A QUALITATIVE ANALYSIS OF FACTORS CONTRIBUTING TO INCREASED HIV INCIDENCE FOR GAY AND BISEXUAL MEN: IMPLICATIONS FOR PREVENTION

by

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A thesis submitted in conformity with the requirements for the degree of Master of Arts
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Abstract

HIV incidence continues to rise in the population of gay and bisexual men (Joint United Nations Program on HIV/AIDS, 2008), a high-risk group due to the complexity of promoting sexual behavior change on an enduring basis. In the present study, interview data from fifteen self-identified gay or bisexual men living in an urban Canadian city was analyzed in order to determine the most salient psychosocial factors in decision-making leading to safe sexual choices, and the psychological implications of these factors for the mental health and well-being of participants. Results suggest three core factors are most relevant to sexual decision-making for gay/bisexual men: self-efficacy, sexual communication and/or negotiation, and individual assessment of risk. A conceptual model of factors influencing sexual decision-making is presented. These results are discussed in terms of their implications for future HIV prevention interventions and the clinical practice of counselling psychology with gay and bisexual male clients.
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Chapter One: Introduction

Globally, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) remain a public health problem of unprecedented magnitude (Joint United Nations Program on HIV/AIDS [UNAIDS], 2008). At present, 33.2 million people worldwide are living with HIV or AIDS, and the virus has been estimated to have already caused 25 million deaths around the world (UNAIDS, 2008; Canadian AIDS Treatment Information Exchange [CATIE], 2009). Despite widespread AIDS prevention education programs and gains in the expansion of treatment paradigms and treatment access, the HIV epidemic cannot be reversed, nor those gains sustained, without more progress in reducing the rate of new HIV infections (UNAIDS, 2008).

In North America and western-European nations, men who have sex with men (MSM) continue to represent the single largest HIV exposure category, accounting for a higher proportion of AIDS cases than any other group. Statistics for individual countries reveal the following proportions of MSM exposure as a primary risk category: Canada (65%); Australia (64%); and the United States (44%) (Jaffe, Valdiserri, & DeCock, 2007; Natale, 2009). The first HIV infections in North America, highly publicized in the gay community, are estimated to have occurred in 1978 (Jaffe et al., 2007). As additional men began to be diagnosed at the outset of the epidemic, gay communities in North America, Western Europe, and Australia mobilized aggressive intervention programs to support their community members and fight the spread of the unknown disease (Jaffe et al., 2007; Kippax et al. 1993). Incidence of new infections peaked in 1984, and then decreased during the remainder of the 1980’s (Wolitski, Valdiserri, Denning, & Levine, 2001). Among other factors, the combined effect of variables such as population saturation (many gay or bisexual men at the highest risk had already become infected), the
possible death of ‘core transmitters’ (infected men with high numbers of sex partners), and the results of early HIV prevention interventions (which reduced transmission by promoting changes in sexual behavior), are likely reflected in the decreased rates of HIV infection noted among MSM in the 1980’s (Jaffe et al., 2007).

In this context, early HIV prevention efforts were designed to meet the immediate needs for risk identification and risk education services, and as such, were primarily information-based (DiClemente & Peterson, 1994). The underlying assumption was that the public would be better able to adopt HIV-preventative behaviours if provided information promoting a greater understanding of the behaviours related to HIV transmission (DiClemente & Peterson, 1994). For roughly a decade and a half this approach proved successful, and correspondingly, up until the mid-1990’s the incidence of new HIV infections slowed in North American gay communities (Calzavara et al., 2002; Kellogg, McFarland, & Katz, 1999). Nevertheless, as one researcher points out, “...the do-or-die atmosphere of the early epidemic demanded swift collective action using available capital and knowledge; however, the historical contingency in which the safe sex culture developed could not engender enduring success” (Rowe & Dowset, 2008, p. 340).

As a result, since 1996/1997 the numbers of new HIV infections in North American and western European gay male communities have been steadily increasing. In Canada, increases have been documented in Toronto (Calzavara et al., 2002), Ottawa (Calzavara et al., 2002), and Vancouver (Hogg et al., 2001), and internationally, increases have been documented in Britain (Dodds, Nardone, Mercuy & Johnson, 2000), and the United States (Kellogg et al., 1999). For instance, between 1998 and 2005, a 55% increase in HIV incidence for MSM was reported by thirteen western European nations (Jaffe et al., 2007). Canadian data indicates that in 2005, the overall number of people living with HIV or AIDS in Canada was estimated to be 58,000,
representing a 16% increase in HIV incidence from 2002 to 2005 (Public Health Agency of Canada, 2007). Of all new HIV infections in Canada during that period, it was estimated that 45% occurred in the population of MSM (Canadian AIDS Treatment Information Exchange, 2009; Public Health Agency of Canada, 2007). In 2005, regardless of highly significant increases in HIV incidence among Black, female, Hispanic, and Aboriginal populations in Canada, MSM still accounted for 51% of all Canadians living with HIV/AIDS, making them the single largest exposure category in Canada (Canadian AIDS Treatment Information Exchange, 2009; Public Health Agency of Canada, 2007). By 2008, the percentage of all newly-diagnosed HIV infections in the exposure category of MSM had risen to 61%, slightly increasing the overall percentage of men living with HIV in Canada to 53.3% (Public Health Agency of Canada, 2008). In the United States, the estimated increase in HIV incidence over 2001 to 2005 was 13% for MSM (Jaffe et al., 2007). At present in the United States, over 40,000 new HIV infections are reported each year (Kalichman et al. 2007b; Natale, 2009). Of these new infections, the overwhelming majority were men (77%) and of that subset, over 70% occurred among the risk exposure category of MSM (Kalichman et al. 2007b; Natale, 2009).

Thus, for more than a decade now HIV infection incidence has remained steadily on the rise in gay and bisexual male communities (Jaffe et al., 2007; Kippax et al. 1993; UNAIDS, 2008). This high rate of new HIV infections can have a serious impact upon the individual mental health of all community members who are affected in many ways by the virus (Fassinger & Arseneau, 2005). Over time, the profound trauma and loss experienced in gay male communities is assumed to exert continual and uniquely negative effects on the men in these communities (Fassinger & Arseneau, 2005).
Evidence from epidemiological studies indicates that the primary mode of HIV transmission for gay and bisexual men is unprotected anal intercourse (Kalichman et al., 2007b). Although numerous HIV prevention programs have been mounted to varying degrees of success with these men, there is evidence that many programs fail to reach or impact upon many populations highly vulnerable to HIV infection, such as MSM (UNAIDS, 2008). Gay and bisexual men can be a complex and elusive population to successfully target with HIV prevention interventions, due to the diversity of group membership and complex community dynamics (Kelly, 1995; UNAIDS, 2008). Even for wealthy, industrialized nations with established intervention and risk-education programs, existing interventions appear not to be effective for all individuals, and are no longer adequate for prevention (DiClemente & Peterson, 1994; Jaffe et al., 2007; Kelly, 1995). Gay and bisexual men face a disproportionate risk of exposure to HIV in diverse settings worldwide, primarily due to aspects of their sexual life, a complex realm in which to promote behaviour change (Jaffe et al., 2007). As a population, gay and bisexual men can also be under-served with respect to HIV prevention services (Jaffe et al., 2007; UNAIDS, 2008).

Within the context of gay and bisexual men, chosen interventions need to be specifically attuned to particular dynamics present in the gay and bisexual sociocultural milieu (Kelly, 1995). Successful interventions for some subgroups of gay men, such as particular age or racial populations, are not always successful with other subgroups of gay men (Kelly, 1995). Furthermore, the social context of the disease can change over time. For instance, for some individuals the introduction of antiretroviral therapy has made HIV/AIDS appear more manageable and less terrifying an illness (Dilley et al., 2002; Jaffe et al., 2007; Van de Ven, Rawstone, Nakamura, Crawford, & Kippax, 2002). Additionally, the ways in which human
sexuality is constructed over the lifespan at both the individual and larger community levels is dynamic and incredibly complex. Sexual decision-making is not a straightforward or unidimensional process (Green, 2008). Instead, it is derived from a complex combination of emotional and psychological states, and meanings associated with one’s sense of identity, sense of self, and self-worth (Green, 2008). The kinds of sexual choices one makes are therefore integrally linked to one’s mental health and well-being.

Rationale

For various reasons, regardless of the threat of a terminal illness, some gay and bisexual men are still choosing to have unprotected anal sex, or, to “bareback,” as it has been called. A number of factors have been implicated as most salient to the increased rate of HIV transmission via barebacking among gay and bisexual men in North America. Key factors thought to be involved include treatment optimism (Dilley et al., 2002; Jaffe et al., 2007; Van de Ven et al., 2002), the structure of the gay community itself (Green, 2008), the perception of limited personal self-efficacy (Gillis, Duggan, Ferguson, & Schluter, manuscript submitted for publication; Green, 2008), safer-sex fatigue (or ‘condom fatigue’; Wolitski et al., 2001), substance use (Dingle & Oei, 1997; Myers et al., 1992), relationship status (Gillis et al., manuscript submitted for publication; Green, 2008; Rosser et al., 2008; Wilton, 2008), low self-esteem (Chae & Yoshikawa, 2008; Green, 2008; McLaren et al., 2008; Martin & Knox, 1997; Van Gorder, 1993; Wilton, 2001), a desire for interpersonal connectedness (Adam, 2006; Gillis et al., manuscript submitted for publication; Lewis, Gladstone, Schmal, & Darbes, 2006), and physical sensation (Carballo-Diegues & Bauermeister, 2004; Dilley et al, 2002).

Many of the above factors are central to the field of counselling psychology (Gelso & Fassinger, 1990). A number are also relevant to common counselling interventions that
psychological professionals use with their clients, such as interventions improving self-esteem, providing psycho-education, offering emotional support around loneliness and the desire for connection, and helping to increase self-efficacy (Gelso & Fassinger, 1990). The significant impact of these factors on individual mental health may also compound any negative overall impact on sexual decision-making. The high rate of new HIV infections could, therefore, belie the significance of psychological and psychosocial factors for HIV transmission in this population. Overall, exploring the ways in which these variables operate to affect the attitudes, knowledge, and behaviour of gay men can inform future HIV interventions as well as underscore the importance of incorporating these variables in individual counselling paradigms with gay clients. As a result, although many of the constructs involved in HIV prevention stem from social psychology, community psychology, and more large-scale, generalized constructs in health psychology; they are nonetheless highly relevant to counselling psychology.

Many HIV+ positive individuals, and friends and family members of HIV+ individuals, seek counselling for coping strategies and emotional support in confronting mortality or bereavement (Green, 1989). Mental health practitioners have described working with clients living with AIDS as having significant rewards for the practitioner that extend far beyond the possible ramifications of sadness, vicarious trauma, and grief (Batchelor, 1988). Instead, these clients afford clinicians the rare opportunity to examine real and profound issues of life and death, which can powerfully impact clinicians in a professional capacity as well as in an individual capacity, as fellow human beings (Batchelor, 1988). Possible issues relevant to HIV or AIDS that could arise in individual counselling include concerns regarding sexual impulsivity, relationships, one’s own impending death, the death of a loved one, or emotional issues surrounding HIV status disclosure to sex partners (Harris & Alderson, 2007). The latter issue is
particularly relevant since the 1998 Cuerrier decision in Canada, a ruling legally mandating all HIV+ individuals to disclose their status to sexual partners or risk prosecution for causing serious bodily harm, and the introduction of mandatory status disclosure laws carrying criminal penalties in the United States (Canadian AIDS Society, 2004; Galletly & Dickson-Gomez, 2009).

Counselling psychology practice is also critically relevant to the concept of “safer sex” and sexual behaviour change. Interventions to change behaviour at the individual level consist of tasks such as psycho-education and skill-building, counselling, and prevention case-management (Coates, Richter, & Caceres, 2008). Individually-based counselling interventions for HIV prevention have been found to be effective in preventing infection in the short-term, and therefore continue to represent a positive means of supporting gay men and reducing the propensity for HIV infection in those clients (Coates et al., 2008). Like the majority of effective community-based interventions, counselling interventions are routinely couched in psychological and behaviour science theory in order to promote behavioural change (e.g.: Chesney et al., 2003). Consistent with the theoretical basis of cognitive-behavioural or behaviour therapies, whose general goals are to create novel conditions for learning and increase the options for personal choice (Salkovskis, 2002), the majority of individualized counselling interventions for HIV prevention in the population of gay and bisexual men aim to provide psychosocial support and information, to shift individual cognitions surrounding risk, and to emphasize autonomy of personal safe-sex choices (Kelly, 1995).

However, the current state of research on HIV prevention has promoted a move towards larger-scale, community-based HIV prevention programs as opposed to individual counselling-based interventions (Global HIV Prevention Working Group, 2008). Primarily, this is because
behavioural interventions are now generally perceived to have limited efficacy in changing behaviour over the long-term (Global HIV Prevention Working Group, 2008). For example, a meta-analysis of HIV interventions for MSM revealed that the positive effects of behavioural intervention can successfully reduce the incidence of unprotected anal sex only for about 1-3 years post intervention (Johnson et al., 2009). Over time, the effects of behavioural interventions are seen to wane, particularly in the face of socially complex sexual interactions (Johnson et al., 2009). Cognitive-behavioural approaches may be effective for many individuals, but they are unlikely to address the specific needs of the countless, complex populations at risk (Global HIV Prevention Working Group, 2008). Furthermore, in the case of gay and bisexual men, prevention is doubly challenged by the complexity of human sexuality and sexual arousal:

While [cognitive-behavioural] approaches may work well for many people, they are unlikely to address the needs of the myriad populations at risk of infection. Because human sexuality … [is] not always subject to cognitive control or mediation, cognitive approaches alone will not produce behaviour change in many people” (Global HIV Prevention Working Group, 2008, p. 19).

Secondly, individual prevention interventions have also been characterised as logistically impractical, time-consuming, and ineffective in terms of the vast numbers and diversity of men to be reached (Global HIV Prevention Working Group, 2008; Kegeles, Hays, & Coates, 1996).

Lastly, there is now a prevalent belief that changing the social norms and attitudes surrounding safe sex may be a crucial element to sustained, long-term behaviour change, and it has been suggested that community-based interventions will be most successful in this regard (Global HIV Prevention Working Group, 2008). The transmission of HIV is a dyadic event that takes place between individuals in social contexts (Coates et al., 2008). Therefore,
behavioural strategies applied to social units as a whole may have greater potential than those strategies operating at the level of individuals in isolation (Coates et al., 2008). The report of the Global HIV Working Group on Behaviour Change and HIV Prevention further emphasizes this point by suggesting that to reduce HIV incidence, interventions for HIV prevention must change social norms and attitudes, and shift the general consciousness and function of social networks (2008). At the same time, however, they point out that there are comparatively few validated HIV prevention programs operating at the community level (Global HIV Working Group on Behaviour Change and HIV Prevention, 2008).

Consequently, there is a call for greater research on community-based, psychological HIV prevention interventions in the population of gay and bisexual men. This is particularly the case for those community interventions most likely to influence social norms and attitudes, as this domain may be integral to promoting long-term behaviour change and reduced HIV incidence overall. However, in order to design and implement wide-ranging psychological interventions that will best effect change in attitudes and normative behaviour surrounding sex and HIV transmission, one must first understand the norms surrounding sexual decision-making for gay and bisexual men, as well as the factors most saliently contributing to unsafe sexual decisions. Sexual decision-making is a process strongly influenced by psychological and emotional factors as well as social norms (Pinkerton & Abramson, 1995). This may be particularly significant for the gay community: a relatively insular, sexually stratified subculture structured around the prospect of sexual or romantic pairing (Green, 2008).

The Present Study

The present study was designed to elucidate the most salient factors influencing sexual decision-making for gay and bisexual men in a large, urban Canadian city. The study involved
analysing semi-structured interview data from interviews with gay and bisexual men relating to their sexual practices, relationships, substance use, life experiences, and community dynamics.

The objectives of the study were to:

a) Identify which factors differentially lead to safe versus unsafe sex in gay male sexual decision-making and to explore the implications of these factors for the practice of counselling psychology with gay and bisexual clients;

b) Provide recommendations for the design of future psychological HIV intervention strategies based on the respondents’ norms of sexual decision-making; and

c) Validate and ground all findings and recommendations in the voices of the study participants – their feelings, experiences, and opinions.

In these ways, the present study contributes to the dialogue surrounding what shape future psychological HIV prevention efforts should take, and what should be included in those interventions. This research has important implications for counselling psychology. The current study highlights the most potentially significant features of counselling-based HIV prevention strategies, and also informs counselling practice by elucidating for professionals the most salient issues in gay men’s relationships, emotional life, and sexual practices. Moreover, a tertiary study goal was the creation of a conceptual model detailing the relative influence of the identified factors, in a diagrammatic representation of sexual decision-making (please see Figure 4).

Outline of This Document

Chapter one is the introduction and rationale provided for the study. Chapter two, the literature review, is comprised of three main components to be described in greater detail in the introduction to the literature review on the following page. Methodology and procedures of the present study are outlined in chapter three. Chapter four will report the study results, including
demographic information, descriptive statistics, and qualitative analyses highlighting qualitative themes relevant to sexual decision-making. Lastly, chapter five will discuss these findings in terms of their implications for future HIV prevention intervention efforts and the clinical practice of counseling psychology with gay and bisexual clients. This chapter will close with remarks on the limitations of the present study and directions for future research. For a glossary of specific terms utilized in this paper, please see Appendix C on page 142.
Chapter Two: Literature Review

Structure of the Literature Review

The literature review has three main components. First, the review will outline for the reader a number of the factors considered most relevant to the increases in HIV incidence. These factors are categorized and presented in a step-wise fashion, narrowing the focus from a) the macro, or structural level, to b) the organizational and community level, to c) the individual level; and lastly to d) the level of specific factors contextual to the AIDS epidemic. The second section of the literature review is an overview of the most relevant psychological models of behaviour change. Understanding these theories and principles that underlie sexual behaviour change will provide the psychological context in which to consider the ramifications of the identified factors for both large-scale psychological interventions and for individual counselling psychology. Lastly, the third major component of the literature review will present process and outcome data for a number of community-based intervention strategies. For reasons outlined in the rationale, this portion of the review will primarily emphasize large-scale, community-based, Canadian psychological interventions.

Factors Related to Increased HIV Incidence for Gay and Bisexual Men

In general, a highly complex constellation of factors are tied to any decision to engage in unprotected sex. As described above, the medical and psychological research community has underscored the importance of a number of specific domains that can contribute to making unsafe or risky sexual decisions. Again, these include factors such as treatment optimism, low self-esteem, and substance use, and others (Jaffe et al., 2007; Martin & Knox, 1997; Myers, Rowe, Tudiver, Kurtz, Jackson, Orr & Bullock, 1992; Van de Ven et al., 2002). These factors can lead to psychological issues such as increased sexual impulsivity, personal/cultural
devaluation, an increased willingness to take risks, and/or the perception of limited self-efficacy. Exploring the impact of these variables on decision-making is thereby relevant to psychological clinical work with gay and bisexual men, as these factors can all be implicated in decreased overall mental health as well as increased likelihood of HIV transmission for gay or bisexual men (Gillis et al., manuscript submitted for publication; Wilton, 2001).

For the purposes of this literature review, this paper will categorize the majority of these factors according to whether they are a) **structural factors present in the environment** (elements in the larger sociocultural environment that are out of the realm of individual control, yet contribute to mental health and shape behaviour), b) **community / institutional and organizational factors** (variables directly linked to dynamics present in the gay community), c) **individual factors** (variables intimately related to the person themselves and their individual psychological make-up, as well as personal characteristics which can determine sexual desirability and impact upon self-esteem), and d) **contextual factors central to the epidemic** (elements related to the socio-cultural perception and understanding of HIV/AIDS in the population of gay and bisexual men). Overall, factors contained within the above categories combine in varying ways and to varying degrees for each individual man: for many, resulting in impaired sense of self and/or an increased propensity for unsafe sex (Gillis et al., manuscript submitted for publication).

**Structural factors.** Structural factors, those elements in the sociocultural environment that are beyond an individual’s control, yet which strongly influence their psychological well-being and behaviour, are often overlooked, but highly relevant to the design of successful intervention programs (Rosser & Horvath, 2007; Sumartojo, 2000). Structural variables include those elements of the environment that can either assist or impede efforts to prevent the
transmission of HIV, such as social, physical, organizational, cultural, community, legalistic, and public policy dimensions (Rosser & Horvath, 2007). Although some researchers argue that there is a paucity of research looking at the impact of structural factors on well-being and HIV prevention in gay and bisexual men (e.g.: Rosser, West, & Weinmeyer, 2008, reviewed later on in this section) there are indeed some studies that have explored structural factors, both present in the larger community and within gay male communities specifically (for example, see Rosser & Horvath, 2007). The push for more structurally informed HIV prevention research is well-founded, as available studies highlight the general potential of structural change to lower HIV prevalence rates and identify new approaches to long-term HIV prevention (Blankenship, Bray, & Merson, 2000).

