due to AIDS, and being alone, can and does contribute, I believe, to an increased level of risk.

Men over 40 in this study made it clear that they understand the health risks involved in some of their high risk activities. But time after time, even though it was not always made explicit, some aspect of getting older did play a role, either directly or indirectly, in their decisions to take a risk.

I believe that one cannot ignore the discussions of psychological factors and their concomitant role in gay men's decision-making about sex. Loneliness, aging, living alone, the loss of partners and friends are, I am convinced, important variables in our evaluation of high risk sexual activity. However, much of this has been ignored in the academic literature.

Moreover, I am convinced that we must acknowledge that, whether young or old, gay men take risks for countless reasons. As I began this study I hypothesized that there was a clear generational divide between these two categories of gay men. However, I discovered that lumping all older gay men together or all young gay men together in the same category is not useful. Neither group of men are part of a single, homogenous community. They are as divergent as all social groupings. There is indeed a particular history which does separate the older generation of gay men from men of a younger

generation. However, this alone does not account for all the choices they make in their sexual relations.

I tend to think that psychological and emotional factors, in combination with a series of social and individual motivations, are the best possible explanation for why gay men abandon years of safer sex activities or do not engage in them at all. In my own experience, I truly believe that we have underestimated what it is like to get older in the gay community. I remember vividly being a young 25 year old "out" gay man. I would be surprised if I ever imagined giving a gay man in his 40s or 50s the time of day. I was much more concerned with all the advantages of being a young man, whether that is sexually, socially and psychologically. Today, I am that older gay man.

In a community that is so predominantly centred on age, growing older often seems like a death sentence for some. Very few activities or resources are directed towards us. As a result, many turn to sex parties and saunas for the physical and personal attention they lack in their private and social lives. It is not surprising then, when faced with these difficult life transitions that this generation of gay men will occasionally or even intentionally abandon decades of safer sex methods.

Conclusion

I would like to conclude with some personal and sociological observations about this study and, I guess, its relationship to my own journey as a gay man. One's own personal evolution is always a work in progress. This attempt to discover some new realities about other gay men's lives has certainly been that for me. I could never have imagined a few short months ago that I would be writing about so many intimate details

of my life. In many ways, it has been truly cathartic. I have spoken about these topics in many ways to many people over the course of my lifetime. But none of that has prepared me for what it actually feels like to put it in writing. I edited this chapter many times. There were things I wanted to say, and then I changed my mind. As important as this document is to me, I realized that some family members may not be all that happy about it. However, none of it stopped me from talking about the essentials, particularly since I believe they have the most impact on my observations about this subject matter.

There was really no way that I could leave my own personal evolution aside, especially when it reflects so much of what I heard during the interviews for this study. I must admit I was tempted to challenge some of the observations made by some of the subjects in this study. Although difficult, I let them do the talking. I wondered later if what I was feeling was just a personal disagreement or was it something else. It probably was a little of both. There is no doubt that as someone who lived through the deadly years of the epidemic, I had some well developed views on safer sex strategies.

I would like to reiterate how important this study became for me. I certainly had some definite opinions about why some gay men would not use condoms, why they would risk STDs and even, HIV. Some of these opinions were confirmed by the participants in this study. Others, however, were not.

Most importantly, this study became an important sociological and personal journey that I have not regretted. Gay men are now, I believe, in a transitional phase of safer sex. Although the majority of gay men still engage in protected sexual intercourse, new definitions are arising in the safer sex lexicon, whether that is negotiated risk, safety or barebacking. The unidimensional view of safer sex is disappearing as more and more

gay men are living in committed monogamous relationships that are now legally sanctioned by the Canadian state.

It seems quite clear to me that there is no single distinguishing sociological factor that puts younger or older gay men at risk. Younger and older gay men have different histories. The social and societal repression suffered by an older generation of gay men is now less severe. Some issues between these two different age groups are similar: new medications and changing safer sex strategies. Some are different: aging and personal loss.

No matter what the underlying factors are, things are changing for gay men. Are they re-defining strategies for safer sex strategies? I believe so. The events of the last ten years cannot but change how gay men approach the safer sex strategies of a previous generation.

I believe that most gay men understand the realties of HIV and STDs. This has been an unqualified success of ACOs. However, the survivors of the AIDS epidemic and a new generation of gay men do not approach sex as an activity which necessarily equates with death.

Many gay men still die of HIV-related complications. The numbers of gay men still becoming infected is worrisome. Epidemiological and scientific studies have certainly done their part in giving us the science of HIV.

However, my own personal journey has certainly told me that awareness alone is not enough to prevent HIV. As long as gay men still make up the most statistically significant social group being infected and dying from AIDS, we have a responsibility as

researchers to discover and understand the personal journeys of gay men of all age groups.

Appendix B

Interview Data

There were a total of thirty-six interviews. Following is a breakdown of the age, income, and educational attainment of the interviewees:

Age	Income ($)	Education	Interview
21	>20,000	College	2003
22	<20,000	College	2003
23	<30,000	University	2003
23	>30,000	College	2004
24	<20,000	High School	2003
24	<30,000	College	2004
26	>20,000	College	2003
26	>30,000	University	2004
27	<35,000	University	2003
27	>30,000	University	2004
28	<15,000	High School	2004
29	>35,000	University	2003
30	>30,000	University	2003
31	>20,000	High School	2003
32	>35,000	University	2004
33	<20,000	High School	2003

Age	Income ($)	Education	Interview
35	>30,000	College	2003
35	>20,000	High School	2004
36	>40,000	University	2003
36	>40,000	College	2004
37	<30,000	University	2004
39	>20,000	University	2003
45	>50,000	University	2003
46	<35,000	College	2003
47	<30,000	College	2003
47	>20,000	High School	2004
48	>40,000	University	2003
48	>45,000	University	2004
49	<35,000	University	2003
50	>55,000	University	2003
50	<30,000	College	2004
51	>30,000	University	2003
51	<40,000	College	2004
52	<50,000	University	2003
52	<25,000	College	2004
54	>45,000	University	2003
55	>20,000	College	2003

Appendix C

Ethics Committee Approval Forms

Bibliography

Abramson, P. and Herdt, G. (1990) *'The Assessment of Sexual Practices Relevant to the Transmission of AIDS: A Global Perspective'* in **Journal of Sex Research,** 27, (2), pp. 215-232.

Achilles, N. (1967) *"The Development of the Homosexual Bar as an Institution"* in J. Gagnon and W. Simon (Eds.) **Sexual Deviance,** pp. 228-44. New York: Harper and Row.

Adam, B.D. (1987) **The Rise of a Gay and Lesbian Movement,** Boston: Twayne Publications.

Adam, B.D., Sears, A. and Schellenberg, E.G. (2000) *'Accounting for unsafe sex'* in **Journal of Sex Research,** 37(1), pp. 259-271.

Adam, B.D., Husbands, W., Murray, J. and Maxwell, J. (2003) **Renewing HIV Prevention for Gay and Bisexual Men: A Research Report on Safer Sex Practices among High-Risk Men and Men in Couples in Toronto,** Health Canada: Canadian Strategy on HIV/AIDS.

Adam, B.D., Husbands, W., Murray, J., and Maxwell, J. (2005) *'AIDS optimism, condom fatigue, or self esteem? Explaining unsafe sex among gay and bisexual men'* in **Journal of Sex Research,** 42(3), pp. 238-248.

Adib, S.M. and Joseph, J.G. et al. (1991) *'Predictors of Relapse in Sexual Practices among Homosexual Men'* in **AIDS Education and Prevention,** 3, pp. 293-304.

Altman, D. (1976) **Coming Out in the Seventies,** Boston: Alyson Publications

------------- (1982) **The Homosexualization of America, the Americanization of the Homosexual,** New York: St. Martin's Press.

------------- (1994) **Power and Community: Organizational and Cultural Responses to AIDS,** London: Taylor and Francis Ltd.

Ariss, R. (1994) *'Performing Anger: Emotion in Strategic Responses to AIDS'* in **The Australian Journal of Anthropology,** v. 4, issue 1: pp.18-30.

Arno, P.S .and Feiden, K.L. (1992) **Against the Odds: The Story of AIDS, Drug Development, Politics and Profits,** New York: Harper Collins.

Bailey, R.W. (1999) **Gay Politics, Urban Politics: Identity and Economics in the Urban Setting,** New York: Columbia University Press.

Bandura, A. (1977) '*Towards a unifying theory of behavioural change*' in **Psychological Review,** 84, pp.191-215.

Bayer, R. (1989) **Private Acts, Social Consequences: AIDS and the Politics of Public Health,** New York: Free Press.

BBC News World Edition (Sept. 5, 2002) *"Man 're-infected with HIV'"*. news.bbc.co.uk/2/hi/health/2238079.stm

Becker, H. (1953) '*Becoming a marijuana user*' in **American Journal of Sociology,** 59, pp. 235-42.

Becker, M.H. and Joseph, J.G. (1988) *AIDS and Behavioural Change to Reduce Risk,* in **American Journal of Public Health,** 78, pp. 394-410.

Bellaby, P. (1990) '*To risk or not to risk? Uses and Limitations of Mary Douglas on risk acceptability for understanding health and safety at work and road accidents*' in **Sociological Review,** 38, p. 465-83.

Bennett, K.C. & Thompson, N.L. (1980) '*Social and psychological functioning of the ageing male homosexual*' in **British Journal of Psychiatry,** 137, pp. 361-70.

Benotsch, E., Kalichman, S., and Cage, M. (2002) '*Men who have sex partners via the internet: prevalence, predictors and implications for HIV prevention*' in **Archives of Sexual Behaviour,** 31, pp. 177-83.

Berger, R.M. (1980) '*Psychological adaptation of the older homosexual male*' in **Journal of Homosexuality,** 5, pp. 161-175.

Berger, R.M. & Kelly, J.J. (1986) '*Working with homosexuals of the older population*' in **Social Casework: The Journal of Contemporary Social Work,** 67, pp. 203-210.

Berger, R. (1996) **Gay and Gray,** New York: Haworth Press.

Berkowitz, R. and Callen, M. (1983) **How to Have Sex in an Epidemic: One Approach,** New York: Front Publications.

Binson, D. et al. (1995) '*Prevalence and Social Distribution of Men Who Sex with Men: United States and Its Urban Centres*' in **Journal of Sex Research,** 32, pp. 245-254.

Bloor, M. (1995a) **The Sociology of HIV Transmission,** London: Sage.

Bloor, M. (1995b) '*A user's guide to contrasting theories of HIV-related risk behaviour*' in Gabe, J. (Ed.) **Medicine, Health and Risk,** Oxford: Blackwell.

Bolton, R. (1992) *'Mapping Terra Incognito: Sex Research for AIDS Prevention-An Urgent Agenda for the 1990s'* in Herdt, G. and Lindenbaum, S. (Eds.) **The Time of AIDS,** (pp. 124-158). Newbury Park: Sage.

Bolton, R. (1992a) *AIDS and Promiscuity: Muddles in the Models of HIV Prevention* in Bolton, R. and Singer, M. (Eds.) **Rethinking AIDS Prevention:Cultural Approaches,** Philadelphia: Gordon and Breach publishers.

Bolton, R., Vincke, G. Mak. and Dennehy, E. (1992b) *Alcohol and Risky Sex: In Search of an Elusive Connection* in Bolton, R. and Singer, M. (Eds.) **Rethinking AIDS Prevention: Cultural Approaches,** Philadelphia: Gordon and Breach Science publishers.

Boulton, M., Hart, G. and Fitzpatrick, R. (1992) *'The sexual behaviour of bisexual men in relation to HIV transmission'* in **AIDS Care,** 4, pp. 165-72.

Boulton, M., Schramm-Evans, Z., Fitzpatrick, R. and Hart, G. (1991) *'Bisexual men: women, safer sex and HIV transmission'* in Aggleton, P., Hart, G. and Davies, P. (Eds.) **AIDS: Responses, Interventions and Care,** London: Falmer Press.

Brandt, A. and Rozin, P. (1997) **Morality and Health,** London: Routledge.

Brodie, M., Hamel, E, et al. (2004) *'AIDS at 21: Media Coverage of the HIV Epidemic 1981-2002'* in Columbia Journalism Review, Supplement, March/April.

Bronski, M. (1998) **The Pleasure Principle: Sex, Backlash, and the Struggle for Gay Freedom,** New York: St. Martin's Press.

Brummelhuis, H. ten and H. G. (Eds.) (1995) **Culture and Sexual Risk,** New York: Gordon and Breach.

Cain, R. (1993) *'Community-Based AIDS Services: Formalization and Depoliticization'* in **International Journal of Health Services,** vol. 23, number 4, pp. 665-684.

-----------(1995) *'Community Based AIDS Service Organizations in the Canadian Context'* in **Health and Welfare Canada**: Ottawa.

-----------(1997) *'Environmental Change and Organizational Evolution: Reconsidering the Niche of Community Based AIDS Organizations'* in **AIDS Care,** vol.9, no. 3, pp. 331-344.

Calnan, M. (1987) **Health and Illness: The Lay Perspective,** London: Tavistock.

Calzavara, L., Burchell, A., Major, C., Remis, R., Corey, P., Myers, T., et al. (2003) **Increasing HIV incidence among MSM repeat testers in Ontario, Canada, 1992-1998.** Presented at the World AIDS Conference. Durban, South Africa.

Canadian HIV/AIDS Legal Network (March 1999) **The Links Between HIV/AIDS and Homophobia.**

Canadian Public Health Association (1998) **Safe Spaces: HIV Prevention for gay, lesbian and bisexual youth,** Ottawa: CPHA.

Carrier, J. and Bolton, R. (1991) *'Anthropological Perspectives on Sexuality and HIV Prevention'* in **Annual Review of Sex Research,** 2, pp. 49-76.