In the context of HIV prevention for gay and bisexual men, relevant structural factors present at the broadest societal plane could include access to basic human rights, societal discrimination, and the economic climate (Rosser et al., 2008). In a recent study exploring the impact of structural factors on HIV prevention in 13 rural states in the United States, more successful HIV prevention programs were not randomly distributed, but instead appeared associated with certain structural variables present at the state level (Rosser & Horvath, 2008). One key structural factor was a state’s degree of religious adherence, particularly the Evangelical Protestant faith, which was inversely related to success in HIV prevention (Rosser & Horvath, 2008). A second major factor was increased gay community structure, which was positively related to successful prevention (Rosser & Horvath, 2008). Lastly, the allocation and overall total amount of funds devoted to community-based interventions and/or to programming targeting gay men was highly relevant in successful outcomes (Rosser & Horvath, 2008). Generally, states that spent a larger proportion of their funding on programming targeting MSM
and on contracts to community-based organizations evinced greater overall success (Rosser & Horvath, 2008). In the less successful states, less than 3% of total HIV prevention funding was directed towards programs targeting MSM (Rosser & Horvath, 2008). Furthermore, half of those states reported the return of some federal government HIV prevention funding unspent (Rosser & Horvath, 2008).

Legal and human rights, including the basic individual rights to cohabit, have sex, and marry, are also key to community mental health and shifts in gay culture. A recent macro-analysis drawing on reports from key HIV/AIDS expert representatives at the 8th International AIDS Impact Conference (2007) from 17 cities in 14 nations worldwide (France, Denmark, Sweden, Canada, England, Poland, the Netherlands, Estonia, the Czech republic, Bulgaria, South Africa, New Zealand, Australia, and the United States) suggests that a lack of human rights, societal oppression, homophobia, and the HIV epidemic were all powerful driving forces behind the initial cohesion of many gay communities around the world (Rosser et al., 2008). The results of this study, which compares physical evidence of structural change from these countries with the opinions of the national experts from each city, indicates that at present, with greater societal acceptance, increased civil rights protection, and the development of more advanced forms of medical treatment for HIV, the daily experiences of gay men may be changing (Rosser et al., 2008). There is also evidence of a shift away from a focus on gay ‘community,’ especially that based in the bar scene, to increased online communication and sexual networking on the web (Rosser et al., 2008). This is even more evident for certain HIV-positive men, who seek out sero-concordant partners online (Rosser et al., 2008). Results from the diverse cities listed above reveals that gay men in most large democratic centres are now less involved in political activism, and also appear less interested in fighting for their civil rights (Rosser et al., 2008). However,
this is not true for all countries. Gay male communities in many Eastern Bloc countries are still intensely united in struggle for various civil liberties (Rosser et al., 2008).

**Community, institutional and organizational factors.** The literature stresses the importance of a connected, mutually-supportive gay community in creating social cohesiveness that is thought not only to increase overall individual psychological well-being, but also to modify the risk of acquiring HIV (Davis, 2008; Rosser et al., 2008). However, research also points to “problematic aspects of the gay community which are seen to create a context in which people are less likely to practice safer sex” (Gillis et al., manuscript submitted for publication, p. 15). In this sense, the gay community itself is fundamental to, and has an unmistakable impact on, the individual psychological functioning of its members. This has relevance to both large-scale behavioural interventions designed to temper risk of HIV infection, as well as to individualized, one-on-one counselling with gay and bisexual male clients. Gay communities are made up of very different individuals who are unlikely to be biologically related, but who share a desire for psychological and physical security separate from the hetero-normative dominant culture (Haldeman, 1995). This highlights the significance of common cultural values among community members (Haldeman, 1995). As a result, an awareness of the gay community and its culture, traditions, and institutions is a significant asset for all clinicians working with gay male clients (Haldeman, 1995). The gay community is of further consequence for counselling psychologists in terms of attachment formulation for gay clients, due to the significance of community support during the coming-out process (Haldeman, 1995). The initial experience of a Lesbian-Gay-Bisexual-Transgender (*LGBT*) identity can be highly isolating due to homophobia and homonegativity (Haldeman, 1995).
As a result, it appears that community structures and dynamics have the propensity to impact upon the mental health of its members in either positive or negative ways. For instance, there is increasing evidence of sexual, social, and community stratification in gay communities (Green, 2008). The current context of web-based virtual innovation has also prompted a shift in what constitutes community membership and social interaction (Green, 2008). Novel changes are occurring in the gay community’s sexual subculture (Green, 2008). An increased use of Internet chat rooms and sexual networking sites is evident, “barebacking” has emerged as a form of discrete social identity, and ‘poz-only’ (HIV sero-positive) sex parties now exist. These and other forms of specialized online social and sexual networking for HIV positive individuals are also new environments for HIV prevention (Green, 2008; Rosser et al., 2008). Furthermore, an overall increase in crystal methamphetamine use associated with sex has occurred, particularly for younger gay men (Green, 2008; Rowe & Dowsett, 2008). As a result, gay male community members often report a lack of connection or support from the gay community (Gillis et al., manuscript submitted for publication). The experience of rejection, as well as internalized homophobia or homonegativity, are also relevant factors (Gillis et al., manuscript submitted for publication; Rosser et al., 2008).

At the community level, psychological well-being and behaviours related to HIV risk can be impacted by the density of urban gay neighbourhoods, collective community identification, healthy self-identification within the community, and a sense of being accepted by your community (Rosser et al., 2008). Within the community, at the organizational and/or institutional levels, relevant variables that can improve overall psychological well-being and moderate risk for HIV infection include the availability of information and HIV-specific
prevention services, the presence of social groups and positively-motivated gay venues and virtual communities that can provide help and support (Rosser et al., 2008).

**Structural decline of the gay community.** There is evidence that for many North American, Western-European, and Latin American countries, the gay communities that had flourished in the large urban centres now appear to be in decline (Rosser et al., 2008). A recent macro-analysis drawing on reports from key HIV/AIDS expert representatives at the 8th International AIDS Impact Conference (in 2007) from 17 cities in 14 nations worldwide demonstrated that overall, the sense of ‘community’ in gay neighbourhoods was now decreasing, and that the neighbourhoods themselves are slowly disappearing (Rosser et al., 2008). This was true for all cities with the exception of London and New York, which reported thriving gay communities (Rosser et al., 2008). Neighbourhoods disappearing are due in part to greater assimilation with the general population over time, as some gay men appear to be moving into the suburbs, and young straight people are moving into the gay neighbourhoods (Rosser et al., 2008). Interestingly, although the size of the gay communities was found to decrease, the overall proportion of gay men in the city populations was not – across the board, the numbers of gay men in the studied locales were reported to be stable or increasing (Rosser et al., 2008).

Furthermore, for all cities included in the analysis, the number and popularity of gay bars and clubs was described as waning, and the closure of many gay social venues was reported (Rosser et al., 2008). This appeared to be just one symptom of overall structural decline – with gay visibility, friendship, and community socialization declining in favour of more individualistic gay internet culture (Rosser et al., 2008). The impact of these changes in the community on overall mental health and behaviours related to HIV prevention is thought to be damaging (Rosser et al., 2008). Structural decline of the community increases the propensity for
HIV risk and the complexity of sexual decision-making, while decreasing the most effective means of prevention (Rosser et al., 2008). Others have also argued that shifting the responsibility of HIV prevention from its initial collective community response model to the level of the individual has resulted in an ineffective HIV prevention response, and the development of insufficient, lay person constructions of risk-management that may in fact increase HIV risk (Flowers, Duncan & Frankis, 2000).

**Community sexual stratification.** There is strong evidence that the gay community is becoming increasingly socially, culturally, and organizationally exclusionary, particularly with regard to oppressive mainstream norms of body image and its determinants (Duncan, 2007; Green, 2008; Tiggemann, Martins, & Kirkbride, 2007; Yelland & Tiggemann, 2003). Individual factors such as age, ethnicity and physique all combine to play an integral role in the sociocultural assessment of who is considered most attractive, and this stratification is due, in part, to the idealized and unattainable standard of beauty present at the community level (Tiggemann et al., 2007). The dominant gay male culture is thought to place a premium on attractiveness (Tiggemann et al., 2007). Similar to the experience of heterosexual women, gay men are seeking to attract and please the sensibilities of men, and may therefore be more likely to view their bodies as sexual objects (Tiggemann et al., 2007). This form of social standing, essentially sexual marketability, derived from how well one’s appearance maps onto socially-guided idealized forms of beauty, has been referred to by some researchers as “sexual status” (Green, 2008).

Generally speaking, high sexual status in the community is determined by how closely one’s appearance resembles the socially-supported, idealized version of sexual desirability. In the gay community, the literature suggests that the vision is a young (20’s to early 30’s), middle-
class, athletic, handsome white male (Duncan, 2007; Green, 2008; Tiggemann et al., 2007; Yelland & Tiggemann, 2003). Other forms of sexual marketing and eroticism exist, such as the husky, hairy body type known as a ‘bear’ (Duncan, 2007). However, the young, white, fit and rugged male is a more universal sexual preference for gay men.

Within sexual hierarchies of preference, a pecking order also exists. For instance, Caucasian males tend to be preferred over all other ethnicities, but among other ethnicities, Black, Hispanic and Aboriginal males tend to be preferred over Asian males (Chae & Yoshikawa, 2008). As a result, the degree of body image disruption, rejection, avoidance, and isolation a man will experience in the social and sexual arenas depends on how far he diverts from the community ideal (Chae & Yoshikawa, 2008). As Green (2008) depicts, structures of sexual status are differentially distributed across the population, meaning that individual men are adversely affected to varying degrees, based on their specific circumstances and how socially attractive they are judged to be. The determinates of sexual status (one’s age, physique, attractiveness, ethnicity, and class) are discussed in greater detail at the level of the individual in the following section.

**Social cohesiveness / community membership.** Lacking a sense of belonging and acceptance in the larger gay community can play a significant role in sexual decision-making as well. Research suggests that when some gay men come out of the closet for the first time, they expect to be welcomed into a community of like-minded and accepting people (Gillis et al., manuscript submitted for publication). However, this is not always the case. Members of the gay community must still face similarly oppressive social standards, idealized sexual norms, and value-judgment based on sexual desirability, in addition to internalized homophobia (Gillis et al., manuscript submitted for publication; Green, 2008). Gay men often report a sense of
disappointment with the gay community, and a feeling they do not fit in (Gillis et al., manuscript submitted for publication). This poor attachment to the community can leave gay men feeling isolated and lonely, resulting in vulnerability and an increased likelihood of risky sexual decision-making (Gillis, Duggan, Ferguson, & Schluter, manuscript submitted for publication). At the same time, however, gay men can report that they feel an increased sense of community once diagnosed as HIV positive (Zea, Reisen, Poppen, Bianchi, & Echeverry, 2005).

Some gay and bisexual men feel unable to connect to nearby gay communities, and thereby feel ostracized by their peers. For example, gay Asian men report experiencing widespread intolerance and discrimination from the gay male community more than any other ethnicity (Wilson & Yoshikawa, 2004). A recent study that investigated the link between depressive mood, HIV risk behaviour, and perceived group devaluation in gay Asian men has direct implications for both individual counselling and wide-scale HIV interventions (Chae & Yoshikawa, 2008). The more the Asian men in the sample felt unwanted sexually and devalued personally by the gay community at large, the more likely it was that they would also experience depressed mood (Chae & Yoshikawa, 2008). However, for Asian men who had access to gay Asian communities, feeling like an active member of the gay Asian community and having positive evaluations of oneself in that context was correlated with low levels of depression (Chae & Yoshikawa, 2008). These results highlight the importance of incorporating positive group identity in moderating the effect of perceived group devaluation in any alienated grouping.

Similarly, other gay men feel unwelcome or socially unable to connect to their own cultural communities. Evidence relating to the experiences of gay, bisexual, or “two-spirit” men

1 For First Nations peoples, self-identifying as two-spirit is a non-colonial means of depicting sexual preference and representing the differential contributions to one’s personality of
from First Nations communities supports this assertion (Gilley & Co-Cké, 2005). Like MSM, First Nations populations in Canada are overrepresented in terms of their prevalence rates of HIV infection (Canadian Public Health Association, 2005). However, within this cultural group, the risk of acquiring HIV is much greater for women, intravenous drug users, and young people than for MSM (Canadian Public Health Association, 2005; Public Health Agency of Canada, 2007). Nevertheless, gay, bisexual, and two-spirit First Nations men remain a clinically complex and high-risk population for HIV infection (Gilley & Co-Cké, 2005). These men’s overall mental health and self-efficacy in sexual decision-making can be compromised by a number of other relevant issues, such as systematic societal discrimination and a greater propensity for victimization (Simoni, Walters, Balsam & Meyers, 2006). Two-spirit men report experiencing homophobia and a feeling of alienation from the social and ceremonial aspects of their tribal communities. Instead, they look for support and connection in the social segments of gay male communities, which also happen to be substance-use focused (Gilley & Co-Cké, 2005). However, the experience of isolation from one’s tribal or cultural networks, combined with the possibility of not being fully accepted by the gay community either, has been found to lead to increased risky sexual behaviour and a greater propensity for victimization for these men (Simoni, Walters, Balsam & Meyers, 2006). As a result, there arose a movement within First Nations support groups and service organizations to create available cultural alternatives for increased ceremonial and social involvement of First Nations men of varying sexual and gender both male and female gender identities (Simoni, Walters, Balsam & Meyers, 2006). This identification also allows some First Nations peoples to rise above the binary Judeo-Christian and Eurocentric categories of gender, and to reconnect with indigenous traditions associated with sexuality and gender identity (Simoni, Walters, Balsam & Meyers, 2006).
orientations (Gilley & Co-Cké, 2005). The goal is greater cultural investment in one’s traditional community, as that can engender an enhanced sense of self-acceptance and social belonging, resulting in reduced likelihood of substance abuse and risk of HIV infection (Gilley & Co-Cké, 2005).

Similarly, there is a significant propensity towards depression in gay and bisexual Latino men in the United States, who, as a group, often report experiencing significant challenges or resistance in their ability to ‘be themselves’ or connect with the gay community (Guarnero & Flakerud, 2008). Latino culture is highly diverse and reflective of many different cultural traditions, for example that of Mexico, Central or South America, and the Caribbean (Guarnero & Flakerud, 2008). This cultural group emphasizes traditional conceptions of masculinity, conformity, and the primacy of the family unit (Guarnero & Flakerud, 2008). There is also a scarcity of alternate Latino gay subcultures within Hispanic communities themselves, due to cultural loathing, severe stigma, threat of violence, and economic hardship (Guarnero & Flakerud, 2008). This can lead to significant challenges for gay and bisexual Hispanic men, who must often hide their sexual orientation from their family, and who cannot easily confront the implicit homophobia within the family structure (Guarnero & Flakerud, 2008). If monetary and material resources are unavailable to them, gay Latino men may feel they have no recourse but to remain within the family and community structures and conceal their sexuality (Guarnero & Flakerud, 2008). This can leave gay Latinos to lead double lives, with “one foot in the gay world” (p. 668), and one foot in the world of the Latino family (Guarnero & Flakerud, 2008). Concealment and denial may result in socio-emotional isolation, feelings of shame and immorality, and internalized homophobia leading to varying degrees of abnormal psychological reaction (Guarnero & Flakerud, 2008).
The consequence of concealment and denial for gay men may be social and emotional isolation, disapproval and prejudice, and judgments of shame and immorality. These circumstances may be overwhelming and result in psychological reactions of anxiety and depression of varying severities (Guarnero & Flaskerud, 2008, p. 668).

In addition to the above examples of specific within-group differences that challenge the development of a secure sense of community membership, there is also evidence that, regardless of cultural or ethnic background, belonging to the gay community is a requisite emotional need for the majority of gay or bisexual men. In a 2008 study that explored sense of belonging as a predictor of depression in gay Australian men, the authors found that men who felt connected to, accepted by, or as though they belonged to either the gay community or the larger area community, had lower levels of depression than men who did not have that sense of connection (McLaren, Jude, & McLachlan, 2008). Furthermore, men who felt a strong connection with either of the above communities were more likely to have a more positive outlook on acceptance generally, and tended to feel enhanced belonging in the other group as well (McLaren et al., 2008). Other research seems to support this finding. In response to high levels of discrimination and sexual prejudice in western nations, and even among an individual’s friends and family, gay men appear to look to others in the community for support (Kelly, 2001; McLaren et al., 2008).

As a result, social cohesiveness and positive community membership are seen to be directly relevant to decreases in HIV transmission. Not only does rejection by a community decrease one’s power/status in terms of the practical ability to negotiate safe sex, it also excludes men from the positive social support structures that contribute to overall mental health and well-being, thereby increasing the likelihood of mood disturbance. Mood disturbance in gay men, such as depression, anxiety, or anger management concerns, can contribute to low self-esteem
and thereby increase the likelihood of high-risk sexual behaviours. For example, the gay Asian men in the study discussed earlier experienced high levels of depression as members of a low-sexual status, devalued ethnic minority group who rated themselves most sexually attracted to white men (Chae & Yoshikawa, 2008). The greater the severity of their depression, the more those men endorsed the practice of unprotected anal sex with non-primary partners (Chae & Yoshikawa, 2008). Furthermore, those participants who held a more negative conception of their own cultural community also had higher levels of unprotected anal sex overall (Chae & Yoshikawa, 2008).

Moderating the effects of depression and anxiety at the community level in the gay male population is crucial and especially urgent given the increased likelihood of making unsafe sexual decisions as a result of feeling depressed, socially isolated, or unwanted (Chae & Yoshikawa, 2008; Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Meyer & Dean, 1998; Rosario, Rotheram-Borus, & Reid, 1996). Loneliness and social anxiety can also lead to increases in alcohol and substance use/abuse, both as a withdrawal response to feeling isolated, or as a defence mechanism meant to bolster one’s confidence in the bar and club scene (Green, 2008). Consequently, for gay men, belonging to the gay community serves a protective function (McLaren et al., 2008). Collectively, these results suggest that that HIV prevention interventions should focus on enhancing gay men’s sense of belonging in both types of community, and also suggest that gay men’s reliance on other gay men directly benefits their mental health overall (McLaren et al., 2008). Rowe and Dowssett point out that an individual’s “...ambivalence towards safe sex and toward gay community are inseparable, suggesting the inter-related, mutual fragility of the two concepts” (2008, p. 340). Therefore, as time goes on, the changing notion of what constitutes community will need to be reflected in prevention efforts – whether that remains
one larger gay community, an online / virtual community, or multiple smaller ‘tribes’ as some have suggested may be imminent in the future of gay culture (Rowe & Dowsett, 2008).

**Sexual identity formation and community attachment.** The development of sexual identity in the context of minimal community support is another key contributor to sexual decision-making. Young gay and bisexual males are reportedly now self-identifying at earlier ages developmentally when compared with gay men in previous generations (Harper, 2007). Furthermore, they are doing so in environments that remain pervasively heterosexist, and at young ages where most youths would normally still be living with their parents (Harper, 2007). Stressors during the formative stages of the development of sexuality and masculinity can result in an impaired ability of gay male adolescents to fully self-actualize one’s personality (Harper, 2007). Discriminatory societal preconceptions of masculinity can, for some young men, lead them to feel as though they are not ‘real men’, which in turn can lead to increased risky sex (with both males and females) as an overt expression of masculinity (Harper, 2007). In a similar vein, there is evidence that for adult gay men, doubts concerning one’s masculinity were directly linked to an individual’s own rate of participation in sexual risk behaviours (Levine, 1998; Wolfe, 2003). One study also found that for adult gay men, the endorsement of stereotypically masculine traits was satisfied via frequent barebacking with multiple partners (Harper, 2007).