Catania, J.A., Coates, S.M., Kegeles, M., Ekstrand, J.R. Guydish and Bye, L.L. (1989) *Implications of the AIDS Risk Reduction Model for the Gay Community: The Importance of Perceived Sexual Enjoyment and Help-Seeking Behaviors* in Mays, V.M., Albee, G.W. and Schneider, S.F. (Eds.) **Primary Prevention of AIDS: Psychological Approaches,** Newbury Park, CA: Sage Publications.

Catania, J.A., Kegeles, S.M. and Coates, T.J. (1990) *'Towards an understanding of risk behaviour: An AIDS risk reduction model (ARRM)'* in **Health Education Quarterly,** 17, pp. 53-72.

Catchpole et al., (1996) *Continuing transmission of sexually transmitted diseases among patients infected with HIV-1 attending genitourinary medicine clinics in England and Wales* in **British Medical Journal,** 312, pp. 539-542.

CBC News- Disclosure (November 20th, 2001) **Russian Roulette: Transcript.**

Centers for Disease Control (1986) **Morbidity and Mortality Weekly Report: Report on AIDS,** (pp.23-39). Atlanta: Centers for Disease Control.

Centers for Disease Control & Prevention (1998) **The role of STD detection and treatment in HIV prevention: CDC Update.**

Centers for Disease Control (Nov. 2001b) **No Turning Back: Addressing the HIV Crisis Among Men Who Have Sex with Men,** Atlanta: Centers for Disease Control.

Centers for Disease Control (July 30, 2002) *'Online Access to Risky Sex'* in **HIV/AIDS, Sexually Transmitted Diseases, and Tuberculosis Prevention News Update,** Atlanta: Centers for Disease Control.

Choi et al. (1999) *'Risk and protective factors affecting sexual behaviour among young Asian and Pacific Islander men who have sex with men: Implications for HIV prevention'* in **Journal of Sex Education & Therapy,** 24, pp. 47-55.

Clemens, E.S. (1996) *'Organizational Form as Frame: Collective Identity and Political Strategy in the American Labour Movement, 1880-1920'* in McAdam, McCarthy and Zald (Eds.) **Comparative Perspectives on Social Movements,** Cambridge: Cambridge University Press.

Clift, S. and Forrest, S. (1999) *'Gay men and tourism: destinations and holiday motivations'* in **Tourism Management,** 20, 3, pp. 615-625.

Clift, S. and Stears, D. (1991) *'Moral perspectives and safer sex practice: Two themes in teaching about HIV and AIDS in secondary schools'* in Aggleton, P., Hart, G., Davis, P. (Eds.) **AIDS: Responses, Interventions and Care,** London: Falmer Press, pp.169-89.

Coalition for Lesbian and Gay Rights in Ontario (1997) **Systems Failure: A Report on the Experiences of Sexual Minorities in Ontario's Health Care and Social Services Systems,** Toronto: CLGRO.

Cohen, M. (1992) *'The global response: Prevention'* in Mann, J., Tarantola, D. and Netter, T. (Eds.) **AIDS in the World,** Cambridge, MA: Harvard University Press, pp.325-448.

Cohen, M. and Hubert, M. (1997) *'The Place of Time in Understanding Sexual Behaviour and Designing HIV/AIDS Prevention Programs'* in Van Campenhoudt, L., Cohen, M., Guizzardi, G. and Hausser, D. (Eds.) **Sexual Interactions and HIV Risk: New Conceptual Perspectives in European Research,** London: Taylor and Francis, pp. 196-222.

Cohen, P.F. (1998) **Love and Anger: Essays on AIDS, Activism and Politics,** Binghamton, N.Y.: Harrington Park Press.

Colfax, G.N., Mansergh, G., Marks, G., Guzman, R., Rader, M. and Buchbinder, S. (2002) *'"Barebacking" in a Diverse Sample of Men Who Have Sex with Men',* **AIDS care,** 16, pp. 653-9.

Connell, R.W., Crawford, J., Dowsett, G.W, et al. (1990) *'Danger and Context: Unsafe Anal Sexual Practice Among Homosexual and Bisexual Men in Working-Class Milieux'* in **Australian and New Zealand Journal of Sociology,** 26, (2), p. 129.

Corea, G. (1992) **The Invisible Epidemic: The Story of Women and AIDS,** New York: Harper Collins.

Crimp, D. (1990) **AIDS Demographics,** Seattle: Bay Press.

Crossley, N. and Crossley, M.L. (1998) *'HIV, empowerment and the sick role: An investigation of a contemporary moral maze'* in **Health,** 2, (2), pp. 157-74.

Crossley, M.L. (2002) *'The perils of health promotion and the 'barebacking' backlash'* in **Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine,** 6, (1), pp. 47-68.

Davidovich, U., de Wit, J.B.F., & Stroebe, W. (2000) *'Assessing sexual risk behaviour of young gay men in primary relationships: The incorporation of negotiated safety and negotiated safety compliance'* in **AIDS,** 14 (6), pp. 701-706.

Davies, P., Hickson, F.C.I., Weatherburn, P. and Hunt, A. (1993) **Sex, Gay men and AIDS,** London: Falmer Press.

Davies, P.M. and Weatherburn, P. (1991) *Towards a General Model of Sexual Negotiation* in Aggleton, P., Hart, G. and Davies, P.M. (Eds.) **AIDS: Responses, Interventions and Care,** London: Falmer Press.

Davies, P.M., Weatherburn, P., Hunt, A.J., Hickson, F.C.I., McManus, T.J. and Coxon, A.P.M. (1992) *'The sexual behaviour of young gay men in England and Wales'* in **AIDS care,** 4, 3, pp. 259-72.

DeAngelis, T. (2002) *'A new generation of issues for LGBT clients'* in **Monitor on Psychology,** 33, no. 2, pgs. 1-6.

Deitcher, D. (Ed.) (1995) **Question of Equality: Lesbian and Gay Politics in America since Stonewall,** Toronto: Scribner.

D'Emilio, J. (1983) **Sexual Politics, Sexual Communities: The Making of a Homosexual Minority in the United States, 1940-1970,** Chicago: University of Chicago Press.

---------------- (1992) **Making Trouble: Essays on Gay History, Policies, and the University,** New York: Routledge.

--------------- (2002) **The World Turned: Essays on Gay History, Politics and Culture,** Durham: Duke University Press.

Dempsey, C. (1994) *'Health and Social Issues of gay, lesbian and bisexual adolescents'* in **Families in Society: The Journal of Contemporary Human Services,** March, pp. 160-167.

DiClemente, R.J. et al. (2002) *'Protease inhibitor combination therapy and decreased condom use among gay men'* in **Southern Medical Journal,** 95(4), pp. 421-5.

Dodds, J.P. Nardone, A., Mercey, D.E. et al. (2000) *'Increase in High Risk Sexual Behaviour among Homosexual Men, 1996-8'* in **BMJ,** 320, pp. 1510-1511.

Dolcini, M.M., Catania, J.A., Stall, R.D. and Pollack, L. (2003) *'The HIV Epidemic Among Older Men Who Have Sex With Men'* in **Journal of Acquired Immune Deficiency Syndromes,** Vol. 33, Suppl.2, pp. S115-S121.

Douglas, M. (1985) **Risk Acceptability according to the Social Sciences,** New York: Sage Foundation.