Parallel to the experience of gay and bisexual men in North America (Kelly, 2001; McLaren et al., 2008) Susan Kippax and her team explored the concept of identity formation in gay and bisexual men in Sydney, Australia, and sense of gay male identity vis-à-vis varying forms of attachment to the gay community (Kippax, Connell, Dowsett, & Crawford, 1993). This is a key concept, as attachment to the gay community has been shown to play a significant role in HIV prevention (Kippax et al., 1993). In the Australian study, the best predictors of the ability to
change one’s sexual practices to adopt safe-sex techniques were sexual and social engagement in the gay community, education level, and knowledge of unsafe sexual practices. A direct parallel was evident between engagement in the gay community and degree of adoption of safe sex practices: the greater the engagement, the greater the adoption of safe sex practices (Kippax et al., 1993). This was manifested in the comparison between the urban and rural locales, where men in urban locations were more likely to discuss with friends issues related to HIV prevention and assimilate novel adapted safer-sex behaviours into their regular sexual practices (Kippax et al., 1993). However, men in rural locales were less likely to do this, and were more likely to engage in more rudimentary strategies for prevention, such as simply ceasing to have sex.

Accordingly, as Kippax points out, the importance of gay community is “obvious” (p.123), as this form of gay male social networking was found to facilitate more complex forms of behavioural change in the sexual practices of individual men within the network (Kippax et al., 1993).

Kippax et al.’s results further revealed a number of community and attachment-style differences related to a variety of other structural variables. For example, while men from all social classes and backgrounds could participate in the sexual and social aspects of community life, political and cultural attachment to the community was primarily limited to middle-class men (Kippax et al, 1993). Age served to stratify respondents as well. For younger participants, attachment to the community was mainly sexual or social, rather than cultural or political (Kippax et al, 1993). Therefore the gay community, in its cultural and socio-political forms, supports and enables men in the negotiation of safer sex, but at the same time, the cultural setting in which men seek partners and negotiate the terms of safe sex has changed (Kippax et al., 1993). Similarly, other literature has suggested that the use of the Internet for meeting partners
contributes to the decision to have unprotected sex (Parsons & Bimbi, 2007). However, this evidence may also speak to cases of HIV positive men seeking out sero-concordant sexual partners on the Internet. This serosorting behaviour may lead to an increase in unprotected anal sex, but not to an overall increase in HIV incidence.

**Cultural inclusivity.** In a 2003 review assessing the overall effect of HIV prevention interventions that specifically included community culture in their program design, two strategies were found to be most commonly employed overall (Wilson & Miller, 2003). First, many programs adapted the format of the intervention by appealing to a particular target audience via the use of culturally-relevant images, dialogue, actors or videos. Other programs adapted the actual content of the intervention by adding in culturally specific themes in story content addressing their specific values, experiences and understanding (Harper, 2007; Wilson & Miller, 2003). The results revealed that although changing the presentation format was the more commonly used approach across interventions, of the two approaches, adding in cultural content was more successful (Harper, 2007; Wilson & Miller, 2003). Finally, the review recommended an expansion of the ways in which culture is defined in the context of HIV prevention (Wilson & Miller, 2003).

**Community-mediated sexual identities.** Lastly, there are also reports of subversive community-based identities cropping up in gay subculture that are theorized to relate to increases in rate of HIV transmission. In the context of HIV prevention, these include ‘barebackers’, individuals who intentionally go out of their way to have unprotected anal sex as a definitive part of their sexual identity. In addition, some authors have noted the phenomena of ‘gift givers’, HIV+ individuals who seek to pass on the HIV virus, and ‘bug chasers,’ individuals who ‘chase’ the thrill of coming close to infection (Gauthier & Forsyth, 1999; Parsons & Bimbi, 2007). The
prevalence of these individuals and their role in HIV transmission remains controversial. There is evidence that barebacking as an identity can also be fetishized at times, and may be emerging as a cultural phenomenon or identity in the gay community (Parsons & Bimbi, 2007). Initially, the term barebacking emerged to denote sero-positive men seeking unprotected sex with sero-concordant partners, but it has largely just come to mean sex without a condom (Parsons & Bimbi, 2007). Barebacking then morphed into a form of identity for some men who, as a group, exhibit certain trends towards specific behaviours. For example, self-identified barebackers reject the association between disease and sex, and endorsed significantly more crystal methamphetamine use and higher peer norms related to risky or unprotected sex than other men (Parsons & Bimbi, 2007). However, in his review of Barebacking: Psychosocial and Public Health Implications, Davis (2008) highlights the difficulty researchers experience in arriving at an exact definition of barebacking that will capture the diversity of usages in circulation in gay male culture.

**Individual / interpersonal factors.** Individual factors are those variables that are intimately related to a person’s personality, tendencies, and history. They are also often integrally related to determining an individual’s sexual status in the community. At the individual level, a number of different variables have been documented to negatively impact upon overall individual mental health as well as augment sexual decision-making. These factors include HIV status, sexual marketability, low self-esteem, internalized homophobia, interpersonal/relationship dynamics, a desire for connection to others, and substance use/abuse (Rosser et al., 2008). A discussion of individual sexual status, essentially one’s socio-sexual marketability or desirability to men in the community, is an important inclusion among the above variables (Green, 2008). Lastly, interpersonal factors include variables like monogamy,
disclosure of HIV status to partners, demographic differences between partners, and the possibility of interpersonal violence (Rosser et al., 2008).

**HIV status.** HIV status is an important factor to consider in the context of sexual decision-making and HIV prevention. Foremost, for many HIV sero-negative individuals, initial knowledge of a sexual partner’s positive status activates psychological states such as threat, fear, or anxiety (Zea et al., 2005). In terms of the Health-Belief-Model, close physical or intimate proximity to that partner can then act as a cue to engage in self-protective mechanisms such as deciding to forgo sex, or to engage in safer-sex (Rosenstock, 1974; Rosenstock et al., 1994). Cues have been suggested to be most strongly associated with successful HIV prevention behaviour change when individuals have a high degree of perceived AIDS-related threat (Rosenstock, 1974; Rosenstock et al., 1994). Accordingly, in the hierarchy of factors leading to sexual risk-taking, the HIV status of sex partners is rated as a more important deciding factor for MSM than many other factors, including, for example, perceptions of treatment optimism (see Cox, Beauchemin, & Allard, 2004).

HIV status also appears to be a determining factor in some men’s approaches to having unprotected sex. Barebacking, for instance, runs the behavioural gamut of a single relapse from safe sex behaviour to continued, purposeful unprotected sex as part of a barebacking identity (Parsons & Bimbi, 2007). Barebacking is also clearly not limited to HIV positive males (Parsons & Bimbi, 2007). The practice was endorsed equally between all subgroups of gay and bisexual men, regardless of their HIV status (Parsons & Bimbi, 2007). Interestingly, however, there was evidence that HIV positive and HIV negative men differed in their approach to barebacking in a number of ways (Parsons & Bimbi, 2007). HIV negative men identifying as barebackers had lower peer norms with regard to unprotected sex, and had significantly higher levels of sexual
compulsivity and romantic obsession (Parsons & Bimbi, 2007). Conversely, among HIV positive men, drug and/or alcohol-influenced sexual expectations and a higher peer norm for unprotected sex were the factors with the most significant effects on barebacking (Parsons & Bimbi, 2007). Observed differences between self-identified barebackers and non-barebackers may help guide outreach interventions targeted specifically towards men who bareback, in addition to helping develop campaigns dissuading those men who seek unprotected casual sex from turning into barebackers themselves (Parsons & Bimbi, 2007).

Sexual marketability. In the literature, sexual sociality appears to be a defining feature of some parts of the gay male culture, suggesting that social interaction in the gay community is structured around the prospect of sexual or romantic pairing (Duncan, 2007; Green, 2008; Green, 2006; Hospers & Jansen, 2005; Kaminski, Chapman, Haynes, & Own, 2005). Adam Isaiah Green, a sociologist at the University of Toronto, has studied what he and others refer to as the Toronto gay “Village” extensively (2008). His most recent research and longitudinal fieldwork explores sexual sociality in this urban enclave, as well as seeks to understand the impact of community sexual standing on individual health (Green, 2008). In the specific context of Toronto’s gay community, Green’s results show a distinct trend towards implicit organized sexual hierarchy. As Green stated, “…race-ethnicity, class, and age locate individuals within a stratified system whereby attributions of attractiveness establish a structure of probabilities for sexual partnership, right of sexual choice, perceptions of group belonging, and the attainment of social significance” (Green, 2008, p. 437). Therefore, for many men, in different ways and at different times in their lives, the desire to engage in unprotected sex is guided by personal contextual factors such as age, ethnicity, appearance, and class. However, Green (2008) also notes that if these attributions of attractiveness are partly due to individual preferences, they are
not distributed randomly across groups or between community members in the Village. Instead, middle-class, Caucasian, good-looking, and muscular men in their twenties and thirties enjoy a distinct status advantage (Green, 2008).

However, status disadvantage occurs for the remaining members of the community, who all fall varying degrees from the beauty ideal along the continuum of sexual status. Low sexual status results in recurring rejection, challenges in meeting desired men for sexual or romantic pairings, unwelcoming community interactions, a sense of deliberately cultivated social insignificance, low self-esteem, the perception of loss of control or autonomy in one’s intimate life, and “hopeless resignation” (Green, 2008, p. 445). As a result, low sexual status may engender negative psychological and emotional states such as depression, hopelessness, isolation, and anxiety (Green, 2008). In this way, the individual perception of low sexual status can hinder the capacity to outline the overall terms of a sexual encounter, such as the ability to negotiate sexual pleasure, deciding who does what, and to whom, and engaging in communication surrounding safe sex (Green, 2008). Moreover, repeated social or sexual rejection based on low status may lead to an increased use of alcohol or drugs socially in order to buffer one’s self-esteem, which is also associated with impaired sexual decision-making (Green, 2008). Low sexual status thereby has distinct consequences for public health and HIV transmission (Green, 2008).

Green’s results highlight the unique difficulties engendered in the context of sexual interactions that involve two partners of discordant sexual status. In that case, there is evidence that the less desirable partner is likely to experience reduced self-efficacy, less control over the sexual interaction, and a sense that they are in some way obligated to please the more desirable partner preferentially (Green, 2008).
The importance placed on this form of status-ordering of individuals in the community and sub-group affiliation creates distinct challenges for HIV prevention. The defining elements that determine where one falls in this sexual hierarchy are explored individually below.

Age. Generally, youth is considered more sexually attractive and therefore preferable in the gay community (Duncan, 2007; Green, 2008; Tiggemann et al., 2007; Yelland & Tiggemann, 2003). Aging, therefore, can have significantly negative emotional consequences for gay men, particularly for those who enjoyed high sexual status in their youth, but who no longer receive the same social response in later adulthood (Green, 2008). This loss of desirability is often referred to as ‘frightening’ by gay men (Green, 2008). Similarly, age and body type combine to determine attractiveness and desirability in certain social venues, such as bathhouses, bars, and clubs (Green, 2008). One’s age can have overt consequences in this sense. Bathhouses, for example, can have a tendency to loosely divide patrons based on whether they are young, old, fit, or overweight, to the sexual disadvantage of the unattractive, older or overweight (Green, 2008). For those individuals, low sexual status may in turn result in decreased self-efficacy in navigating sexual interaction, and an impeded ability to advocate for themselves regarding their sexual wants and needs (Green, 2008; Natale, 2009). This may be particularly true for low status men when having sex with a more attractive or socially-desirable partner (Gillis et al., manuscript submitted for publication). As a result, for example, older men may compromise their desire for safe sex in order to solidify a sexual encounter with a good-looking younger man looking to have unprotected sex (Green, 2008).

Being a younger gay man can also impact upon HIV transmission and prevention in a number of significant ways. First, younger gay and bisexual men have grown up accustomed to the presence of condoms as a normative part of the sexual sphere, and in an environment where
information about HIV/AIDS is widely disseminated (Hays, Kegles, & Coates, 1990). As a result, although young gay men currently are likely to endorse sex with condoms, they have also largely been spared the evident devastation of the early days of the HIV epidemic, when no treatment was available for HIV (Jaffe et al., 2007). Accordingly, research evidence indicates that, although this subpopulation has lower rates of new HIV infection, when compared with older MSM, young MSM are more likely to both engage in unprotected anal sex and have a greater overall number of sexual partners (Ekstrand, Stall, Paul, Osmond & Coates, 1999; Hays et al., 1990; Kelly et al., 1990; Valdiserri et al., 1988). Young gay and bisexual men are also more likely to endorse unprotected sex while under the influence of drugs, particularly party drugs like crystal methamphetamine, ecstasy, or alcohol (Grov, Parsons, & Bimbi, 2008). As a result, they possess a substantially increased risk of HIV infection over time (Wolitski et al., 2001).

Ethnicity. One’s ethnic group plays an instrumental role in determining sexual and social desirability in the gay community (Green, 2008; Wilton, 2008). As described earlier, an individual’s ethnic background plays a key role in the racist sexual stratification of gay culture. This sexual stratification emphasizes the desirability and attractiveness of certain ethnicities over others, to the detriment of non-Caucasians (Green, 2008). Caucasian males are preferred over all ethnicities, but among other ethnicities, Black, Hispanic, and First Nations males are preferred overall to Asian males (Chae & Yoshikawa, 2008). Therefore, depending upon the socio-cultural ‘value’ of one’s ethnic background, gay men can have a very different experience of the same gay community dating scene or social meat market. For example, Black gay and bisexual men have developed supportive networks almost like extended families in gay communities. These support networks function as a means of affirming both the sexual and racial identities of
Black gay men in the context of racism present in largely Caucasian gay communities, and significant homophobia present in Black communities (Wilton, 2008). Stigma and institutional homophobia in Black institutions and service organizations can also result in the exclusion of Black gay and bisexual men from certain programmatic prevention efforts (Wilton, 2008).

Minority stress is a theoretical sociological model that describes processes of stress that lead to unfavorable health outcomes for members of a given marginalized group (Meyer, 2003). Consistent with this theory, discrimination based on one’s ethnic background can deplete self-esteem and mental health, and contribute to numerous factors related to sexual decision-making (Hatzenbuehler et al., 2008). The degree of body image disruption, rejection, avoidance, and isolation a gay man experiences in the community depends on how far he diverts from the idealized notion of attractivity, and that ideal does not include ethnicities other than Caucasian (Chae & Yoshikawa, 2008). For example, as touched on above, gay Asian men report experiencing intolerance and discrimination most often of all ethnicities in gay social settings (Wilson & Yoshikawa, 2004). Direct associations have been found between negative emotional, behavioural, and health repercussions and perceived racism or ethnic group devaluation for Asian men in the gay community (Chae & Yoshikawa, 2008). The more that socially unvalued ethnic group members felt sexually rejected and personally devalued by the gay community at large, the more likely it was that they would also experience depressed mood, leading to greater practice of unprotected anal sex with non-primary partners (Chae & Yoshikawa, 2008).

Physique/body image. Physical appearance or physique is often tied to age, and like the community preference for younger men, an athletic, muscular body type is the preferred body image (Duncan, 2007; Tiggemann et al., 2007; Yelland & Tiggemann, 2003). Again, however, it would be a generalization to say that the only physical ideal present in gay culture is that of the
young, white, slim, yet muscular, male with a mesomorphic figure (Faulkner & McMurray, 2002). Other forms of socially-constructed sexual identity, such as ‘bears’ or ‘leather’ guys, are common (Green, 2008) and some researchers argue that a focus on the idealized, normative requirements of the imagined ‘gay community’ detracts from the ability to understand the true lived reality of gay men’s lives, in which body and identity negotiation is complex and not necessarily “reducible to ‘negative body perception’ or ‘body image dissatisfaction’…” (Duncan, 2007, p. 334). Nonetheless, downplaying the significance of the young, white, handsome and muscular ideal as a sociocultural force for gay men would undermine the seriousness of its apparent negative effects (Duncan, 2007). As gay men integrate themselves into the gay socio-cultural context, they are habitually exposed to the physical ideal of the most ultimately attractive gay man, and in turn, are compelled to conform to that model (Duncan, 1997).

Gay men possess a lower body mass index (BMI) than heterosexual men (Epel, Spanakos, Kasl-Godley & Brownell, 1996) and it has been widely found that gay men have a higher degree of dissatisfaction with their bodies than do heterosexual men, at times commensurate to that of women (Tiggemann et al., 2007). Research suggests that this bodily dissatisfaction results in significant disordered eating as well as a propensity towards formally diagnosed eating disorders (Duncan, 2007; Tiggemann et al., 2007; Yelland & Tiggemann, 2003). For instance, the latter study found that, on measures of ‘drive for thinness’ or ‘bulimia,’ the results for gay men were not significantly different from women (Tiggemann et al., 2007). Furthermore, gay men report that they feel their outward appearance is highly important to others (Yelland & Tiggemann, 2003), and endorse peer pressure for them to look good (Hospers & Jansen, 2005). They are also more likely to possess distorted cognitions surrounding the importance of having an ideal body (Kaminski et al., 2005).
In general, a man’s body image is comprehensively related to his overall self-esteem, whether gay or straight (Tiggemann et al., 2007). However, only for gay men does self-esteem appear negatively related to the importance to other men of weight, appearance, and physique (Yelland & Tiggmann, 2003). Again, this may reflect increased pressure on men in gay communities to conform to the ideal body type (Yelland & Tiggmann, 2003). As described above in the introduction to the section, poor body image derived from the perception of low personal sexual desirability among one’s peers can engender low self-esteem, and a correspondingly decreased sense of self-efficacy in navigating safe-sex behaviours. In particular, less traditionally ‘attractive’ men, with a less muscular or less sexually appealing physique, can experience status discordance when they are paired with partners whose bodies and outward physical appearance is considered subjectively more desirable (Green, 2008).

Discordance of sexual status among sexual partners thereby sets the stage for decreased agency on the part of the less socially/sexually desirable man, impeding his ability to be adamant in the demand for safe sex, to negotiate favoured sexual acts/positions, or to appropriately evaluate the costs and benefits of the kinds of sexual risks he may be willing to take (Green, 2008). Other studies have further highlighted the harmful effects of self-comparison with idealized bodily stereotypes, which, for gay men included significantly decreased self-esteem, and disrupted psychological states and behaviour patterns (Faulkner & McMurray, 2002). Overall, gay and bisexual men diet more often, are more dissatisfied with their bodies and afraid of gaining weight, and are more critical of their muscularity (Kaminski et al., 2005).

Interestingly, a number of gay male authors, journalists, and academics have described their personal experiences of coming out, and subsequently their search for acceptance and
membership in gay communities, as contextualized by struggles with weight, self-esteem, and exercise (Duncan, 2007).

Duncan goes on to contend that some have argued that the experience of these men reflect “personal failings” (p. 334), and that it has been argued that the idealized body type celebrated by gay men reflects an “ahistorical ideal of male beauty” (Duncan, 2007, p. 334). However, the present study argues that the gay community is definitive in the cultivation of body image and sense of self, particularly because all study participants were community members. The men in this study are self-identified gay or bisexual men – they are not defined as ‘men who have sex with men’. These men have come out, and have deliberately affiliated themselves with the social context of Toronto’s larger gay community in varying ways (and to varying degrees, based on their personal circumstances). The community dynamics that contribute to the cultivation of self-esteem, well-being and acceptance are directly relevant to self-efficacy in protecting oneself from HIV infection. This assertion in no way implies a decontextualization of gay men and their bodies from the societal and political role the body has played in “asserting the public legitimacy of gay male identity and sexuality” (Duncan, 2007, p. 334). However, to reject the importance of idealized male beauty and sexual status in the gay community would be a disservice to the experience of gay men who do not fit this ideal stereotype. It would be a gross understatement not to suggest that the life experiences of those men might be different from that of gay men who do come closer to the ideal standard of beauty. Furthermore, one would be an amiss not to suggest that this difference might parlay into HIV prevention, particularly given the evidence presented here that suggests it does.

Social class. A collection of meanings related to complex political, group and psychosocial disparities present in human environments, in this context social class is used to
refer to an individual’s subjective sense of their personal social standing in the gay community, which is influenced by socially-valued cultural variables such as occupation, the physical presentation of oneself, and one’s socio-economic status, etc. (Liu et al., 2004). The social outcomes of an individual’s social class have the propensity to impact upon mental health, as, for example, higher rates of hostility and depression are often reported by individuals of lower social classes (Lorant et al., 2003). Similarly, a decreased sense of optimism and personal autonomy in one’s life is endorsed more often by individuals belonging to lower social classes as compared with those of a higher social standing (Chen, Matthews, & Boyce, 2002). An individual’s social class, social standing or socioeconomic status can also affect their sexual life in multifarious ways. In the context of risky sex behaviour and protecting oneself from HIV, it has been found that feelings of rejection, poor community attachment, and transient low self-esteem engendered by social class can mediate risky sex behaviour (Green, 2008; Dowsett, Williams, Carballo-Die´guez, & Ventuneac, 2008; Ayala & Díaz, 2001; Hope & MacArthur, 1998). For example, there is evidence that white-collar occupations or objective measures of wealth/status may mediate some of the stress engendered by low sexual status in the community (Green, 2008). Indeed, some gay men endorse routinely feeling judged on the basis of socio-economic status (Dowsett et al., 2008).

One four-year study that examined the impact of class and race on sexual behaviour and HIV protection for gay Latino men in the United States revealed that the men in their sample believe both their identity and their social life to be heavily determined by race and class (Ayala & Díaz, 2001). From the qualitative and focus group data, study participants who negatively emphasized the qualitative effects of race and class in their lives also self-reported higher amounts of unprotected anal sex (Ayala & Díaz, 2001). In addition to mediating increased
discrimination in the community, class can also more directly impact upon HIV prevention via the effects of poverty, by impeding a man’s ability to purchase materials like condoms, for example. Furthermore, limited formal education, which is associated with low socioeconomic status, can adversely affect the ability to practice safe sex because an individual may possess less well-developed cognitive reasoning skills, or limited knowledge about HIV viral transmission (Reisberg, 1997). For example, a British study found that both unemployed gay men and men in manual labour or working class occupations were more inconsistent in their safe sex practices than other gay men (Hope & MacArthur, 1998).

**Self-esteem.** Self-esteem is the subjective personal appraisal or valuation of one’s overall self-worth associated with individual emotions and beliefs about oneself (Orth, Robins, Trzesniewski, Maes, & Schmitt, 2004). Having low self-esteem has been determined to be a significant risk factor for depression across the lifetime (Orth et al., 2004). Low self-esteem or poor self-valuation is a commonly proposed motivating factor in unsafe sexual behaviour for gay and bisexual men, as well as in the implementation and maintenance of consistent safer sex habits (Chae & Yoshikawa, 2008; Green, 2008; Martin & Knox, 1997; McLaren et al., 2008; Van Gorder, 1993). In light of the evidence of unique stressors to the psychological well-being and self-esteem of gay and bisexual men, psychologists have advocated improving self-esteem as a means of diminishing the likelihood of gay men to engage in unsafe sex (Martin & Knox, 1997). The importance of ‘gay self-esteem’ has been espoused by the New York organization *Gay Men’s Health Crisis*, purportedly the oldest HIV/AIDS prevention service and treatment agency in the United States (Gay Men’s Health Crisis website, 2009; Martin & Knox, 1997). Accordingly, some gay men have reported that low personal self-esteem was one of the obstacles they wrestled with in their efforts to maintain safe sex behaviour patterns (Van Gorder, 1993).
Martin and Knox (1997) highlight the results of a study involving gay male focus groups in San Francisco, wherein one respondent noted, “I did not value my life enough to prevent myself from getting totally blasted and ending up as a receptacle for someone else” (Van Gorder, 1993, p. 7). Similarly, in an ethnographic study of men in the Toronto gay and bisexual community, reduced self-esteem was often reported by men who felt rejected by other men in the community and who therefore perceived themselves to possess low sexual desirability (Green, 2008). This feeling intensified even more significantly when men were rejected by others perceived to be low status as well (Green, 2008).

With respect to sexual status and self-esteem, many gay men report that on a day-to-day basis, they feel as though they are consistently judged on the basis of factors such as fitness, ethnicity, masculinity, and socio-economic status (Dowsett et al., 2008). Regardless of the basis on which the determination was made, gay men who are negatively evaluated on the basis of personal characteristics perceive themselves as possessing low sexual status, and are socially isolated, repeatedly rejected by possible sexual partners, overtly shunned, and at times actually blatantly avoided in social interaction (Green, 2008). This, Green argues, directly impacts upon their psychosocial ‘resources,’ which include self-esteem and sense of control (2008). Other evidence supports the assertion that the psychosocial stressors associated with low sexual status, in addition to the experience of discrimination, overt sexual appraisal, racism, and rejection by one’s own peers in one’s own community, can severely impact upon men’s self-esteem and bring up emotional issues regarding inadequacy, body image and sexual insecurity (Chae & Yoshikawa, 2008; McLaren et al., 2008).

Once more consistent with the model of minority stress, the model describing processes of stress that lead to unfavorable health outcomes for members of a given marginalized group, as
sexual minorities, gay and bisexual men are much more likely than not to experience objective prejudice, homophobia, and antigay violence, and can therefore come to expect rejection, fear and hate from the heterosexual population (Hatzenbuehler et al., 2008; Meyer, 2003). Evidence strongly suggests that individuals with sexual minority status experience discrimination more frequency than heterosexuals (Hatzenbuehler et al., 2008). This can have deleterious behavioural and emotional consequents for gay men, leading to increased psychological distress (Hatzenbuehler et al., 2008; Mays & Cochran, 2001; Meyer, 1995) and escalated HIV risk behavior (Hatzenbuehler et al., 2008; Meyer & Dean, 1998; Rosario et al., 1996). A final and significant mental health consequence of minority stress for gay men is the possible internalization of negative societal attitudes, or the direction of those attitudes towards the self (Meyer, 2003; Meyer & Dean, 1998). Internalized homophobia can engender reduced self-esteem, a significantly decreased sense of self, decreased self-confidence, and higher levels of sex guilt, leading to risky sex decision-making (Frost & Meyer, 2009; Leveqsue & Vichesky, 2006).

Therefore, there is significant evidence suggesting that risky sex is a reflection of poor self-valuation (Chae & Yoshikawa, 2008; Green, 2008; Hartinger, 1992; McLaren et al., 2008; Martin & Knox, 1997; Van Gorder, 1993). At the same time, studies examining this association using formal measures of self-esteem (such as the popular Rosenberg Self-Esteem Scale, or RSES) have found inconsistent or negligible evidence for low overall self-esteem as a marker of risk-taking sexual behaviour (e.g.: Dawson, Fitzpatrick, Boulton, McLean & Hart, 1991; O’Brien, Wortman, Kessler & Joseph, 1993; Paul, Stall, Crosby, Barrett & Midanik, 1994). In response, psychologists have argued that overall self-esteem, particularly that assessed by self-report at, say, the time of an interview, is not the most useful model for helping to understand
risky sexual behaviour in the population of gay men (Perkins, Leserman, Murphy, & Evans, 1993; Martin & Knox, 1997). This is because risky sex choices only occur episodically – they are not usually consistent behaviours (Martin & Knox, 1997; Perkins et al., 1993).

As a result, it has been suggested that unsafe sexual choices are associated with transient states of reduced self-esteem or “unstable” self-esteem (p. 265), rather than having low self-esteem as a permanent personality trait (Martin & Knox, 1997). One study that directly tested this construct of transient low self-esteem revealed that the men in their sample who barebacked with multiple casual partners also had the highest instability in their self-esteem (Martin & Knox, 1997). These men may possess a less securely actualized sense of self, and may thereby also be more susceptible to negativity, rejection, or threat. Self-esteem instability in this study was also strongly tied to loneliness, leading the authors to speculate that the two constructs may interact in some way to potentiate risky sexual practices (Martin & Knox, 1997). The authors further suggest that instances of high-risk sex may be more likely to occur in men with unstable self-esteem who also use avoidance to cope with stress (Martin & Knox, 1997). Given that the use of alcohol or drugs is another widespread avoidance coping strategy, this fact may help explain the association of substance use with high-risk sexual practices in the gay male population (Martin & Knox, 1997).

**Substance use.** An individual’s proclivity towards substance (i.e.: alcohol and drug) use/abuse is also directly relevant to increases in HIV transmission. Alcohol, a central nervous system depressant, lowers behavioural inhibition and can result in impulsivity, and psychoactive drugs clearly alter perception, cognitive capacity, and decision-making skills (Rosenzweig, Leiman & Breedlove, 1999). There is also evidence that alcohol can have negative immunological consequences for HIV transmission, in that moderate alcohol consumption for an
HIV+ person significantly increases viral HIV replication in peripheral blood mononuclear leucocytes (which results in decreased T-helper and T-suppressor cell action) (Bagasra, Kajdacsy-Balla, Lischner & Pomerantz, 1993).

In a number of research studies, sexual expectation and sexual behaviour while under the influence of substances (notably alcohol or methamphetamines) has been found to contribute significantly to the decision to have unprotected sex (Parsons & Bimbi, 2007). Party drugs generally have swept onto the gay bar scene in the past two decades, and have been implicated in increased HIV transmission (Dingle & Oei, 1997; Myers et al., 1992). Popular party drugs in the gay circuit include ketamine (called K or “special K”), methylenedioxymethamphetamine (MDMA, most commonly called ecstasy, or “e”), gamma-hydroxybutyrate (GHB / Rohypnol, commonly referred to as “G”), and crystal methamphetamine (Dingle & Oei, 1997). These drugs can heighten the experience and sensation of physical desire, and also impair an individual’s ability to make safe, health-conscious spur-of-the-moment sexual decisions (Dingle & Oei, 1997). In particular, the literature suggests a strong positive correlation between crystal methamphetamine use and increased HIV transmission in gay men (Colfax et al., 2005; Halkitis et al. 2001; Parsons & Bimbi, 2007; Purcell et al., 2005).

Use of methamphetamine in the population of MSM is significantly higher – up to ten times higher – than the average population (Groh et al., 2008). Furthermore, self-identified barebackers report a particularly high prevalence rate of crystal methamphetamine usage, a connection that is a common finding in the literature (Colfax et al., 2005; Halkitis et al. 2001; Parsons & Bimbi, 2007; Purcell et al., 2005). Correspondingly, a study of HIV positive gay and bisexual men found that methamphetamine use, compulsive sexual behaviour, and having sex under the influence of substances were all directly predictive of having identification as a
barebacker (Halkitis et al. 2005). Underlining this finding may be the fact that some of methamphetamine’s most sought-after effects operate at the individual level by boosting self-confidence in sexual interaction and increasing sexual pleasure (Green & Halkitis, 2006; Grov et al., 2008; Purcell et al., 2005). Methamphetamine is associated with the perception of increased self-esteem and less social awkwardness, increased libido and decreased sexual inhibitions, superior sexual endurance, and a higher pain threshold (Green & Halkitis, 2006). Some researchers have also suggested that the social dynamics present in the sexual subculture of gay communities exacerbate the problem of methamphetamine use by stressing a certain form of sexual desirability and peak sexual performance, compounding gay men’s risk of contracting HIV (Green & Halkitis, 2006).

Lastly, there is also a trend in the literature suggesting that sexual risk behaviours in gay men are inherently related to the gay social context. ‘Gay culture’ in itself is implied to connote substance use due to the cultural emphasis placed on social venues such as bars, discos, clubs, and bathhouses, where substance use is prevalent (Wilton, 2008). This may indeed contribute to the rate of substance use. However, it is also important to keep in mind that substance use can be related to numerous other more complex variables. For example, for certain groups of gay men who feel poorly connected to the gay community or discriminated against by its members alcohol or drug abuse is often turned to in order to mitigate feelings of sadness, anxiety, isolation, or loneliness (Wilton, 2008).

**Interpersonal / relationship variables.** Lastly, interpersonal variables also have an impact on sexual decision-making, and include factors such as relationship context / monogamy, HIV status disclosure, qualitative experience of sexual pleasure, a need for connection to others, demographic differences between partners, and the possibility of interpersonal violence (Rosser
et al., 2008). These variables are generally characterized in the literature as influential in the decision to have unprotected anal sex (Gillis et al., manuscript submitted for publication).

The status of one’s relationship / partner impacts upon the likelihood of making certain sexual health choices for gay and bisexual men, as higher rates of unprotected anal sex were reported in the context of monogamous primary partner relationships (or those perceived to be monogamous) as opposed to casual partnerships (Wilton, 2008). Within both long-term and casual relationships, the use of condoms is routinely negotiated in some fashion (Gillis et al., manuscript submitted for publication). The literature generally supports the contention that condom use is negotiated away when relationships develop to the point that they are believed to be exclusive, committed and monogamous, as an indicator of a special bond and a certain level of trust between two men in love (Adam, 2006).

Some within-group differences have been observed, however. Alcohol abuse is associated with having both primary and casual sex partners, as well as with an overall greater reported number of sexual partners in the recent past (Wilton, 2008). Conversely, drug abuse is associated with having mostly/only casual sex partners, and with having had unprotected sex during an individual’s most recent previous sexual experience (Wilton, 2008). An individual’s HIV status also appears to be associated with interpersonal interaction and/or relationship status. A selection of longitudinal data from the San Francisco Men's Health Study that focused only on gay men was stratified by relationship and HIV status, revealing a number of group differences (Hoff, Coates, Barrett & Collette, 1996). The results indicated that HIV negative men were more likely to be in long-term primary relationships than HIV positive men, and also concluded that the men whom were in primary relationships had higher rates of barebacking than single men (Hoff, Coates, Barrett & Collette, 1996).
Disclosure of one’s positive HIV serostatus to a close member of one’s social network has also been linked to HIV prevention, due to its apparent effect on overall well-being and self-efficacy in safe-sex behaviours. One study exploring the consequences of HIV-positive serostatus disclosure for gay Latino men found that disclosure was positively associated to greater self-esteem, qualitatively better social support, and low levels of depression (Zea et al., 2005). Furthermore, the authors suggested that the degree of social support actually mediated the association between HIV-positive disclosure and both self-esteem and depression (Zea et al., 2005). Disclosure resulted in increased social support, which then positively impacted upon emotional health and well-being (Zea et al., 2005). However, men in the study differed significantly in terms of the target individuals they chose to disclose to (for example, 85% chose to disclose to their best friend, whereas only 23% disclosed to their fathers) (Zea et al., 2005). Therefore, it appeared that the directly positive and encouraging consequences of disclosure were influenced by who the disclosure was made to, as opposed to just the act of disclosing itself.

The particulars of physical interaction, such as the desire for intimacy and connection with a partner, the qualitative experience of sexual pleasure and the physical sensation of sex without a condom, and emotional and physical satisfaction, are all important factors in HIV transmission. The desire for connection to another individual is a powerfully motivating social force (Beckerman, Heff-LaPorte & Cicchetti, 2008; Lewis et al., 2006). Barebacking can play an instrumental role in enhancing the feelings of intimacy and closeness with another man that occur in relationships believed to be exclusive, committed and monogamous, as an indicator of a special bond and a certain level of trust (Adam, 2006; Gillis et al., manuscript submitted for publication; Rowe & Dowsett, 2008). Closeness and connection in primary partner relationships
is a significant influence in the gay community (Lewis et al., 2006). As a result of homophobia and other social constraints, gay couples often lack macro-level societal structural supports and also receive less psychosocial support from family and friends (Lewis et al., 2006). These factors might lead gay men to be more dependent on their primary partner relationships for support and to have their emotional needs met (Lewis et al., 2006). This also means that an individual’s partner is often the most important and influential person in that individual’s life (Lewis et al., 2006). To that end, in some long-term sero-discordant relationships, there is evidence of HIV negative gay men deliberately seeking seroconversion to positive HIV status (Beckerman, Heff-LaPorte & Cicchetti, 2008). In addition to safe sex fatigue and the fatalistic expectation that one will acquire AIDS in the end anyway, one of the salient motivations identified in seeking to become HIV positive was the desire to be closer to one’s HIV positive partner (Beckerman, Heff-LaPorte & Cicchetti, 2008).

Some studies report that the primary reason many gay men engage in barebacking is that they simply find that the physical sensation of sex is better without a condom (Carballo-Diegués & Bauermeister, 2004; Dilley et al, 2002). In one sample of 124 men who had engaged in high-risk unprotected sex in the past year with an HIV-positive or unknown serostatus man, 76% reported that the desire for sex to ‘feel good’ superseded thoughts of protection (Dilley et al, 2002). Therefore, in certain circumstances, and with the right partner, gay men may put themselves at a greater than normal degree of risk in order to attain this sensation when desired (Gillis et al., manuscript submitted for publication). Condoms can be seen as a barrier in this sense as they are associated with a lack of sensation, which can have a corresponding detrimental impact on maintaining an erection (Gillis et al., manuscript submitted for publication).
Lastly, there appears to be evidence that, over time, anal intercourse is psychosocially structured in different ways by different men (Kippax et al., 1993). A major finding of an Australian study entitled the Social Aspects of the Prevention of AIDS (SAPA) Project was that sexual and emotional pleasure was strongly associated with a number of structural variables, among which age stood out (Kippax et al., 1993). A significant relationship between age and which sexual practices were chosen as most emotionally and physically satisfying emerged in the data. Older gay and bisexual men were seen to choose barebacking as most emotionally and physically satisfying, and less likely to select kissing and sensuous touching (Kippax et al., 1993). Conversely, young gay and bisexual men were much more likely to choose kissing and sensuous touching as most emotionally and physically satisfying, and less likely to endorse barebacking (Kippax et al., 1993). The results of this study suggest that time significantly impacts the ways in which sexual pleasure is understood by different men, which may in turn differentially affect the relative frequency of the behaviour between young and older gay men. Distinct differences emerged, one generational and one a function of maturity (Kippax et al., 1993). This finding may somehow be a function of the effect of the HIV epidemic, or may be due to age-related confounds (for example, lack of experience on the part of young gay or bisexual males; Kippax et al., 1993).

**Contextual factors central to the epidemic.** Contextual factors central to the epidemic are elements related to the socio-cultural perception of HIV/AIDS in the population of gay or bisexual men, including variables such as treatment optimism, misunderstood transmissibility, and safe sex fatigue.

**Treatment optimism.** Treatment optimism is a primarily North American phenomenon that entails the average individual ceasing to really think of HIV/AIDS as a major threat to his or
her health or well-being at this point (Dilley, Woods, & McFarland, 1997; Jaffe et al., 2007; Van de Ven et al., 2002). Indeed, there is evidence that gay men worry less now overall about contracting HIV, and conceive of it as a treatable but chronic health condition instead of a terminal illness (Dilley et al., 1997; Gillis et al., manuscript submitted for publication; Jaffe et al., 2007). This is due in part to the recent evolution in improved medical treatments for HIV, such as highly active antiretroviral therapy (HAART) with the result that sero-positive individuals are now living fuller, longer, healthier lives (Dilley et al., 1997; Gillis et al., manuscript submitted for publication; Jaffe et al., 2007).

The vastly improved ability to treat and control the virus is momentous, but brings with it the negative side effect of implicitly encouraging men to view HIV as a non-life-threatening condition, and to thereby feel less concerned about the possibility of contracting it (Jaffe et al., 2007; Van de Ven et al., 2002). It is an ongoing challenge for prevention that the present general conception of HIV as a terminal but manageable illness is to a degree fuelled by the advances in medical treatment that can finally maintain the virus at a manageable level (Kalichman et al., 2007a). HAART involves several HIV treatment medications (generally about three) taken in combination, which together bolster and maintain immune fitness and control the viral load in one’s body (Body Health Resources Foundation, 2006). In what many men refer to as a medication ‘cocktail,’ any of about thirty HIV treatment medications from various pharmacologic classes can be combined in a treatment regime that is specific to the individual, their overall health, and the stage of their illness (Body Health Resources Foundation, 2006; Jaffe et al., 2007). At the same time, however, no single medication taken alone has found to be effective, and many individuals in the gay community possess a poor understanding of what the actual lived reality of taking these kinds of very serious medications is, including the side effects
one experiences, etc. (Gillis et al., manuscript submitted for publication; Kalichman et al., 2007a; Kalichman et al., 2007b).

Nonetheless, individual beliefs concerning treatment are extremely important, in that they can reduce one’s motivation to practice safer sex (Kalichman et al., 2007a; Kalichman et al., 2007b). For instance, almost 30% of subjects in an Australian sample of MSM reported that as a result of HIV treatment medications, they were less worried about catching HIV (Dilley et al., 1997). Furthermore, around 13% of the same population indicated that they agreed (‘strongly’ or ‘somewhat’) with the statement, I am more willing to take a chance of getting infected when having sex (Dilley et al., 1997). As a result, high risk sexual behaviour is thought to be significantly associated with beliefs of treatment optimism (Cox et al., 2004).