--------------- (1992) **Risk and Blame: Essays in Cultural Theory,** London: Routledge.

Douglas, M. and Calvez, M. (1990) *'The self as risk taker: a cultural theory of contagion in relation to AIDS'* in **Sociological Review,** 38, pp. 445-64.

Douglas, M. and Wildavsky, A. (1982) **Risk and Culture: an Essay on the Selection of Technical and Environmental Dangers,** Berkeley: University of California Press.

Dowsett, G. (1996) **Practicing Desire,** Palo Alto: Standard University Press.

Drescher et al. (2002) *'Why Barebacking?"* in **Journal of Gay and Lesbian Psychotherapy,** 9, Issue 3/4, pp. 5-12.

Duberman, M. (1999) **Left Out: The Politics of Exclusion, Essays/1964-1999,** New York: Basic Books.

Dukers, N., Goudsmit, J., de Wit, J., Prins, M., Weverling, G., & Coutinho, R. (2001) *'Sexual risk behaviour relates to virological and immunological improvements during highly active antiretroviral therapy in HIV-1 infection'* in **AIDS,** 15(3), pp. 369-378.

Ekstrand, M.L. and Coates, T.J. (1990) *'Maintenance of Safer Sexual Behaviours and Predictors of Risky Sex: The San Francisco Men's Health Study'* in **American Journal of Public Health,** 80(8), pp. 973-77.

Ekstrand, M., Stall, R., Paul, J., Osmond, D., & Coates, T. (1999) *'Gay men report high rates of unprotected anal sex with partners of unknown or discordant HIV status'* in **AIDS,** 13(1), pp. 525-1-533.

Ekstrand, M.L. Stall, R.D. and Paul, J.P. et al. (2000) *'Gay men report high rates of unprotected sex with partners of unknown or discordant HIV status'* in **AIDS,** 13, pp. 1525-1533.

Elford, J., Bolding, G., Maguire, M. and Sherr, L. (2000) *'Combination therapies for HIV and sexual risk behaviour among gay men'* in **Journal of Acquired Immune Deficiency Syndrome,** 23(3), pp. 266-271.

Environics Research Group Survey (May 2001) www.religioustolerance.org/hom_poll4.

Epstein, S. (1990) '*Gay Politics, Ethnic Identity: The Limits of Social Constructionism*' in E. Stein (Ed.) **Forms of Desire: Sexual Orientation and the Social Constructionist Controversy,** London: Garland. pp. 239-93.

Epstein, S. (1996) **Impure Science: AIDS, Activism and the Politics of Knowledge,** Los Angeles: University of California Press.

Farmer, P. (1992) **AIDS and Accusation: Haiti and the Geography of Blame,** Berkeley: University of California Press.

Fee, E. and Krieger, N. (1993) '*Understanding AIDS: historical interpretations and the limits of biomedical individualism*' in **American Journal of Public Health,** 83 (10), pp. 1477-86.

Fitzgerald, F. (1986) **Cities on a Hill: A Journey through Contemporary American Cultures,** New York: Simon & Shuster.

Flynn Saulnier, C. (1998) '*Prevalence of suicide attempts and suicidal ideation among lesbian and gay youth*' in **Journal of Gay and Lesbian Social Services,** vol.8, no.3, pp. 51-68.

Forest, S. and Kanabus, A. (Oct. 2004) "*AIDS & Young Gay Men.* From www.avert.org./aidsyounggaymen.htm.

Foucault, M. (1980) **Power/Knowledge,** C. Gordon. Brighton: Harvester.

Foucault, M. (1988) '*The ethic of care for the self as a practice of freedom*' in J. Bernauer and D. Rasmussen (eds.) **The Final Foucault,** pgs. 1-20. Cambridge: MIT Press.

Friend, R.A. (1987) '*The individual and social psychology of aging: Clinical implications for lesbians and gay men*' in **Journal of Homosexuality,** 14, pp. 307-331.

Frischer, M., Bloor, M., Goldberg, D., et al. (1992) '*Reduction in needle-sharing among community-wide samples of injecting drug users*' in **International Journal of STD and AIDS,** 3, pp. 288-90.

Gabe, J. (1995) '*Health, medicine and risk: the need for a sociological approach*' in Gabe, J. (Ed.) **Medicine, Health, and Risk,** Oxford: Blackwell.

Gallagher, B. and Wilson, A. (1987) '*Sex and the Politics of Identity: An Interview with Michel Foucault*' in M. Thompson (Ed.) **Gay Spirit: Myth and Meaning,** New York: St. Martin's Press. pp. 25-35.

Gamson, J. (1989) *'Silence, Death and the Invisible Enemy: AIDS Activism and Movement'* in **Social Problems,** vol. 36: pp. 351-367.

Gauthier, K. D. and Forsyth, C.J. (1999) *'Bareback sex, bug chasers and the gift of death'* in **Deviant Behaviour,** 20, pp. 85-100.

Gaytoday.badpuppy.com/garchive.viewpoint.051799vi.htm.

Gendin, S. (1999) *They Shoot Barebackers, Don't They? In* **Poz,** Feb, pp. 48-55.

Gold, R. (1993) *'On the Need to Mind the Gap: On-Line Versus Off-Line Cognitions Underlying Sexual Risk-Taking'* in Terry, D.J., Gallois, C. and McCamish, M. (Eds.) **The Theory of Reasoned Action: Its Application to AIDS-Preventive Behaviour,** Oxford: Pergamon. pp. 227-52.

Goldstein, N. and Manlowe, J. (Eds.) (1997) **The Gender Politics of HIV/AIDS in Women: Perspectives on the Pandemic in the US,** New York: New York University Press.

Goodroad et al. (2000) *'Bareback sex and gay men: An HIV Prevention Failure'* in **Journal of Assoc Nurses AIDS Care,** Nov-Dec; 11(6), pp. 29-36.

Gould D.B. (2000) *'Demonstrations and Actions'* in B. Zimmerman (Ed.) **Encyclopedia of Lesbian Histories and Cultures,** pp. 230-32. New York: Garland Publishing Co.

Green, A. (2002) **Sexual Orientation and Social Structure: A Comparative Study of Urban Heterosexual and Homosexual Careers,** Ann Arbor: UMI Dissertation Services.

Grossman, A., D'Augelli, A. and Hershberger, S. (2000) *'Social support networks of lesbian, gay, and bisexual adults 60 years of age and older'* in **Journals of Gerontology: Series B,** 55B (3), pp. 171-179.

Halperin, Karin (2000) *'Risky Business: Reassessing prevention strategies in the real world'* in **HIV+ Report, Prevention: A Special Report,** Number 7.

Hamer, D.H. and Copeland, P.F. (1994) **The Science of Desire: The Search for the Gay Gene and the Biology of Behaviour,** New York: Simon and Schuster.

Handsfield H.H. et al. (1989) **Trends in Gonorrhea in Homosexually Active Men—King County, Washington, 1989,** MMWR, Nov. 10, 1989, 38(44); 762-764.

Hardy, R. (1999) **The Crisis of Desire: AIDS and the Fate of Gay Brotherhood,** New York: Houghton Mifflin.