**Misconstrued transmissibility.** Beliefs about HIV transmissibility are also directly associated with increases in HIV transmission (Crepaz et al., 2006; Kalichman et al., 2007a; Kalichman et al., 2007b). There are almost thirty medications available now in the United States for the treatment of HIV/AIDS (Body Health Resources Foundation, 2006). However, the medications prescribed to treat the disease can also play a role in shifting the sociocultural understanding of how the virus is transmitted. The combined impact of fewer gay men visibly dying of AIDS (Kelly & Kalichman, 2002), and the new treatment medications available (which are able to reduce viral load to remarkably imperceptible levels; e.g.: Schuman et al., 2001), have for some men resulted in inaccurate beliefs about HIV transmissibility, both for HIV-positive and HIV-negative individuals. For example, as one researcher noted, barebacking can be reliably predicted by individually-held beliefs that HIV treatment can reduce the risks for transmitting the virus to partners (Kalichman et al., 2007b). Studies show that, at the time the first effective HIV-suppressive therapies became available in the mid to late 1990’s, prevention-
related beliefs about the benefits of undetectable viral load and antiretroviral (ARV) medications became common for gay and bisexual men (Kalichman et al., 2007b). There is a lessened degree of HIV transmission risk when positive serostatus partners have negligible viral load (Butler et al., 2008). However, the assertion that these individuals are not infectious is incorrect, as there is always a possible risk of HIV transmission (Butler et al., 2008).

Furthermore, the degree of perceived reduced / increased HIV risk associated with being either an insertive (‘top’) or receptive (‘bottom’) sexual partner can also strongly influence sexual decisions. The estimated per-contact risk of becoming infected with HIV as a receptive partner barebacking with an infected insertive partner is 0.82% (Vittinghoff et al., 1999). When the serostatus of the insertive partner is unknown, that risk for the receptive partner falls to 0.27% (Vittinghoff et al., 1999). The estimated risk per sexual contact of acquiring HIV as a ‘top’ is 0.06%, and the per-contact risk of acquiring HIV through unprotected oral sex is 0.04% (Vittinghoff et al., 1999). Thus, individuals who predominantly ‘top’ or have unprotected sex do have a reduced risk of acquiring the HIV virus, but remain at risk.

**Safer sex fatigue.** Lastly, safer sex fatigue, or ‘AIDS burnout’ is essentially the exhaustion of prevention behaviours due to many years of exposure to HIV prevention media and long-term campaigns for safe sex practices (Wolitski et al., 2001). The degree of safe-sex message exposure results in disillusionment and a lack of motivation to utilize condoms during sex – therefore independently predicting the nature and extent of unprotected anal sex for HIV positive men (Wolitski et al., 2001). This phenomenon could have arisen in part due to gaps in service prevention for gay men as HIV prevention services grew to meet the acute needs of other target populations (Wolitski et al., 2001). Moreover, safe sex messages judged to be outdated, redundant (telling people what they already know to be true), or unsophisticated can also
contribute to the overall sense of frustration, and have been criticized by the community in past (Wolitski et al., 2001).

**Relevant psychological models of behaviour change.** As there is no medical cure or preventative vaccine for AIDS, the sole means by which one can prevent HIV infection remains behaviour change (DiClemente & Peterson, 1994; Kelly, 1995; Kelly, Murphy, Sikkema, & Kalichman, 1993). Effectively all new HIV infections could be prevented if individuals were able to successfully change high-risk behaviours in order to reduce their risk for HIV infection, as well as maintain that behaviour change (Kelly, 1995). At the same time, human sexuality is immeasurably complex, and these risk behaviours occur within the framework of people’s interpersonal relationships. Sexual beliefs and practices are shaped and strongly reinforced at multiple interrelated levels of enquiry: from the media to physiology, to social pressure and sexual fantasy (DiClemente & Peterson, 1994; Kelly, 1995). As a result, initiating and/or negotiating shifts in sexual patterns and interpersonal relationships is challenging, as one must contend with numerous physical, social, psychological, and cultural obstacles (Kelly, 1995; Kippax et al., 1993).

Regardless, there is clear evidence that behaviour change is effective in reducing transmission. The most effective HIV risk reduction interventions are those that extend above and beyond the provision of basic factual information, and instead promote behavior change by sensitizing individuals to personal risk and normalizing that risk, strengthening one’s intention to reduce personal risk, improving sexual communication and safe-sex navigational skills, providing support and positive reinforcement to individuals as a consequence of successful behaviour change, and bringing about the experience of increased self-confidence as a result (Kelly, 1995). Furthermore, there is evidence that interventions promoting behavior change are
most likely to be successful when theoretically anchored in behavioural science theory (DiClemente & Peterson, 1994; Kelly & Murphy, 1992; Kelly, Murphy, Sikkemas, & Kalichman, 1993). There are a number of existing theories and/or models that can help explain sexual decision-making in the context of HIV/AIDS. These include a) the Knowledge-Attitudes-Behaviour Model, b) the Health Belief Model, c) Social Cognitive Theory / Theory of Self-Efficacy, d) the AIDS Risk Reduction Model, e) the Theory of Reasoned Action, and f) Positive Valences Theory.

**The knowledge-attitudes-behaviour model.** The Knowledge-Attitudes-Behaviour Model (*KAB or KAP*) essentially implies that, in a linear fashion, possessing information about something will influence or determine one’s behaviour surrounding that entity (Fisher & Fisher, 1992). With respect to HIV/AIDS, learning about the disease’s impact on the body and how it is transmitted was thought to be sufficient to cause a change in unsafe sexual behavior (Kegeles, Catania, Coates, & Adler, 1986). As a result, at the outset of the epidemic widespread health education campaigns based on this model were implemented for target populations like MSM, and later the general public (Fisher & Fisher, 1992). Overall, these safe-sex and HIV educational campaigns have had an incredible impact on safe-sex practices in gay communities, indicating that knowledge of HIV is indeed necessary for behavior change (e.g.: Emmons, Joseph, Kessler, Montgomery & Ostrow, 1986; Fisher & Misovich, 1990b; Kegeles, Catania, Coates, & Adler, 1986; Kelly, St. Lawrence, Brasfield, Lemke, et al., 1990; McKusick, Coates, Wiley, Morin, & Stall, 1987).

However, evidence for the overall relationship between knowledge and prevention has been found to be ambiguous for the population of gay and bisexual men (Fisher & Fisher, 1992). Whereas early on, researchers argued that knowledge leads to prevention, some researchers also
argued that there is no relationship, as behaviour change is not sustained (Joseph, Montgomery, Kirscht, et al, 1987; McKusick et al, 1987; St. Lawrence, Kelly, Hood, & Brasfield, 1987). As a result, it has been suggested that as opposed to helping maintain behaviour change over time, information may work particularly well in initial risk behaviour change: that which occurred in the context of the panic of the HIV epidemic, before knowledge about the disease is prevalent (Fisher & Fisher, 1992; Joseph, Montgomery & Kirscht, et al, 1987). As Bandura later suggested, information alone is not likely to exert significant influence on habitual negative health behaviours unless people are also provided support, resources, and the behavioural means to do so (Bandura, 1994).

Given the continually rising rate of new infections and the fact that, according to the literature, most gay men have at least some knowledge of HIV transmission and prevention, clearly, information is a necessary but insufficient condition for sexual risk behaviour change in the case of HIV (Fisher & Fisher, 1992). Perhaps it is relatively uncomplicated behavioural actions, such as engaging in abstinence, which are most easily impacted upon by information, which would then be an intervention sufficient in itself to promote change (Fisher & Fisher, 1992). Information would also be necessary for more complex behavioural tasks, such as sexual decision-making or negotiating sexual parameters with partners. However, the complex and highly socialized nature of those kinds of actions inherently results in many challenges to sustained behaviour change. The complexity of human sexual-social interaction thereby makes information alone insufficient to sustain one hundred percent behaviour change all the time (Fisher & Fisher, 1992).

**The health belief model.** The Health Belief Model (HBM) is an early, widely-used theory proposed to help explain health-related behaviour; for example, the general widespread
failure of the American public in the 1950s to participate in programs designed to prevent or
detect disease, or the difficulty individuals experience complying with medical regimens and
following through with medications (Becker, 1974; Rosenstock, Strecher & Marshall, 1994).
Based on behavioural psychology principles relating to stimulus-response instrumental
conditioning and cognitive theory, the model suggests that individuals learn via events that serve
as ‘reinforcements’ (Rosenstock, Strecher & Marshall, 1994). Reinforcements affect the
physical drives that activate behaviour, for example, emotional states such as tension, fear, or
perceived threat (Rosenstock, Strecher & Marshall, 1994). The HBM is essentially a ‘value-
expectancy’ theory which is predicated on the desire to get well and/or evade illness (the value),
and the belief that a particular health action existing as an available resource to an individual will
ameliorate or prevent sickness (the expectation) (Rosenstock et al., 1994). Cognitive theory
plays a key role in this model by emphasizing mental processes like reason, hypothesis, and
expectation (Lewin et al., 1944).

The Health Belief Model is comprised of four components: a) perceived individual
susceptibility to a health condition; b) perceived severity of that given health condition (or
‘degree of threat’ to the individual); c) perceived benefits or value of performing a particular
risk-reduction behaviour (which is influenced by an individual’s personal beliefs surrounding the
efficacy of various behaviours in preventing a health condition); and d) perceived barriers to
action (essentially a personal cost-benefit analysis of the benefits and negative side effects of a
behaviour, such as expense, time, convenience, or dangerous outcomes) (Becker, 1974;
Rosenstock et al., 1994). These four components, combined in various permutations on an
individual level, collectively result in a person’s readiness to act (Becker, 1974).
It was later further postulated that ‘cues’ to action, when perceived threat and benefits are high, act as catalysts for engaging in behavioural action as proposed by the theory (Rosenstock, 1974). Cues to action can include experiences such as viewing relevant media productions, knowing someone with AIDS or HIV, or discussing HIV with a physician or with friends, and can all differentially affect readiness to act (Rosenstock, 1974; Rosenstock et al., 1994). Cues are suggested to be most strongly associated with engaging in successful prevention-behaviour when individuals have a high degree of perceived AIDS-related threat (Rosenstock, 1974; Rosenstock et al., 1994). The model hypothesizes that if the degree of behavioural activation or readiness to act is above a certain threshold, and if the conditions are such that they would permit an action, then the behaviour would be likely to occur (Becker, 1974; Rosenstock et al., 1994). At the same time, the theory has its limitations, and it has been suggested that adding the construct of self-efficacy to the traditional HBM could improve the models capacity to explain and predict behaviour (Rosenstock et al., 1994).

**Social cognitive theory / theory of self-efficacy.** Effective behavioural self-regulation requires skills in self-motivation and self-direction, not willpower alone (Bandura, 1977; Bandura, 1994). As Bandura himself pointed out, “...there is a major difference between possessing self-regulative skills and being able to use them effectively and consistently under difficult circumstances” (Bandura, 1994, p. 44). Self-efficacy relates to an individual’s belief that they can exercise control over their own emotional life, thoughts, behaviour, and motivation (Bandura, 1994). Thus, self efficacy is the *conviction* that one is able to effectively execute the behaviour necessary to produce the desired outcome (Bandura, 1977). An individual’s beliefs about what they are capable of doing influence what they choose to do or what actions they decide to take in certain situations, how hard they will work at this behaviour and/or persevere in
the face of challenges, whether they engage in negative or positive self-reflective thought patterns / self-talk, and the amount of stress, anxiety or depression an individual will suffer in difficult situations (Bandura, 1977; Bandura, 1994).

Bandura suggested that ‘expectation’ functions as a mechanism of operation for efficacy, meaning that individual expectations of one’s ability to master a task can influence both one’s initiation and one’s perseverance in self-protective / coping behaviours (Bandura, 1977). In the model, expectations can vary on several dimensions, including magnitude, generality, and strength, all of which can directly affect success in the long run (Bandura, 1977). Magnitude refers to how challenging a task appears to a specific person. If a task appears simpler, the expectation that one can perform it is higher (Bandura, 1977). More complex or challenging tasks can potentially have the effect of lowering an individual’s expectation that they can actually perform the task (Bandura, 1977). Expectations can also vary in their generality: some experiences do not tend to generalize beyond a single instance, thereby instilling mostly situation-specific or circumscribed expectations of ability; whereas other experiences will instil a more generalized sense of mastery in a person that extends above and beyond the particular instance (Bandura, 1977). Lastly, expectations can differ in how strong they are (Bandura, 1977). Disconfirming experiences, for example, failure to feel satisfaction after behaviour change, or relapse in the behaviour, can easily stifle weak expectations of mastery, leading to the end of the behaviour (Bandura, 1977). In contrast, if a person’s expectations of mastery are strong, they are more likely to persist with the self-protective or coping behaviour despite those kinds of disconfirming experiences (Bandura, 1977).

Personal expectation of efficacy is also theorized to be influenced by four main sources of information: a) past performance accomplishments, as past success will raise one’s
expectation of mastery, but failure will lower it – particularly if it occurs early on; b) vicarious experience, via social comparison to the successes and failures of others; c) verbal persuasion, or leading people to believe that they can successfully cope with experiences that were previously overwhelming; and d) emotional arousal (Bandura, 1977). In the case of emotional arousal, challenging or difficult situations often elicit physiological stimulation of the central nervous system, leading to the perception that one is stressed or anxious, etc. The resulting emotional state(s) in turn inform overall behavioural success, in that high arousal generally hinders performance, and on the whole, humans are also more likely to expect mastery when they do not feel nervous, stressed or agitated (Bandura, 1977).

It was Bandura who first called attention to the idea that the strength of an individual’s conviction in their personal effectiveness will likely determine whether they will even attempt to cope with challenging situations (Bandura, 1977). Indeed, individual assessment of one’s capacity to be able to engage in long-term behavior change can be quite daunting, as permanently changing one’s health behaviours can often appear an insurmountable task (Bandura, 1977). Useful analogies here could include ceasing to smoke in the face of perceived cancer threat; or ceasing to eat high-fat, sugary, or fast-food items in the face of chronic cardiac disease and/or diabetes. Because human beings are fallible, at some point every individual will likely continue to engage in some kind of action that is not self-protective of their health or well-being in some way, despite knowledge of that risk. In the context of HIV prevention for gay men, self-efficacy represents the ability to successfully psychosocially navigate one’s complex life experiences by asserting oneself when conflict arises or sexual negotiation is required (Gillis et al., manuscript submitted for publication). This skill is often challenged by the many complex
variables related to social interaction at play in the gay and bisexual socio-cultural milieu, which then act as constraints on self-protective behavior (Bandura, 1994).

Overall, self-efficacy is argued to be a key variable in behavioural models of prevention-related behaviour change. An individual believing that they are at risk of contracting HIV is advantageous to prevention only if that individual also believes that changing their behaviour will lessen that risk, and furthermore that changing their behaviour (and being consistent in that change) is something they themselves can actually do – and do successfully (Kelly, 1995).

**The theory of reasoned action.** Introduced in 1967, the Theory of Reasoned Action is a model of human behaviour that emphasizes human rationality, and the relationships between beliefs, attitudes, intention, and behaviour (Ajzen & Fishbein, 1980; Fishbein, 1980; Fishbein & Ajzen, 1975). Fishbein and Ajzen argued that social behaviour is not determined by unconscious or impulsive/capricious motives, and instead maintained that humans are rational, thoughtful beings who make “systematic use” (p. 5) of any information available to them in their environment (Ajzen & Fishbein, 1980). Their theory stipulates that behavioural action is voluntary and usually consistent with one’s intentions (which are conscious thought patterns), and that individuals weigh the possible implications of any action based on beliefs and information they possess (Ajzen & Fishbein, 1980). Individuals can then, the authors argue, engage in a conscious decision to either act in a particular way, or not (Ajzen & Fishbein, 1980).

In this model, behaviour is understood in the context of a step-wise causal chain of events connecting beliefs (and then attitudes, and then intentions) to the final step: behavioural action (Ajzen & Fishbein, 1980; Fishbein, 1980; Fishbein, Middlestadt, & Hitchcock, 1994). Essentially (progressing backwards in the model from the end result to the steps leading up to that result), an individual’s behaviour is determined by, or a function of, their intention to
perform that behaviour (Fishbein et al., 1994). Intention is dually guided by both an individual’s attitude (overall feeling about the behaviour, positive or negative) and the subjective norms regarding the performance of that behaviour (social pressure to perform said behaviour perceived at the individual level) (Fishbein et al., 1994). In turn, attitudes and subjective norms are theorized to be a function of motivating cognitive / belief structures that underlie both (Fishbein et al., 1994). That is to say, attitudes are influenced by outcome-value-weighted beliefs that performing a specific action will lead to a particular end result; and subjective norms are influenced by general societal or group beliefs about whether a certain behaviour is ‘good’ or ‘bad,’ and whether one should or should not perform it (i.e.: the meaning of a behaviour at the societal level) (Fishbein et al., 1994). The idea, then, is to alter the salient beliefs that determine behaviour at their fundamental levels. Additional factors can amalgamate to help solidify the decision to act: for example, an individual is more likely to engage in a target behaviour if their social group endorses that behaviour as positive or desirable; this combination further increases the likelihood of behaviour change (Fishbein & Middlestadt, 1989; Fishbein et al., 1994).

Therefore, in the Theory of Reasoned Action, behaviour (although influenced by factors such as perceived susceptibility) is ultimately determined by a cognitive structure that is made up of underlying normative beliefs (Fishbein et al., 1994). Thus, in this theory, changing behaviour is merely a matter of shifting the underlying beliefs (Fishbein et al., 1994). This theory can be particularly useful in health interventions that are largely communicative, educational, or informational in nature (Fishbein et al., 1994). As noted earlier in the context of the Knowledge-Attitudes-Behaviour theory, informational interventions have frequently been criticized and labelled ineffectual in producing behaviour change. Again, however, from Fishbein and Ajzen’s perspective, the issue of behaviour change does not necessarily hinge on converting knowledge
to behaviour, but instead on determining the most appropriate type of information that needs to be provided, or which structural changes are necessary (Fishbein et al., 1994). The contention is that information-based HIV prevention interventions often fail as a result of convincing people of some fact they already believe, or giving people information they already possess (Fishbein & Middlestadt, 1989).

**The AIDS risk reduction model.** In the late 1980’s and early 1990’s, a number of prominent experts in the field introduced yet another behavioural model in HIV prevention, the AIDS Risk Reduction Model (ARRM) (Catania et al., 1989; Catania, Kegeles & Coates, 1990). The ARRM was designed to account for some of the deficiencies in previous public health models, and in fact, included combined elements of the Health Belief Model (Becker, 1974), the Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein, 1980; Fishbein & Ajzen, 1975), and the theory of self-efficacy (Bandura, 1977; Bandura, 1994). Furthermore, the model can account for various help-seeking models, diffusion theory, and the *Transtheoretical Model of Change* (Gillis, Meyer-Bahlburg, Exner, & Ehrhardt, 1998).

The model is based on the premise that in order to protect oneself from HIV infection, individuals at great risk must recognize that their high-risk sexual behaviour is problematic; however, it also stresses the importance of going further than just the process of labelling, instead dictating that to be effective, individual actors must make a strong personal commitment to changing their behaviour (Catania, Kegeles & Coates, 1990). This part of the process may involve a cost-benefit analysis (Catania, Kegeles & Coates, 1990). Three non-linear stages have been delineated in the model: a) *labelling*, accurately distinguishing one’s behaviour as risk-inducing; b) *commitment*, the conscious decision to reduce one’s risk and instead sustain new, safe sexual behaviours; and c) *enactment*, which represents the actual process behind the shift:
seeking information and solutions, and putting new behaviours into practice with the end result being decreased sexual risk on the part of gay men (Catania, Kegeles & Coates, 1990; Gillis et al., 1998). The predictive validity of the model was later assessed and a more expanded version suggested (by Gillis et al., 1998) that emphasizes the added predictive validity of a variable denoting ‘previous sexual risk behaviour’ (Gillis et al., 1998). The authors also found some additional variables that were central to determining success, such as: intention, sex guilt, self-efficacy and self-deception (Gillis et al., 1998).

**Positive valences theory.** In the late 1990’s, one last model was proposed to help guide interventions for changing HIV-risk sexual behaviour. A research team at the Centre for AIDS Intervention Research at the Medical College of Wisconsin realized that although the existing psychological models in HIV/AIDS prevention were predictive (to a degree) of varying determinants of change in health behaviour, a key element relevant to behaviour change was missing (Kelly & Kalichman, 1998). Kelly and Kalichman underlined the importance of sexual behaviour, recognizing that this arena is highly complex, dynamic, and quite different from many other behaviours targeted by health behavior intervention programs (Kelly & Kalichman, 1998). Although sexuality may involve cognition and behaviour, it is also heavily influenced by emotion, sexual arousal, and the dynamics present in relationships (Kelly & Kalichman, 1998). Therefore, this team posited, by taking into account specific factors related to sexual interaction and sexual relationships, it may be possible to enhance our understanding of the reasons people engage in sexual risk behaviour, and to improve upon existing HIV prevention interventions (Kelly & Kalichman, 1998).