Hart, G. (1992) *'Relapse to unsafe sexual behaviour amongst gay men: a critique of recent behavioural HIV/AIDS research'* in **Social Health and Illness,** 14, pp. 216-32.

Hart, G. and Boulton, M. (1995) *'Sexual Behaviour in Gay Men: Towards a Sociology of Risk'* in Aggleton, P., Davies, P. and Hart, G. (Eds.) **AIDS: Safety, Sexuality and Risk,** London: Taylor and Francis.

Hayes, R.B. Kegeles, S.M. and Coates, T.J. (1992) *'Changes in peer norms and sexual enjoyment predict changes in sexual risk-taking among young gay men'* in **AIDS 8, 2,** 19-24 July, PG D417 (Abstract no. POD 5183).

Hayes, R.B., Kegeles, S.M. and Coates, T.J. (1990) *'High HIV risk-taking among young gay men'* in **AIDS 4,** pp.901-7.

Hayes, R.B., Kegeles, S.M. and Coates, T.J. (1991) *'Understanding the high rates of HIV risk-taking among young gay and bisexual men: the Young Men's Survey'* in **AIDS 7,** 16-21 June, PG 48 (Abstract no. MC.101).

Health Canada (April, 2003) **HIV/AIDS Epi Update: HIV Infections Among MSM In Canada,** Ottawa.

Hellquist, G. (1996) **A Strategy towards population health and wellness,** Saskatoon, SK: Gay and Lesbian Health Services.

Herdt, G. (1989) **Gay and Lesbian Youth,** New York: Haworth.

Herdt, G (1992) (Ed.) **Gay Culture in America: Essays from the Field,** Boston: Beacon Press.

Herdt, G. (1997) **Same Sex, Different Cultures: Perspectives on Gay and Lesbian Lives,** New York: Westview Press.

Herdt, G. and Boxer, A. (1991) *'Ethnographic Issues in the Study of AIDS'* in **Journal of Sex Research,** 28 (2): pp. 171-87.

------------ (1996) **Children of Horizons: How Gay and Lesbian Youth are Forging a New Way Out of the Closet, 2nd Ed.,** Boston: Beacon Press.

Herdt, G. and Lindenbaum, S. (Eds.) (1992) **The Time of AIDS: Theory, Method and Practice,** Newbury Park: Sage.

Herrel, R. (1992) *'The Symbolic Strategies of Chicago's Gay and Lesbian Pride Day Parade'* in Herdt, G. (Ed.) **Gay Culture in America,** pp. 225-52. Boston: Beacon Press.

Hogg, R.S., Weber, S.E., Chan, K., et al. (2001) *'Increasing incidence of HIV infections among young gay and bisexual men in Vancouver'* in **AIDS**, 15, pp. 1321-1323.

Hooker, E. 1967 (1961) *"The Homosexual Community"* in J. Gagnon and W. Simon (Eds.) **Sexual Deviance,** pp. 167-84. New York: Harper and Row.

Horowitz, C. (Feb. 20, 1995, 33) *'Has AIDS Won?'* **New York.**

HPA Communicable Disease Surveillance Centre (HIV and STI Department) and the Scottish Centre for Infection and Environmental Health (April, 2003) in **Unpublished Quarterly Surveillance Tables,** No. 64.

Hunt, A.J., Davies, P.M., McManus, T.J., Weatherburn, P., Hickson, F.C.I., Chrisofinis, G., Coxon, A.P.M. and Sutherland, S. (1992) **British Medical Journal,** 305, pp. 561-2.

Imrie, J., Stephenson, J., Davis, M., Hart, G., Davidson, O., & Williams, I. (2002) **Recent experience of sexual dysfunction is associated with high-risk sexual behaviours,** Presented at the International AIDS conference, Barcelona.

Ingham, R., Woodcock, A. and Stenner, K. (1992) *'The limitations of rational decision-making models as applied to young people's sexual behaviour'* in Aggleton, P., Davies, P. and Hart, G. (Eds.) **AIDS: Rights, Risk and Reason,** London: Falmer Press.

Johnson, B. (1987) *'The environmentalist movement and grid/group analysis: a modest critique'* in Johnson, B. and Corvello, V. (Eds.) **The Social and Cultural Construction of Risk,** Dordrecht: Reidel.

Johnson, W. (1995) **HIV-Negative: How the Uninfected are Affected by AIDS,** New York: Insight Books.

Joseph, J.G. and Montgomery, S.B. et al. (1987a) *'Magnitude and Determinants of Behavioural Risk Reduction: Longitudinal Analysis of a Cohort at Risk for AIDS'* in **Psychology and Health,** 1, pp. 73-95.

--------- (1987b) *'Perceived Risks of AIDS: Assessing the Behavioural Consequences in a Cohort of Gay Men'* in **Journal of Applied Social Psychology,** 17, pp. 231-50.

Junge, B. (2002) *'Bareback sex, risk, and eroticism'* in Lewin, E. and Leap, W. (Eds.) **Out in Theory,** Urbana: University of Illinois Press.

Kalichman, S.C., Greenberg, J. & Abel, G.G. (1997) *'HIV-seropositive men who engage in high-risk sexual behaviour: Psychological characteristics and implications for prevention'* in **AIDS Care,** 9, pp.441-450.

Kaplan, M. (1990) *'AIDS and the psycho-social disciplines: The social control of "Dangerous" behaviour'* in **Journal of Mind and Behaviour,** 11, pp. 337-52.

Katz, M.H. et al. (2002) *'Impact of highly active antiretroviral treatment on HIV seroincidence among men who have sex with men'* in **American Journal of Public Health,** 92(9), pp. 1387-8.

Kaufman, G. and Raphael, L. (1996) **Coming Out of Shame: Transforming Gay and Lesbian Lives,** New York: Doubleday.

Kegeles et al. (1999) *Mobilizing young gay and bisexual men for HIV prevention: a two-community study'* in **AIDS,** 12, pp. 1753-1762.

Kellogg, T., McFarland, W., & Katz, M. (1999) *'Recent increases in HIV seroconversion among repeat anonymous testers in San Francisco'* in **AIDS,** 13(2), pp. 303-2-316.

Kelly, J.A. and Kalichman, S.C. et al. (1991) *'Situational Factors Associated with AIDS Risk Behaviour Lapses and Coping Strategies Used by Gay Men Who Successfully Avoid Lapses'* in **American Journal of Public Health,** 81(10), pp. 1335-38.

Kelly, J.A., St. Lawrence, J.S. and Diaz, Y.E. (1991) *'HIV risk behaviour reduction following intervention with key opinion leaders of a population: and experimental community level analysis'* in **American Journal of Public Health,** 81, pp. 168-71.

Kelly, J. A., St. Lawrence, J.S., Brasfield, L., Stevenson, L., Diaz, Y., and Hauth, A. (1990) *'AIDS Risk Behaviour Patterns Among Gay Men in Small Southern Cities'* in **American Journal of Public Health,** 80(4), pp. 410-418.