Consequently, they strongly suggested that others begin to consider the nature of the relationship in which the sexual behaviour is taking place, the incidence of substance use before
sex, and the presence of any individual personality dimensions reflecting heightened adventurism, risk-taking, sexual sensation seeking, and erotophilia (Kalichman et al., 1994; Kelly & Kalichman, 1998). Lastly, they stressed that emphasis be placed on the pleasure or inherent reinforcement value derived from unsafe sex, an important yet largely ignored factor highly relevant to the likelihood of HIV risk behaviour change (Kelly & Kalichman, 1998). The authors then set out to investigate exactly this, and determined that the reinforcement/pleasure derived from unprotected sex did indeed account for a great deal of the variance in behaviour change; above and beyond the intent to change, possessing positive attitudes about condoms, and knowledge of what behaviours lead to HIV transmission – which were all positively associated with sustained condom use as well (Kelly & Kalichman, 1998). Importantly, their results also demonstrated that only two factors reliably predicted the frequency of continued condom usage: substance use before sex, and the subjective reinforcement value of condomless sex (Kelly & Kalichman, 1998).

**Review of selected community-based psychological intervention strategies.** Changing one’s behaviour remains the sole means of preventing HIV infection at present (Kelly et al., 1993), and yet, the field of prevention has taken a back seat to treatment. Still, the question remains: what aspects or modes of intervention are most successful and for what reason? What aspects are most likely to lead to sustained behaviour change over time? Generally, effective HIV prevention programs rely on similar principles of behaviour change. Overall, interventions that are more vast in scope and that endeavour to influence AIDS risk-reduction information, motivation, and behavioral skills are the ones that appear to produce the greatest degree of HIV risk-reduction behavior change (e.g., Fisher & Fisher, 1992; Kelly et al., 1989; Kelly, St. Lawrence, Stevenson, et al., 1990; Valdiserri et al.,1989). However, the same intervention
program is not best-suited for everyone, as again, many different cultural, social, risk factor, and lifestyle issues characterize various populations at risk of HIV infection (Kelly, 1995). Furthermore, any given intervention has to suit an individual’s particular psychosocial circumstance as well as target those at greatest risk with the type of intervention(s) deemed most necessary. Although in the 1980’s and 1990’s the need for HIV awareness and understanding of transmission/prevention might have been crucial, at this juncture perhaps the need for reflection on one’s own HIV status and for sexual negotiation skills may be more important (Bonell, Strange, Allen, & Barnett-Page, 2006).

Community-based psychological interventions for HIV prevention have been widely promoted as imperative to preventing HIV (Coates & Greenblatt, 1988; Kelly, 1988; Kelly et al., 1993). Interventions at the community level have the propensity to reach much larger numbers of people than interventions targeting the individual, but lack the perceived persuasive benefits of individual-level interaction (Kegeles et al., 1996). However, other theorists have disagreed, documenting wide-scale community-based interventions that have been expanded to include even short periods of individual intervention (i.e.: the possibility of extended individual conversations with participants of five minutes or more) a factor which allowed for improved results (e.g.: Kelly & St. Lawrence, 1990). Community-level interventions may also be more effective in addressing the organizational aspects of a community, or the social systems present in the community itself which may contribute to risk-taking sexual behaviour (Kegeles et al., 1996).

**Group intervention.** Group interventions are another common means of HIV intervention strategy. One large study (Kelly & St. Lawrence, 1990) aimed to explore what the impact of community-based psychological group interventions (e.g.: 12 sessions) might be in
terms of long-term HIV risk reduction. Their primarily educational and cognitive behavioural intervention, couched in terms of the Health Beliefs Model, was entitled “Project ARIES” and was developed in conjunction with guidance provided by popular or leading men in the gay community (Kelly & St. Lawrence, 1990). The authors offered gay men the opportunity of participation in a group intervention program that provided psycho-education, cognitive skills teaching (related to problem solving, etc), assertiveness training, and that attempted to redefine peer group norms (Kelly & St. Lawrence, 1990).

Overall, the intervention was successful in changing immediate sexual behaviour, but for many subjects, the frequency of unprotected anal sex had increased once more by two-year follow up (Kelly & St. Lawrence, 1990). Essentially, they concluded that giving information to people is both easy and useful, but promoting and supporting real sustained behaviour change over time is much harder than it initially appears (Kelly & St. Lawrence, 1990). At the same time, their program was popular and well-accepted among participants, perhaps because of the guiding influence of the leading gay community members who worked with the clinical team (Kelly & St. Lawrence, 1990). The results of this intervention demonstrate that although mass interventions (like leafleting, etc.) are common and necessary in order to reach large numbers of people, smaller, face-to-face interventions are also extremely effective for high-risk groups, in this case, at least in the short-term (Kelly & St. Lawrence, 1990). Implications of this research for HIV prevention intervention include: a) that a program be readily accessible to the given target population; b) that a program be perceived as non-judgmental; understanding; and affirmative of the gay lifestyle; and c) that some other additional factor is required to motivate behaviour sufficient to sustain change in the long-term (Kelly & St. Lawrence, 1990).
Another study, the “Talking Sex Project,” was a fairly large-scale (612 participants) intervention program in Toronto, Canada that compared the effect of single-session group interventions led by qualified volunteer peers and four-session group interventions conducted by a paid counselor (Tudiver et al., 1992). The core outcome measures included an increase in knowledge about AIDS transmission, decreased unprotected anal sex, and shift in attitudes concerning condoms and their use (Tudiver et al., 1992). The study was successful in achieving all its core goals, and there was a demonstrated overall shift towards safe sex over time (Tudiver et al., 1992). Of note in their results was the differential effect imparted by the two different forms of intervention group: there was a distinct advantage imparted by the single-session volunteer-led group in terms of its sustained effect on sexual behavior (Tudiver et al., 1992). The single-session groups were all led by male peer volunteers, and all of those men were either gay or bisexual (Tudiver et al., 1992).

**Outreach intervention.** Many researchers have argued that the vast numbers of gay and bisexual men worldwide who need to be reached by a specific intervention simply makes the majority of individual-level interventions logistically unrealistic, as well as prohibitively costly (Kegeles et al., 1996). Wider-scale interventions are of great consequence as they are logistically less complex and allow for a greater possible propensity to reach individuals whom might normally never seek out the intervention on their own (Kegeles et al., 1996; Kelly, 1988). Outreach is the primary form of large-scale intervention with high-risk groups, as one can not only reach large numbers of people more effectively and at once, but one can also target particular subgroups within a high risk group.

The Aids Committee of Toronto [ACT] has a number of outreach programs (e.g.: the condom dispenser network; club, party, and special event outreach; bathhouse outreach; and
youth outreach), including online resources, such as educational websites (www.torontovibe.com and www.himynametina.com) and blogs (such as ‘interACTion’) (ACT website, 2009). ACT also provides “SEXploration” (which involves community forums, bathhouse tours and safe-sex training), a number of educational initiatives, and harm-reduction workshops and programming, both generally and also for vulnerable groups (e.g.: gay and bisexual seniors) (ACT website, 2009). However, prevention efforts like these on the part of Aids Service Organizations like ACT are frustrated by trends in media and advertising, such as medication advertisements that contribute substantially to treatment optimism by depicting HIV+ men on medication as robust, healthy, and vigorously athletic, etc. (Shea & Co., 2002a). ACT reasoned that their prevention activities could not compete with the flashy commercial media saturating gay commercial venues and the press, as it was clear that HIV incidence was continuing to rise.

In what was designed to be a “new type of response” (p. 2) to the gay community’s need for education (and designed and implemented as a large-scale, flashy ad campaign), in June, 2001, ACT launched the Welcome to Condom Country campaign (Shea & Co., 2002a). Running for six months, this social marketing campaign comprehensively tapped both large-budget media exposure and community marketing (Shea & Co., 2002a, p. 4). The media campaign included television advertisements, public service announcements, posters in Toronto Transit Commission (TTC) vehicles and buildings, and newspaper and magazine ads (Shea & Co., 2002a). Community marketing included street and building banners, a website, handouts (e.g.: condoms, drink coasters, etc,) and posters, and having a presence at Pride and in the Pride Parade (Shea & Co., 2002a). One of the primary campaign objectives was to encourage the adoption of new safer-sex behaviours and practices, and in so doing contribute to reducing the

2 A television advertisement from the “Welcome to Condom Country” campaign is available at: http://www.nohivnouids.com/?s=welcome+to+condom+country
overall rate of HIV incidence for men in Toronto who have sex with men (Shea & Co., 2002a). In addition to being wide-reaching, the campaign was also controversial, provocative, and made international news. Although the campaign was certainly successful in reintroducing AIDS into the gay public consciousness, in turn promoting discussion and condom use (Shea & Co., 2002b) it is unclear how effective the campaign was in encouraging long-term sustained behavior change.

The issue of how to best motivate sustained behavioral change over time is a key issue for prevention, because, unlike smoking or dieting, in the case of HIV, it only takes one relapse of the unsafe behavior to acquire a terminal illness. One study aimed to address exactly that issue by focusing on what they believed to be central to long-term sexual behavior change. Inspired by diffusion theory (Rogers, 1983), the team attempted to shift peer group norms as a means of encouraging safe sex behavior in gay and bisexual men (Kelly, et al., 1992). This study achieved this via an ‘informal outreach’ intervention (Kegeles et al., 1996) of peer education and safe sex norm-endorsement (Kelly, et al., 1992). Developing the intervention was a complex process that involved identifying three key smaller cities in the United States (Biloxi, Monroe, and Hattiesburg) and conducting initial survey data, and training bartenders at most large gay venues in those cities to observe their patrons and identify ‘trendsetters’ – those gay men who were most popular, who greeted other men and socialized the most, and who were most sought out for advice by their friends, etc. (Kelly, et al., 1992). Trendsetters who were nominated by more than one bartender were subsequently chosen to be study ‘opinion leaders,’ and trained in the intervention (Kelly, et al., 1992). The average number of opinion leaders recruited for each city was roughly 7% of the gay bar and club scene population at baseline survey (Kelly, et al., 1992).
For the study intervention, the opinion leaders contracted to interact with their peers and endorse HIV risk reduction when they could, by a) correcting misconceptions about HIV transmission or risk, b) advocating various behavioural strategies for risk reduction (e.g.: ‘I always keep condoms nearby, and sometimes out in the open beside my bed…’), and c) personally endorsing the significant benefits and, importantly, social acceptability, of making these sorts of precautionary behavioral changes (Kelly, et al., 1992). Post study completion, the intervention was shown to effect a systematic reduction in unprotected anal sex in all three cities, of 15% to 29% from baseline levels (Kelly, et al., 1992). Incredibly, during post intervention venue surveys, only 1% of the gay and bisexual male population endorsed unprotected, receptive anal intercourse with more than just one primary partner (Kelly, et al., 1992). This intervention underscored the important potential of communication and dominant social peer group norms to influence HIV-risk behavior for gay and bisexual men. Thus, the significant utility and relevance of norm-changing approaches to affect behavior is the primary implication of this research for HIV prevention intervention.

Influenced by the successful results described in the above intervention (Kelly, et al., 1992) a British group sought to assess whether the same commercial gay venue-based outreach in a large city –characterized by greater diversity and decreased mutual support between gay men– would be as effective as some of the successful results attained from previous outreach programs in smaller cities (e.g.: Kelly, et al., 1992). Addressing the growing need for enhanced efficacy in safe-sex negotiating skills has been a challenge for researchers testing outreach interventions, as there is some evidence that outreach may be less effective in improving these sorts of skills (Bonnell et al., 2006). The goals of this intervention were to increase sexual negotiation skills, disseminate HIV prevention information and knowledge of HIV services,
instill in the men a desire to protect themselves from HIV and reduce the possibility of exposure, and enhance participants’ awareness of the potential for HIV exposure already present in their current behaviours (Bonnell et al., 2006). The intervention itself consisted of a stand placed in multiple popular gay venues (bars, clubs, etc.) which was staffed by study personnel: either all gay male volunteer staff performing informal outreach, or half gay male/half straight female paid professional staff performing more formal outreach (Bonnell et al., 2006). All outreach staff handed out safe sex materials and information, but how to talk to subjects during the intervention was loosely structured for staff, and thus generally left up to the individual (Bonnell et al., 2006).

The results of this intervention replicated previous research on the importance of psycho-education, by demonstrating that outreach widely impacted upon knowledge of HIV transmission (Bonnell et al., 2006). However, impact on men’s negotiation skills or their ability to reflect upon their personal behavior was reported by only 25% of men post intervention. At the same time, participants reported that men who engaged in short conversations (greater than 5 minutes) with certain study personnel about sexual negotiation, life pressures, and safe sex, etc. had a greater propensity towards changing their behavior and sexual communication/negotiation skills afterwards (Bonnell et al., 2006). As a result, changed or improved negotiation skills was suggested to be a reflection of both a slightly longer period of interaction, and the qualitative aspects of the person performing the intervention (i.e.: do they proactively seek out people to talk to, are they comfortable bringing up and sincerely discussing more sensitive or risqué topics, and can they instigate those kinds of topics without alienating people?). Implications of this research for HIV prevention intervention include a) the fact that informal outreach is feasible in large cities as well as smaller cities, b) outreach staff can be professionals, and don’t have to be gay men (as straight females were rated as equally likable and effective), c) but that outreach staff
must be experienced in performing outreach, very comfortable discussing sensitive and taboo issues, and proactive in seeking out participants.

One intervention that combined the effects of both outreach and group programs was the “Mpowerment Project,” a pilot community-based intervention program for HIV prevention in young gay men embedded in youthful gay community and social life (Kegeles et al., 1996). This intervention was designed around four issues deemed critical to overall intervention success targeting younger males (Kegeles et al., 1996). First, the intervention needed to be specifically captivating and/or enticing to young gay men, whom as a population generally do not tend to seek out HIV prevention services, and thus necessitated relating risk-reduction to the fulfilment of some other compelling variable (Kegeles et al., 1996). In this case, that was social life. A second concern in designing the Mpowerment Project intervention involved the power and social importance of peer influence on young gay men, suggesting the need for a peer-based outreach intervention, which has strong support in the literature (Bonnell et al., 2006; Kelly, et al., 1992). Third, the intervention aimed to spark increased notions of ‘community’ and autonomy for young gay men specifically (as they would be designing and running the intervention themselves); and fourth, like Kelly’s initial research (Kelly et al. 1991; Kelly et al., 1992) the intervention should involve the influence of persuasive peers.

The Mpowerment Project program involved peer outreach, small groups, and an advertising campaign (Kegeles et al., 1996). Outreach (both formal and informal) was designed to involve the influence of popular, maximally persuasive peers, in order to spread safer sex messages, correct misperceptions, and recruit new men into the project’s effort (Kegeles et al., 1996). The group component consisted of small, fun, peer-led ‘M-groups’ that lasted roughly three hours and imparted the same information as the outreach. The advertising campaign aimed
to increase public consciousness about the study, recruit new individuals, and to provide a continual community reminder of the norm of safe sex (Kegeles et al., 1996).

The results of the Mpowerment project included substantial reductions in unprotected anal sex: a 27% decrease from baseline generally, and a decrease of 45% in unprotected sex with non-primary partners (Kegeles et al., 1996). The implications of this study include the important influence of peer education and support in HIV prevention for young gay men. As the authors point out, their strategy was specifically to include as many young gay men as possible in all aspects of outreach, involving the entire social system of youthful gay culture and encouraging the members to support each other regarding the need for safer sex (Kegeles et al., 1996).

**Online intervention.** Lastly, in today’s highly digitized age, more and more gay men are engaging in information-seeking and social networking on the internet, as well as using the web to seek sexual partners (Rosser et al., 2008). In fact, the use of the internet to find sex partners has represented one of the “greatest recent changes” (p. 867) in MSM sexual risk activity (Hooper, Rosser, Horvath, Oakes & Danilenko, 2008). Large numbers of gay men are e-dating, there is some unsubstantiated evidence that certain subpopulations of gay men are using the internet more than others (i.e.: young men, HIV positive men, and those men who, for whatever reason, are not well-connected with the gay community), and virtual gay communities have been shown to provide help and support in tempering HIV risk (Rosser et al., 2008).

A recent online needs assessment in the United States of what gay men who routinely use the internet to seek sexual partners are looking for (if anything) in online HIV prevention determined that gay men frequently use the internet to seek gay or men’s health information, and that sources of information tended to be gay sites, and random or idiosyncratic searches (Hooper et al., 2008). Subjects did not endorse reading blogs, government sites, or media (Hooper et al.,
2008). More than 80% of the sample reported significant interest in a number of sexual health topics (such as: men’s physical sexual health; aspects of relationships; understanding the effects of sexual history; and advice in being a better lover) (Hooper et al., 2008). However, three items were endorsed by only a minority of men: “help with coming out” (p. 871) (48% interested, 24% neutral, and 28% not interested), “evaluating alcohol/drug use” (p. 871) (41% interested, 25% neutral, and 33% not interested), and “coping with sexual abuse” (p. 871) (32% interested, 30% neutral, and 38% not interested) (Hooper et al., 2008). Additionally, sexually explicit sexual educational information was deemed almost universally acceptable across all demographics (Hooper et al., 2008). Lastly, it is worth noting that at 42%, young men were over-represented in the sample population, perhaps belying the importance of the internet to youth (Hooper et al., 2008).

It is possible that gay men who do not feel strongly connected to the gay community, whom are HIV positive, or whom are in the closet (all factors that also put them at high risk of HIV) may be more apt to socialize online, and thus online HIV intervention may be a highly useful method of reaching those men. Given the evidence that virtual gay communities are populated by men all over the world, and also that these communities can support HIV risk reduction in the same way regular gay communities can, a brief mention of some notable online HIV interventions may be worthwhile to include in this review, as the World Wide Web may in fact represent the locus for the next wave of large-scale community intervention (Rosser et al., 2008). Because this population is at high risk of HIV infection, effective interventions are imperative. However, thus far a limited number of studies reporting the effects of internet HIV interventions have been found to be effective (Kok, Harterink, Vriens, de Zwart & Hospers, 2006).
One novel, recent online intervention comes from the Netherlands, where a research team is taking up the challenge of using advancing internet technology for effective HIV prevention (Kok et al., 2006). In their study, they created an online animated HIV prevention intervention entitled “The Gay Cruise”: a ship populated by hot, muscular, animated male ‘pursers’ who guide a participant through a series of hypothetical scenarios requiring sexual decision-making, providing constructive feedback on the participant’s decisions (Kok et al., 2006). Experience with the Gay Cruise has thus far been quite positive. Four weeks after the Gay Cruise was introduced onto a gay chat website, 12,081 people had visited the site, and 9,508 individuals had chosen a personal pursuer or guide (Kok et al., 2006). Focus group feedback indicates that completing the Gay Cruise online intervention is fun and highly enjoyable (on average of 86%). Furthermore, 53% indicated that the intervention helped them be more in touch with their sex life and know more sexual facts, as well as to be more conscious about sex and dating (Kok et al, 2006). A similar online paradigm, entitled ‘Queermasters,’ is utilized by members of the same Dutch team in another study aiming to promote HIV testing (Mikolajczak, Kok & Hospers, 2008).

**Summary**

The preceding literature review provides a framework in which to understand and consider the results of the present study. The review presented the main structural, community, individual, and contextual factors considered most relevant to the increases in HIV incidence, as these factors all influence sexual decision-making and represent fundamental elements of the decision-making model for gay men in the context of HIV prevention. The literature review also summarized the most relevant psychological models of behaviour change in this context. Again, understanding the theories and principles that underlie sexual behaviour change will provide the
psychological context in which to consider the ramifications of the identified factors for both large-scale psychological interventions and for individual counselling psychology. Lastly, the literature review presented process and outcome data for a number of large-scale, community-based, Canadian psychological intervention strategies. Having this information in mind will allow for effective comparison of the study results to successful and unsuccessful prevention strategies that have already been put in place.
Chapter Three: Methodology and Procedures

Information for the present study was drawn from a non-identifying, coded variable database of gay or bisexual males interviewed during the period of 2002 – 2003. This qualitative dataset is comprised of individual, semi-structured interviews. This interview data was initially collected by Scott Duggan, at that time a masters-level graduate student at the Ontario Institute for Studies in Education, University of Toronto (Duggan, 2003). Duggan’s analysis was designed to identify the most salient factors related to the practice of barebacking in the Toronto gay community (i.e.: treatment optimism, sensation, condom fatigue, and so on; 2003). Among others, the factors he identified are those reviewed in the first component of the literature review for the present study.