Kelly, J.A., St. Lawrence, J.S., Stevenson, L.Y., Hauth, A.C., Kalichman, S.A., Diaz, Y.E., Brasfield, T. L. et al. (1992) *'Community AIDS/HIV risk reduction: the effects of endorsements by popular people in three cities'* in **American Journal of Public Health, 82**, pp. 1483-9.

King, E. (1994) **Safety In Numbers: Safer Sex and Gay Men,** New York: Routledge.

Kippax, S., Crawford, C., Connell, R. and Dowsett, G. (1990) *'the importance of gay community in the prevention of HIV transmission,* in **Social Aspects of the Prevention of AIDS,** a, 7, pp. 1-48.

Kirby, D. (1999) *"Risky Business: Barebacking Celebrates Unprotected Sex and Raises Difficult Issues about AIDS Prevention"* in **The Advocate,** April 13, pp. 40-45.

Kramer, L. (1989) **Reports from the Holocaust: The Making of an AIDS Activist,** New York: St. Martin's Press.

Kubler-Ross, E. (1987) **AIDS: The Ultimate Challenge,** New York: MacMillan Publishing Co.

Lappe, M. (1995) **Breaking Out: The Evolving Threat of Drug-Resistant Disease,** San Francisco: Sierra Club.

Lee, J. (1989) *'Invisible men'* in **Canadian Journal on Aging,** 8(1), pp. 79-97.

Lemp, G.F., Hirozawa, A.M., Givertz, D., Nieri, G.N., Anderson, L., Lindegren, M.L., Janssen, R.S., & Katz, M. (1994). *'Seroprevalence of HIV and risk behaviours among young homosexual and bisexual men: The San Francisco/Berkeley Young men's Survey'* in **JAMA,** 272, pp. 449-454.

Lehr, V. (1993) *"The Difficulty of Leaving 'Home': Gay and Lesbian Organizing to Confront AIDS"* in Fisher, R. and King, J. (Eds.) **Mobilizing the Community: Local Politics in the Era of the Global City,** London: Sage Publications.

Levine, M. (1992) *'Birth and Death of the Gay Clone'* in Herdt, G. (Ed.) **Gay Culture in America,** (pp. 68-86). Boston: Beacon Press.

Levinton, L.C. (1989) *'Theoretical Foundations of AIDS-Prevention Programs'* in Valdiserri, R.O. (Ed.) **Preventing AIDS: The Design of Effective Programs,** New Brunswick: Rutgers University Press.

Locke, K.C. (28 August, 1997) *'When You Go Riding, Use a Saddle-and a Raincoat'* in San Francisco Frontiers.

Luker, K. (1975) **Taking Chances: Abortion and the Decision not to Contracept,** Berkeley: University of California Press.

Lupton, D. (1993) *'Risk as moral danger: the social and political functions of risk discourse in public health'* in **International Journal of Health Services,** 23 (3), pp. 425-35.

Mallinger, S. (1999) *'Gay Today: About Anal Sex, Barebacking: Slogans aren't enough'***gaytoday.badpuppy.com/garchive/viewpoint/040698vi. Htm.**

Martin, J. L. (1986) *'AIDS Risk-Reduction Recommendations and Sexual Behaviour Patterns Among Gay Men: A Multifactorial Categorical Approach to Assessing Change'* in **Health Education Quarterly,** 13(4): pp. 346-58.

Martin, J. et al. (1989) *'Changes in sexual behaviour, substance abuse and mental health'* in **American Journal of Community Psychology,** 17, pp. 269-293.

Maxwell, J. (1998) **Young Gay & Bisexual Men and HIV: A qualitative study of safer sex knowledge and behaviour among young gay and bisexual men,** AIDS Committee of Toronto: Toronto.

Mayne, T. et al. (1998) '*HIV sexual risk behaviour following bereavement in gay men'* in **Health Psychology,** 17(5), pp. 403-411.

McCusker, J. et al. (1992) *'Maintenance of Behavioural Change in a Cohort of Homosexual Active Men'* in **AIDS,** 6, pp. 861-68.

McCusker, J., Zapka, J., Stoddard, A.M. and Mayer, K.H. (1989) *'Responses to the AIDS Epidemic among Homosexually Active Men: Factors Associated with Preventive Behaviour'* in **Patient Education and Counseling,** 13, pp. 15-30.

McFarlane, M., Bull, S.S. and Rietmeijer, C.A. (2000) *'The Internet as a newly emerging risk environment for sexually transmitted diseases'* in **Journal of the American Medical Association,** 284(4), pp. 485-7.

McKay, C. (1998) **Sexual Ideology and Schooling towards Democratic Sexuality Education,** London, ON: The Althouse Press.

McKeganey, M. and Bernard, M. (1992) **AIDS, Drugs and Sexual Risk: Lives in the Balance,** Buckingham: Open University Press.

McKirnan, D.J., Ostrow, D.G., & Hope, B. (1996) *'Sex, drugs and escape: a psychological model of HIV risk behaviour,* in **AIDS Care,** 8(6), pp. 655-669.

McKusick, L. and Conant, M. et al. (1985) *'The AIDS Epidemic: A Model for Developing Intervention Strategies for Reducing High-Risk Behaviour in Gay Men'* in **Sexually Transmitted Diseases,** 12, pp. 229-34.

McKusick, L. and Coates, T.J. et al. (1990) *'Longitudinal Predictors of Reductions in Unprotected Anal Intercourse among Gay Men in San Francisco: The AIDS Behavioral Research Project'* in **American Journal of Public Health,** 80(8), pp. 978-83.

McLean, J., Boulton, M., Brookes, M., Lakhani, D., Fitzpatrick, R., Dawson, J., McKechnie, R. and Hart, G. (1994) '*Regular partners and risky behaviour: why do gay men have unprotected intercourse?* in **AIDS care,** 6.

MESMEN Project. http:// freespace.virgin.net/staffs.mesmen/newsite/safety. htm. p.2.

Mettey, A. et al. (2003) *'Associations between internet sex seeking and STI associated risk behaviours among men who have with men'* in **Sexually Transmitted Infections,** 79(6), pp. 466-468.

Meyer et al. (1994) '*Evolution dans le temps de la seroprevalence VIH chez les patients consultants pour suspicion de maladie sexuellement transmissible (*PREVADAV 1991-1993) in **Bulletin Epidemiologique Hebdomadaire,** 94 (50), pp. 233-234.

Murphy, T.F. and Poirier, S. (Eds.) (1993) **Writing AIDS: Gay Literature, Language, and Analysis,** New York: Columbia University Press.

Murray, J. and Adam, B.D. (2001) *'Ageing and HIV Risk among Gay Men'* in **The Canadian Journal of Human Sexuality,** 10, no. 3-4, (fall/winter), pp. 75-90.

Murray, S.O. (1992) *' Components of Gay Community in San Francisco'* in Herdt, G.(Ed.) **Gay Culture in America,** Boston: Beacon Press.

Nelson, E. (1992) **AIDS: The Literary Response,** New York: Twayne.

Nettleton, S. (1996) **The Sociology of Health and Illness,** Cambridge: Polity Press.