These findings were the starting point for the present study. With an understanding of the most salient aspects of barebacking in the Toronto gay community in mind, the qualitative interview dataset was comprehensively re-analyzed and coded for variables with specific regard to HIV prevention and sexual choice. Additionally, each factor initially identified by Duggan (2003) was critically assessed regarding the way in which it affects sexual decision-making, and the degree to which it contributes to sexual decision-making overall. This allowed for the creation of a new conceptual model delineating gay male sexual decision-making in the context of HIV prevention that also identifies the relative individual influence of the most salient factors in the decision-making process.

Participants

Study participants consisted of 16 self-identified gay or bisexual males from a large, urban, Canadian city. Data from 15 participants was reliable and included in the analysis. One subject’s data was spoiled, and, therefore, not included in the study. Of the sample population,
73.3% (N=11) identified as Caucasian, whereas 26.6% of the population (N=4) identified as non-Caucasian (including Black, Asian, and European). The age of respondents ranged from 19 to 46 years old; the average being 28.31. All study participants self-identified as either gay (86.6%), queer (6.6%), or bisexual (6.6%). Five study participants endorsed membership in some form of relationship (primary partner, open relationship, or polyamorous relationship), and ten participants reported that they were single. Lastly, 6.6% of participants (N=1) reported positive HIV serostatus, 86.6% of participants (N=13) reported negative HIV serostatus, and 6.6% of the sample (N=1) had not been tested and were, therefore, unsure of their status.

**Recruitment**

All participant recruitment and interview data collection was performed by Scott Duggan. Participants were recruited via lesbian, gay, bisexual and transgender (LGBT) groups, local internet listserves relevant to gay and bisexual men, posters, and by word of mouth. All participants were paid ten dollars for their participation in the study. A distinct attempt was made to recruit men of a range of ages and an ethnically diverse sample population. The latter was accomplished via study advertisement in a number of highly ethnically diverse Toronto communities / neighborhoods, and via the deliberate request of non-Caucasian volunteers.

**Procedure**

For the initial data collection, recruited participants were read a description of the study purpose and procedures, and offered the opportunity to ask questions about their participation. A consent form was subsequently provided which participants were required to read and sign. Consequent to the process of informed consent, demographic information was collected via a brief demographic questionnaire, filled out by participants prior to the interview. Semi-structured, face-to-face interviews were conducted individually by a trained graduate student in a
private office at the Ontario Institute for Studies in Education, University of Toronto. Interviews were audio-taped and lasted for 1½ hours, on average. All identifying information was removed from the interview transcript, and interviews were transcribed by a professional typist.

**Measures**

**Demographics.** A demographic questionnaire was administered containing questions related to participants’ age, gender, ethnicity, sexual orientation, and current relationship status. This questionnaire (please see Appendix A) also required participants to indicate whether they have been tested for HIV, and to provide their HIV status at the last date of testing (if applicable, or known).

**Interview data.** During the course of all interviews, participants were neither required to reveal any information they did not want to, nor provide answers to questions they did not wish to. Additionally, study participants were provided with a list of contacts related to support and/or counselling surrounding HIV testing and safer sex practices. Content areas of interview questions included relationships, safe sex practices, HIV/AIDS awareness, barriers to safer sex, and sexual practices and negotiations generally. Interview questions are provided directly below. Please also see Appendix B for a copy of the actual interview question sheet used during the interviews themselves.

**Interview questions.**

a) **Relationships**
   - What are the most important issues in your life at the moment?
   - How important is it for you to have a lover/partner?
   - What are some problems today with finding/maintaining a relationship?

b) **HIV Awareness**
- What are the most important issues in your life at the moment?
- How can someone get infected with HIV? Unprotected sex? Which acts?
- Can you tell if someone is infected? If so, how?
- On a scale from 1 to 10, where 1 is not at all concerned and 10 is very concerned, how concerned about HIV are you?
- What is the average lifespan of an individual with HIV/AIDS?

c) HIV Prevention Advertising Campaigns
- Do you know of any safer sex or HIV prevention campaigns?
- How about the “Condom Country” campaign ads? What do you think of these ads?
  What’s the message? Do you think it’s effective?
- What would an ideal HIV prevention campaign look like?
- What do you think people need to hear?

d) HIV Treatment Optimism and Safer Sex Fatigue
- Are men who have sex with men more or less likely to practice safer sex than say, 5 or 10 years ago? Why or why not?
- Are men who have sex with men more or less concerned about HIV than 5 or 10 years ago? Why or why not?
- How do new treatments like HAART, AIDS ‘cocktails’, or protease inhibitor drugs affect gay men’s concern about HIV and AIDS?
- In your opinion, will there be a vaccine or a cure? When?
- When you first heard about AIDS, could you envision still having to use condoms today?
- Have condoms become easier to use or just more a part of your sexual routine?
- Are gay men just getting tired of using condoms?
e) Sexual Practices and Sexual Negotiation

- Have you heard of the term barebacking? Have you done it? Would you be open to telling me about it? How do you feel about that?

- Is sex better with or without a condom? Why?

- Have you heard of the term “Negotiated safety”? What does it mean to you?

- Is there a point in a relationship when men stop using condoms? If so, when? Under what circumstances?

- Do you bring up the topic of safer sex with a new partner? If so, how? If they refuse, what do you do?

- If someone allowed you to penetrate them without a condom, would you make any assumptions about their HIV status? What would that assumption be?

- What if someone asked or attempted to penetrate you without a condom? Would you make any assumptions about their HIV status? What would that assumption be?

- How do you feel about HIV+ men having sex without practicing safer sex?

- How do you feel about having sex with HIV+ partners?

- Is there a difference between knowing and not knowing someone’s HIV status?

6) Alcohol and Drug Usage

- Do drugs and alcohol affect how some gay men practice safe sex? If so, how?

- Do drugs or alcohol make practicing safer sex more difficult for you? Can you think of an incident where this happened?

g) Self-Esteem and Related Issues

- Compared to the general population, how is the self-esteem of most gay men?
- Do you think there is a perception of the ideal gay man? (Age? Ethnicity? Height? Weight? Muscularity?)

- Thinking about these ideals for a moment, for men who don’t fit the stereotype, could they in any way, cause someone to practice more risky sexual behaviour?

Data Analyses

Analysis was qualitative in nature and entrenched in grounded theory (Rennie, 2006). The grounded theory method was developed by two sociologists, Barney Glaser and Anselm Strauss, in dissent against the prevailing rational attitude towards largely deductive theorizing in the discipline (Glaser & Strauss, 1967). This rigorous qualitative research method grounds research in real-life or real-world data (Glaser & Strauss, 1967). The method involves a bottom-up process of inductive reasoning in which “preconceptions about the topic of interest are put aside as much as possible, so that the resulting understanding or theory is closely tied to the data … or grounded” in it (Rennie, 2006, p. 61). Qualitative analysis of interview transcripts allowed for the identification of key variables relevant to sexual decision-making in the context of HIV prevention and counselling psychology. Grounded theory analyses were performed using Rennie (2006)’s adaptation of constant comparison analysis. This adaptation allows for anywhere between 1 – 5 continuous sentences on the same construct to be categorized together as a ‘unit of meaning’, as opposed to the obligatory categorization of every individual sentence (Rennie, 2006). A key-word and memo-based approach was also implemented (Loftland & Loftland, 1995). In order to enhance validity, iterative analyses (albeit by only one coder) were performed and analyses/theories were refined in view of further data. All qualitative analyses were conducted using the NVivo analysis platform Version 8.0 (QSR International).
All descriptive statistical analyses were conducted using Microsoft Excel. Participants’ individual responses to various key study questions were categorized as to whether the response was affirmative, negative, or neutral/unsure. These results were summarized by overall percent, and then evaluated for general patterns in response based on stratifying variables such as age, ethnicity, relationship status, and so on. In order to loosely group and contrast younger and older individuals in the sample for age contrasts, a division was drawn between the ages of 29 and 30, wherein participants 29 and under were considered “younger” and participants 30 and up were considered “older.”
Chapter Four: Results

Descriptive Statistics Regarding Key Study Variables

For graphical depictions of descriptive statistics, please see Figures 1-3 on the following pages. Overall, more study respondents deemed themselves unconcerned (40%) than concerned (33%) about HIV at present, whereas 27% weren’t sure how concerned they really were.

Furthermore, 60% of the sample believed that gay men were less likely to practice safer sex nowadays; whereas 33% believed gay men were just as likely to still practice safer sex; and 7% weren’t sure. Of the study population, 64% felt that gay men were generally less concerned about HIV (14% felt men were very concerned about HIV, and 21% weren’t sure), and 60% believed that gay men were tired of using condoms (33% disagreed, 7% weren’t sure). An age effect was observed in this context in that men over 30 years of age in our sample were more likely to rate gay men as experiencing condom fatigue than younger men.

With regard to the percentage of the sample who had barebacked, 80% of participants had engaged in unprotected anal sex at least once in their lives. However, an age effect was once more apparent in this context, as individuals who had barebacked included 100% of the participants over 30, but only 57% of the participants under 30. All respondents indicated that they believed substance use could hinder safer-sex decision-making. However, only 27% of the sample population had ever experienced unsafe sex under the influence, and all of those individuals were Caucasian. In the case of self-esteem, 80% of the study participants felt that gay men have lower self-esteem than other men (7% thought gay men had average self-esteem, and 13% weren’t sure), and 67% of the population felt that possessing low-self esteem could impact upon sexual self-efficacy. One hundred percent of study participants endorsed the community presence of a romanticized, unattainably attractive physical stereotype of the ‘ideal’
gay man. Lastly, regardless of the fact that the majority of the sample had not heard of the term “negotiated safety,” all participants who had not previously heard the term were able to correctly infer its meaning.
Figure 2. Participant responses averaged and grouped by age, over or under 30.

Figure 3. Participant responses averaged and grouped by ethnicity: Caucasian, Black, Asian.
Qualitative Analyses

Factors most significantly influencing sexual decision-making. Following comprehensive constant comparison analysis (Rennie, 2006) of the interview data, it became clear that to gay men, their day-to-day sexual decision making was differentially influenced by a complex and entangled set of most salient variables. These variables all operate in different ways for different men at different times in their lives. However, based on the responses of men in our sample, it is possible for this analysis to suggest a conceptual hierarchy of factors that lead to either: a decision to engage in safe sex; a decision to engage in unsafe sex; or a willingness to take a risk. As a result, this analysis will therefore conceptualize sexual decision making as the end point of this hierarchical model. Three key factors related to HIV prevention emerged that were discussed universally by all respondents, as well as brought up or emphasized most often, and discussed at greatest length. These factors were determined by participants to contribute most centrally across the board to the capacity for effective overall sexual decision making, which would theoretically lead to greater success in low-risk sexual choices and decreased HIV transmission. In our sample, these factors included: a) self-efficacy (the conviction that one has control over one’s own emotional life and behaviour, and the ability to actually physically enact that power); b) sexual negotiation / communication (the ability to clearly verbally state one’s needs / wants / thoughts / HIV status, in addition to what one is comfortable with sexually); and c) individual assessment of risk (subjective determinations of just how much risk of HIV transmission a given sexual scenario might impart).

In turn, the three core factors of sexual negotiation / communication, self-efficacy, and individual assessment of risk were all found to be substantially influenced by a number of other salient variables present in the gay sociocultural milieu and determined to be relevant to HIV
transmission. These underlying factors include: self-esteem; relationships and perceived monogamy; HIV status; desire for connection; the type of sexual encounter; an individual’s propensity towards substance use; HIV status; safer-sex fatigue; treatment optimism; and understanding of the more complex aspects of HIV transmission. The results will be discussed in a framework focusing on the three core factors most significantly contributing to the decision-making process, self-efficacy, sexual communication/negotiation, and the assessment of risk.

For a visual representation of the conceptual model of the various factors differentially contributing to sexual decision-making leading to increased HIV transmission, please see Figure 4, below.

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**Figure 4. Conceptual Model of Sexual Decision-Making**

![Diagram showing the conceptual model of factors differentially contributing to increases in HIV transmission via impact on sexual decision-making.]

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*Figure 4. Conceptual Model of Factors Differentially Contributing to Increases in HIV Transmission via Impact on Sexual Decision-Making*
**Self-efficacy.** Researchers have argued that, in the context of HIV/AIDS, self-efficacy represents the degree to which one believes one is capable of facilitating behaviour change, particularly with respect to consistently being able to make safe-sex decisions (Gillis et al., manuscript submitted for publication). There is evidence that at times, certain gay men feel unable (or ineffectual in their ability) to negotiate or insist upon the use of a condom (Gillis et al., manuscript submitted for publication; Wilton, 2001). Resulting from a number of possible causes, mild social anxiety regarding the negotiation of condom use appears to involve low assertiveness, low sense of self, low status in the community, decreased access to social support; and stems from self-efficacy (Hart, 2002).

The current study revealed very similar results. Of all factors discussed by the study population, self-efficacy was found to be qualitatively most strongly associated with self-esteem, which was most often attributed to low sexual status in the community and which was thought to result in low assertiveness, a desire for connection and social support, and an individual’s propensity towards substance abuse. Additionally, according to the study participants, these variables often occur in tandem. Combinations of these factors were described as resulting in significantly decreased self-efficacy in the negotiation of safer sex. Sexual status was emphasized predominantly by participants and strongly linked to self-efficacy and self-esteem. For example, one respondent described a sexual encounter involving someone with low self-esteem and someone that person finds very attractive. In this scenario, the attractive, desired person wants to have bareback sex, and to the respondent’s mind, the person with low-self esteem is “…going to be hard pressed to say no to that person. They’re going to be hard pressed to be confident enough to say, “well, no...”, and insist, “no, I want a condom or else I’m not having sex with you” (Respondent 11). Increased self-efficacy was associated with healthy self-
esteem, limited substance use in sexual scenarios (or possibly, for some individuals, the use of substances after the explicit negotiation of the terms of sex has already taken place) and having positive social and community support.

As described above, poor self-valuation was found to significantly impair sexual decision-making via its negative emotional effects or the withdrawal coping strategies sometimes associated with low self-esteem, such as just “not caring” about prevention because one has such low self-worth (Respondent 13). Other respondents highlighted the tendency of self-esteem to negatively influence HIV transmission in various different ways, such as by increasing the overall number of sexual partners just “…to fill a void” (Respondent 9). Most significantly, however, self-esteem was a discussed as a central influence upon self-efficacy, in that, as one respondent aptly pointed out, “…you need a certain amount of self-esteem to be able to say no or to be able to require someone to use a condom, or limit their practices to a certain subset of practices” (Respondent 14).

Interestingly, the single greatest factor impacting one’s self-esteem and positive body image raised by the great majority of men in the sample population in relation to sexual decision-making was “sexual status” (Green, 2008), in effect, sexual desirability to other men in the community. One’s attractiveness, physique, age, and ethnicity were shown to have a particularly significant influence on self-efficacy via the corresponding impact on self-esteem and body image. Some respondents explained that there are a number of community subgroups (like ‘bears’ and ‘leather’ guys, etc.) that have their own beauty ideals. Nonetheless, 100% of our sample population reported that they feel that there is a prominent, stereotypical notion of an ‘idealized’ most attractive gay man which emphasizes youth, musculature, traditional good looks, and a Caucasian ethnicity. For instance, as one participant explained, “generally, I think it’s
about being young—fairly young - twenties thirties, white, muscular, smooth … and generally white, generally wealthy, generally higher upper class or social ranking, and healthy. Someone [who is] HIV negative” (Respondent 11). This stereotype was of overwhelmingly ubiquitous cultural relevance. Lastly, the Caucasian ethnic background of this ‘ideal gay man’ was emphasized by the majority of the respondents, some disparagingly and some not. Generally, of the few men in our sample who were not Caucasian, all felt as though in the gay community, “people of colour don’t exist” (Respondent 6).

Describing events, thoughts, and experiences from their own lives and the lives of their friends, 67% of men in the sample population reasoned that not fitting this sexual ideal and/or having low community sexual status could make it very difficult for men to effectively assert themselves in complex sexual situations. A number of participants described people of low sexual status (say, overweight or unattractive men, or men of a certain height or ethnic group, etc.) and explained that an individual’s sexual desirability in the community could impact upon their self-esteem and thereby directly affect those individuals’ ability to effectively negotiate sex. Less sexually desirable men were reported by multiple participants to possess weak autonomy in choosing partners and controlling sexual practices.

We aren’t as good as the ideal, so what we need to do is we need to accept who offers themselves up to us. And by doing so we have to let them decide what’s going to be done because, you know, we have to take what we can get. (Respondent 6)

Other men indicated that even though they considered themselves of average attractiveness, they could understand how the general possibility of a sexual encounter with someone extremely desirable could impact upon the sexual self-efficacy of the average gay men. As one participant pointed out, “…if someone who was extremely good-looking came up to them and said, “I want
to have sex and I want to have sex without a condom”, I think that they might say okay. I mean, because frankly, I might say okay” (Respondent 16). Other men also underscored the degree of emotional activation derived from a sexual pairing with someone extremely desirable. Respondents noted that the arousal and affective elation one feels when being paid attention by a notably high status man can bring about decreased efficacy in prudent sexual decision making.

Assessment of self-esteem on self-efficacy appeared to depend on certain stratifying demographics, including age, for example. On average, participants in their teens or twenties (less than 30 years of age) reported that they were unsure whether low self-esteem could impact upon efficacy, and did not necessarily think that it would. However, study respondents aged 30 years and older almost unanimously indicated that low self-esteem could significantly impact upon self-efficacy, and were able to describe several personal experiences or hypothetical examples of such scenarios. In addition to age, ethnicity was a significant stratifying factor reported to impact upon sexual status in the gay social milieu, and thereby also self-efficacy. As one respondent indicated, “…unfortunately, you know, it’s not a [ethnically] diverse crowd” (Respondent 5). A number of men highlighted particular ethnic groupings, and described significantly prejudicial and racist sexual selection practices that deter autonomy in sexual decision making. There appeared to be a particularly significant trend towards low desirability of men of Asian descent, for instance, resulting in reported reduction of autonomy and sexual control for those individuals.

Substance use or abuse was also described as an important factor implicated in self-efficacy in relation to sexual decision making, and a number of significant differences emerged in our sample with regard to men’s beliefs about substance use and safe sex. Although 100% of our sample indicated that substance use can hinder safe sex, only Caucasian men in our sample
endorsed ever having had unsafe sex (or having barebacked) under the influence of substances. Substance use (or abuse) was reported to affect self-efficacy in sexual decision-making in a number of ways. Multiple participants described impaired judgment resulting from substance use (e.g.: “...but I had so much to drink that the judgment thing just wasn’t there”; Respondent 7) that lead to poor basic safe-sex decisions, such as whether or not to put on a condom, or awareness of whether anyone has a condom on. As is commonly found in the literature, substance use was also described as lowering one’s sexual inhibitions, increasing one’s impulsivity, and causing one to be less concerned with safety and HIV transmission. One participant noted that substance use can increase one’s likelihood of being taken advantage of. Another participant pointed out, “…it limits their vision and limits their way of thinking, therefore they are less likely to think, “oh, we should bring a condom” and [instead] just go with what feels good” (Respondent 8).

Consistent with the review of the literature, many men described substance use as significantly enhancing both sexual arousal and sexual pleasure. As noted earlier, the principal effects of some of the more popular recreational substances in the gay community (e.g.: alcohol, “e”, crystal meth, and “G”, etc.) involve heightened feelings of sensuality, sexual desire, and the enhancement of sexual pleasure. Although large amounts of alcohol or drugs such as ecstasy or ketamine can sometimes lead to loss of erection, they were generally understood by study participants to “increase sexual appetite” (Respondent 11). As a result, while describing hypothetical scenarios or experiences from their own lives, participants reasoned that substance use can impact upon sexual decision-making.

I did rather recently try G … and I can totally see how people can go from, you know, getting so wildly passionate about having sex, and then decide right in the heat of the
moment not to wear a condom. ... we both did [G] together, and we were literally going at it until eight in the morning. And there were points...I mean...we always wore a condom, but... there were points where I felt like, 'oh, it would be so easy for me to just to slip this right in…' (Respondent 11)

Lastly, a longing for interpersonal closeness, love, and/or connection with others was cited by a number of men in the study population as influencing self-efficacy in the context of sexual decision-making. Participants described wanting to get close to someone else, and a few described feeling lonely, unwanted, or ostracized from the gay community. Again, low self-esteem and low status in the community play an important role in this context, as the desire to belong (and for others to like you) can be a powerfully motivating factor in sexual decision-making. As one participant pertinently pointed out, “...we’ve got poor self-esteem, all you want to do is be loved, and you’ll do anything you can to get that affection.” (Respondent 16). This was found to directly relate to self-efficacy in decision-making, in that sex without a condom was described by some men as a “wonderfully binding intimate thing” and source of connection (Respondent 1). A number of men also referred to a desire for connection particularly in the context of loneliness, again implicating a perceived lack of desirability involving a socially under-valued age group, ethnic group, etc., as depressing, isolating and alienating.