Odets, W. (1995) **In the Shadow of the Epidemic: Being HIV-Negative in the Age of AIDS,** Durham: Duke University Press.

O'Hara, S. (1997) **Autopornography,** New York: Haworth.

O'Hara, S. (Autumn, 1995) *'Exit the Rubberman'* in **Steam,** 3, Issue 3.

O'Malley, J. (1992) *'AIDS service organizations in transition'* in Mann, J., Tarantola, D. and Netter, T. (Eds.) **AIDS in the World,** Cambridge, MA: Harvard University Press, pp. 774-87.

Otis, J. Ryan, B. et al. (1999) **The Impact of Project 10 on Young Gays and Lesbians (Executive Summary)** Montreal: (For the Regie Regionale de la Sante et des Services sociaux-Montreal-Centre.

Parsons, E. (1990) *'Living with Duchenne Muscular Dystrophy: women's understandings of disability and risk'* in **PhD Thesis**, University of Wales College of Cardiff.

Parsons, E. and Atkinson, P. (1992) *'Lay constructions of genetic risk'* in **Sociology of Health and Illness,** 14, pp. 437-55.

Patton, C. (1985) **Sex and Germs: The Politics of AIDS,** Boston: Southend Press.

Patton, C. (1990) **Inventing AIDS**, London: Routledge.

Patton, C. (1994) **Last Served: Gendering the AIDS Pandemic,** London: Taylor and Francis.

Paul, J. et al. (1995) '*The Impact of the HIV Epidemic on U.S. Gay Male Communities*' in D'Augelli, A.R. and Patterson, C. (Eds.) **Lesbian, Gay and Bisexual Identities over the Lifespan: Psychological Perspectives on Personal, Relational and Community Processes,** (pp. 347-396). New York: Oxford University Press.

Peyser, M. (29/09/1997) *'A Deadly Dance'* in **Newsweek,** vol. 130, no. 13.p. 76.

Prestage, G., Van de Ven, P., Grulich, A., et al. (2001) *'Gay Men's Casual Sex Encounters: Discussing HIV and using condoms'* in **AIDS Care,** 13, pp. 277-284.

Radley, A. (Ed.) (1993) **Worlds of Illness: Biographical and Cultural Perspectives on Health and Disease,** London: Routledge.

Radley, A. (1994) **Making Sense of Illness: The Social Psychology of Health and Disease,** London: Sage.

--------------- (1997) *What Role Does the Body Have in Illness?* In Yardley, L. (Ed.) **Material Discourses of Health and Illness,** London: Routledge.

Remafedi G. (1994) '*Predictors of unprotected intercourse among gay and bisexual youth: knowledge, beliefs, and behaviour*' in **Pediatrics,** 94, pp.163-168.

---------- (Aug.1998)'*The University of Minnesota Youth and AIDS Projects' Adolescent Early Intervention Program: a model to link HIV-seropositive youth with care*' in **Journal of Adolescent Health,** 23(Suppl), pp.115-21.

Remis, R.S. Alary, M. and Otis, J. (2000) *'HIV Infection and Risk Behaviours in young gay and bisexual men'* in **Canadian Medical Association Journal,** 163, 1.

Rhodes, T. (1995) '*Theorizing and researching "risk": notes on the social relations or risk in heroin users "lifestyles"*, in Aggleton, P., Davies, P. and Hart, G. (Eds.) **AIDS: Safety, Sexuality, and Risk,** London: Taylor and Francis.

Richardson, D. (1988) **Women and AIDS,** New York: Routledge.

Richters, J., Hendry, O., & Kippax, S. (2003) *'When safe sex isn't safe'* in **Culture, Health & Sexuality,** 5(1), pp. 37-52.

Rimmerman, C.A. (2002) **From Identity to Politics: The Lesbian and Gay Movements in the United States,** Philadelphia: Temple University Press.

Robinson, T. and Davies, P. (1991) '*London's homosexual male prostitutes: power, peer groups and HIV*' in Aggleton, P., Hart, G. and Davies, P. (Eds.) **AIDS: Responses, Interventions and Care,** London: Falmer Press.

Rodriguez, R. (1992) **Days of Obligation: An Argument with My Mexican Father,** New York: Viking Press.

Rofes, E. (1996) **Reviving the Tribe: Regenerating Gay Men's Sexuality and Culture in the Ongoing Epidemic,** London: Haworth Press.

Rofes, E. (1998) **Dry Bones Breathe: Gay Men creating post-AIDS Identities and Cultures,** New York: Harrington Park Press.

Rooney, M. (1991) **Gay Men: Sustaining Safer Sex?** London: North West Thames Regional Authority.

Rosengarten, M., Race, K., and Kippax, S. (2000) **Touch Wood, Everything will be OK: Gay men's understandings of clinical markers in sexual practice,** Sydney: National Centre in HIV Social Research.

Rotter, J.B. (1966) *'Generalized Expectancies for Internal versus External Control of Reinforcement'* in **Psychological Monographs,** 80, 1, pp.1-26.

Royal Society (1992) **Risk Analysis, Perception and Management: Report of a Royal Society Study Group,** London: Royal Society.

Scarce, M. (21/08/1998) *'Back to Barebacking'* in **NY Blade.**

Scarce, M. (1999) *'A Ride on the Wild Side'* in **Poz Magazine.**

Schiltz, M.A. and Sandfort, Th.G.M. (2000) *'HIV-positive people, risk and sexual behaviour'* in **Social Science and Medicine,** 50, pp. 1571-1588.

Schneider, Beth E. (1992) *'AIDS and Class, Gender and Race Relations'* in Huber, J. and Schneider, B.E. (Eds.) **The Social Context of AIDS,** Newbury Park: Sage Publications.

Sedgewick, E. (1990) **Epidemiology of the Closet,** Berkeley: University of California Press.

Seligman, M.E.P. (1975) **Helplessness: On Depression, Development and Death,** San Francisco: Freeman.

Shilts, R. (1987) **And the Band Played On: People, Politics, and the AIDS Crisis,** Harmondsworth: Penguin Books.

Shindle, K. (3/02/1998) *"Barebacking, Brainless!"* in **Advocate.**

Signorile, M. (1997) **Life Outside: The Signorile Report on Gay Men: Sex, Drugs, Muscles, and the Passages of Life,** New York: Harper Collins.

Sinfield, A. (1998) **Gay and After,** London: Serpent's Tail.

Smith, G., and Van de Ven (Monograph 9/2001) **Reflecting on Practice: Current Challenges in Gay and other Homosexually Active Men's HIV Education,** Sydney: National Centre in HIV Social Research.

Sowadsky, R. (May, 1999) **Barebacking in the Gay Community,** in www.thebody.com/sowadsky/barebacking.html.

Springer, C. and Lease, S. (2000) *'The impact of multiple AIDS-related bereavement in the gay male population'* in **Journal of Counseling and Development,** 78(3), pp. 297-304.

Stall, R.D., Barrett, D., Bye, L. et al. (1992) *'A Comparison of Younger and Older Gay Men's HIV Risk-Taking Behaviours: The Communication Technologies 1989 Cross-Sectional Survey'* in **Journal of Acquired Immune Deficiency Syndromes,** 5, pp. 682-687.

Stall R.D., Coates, T.J. and Hoff, C. (1988) Behavioural Risk Reduction for HIV *Infection Among Gay Men and Bisexual Men: A Review of Results from the United States,* in **American Psychologist,** 43, pp. 878-85.

Stall, R. and Ekstrand, M.L. et al. (1990) *'Relapse from Safer Sex: The Next Challenge for AIDS Prevention Efforts'* in **Journal of Acquired Immune Deficiency Syndrome,** 3(12), pp. 1181-87.

Stockdill, B. (2003) **AIDS at the Intersection of Sexuality, Race, Gender and Class,** Boulder: Lynne Reimer Pub.

Stoecker, R. (1995) *'Community Movement and Organization: The Problem of Identity Convergence in Collective Action'* in **The Sociological Quarterly,** vol. 36, no.1: pp. 111-130.

Stoite, I.G., Dukers, N.H., de Wit, J.B., et al. (2001) *' Increase in sexually transmitted infections among homosexual men in Amsterdam in relation to HAART'* in **Sexually Transmitted Infections**, 77, pp. 184-186.

Stokes, J.P. and Peterson, J.L. (1998) *'Homophobia, self-esteem, and risk for HIV among African American men who have sex with men'* in **AIDS Education and Prevention,** 10, pp. 278-292.

Stoller, N. (1998) **Lessons from the damned: queers, whores and junkies respond to AIDS,** New York: Routledge.

Strathdee et al. (1998) *'Determinants of sexual risk-taking among young HIV-negative gay and bisexual men'* in **Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology,** 19, pp. 61-66.

Strathdee, S.A., Martindale, S.L., Cornelisse, P.G.A. et al. (2000) *'HIV Infection and risk behaviours among young gay and bisexual men in Vancouver'* in **Canadian Medical Association Journal,** 162, pp. 21-25.

Suarez and Miller (2001) *'Negotiating risks in context: a perspective on unprotected anal intercourse and barebacking among men who have sex with men- Where do we go from here?* in Sexual **Behaviour,** June 30 (3): pp. 287-300.

Tomasinski, K. (1992) *'AIDS and Human Rights'* in Mann, J. Tarantola, D. and Netter, T. (Eds.) **AIDS in the World,** Cambridge: MA: Harvard University Press, pp. 537-73.

Treichler, P. (1992) *'AIDS, HIV and the cultural construction of reality'* in Herdt, G. and Lindenbaum (Eds.) **The Time of AIDS,** Newbury Park: Sage.

Tremble, B. et al. (1989) *'Growing Up Gay or Lesbian in a Multicultural Context'* in Herdt, G. (Ed.) **Gay and Lesbian Youth,** (pp. 253-268). New York: Haworth.

Turner, D.C. (1997) **Risky Sex: Gay Men and HIV Prevention,** New York: Columbia University Press.

Vacha, K. (1985) **Quiet Fire,** Trumansburg: Crossing Press.

Valdiserri, R.O. (1990) (Ed.) **Preventing AIDS: The Design of Effective Programs,** New Brunswick: Rutgers University Press.

Valdiserri, R.O., Lyter, D., Levinton, L., Callahan, C.N., Kingsley, L.A. and Rinaldo, C.R. (1989) *'AIDS Prevention in Homosexual and Bisexual Men: Results of a Randomized Trial Evaluating Two Risk-Reduction Interventions'* in **AIDS,** 3, pp. 21-26.

Valleroy, L.A., MacKellar, D., Janssen, R., Jacobs, T., & Young Men's Survey Team (July 1996) **HIV and risk behaviour among young men who have sex with men sampled in six urban counties in the U.SA**. Paper presented at the XI International Conference on AIDS, Vancouver, Canada.

Valocchi, S. (1999) *'The Class Infected Nature of Gay Identity'* in **Social Problems,** vol. 46, no. 2: pp. 207-224.

van den Hoek, J.A.R. et al. (1990) *'Increase in unsafe homosexual behaviour'* (letter), in **The Lancet,** 336, pp. 179-80.

Van de Ven, P., Prestage, G., Crawford, J., et al. (2000) *'Sexual risk behaviour increases and is associated with HIV optimism among HIV-negative and HIV-positive gay men in Sydney over the 4 year period to February 2000'* in **AIDS**, 14, pp. 2591-93.

Van der Veldt, F.W. and van der Pilgt, J. (1991) *'AIDS-related health behaviour: coping, protection motivation and previous behaviour'* in **Journal of Behavioural Medicine,** 14, pp. 429-451.

Wagner, G.J., Remien, R.H. & Carballo-Dieguez, A. (1998) *'Extramarital sex: Is there an increased risk for HIV transmission? A study of male couples of mixed HIV status'* in **AIDS Education and Prevention,** 10, pp. 245-256.

Warner, M. (1993) **Fear of a Queer Planet: Queer Politics and Social Theory,** Minneapolis: University of Minnesota Press.

Warner, T. (2002) **Never Going Back: A History of Queer Activism in Canada,** Toronto: University of Toronto Press.

Watney, S. (1987) **Policing Desire: Pornography, AIDS and the Media,** London: Comedia.

Watney, S. (1994) **Practices of Freedom: Selected Writings on HIV/AIDS,** Durham: Duke University Press.

Weeks, J. (1985) **Sexuality and Its Discontents: Meanings, Myths and Modern Sexualities,** New York: Columbia University Press.

Wellings, K. (1991) *'Netherlands: Country Report'* **European Concerted Action on Assessment of HIV/AIDS Prevention,** London.

Wight, D., Abraham, C. and Scott, S. (1998) *'Towards a psycho-social theoretical framework for sexual health promotion'* in **Health Education Research,** 13(3): pp.317-330.

Williams, L.S. (1986) *'AIDS Risk Reduction: A Community Health Education Intervention for Minority High-Risk Group Members'* in **Health Education Quarterly,** 13(4): pp. 407-21.

Wolfe, K. (Sept. 27, 2002) *'Fears Confirmed in Study of Second-strain HIV reinfection'* in **The Washington Blade:** www.aegis.com/news/wb/2002/WB020904.html

World Health Organization (2003) WHO Information Factsheet, no. 186: www.who.int/onf-fs/en/fact186.html at 17/7/03.

Wotherspoon, G. (Ed.) (1986) **Being Different: Nine Gay Men Remember,** Sydney: Hale & Iremonger.

Yep, G.A et al. (2002) *'The Case of "Riding Bareback": Sexual Practices and the Paradoxes of Identity in the Era of AIDS'* in Journal of Homosexuality, vol. 42 (4), pp. 1-14.

Young, J. (July14, 2005). *'Riding Bareback: Trends in Unsafe-sex practices and its impact on the community'* www.gaylesbiantimes.com

Zalduondo, B. and Bernard, J.M. (1995) *'Meanings and consequences of sexual-economic exchange: gender, poverty and sexual risk behaviour in urban Haiti'* in Parker, R. and Gagnon, J.H. (Eds.) **Conceiving Sexuality: Approaches to Sex Research in a Post-modern World,** London: Routledge.