**Sexual negotiation / communication.** Our results indicate that beneficial and effective sexual communication/negotiation is contingent on a number of most salient variables for gay men. Participants described negotiation and communication skills as primarily influenced by relationship status, self-esteem, and HIV status. Communication and/or negotiation before sex was explained by participants as a form of “…risk assessment among partners entering into different activities, and knowing what level of risk each person is willing to take in the sexual
encounter or the sexual acts that they want to perform ... negotiating compromises within that, and arriving at decisions mutually” (Respondent 9). Sexual negotiation was further depicted as an important determining factor in ensuring that one doesn’t get caught up in the ‘heat of the moment’ and end up having unsafe sex.

The majority of participants emphasized the fact that there is not enough sexual communication that goes on in the gay community generally. However, many respondents endorsed various benefits of communication, such as clarifying non-verbal sexual behaviours that may be subject to misinterpretation. Numerous men in the study felt that the gay sexual culture did not promote negotiation between sexual partners, and that there were particular environments or venues in which men’s ability to discuss what they wanted from a sexual encounter and/or to negotiate safe sex was compromised to an even greater degree. One such environment was the bathhouse. The specific social environment of bathhouses and/or saunas was reported to compound difficulties in sexual negotiation, because in the sauna, communication is primarily achieved via eye contact and body language.

The danger of these socially-sanctioned non-verbal forms of sexual negotiation is that they tend to occur most often in the most sexually-charged environments, when not only is can the message be subject to misinterpretation, but other forces at could be at play as well (i.e.: sexual status anxiety or drug use). One participant described a situation wherein he was bring given oral sex by another man at a bathhouse, a situation in which his personal body language had “strictly said I only want a blowjob” (Respondent 10). Leaning back and enjoying the oral sex with his eyes closed, he didn’t notice immediately what was different about the fellatio when it started to feel differently to him. When he did look down, he discovered that the man was putting “…my penis up his ass. I wasn’t all the way in, but I was part of the way in, I mean...I
hit the ceiling at that point. I was very upset, but I mean, it was already too late” (Respondent 10).

For certain men, a lack of communication was also found to influence assumptions of a potential partner’s sexual practices in sexual decisions. Many explained that the necessity of condom use often goes unspoken: “…when I don’t talk about it….and often you don’t….you just assume condoms” (Respondent 5). For others, a lack of communication was found to influence assumptions of a sexual partner’s HIV status. One respondent noted that HIV positive people can see a sex partner not asking for a condom and understand that as implying that he himself is also HIV positive. Seronegative individuals can also just as easily see partners not putting on a condom, and see that as communicating that their partner is HIV negative.

Generally, for casual-sex interactions in certain contexts or venues, it appears as though there is a paucity of communication surrounding sexual practices or sexual acts. Many men in our sample endorsed difficulty with this challenging and sensitive form of communication (particularly if the two men are not well-acquainted, and/or the union is tenuous). Some respondents also indicated that men in general (both heterosexual and homosexual) have trouble with skills related to perceiving, reflecting upon, and communicating emotions; collectively, when young boys (including young gay boys) grow up, they are socialized to be ‘masculine’- a gender role which does not always promote traits such as sensitivity or communication.

Interestingly, the results also revealed that even confident, assertive men who do routinely decide to have safe sex (and are able to effectively communicate that desire to their sexual partner) can still have difficulty communicating verbally with the other person due to the challenges that overt communication can bring about. Instead, there existed a trend among respondents towards choosing to communicate non-verbally, via behaviour or body language,
with 40% of the sample suggesting they would raise the issue, and 60% preferring to just do it without talking about it. However, of the participants who indicated they would bring it up, a number indicated they might do that after the sexual encounter at hand, after 2-3 encounters with the same person, or at the onset of a relationship.

When communication did occur, men often described it as not being negotiated beforehand. Instead communication was described as directive and, in a sense, dictatorial, like an instruction or command as opposed to actual negotiation or two-way communication taking place between two individuals. Although in itself, this tendency still leads to safer sex, at the same time, it can negate the opportunity for two-way discussion of wants and desires, or for creating a space wherein another individual – particularly a less assertive individual – feels comfortable and safe enough to disclose their wants, needs, or HIV status, etc. Furthermore, men in our sample who responded in this fashion often also tended to more often routinely ‘top’ (i.e.: be the insertive partner, as opposed to ‘bottom’). Assuming a more dominant sexual stance in this regard could possibly result in greater self-efficacy with respect to condom use, given that the insertive partner could simply refuse sex if their demand for a condom was not met. As one participant noted, “…for anal sex, 99.99% of the time I’m on the top, so when we’re ready to do it I just go get a condom and I don’t give a shit what they say” (Respondent 15).

More than 50% of participants endorsed a differentially perceived need for communication in the context of prolonged sexual interaction or longer-term relationships (which are discussed in the subsequent section) as opposed to more casual sexual interactions. As one respondent indicated, “in one-night stands, people are much more likely to always use a condom. In relationships, it’s more likely the people will feel somewhat more comfortable in bending the rules” (Respondent 8). To the study participants, casual sex appeared not to require
sexual negotiation for a number of reasons: a) because attempting to seriously negotiate safe sex with someone you don’t know can make men feel embarrassed or awkward, particularly in certain more public social venues; b) communication can ruin the spontaneity and heat of the moment excitement; and c) safe sex practices were often reported as generally simply implied in casual sex: “...it usually doesn’t come up or isn’t discussed - it’s just very safe sex” (Respondent 8). However, even for respondents with serious concerns about HIV transmission and good self-reported facility of sexual communication in all sexual encounters (including casual sex), it appears that bringing up the subject of safe sex concerns can remain a significant challenge when the union is causal. One participant explained that, even though they were aware it is clearly beneficial to have ‘that conversation’ before one starts having sex with someone else, they knew it was not likely to happen because “it doesn’t happen” (Respondent 9).

In a similar fashion, instigating more serious relationships appeared to be a critical point in interpersonal gay male sexual interaction at which many study participants felt communication became most important, or to some, mandatory. Communication in the context of relationships also implied the need for absolute honesty to a number of participants, who then reasoned that negotiation may be difficult when meeting someone for the first time if that person happens to be HIV positive: “…with communication comes honesty, that’s important. Sometimes there’s things that you may not be ready to disclose, and you can’t push a person to forcibly disclose” (Respondent 12).

Communication was also characterized by respondents as a highly salient variable in the context of HIV status and sexual encounters with HIV+ people, as it appeared more important to the men in our sample to communicate when they knew there was a real risk at hand. The majority of respondents indicated that knowing a potential sexual partner’s HIV status, via
communication between two partners and disclosure on the part of the HIV-positive person, 
would be integral to assessing their own personal risk and making appropriately informed sexual 
decisions. In this context, communication was seen by participants as either mediating or 
amplifying possible risk, and thus it appears sexual negotiation is important in the context of 
nonconcordant serostatus sexual partnerships. However, some men indicated that they would 
prefer not to know someone’s status, as that might simply increase their anxiety level and detract 
from the pleasure derived from the sexual encounter. As a result, many participants reported a 
general preference for having safe casual sex as a matter of course, and negotiating sexual 
practices with more serious relationship partners. However, choosing to be ignorant of possible 
sexual risk in causal encounters is clearly dangerous as an approach to sexual decision making, 
particularly if the circumstances change in the midst of the sexual encounter.

Overall, many men reported that there was a distinct difference between having casual 
sex with an HIV+ person and having a long-term relationship with an HIV + person. In the 
context of casual sex, disclosure of positive serostatus on the part of a sexual partner was 
sometimes reported to lead to a decision not to have sex, or certainly to a re-consideration of that 
decision or the ways in which sex will take place. At the same time, most men in our sample 
were not disinclined to enter into a long-term relationship with an HIV-positive partner. 
Twenty-five percent of the study population was currently (or had previously been) in a long-
term relationship with an HIV+ partner. As another respondent pointed out, “you know, because 
someone is HIV positive … if he’s the right person, am I going to say no because of that? You 
know, is that so insurmountable?” (Respondent 6). Disclosing one’s serostatus was described as 
a significant aspect of sexual negotiation especially in the context of relationships, and many 
respondents indicated that the safe disclosure of HIV serostatus should be encouraged in
prevention campaigns. Overall, regardless of whether participants felt they might or might not have a long-term sexual relationship with someone who was HIV positive, they strongly emphasized the absolutely key role of communication in that context.

Lastly, although not a centrally contributing factor, it is worth noting that self-esteem was also described as impacting upon communication and negotiation skills. Low self-esteem was endorsed as a very common topic among gay male friends, and a number of participants described low self-esteem (derived from having low sexual status, for example) as inhibiting candid communication, in that partners with low autonomy and confidence will be less likely to verbally communicate their sexual boundaries.

**Individual assessment of risk.** In addition to the effects of substance abuse on self-efficacy, in that case having the cognisance and wherewithal to successfully physically perform behaviours related to safe-sex, substance abuse was further reported by the sample population to be an important factor in the individual assessment of risk. Reliable executive functioning is necessary to weigh and rationalize the risks involved in a given sexual act, and also necessitates other cognitive processes (such as retrieving information related to sexual risk and HIV-transmission, etc., from long-term memory storage) in order to effectively draw inferences and comparisons. One respondent who had experienced unprotected sex under the influence of alcohol described the effect of alcohol on his “reasoning” and “decision-making skills” (Respondent 9) and its ramifications for his capacity to successfully assess the risk of the situation and decide on an appropriate course of action.

Executive skills (in addition to a host of additional cognitive skills, including cognitive flexibility) are impaired in varying degrees by substance use, leading to a deficient assessment of the relative danger imposed by individual sexual scenarios, and possible unsafe sex choices as a
result. One participant described an incident that took place during the early part of the AIDS era, when excessive alcohol led to things that he “…wouldn’t ordinarily have done. Sort of like the other person wanted me to do things that...to me, they were sort of crossing the line” (Respondent 7). Another respondent described the experience of one of his friends, who had been sexually assaulted without protection while he and his assailant were both high, and noted that he felt the drugs were a significant factor in the incident.

Perceived monogamy in relationships appeared to be a significant variable in sexual decision making. Many respondents indicated that, after an initial period (of anywhere between a 1-3 months up to 2 years) there normally came a time in a monogamous relationship when two men would begin to bareback. Overall, participants generally strongly emphasized a socially-normalized association between committed relationships and unprotected sex. At the same time, in sharing their thoughts on relationships, some participants related personal experiences of barebacking in open relationships, or of having been cheated on while engaging in unprotected sex with their primary partner. Others further reflected on unsafe sex and fidelity as grey areas in gay sexuality. In this sense, committed relationships could therefore play a role in HIV incidence as they decrease the perception of possible risk, often lead to negotiated barebacking, and may also often involve casual sex with others.

Safer-sex fatigue (or condom fatigue), the eventual exhaustion of prevention behaviours due to many years of exposure to HIV prevention media and long-term campaigns for safe sex practices, appeared to be a salient and motivating variable in participants’ assessment of risk. Multiple respondents indicated that, for various reasons, they believed men were tired of using condoms. Foremost, this was attributed to one having used condoms for a long time, or having had them “shoved down your throat constantly” in the 1980’s, etc. (Respondent 4). Many
participants reported they were simply tired of being inundated with safe-sex messages over and over again. Other men reported that condoms were annoying, or a pain to have to use all the time, and thus they were tired of having to physically bother with them. Additionally, there was a difference in overall responding about safer sex fatigue vis-à-vis the age of the participant. Younger men (categorized here as men below 30 years of age) did not necessarily feel as though gay men were getting tired of using condoms, or reported they weren’t sure; but older men (age 30+) almost unanimously endorsed condom fatigue. Some young gay men noted that they didn’t know what they would feel like in the future, or how they would feel had they had lived through the onset of the AIDS epidemic and watched their friends die. One young respondent also reported that he didn’t feel unfairly obligated to change the way he had sex, or feel as though condoms were suddenly thrust upon him.

Additionally, consistent with the literature, many study respondents talked at length about treatment optimism, the general sense that HIV/AIDS is no longer an acutely life-threatening illness. For instance, one participant explained that, “…I’m learning that with the advances of medicine that we’ve got now it’s more of a manageable chronic ailment than … the [death] sentence that it used to be” (Respondent 15). A number of respondents focused on advances in medical treatment and medications as a driving force in feelings of treatment optimism. Other participants emphasized that prevention campaigns promote ignorance of the real side effects of treatment ‘cocktails’ because of the media’s depiction of men living with HIV and taking medications as healthy, vibrant, and “…running down the beach, and you know, he has HIV, but he’s taking a protease inhibitor and … he’s free!” (Respondent 4).

Lastly, there was some evidence from a number of respondents that with respect to sexual decision-making, there was some confusion over the relative risk of certain sex acts. One subject
angrily related a story of being misinformed by a doctor early on in his sexual career that he did not really have to worry about HIV infection because he was exclusively a top. Another participant described an experience wherein, as a top and in the heat of the moment, his belief in the relative safety of being the insertive partner had allowed himself to have unprotected insertive anal sex, after which he experienced severe panic. Other respondents brought up oral sex and the potential risk involved therein. Although the men in the present study were quite knowledgeable about variables that could increase risk in oral sex (such as having had recent dental work, or having open sores, cuts, or abrasions in one’s mouth) there was little consensus on what the relative degree of risk actually was, and little evidence of men endorsing personal use of a condom for the practice of oral sex. Whereas many participants dismissed the possible risks involved in oral sex as negligible, some participants judged oral sex to be quite risky, particularly with HIV sero-positive partners.

**Prevention Campaigns**

With explicit respect to prevention campaigns and the core factors emphasized as contributing most strongly to sexual decision-making, a number of participants highlighted the need for campaigns to predominantly increase communication and negotiation in particular. For example, when asked what he thought gay men needed to hear regarding prevention, one respondent indicated that: “...I don’t know, just making it so that people talk about [HIV/AIDS] more instead of just not talking about it at all” (Respondent 8), or instead of using fear tactics (Respondent 9). Although only 14% of participants had actually heard of the term ‘negotiated safety’ (or a term approximating negotiated safety) before their participation in this study, 100% of respondents who had not previously been exposed to the concept were able to correctly infer its meaning. Furthermore, the notion was also generally well-accepted by participants including
those new to the idea: “...about the sexual negotiation thing you just said a minute ago .... [I] was like, “oh, that’s cool, I like that” (Respondent 7).

During the interviews the participants were asked about their thoughts on HIV prevention advertising campaigns, and given the space to explain what they felt would be integral to a highly successful HIV prevention effort for gay men. Among study participants over 30 years of age, 100% had heard of the 2001 Welcome to Condom Country campaign, whereas only 71% of young male study participants had. Overall, there had been a positive reception to the campaign. A number of study respondents lauded the Welcome to Condom Country campaign for being funny, provocative or clever. However, two years later, at the time they were interviewed for this study, many respondents questioned the campaign’s overall effectiveness in sustaining changed HIV-risk behaviour. For instance, one respondent described the campaign as “...kind of fun. I think they get the message across, but they’re not really hard hitting. I don’t think that they make a difference” (Respondent 14). Some respondents felt the advertisements were not representative of the gay community at large, and in a similar vein, other respondents felt the campaign was non-inclusive of community members who are HIV positive.

Overall, study respondents suggested that more successful future HIV prevention interventions for gay and bisexual men would: encourage and promote increased sexual communication; really attempt to “debunk” myths and “challenge assumptions” concerning the more finite or confusing details of HIV transmission (Respondent 6); demonstrate to men what the reality of living with HIV (and on medication cocktails) really is; perhaps involve pictures or stories of lived experiences or real people instead of buff, hot models; and if possible, would involve interpersonal engagement of some sort. As one participant indicated, “I think that’s the kind of work that I think is really important - when people literally go out to places where they
know that men are having sex with men, and talk to people about that, and the realities of that. I think that’s really what’s key” (Respondent 6). Whether the impact of interpersonal interaction can generalizes to contrived interpersonal interaction with a live, filmed, or animated person in an online intervention, however, has yet to be seen. At the same time, as one participant pointed out, the internet offers many specific benefits to HIV prevention, communication, efficacy, and sexual decision-making, like facilitated rapport-building; a platform for increased communication; and a higher degree of interpersonal distance so as to allow less awkward discussions of frank or awkward topics.
Chapter Five: Discussion

The present study set out to explore the sexual decision-making processes of gay and bisexual men, illuminating the factors that contribute most saliently to sexual choices bearing greater or lesser HIV risk. The main goals were to better inform future HIV prevention efforts in this population by investigating the most central aspects of sexual decision-making, and to explore what the implications this might have for the practice of counselling psychology with gay and bisexual clients. In order to capture both the factors that can positively- and negatively-impact upon sexual choices (as well as to emphasize the dynamic and inter-related nature of the variables feeding into sexual decisions), the current study conceived of a diagrammatic conceptual model of sexual decision-making (please see Figure 4). This model details the relative impact upon decision-making of factors identified as most salient to HIV transmission for men in the study population. Three core variables were determined to be most salient and relevant overall to sexual decision-making in the context of HIV prevention for study participants. These fundamental variables were communication/negotiation, self-efficacy, and individual assessment of risk.

Implications for Future HIV Prevention Programs

The results suggest that to better inform large-scale, community-based psychological HIV prevention efforts in this population, a central focus in future intervention development needs to be the promotion of interpersonal communication skills, as well as an attempt to normalize the act of communicating as mutually exclusive to a prototypically ‘masculine’ identity. Given our findings detailing the various factors that most strongly influence sexual communication and/or negotiation, it appears that augmenting social norms surrounding communication in both casual sex and relationships could be vital to HIV prevention.
Furthermore, this could be vital to self-efficacy, and this is particularly relevant in the context of casual sex. Although there appeared to be certain prevalent attitudes among men in our sample normalizing communication in long-term relationships, there was very little evidence of social norms standardizing even minimal communication in casual sex interactions.

Theorists have suggested that for HIV prevention programs to be successful in the long-term, they must address the “sociocultural realities” (p. 44) that are influencing people’s ability to protect themselves (Bandura, 1994). Our results further indicate that self-efficacy, the capacity to take protective action to lessen one’s risk of HIV infection, remains a strong predictor of many AIDS-preventative behaviours in the population of gay and bisexual men. This appears to be particularly the case for more complex, negotiation-related behaviours that require significant degree of skill to perform. Translating information into successful self-protection against HIV infection requires not only social skills and the ability to self-regulate, but also a feeling of personal power to exercise control over sexual activities and decisions in interpersonal relationships.

The factors most strongly influencing self-efficacy in our model include largely socio-emotional variables such as self-esteem, security, sense of personal desirability, and longing for love or connection with others. Consequently, risk reduction indeed necessitates the development of self-efficacy via the cultivation of a more prominent positive gay cultural identity, more cultural and ethnic inclusivity in HIV programming, and a strengthening of the notion of gay ‘community,’ Instead of targeting interventions at particular infective behaviours one at a time, overall increases in positive sense of self and secure community membership could “…instil in people the belief that they have the capability to alter their health habits” (Bandura, 1994, p. 33). For example, in a longitudinal study of sexual behaviour in gay men (McKusick,
Wiley, Coates, & Morin, 1986), the authors assessed a number of psychological variables that could potentially impact upon sexual risk-taking behaviours. These factors included perceived threat of exposure to AIDS, amount of self-esteem, degree of peer support available regarding the adoption of safe-sex behaviours, quality of social skill required to effectively navigate safe-sex behaviour, and perceived self-efficacy (McKusick et al., 1986).

Overall, the preeminent predictor of whether men would engage in sexual risk-taking behaviour was self-efficacy, of which low perceived self-efficacy resulted in greater risk of HIV infection (McKusick et al., 1986). Furthermore, the authors found that gay men committed to monogamous pairings had higher degrees of perceived efficacy than those gay men who frequented bath houses and/or bars (McKusick et al., 1986). This again highlights the need to cultivate a sense of positive community identity and membership, possibly via novel, positive, and non-specialized (i.e. not requiring special expertise, skills, or athletic ability, etc.) forms of community social groupings that do not involve drugs or alcohol. As other research has highlighted, community building is one of the most valuable things that can be done in HIV prevention (Murray & Adam, n.d.).

The largest number of relevant factors was deduced to significantly influence the individual assessment of risk, which could possibly be due to the subjectivity of cognitive appraisal, and the social complexity in which these processes take place. Subjective risk assessment was most strongly influenced by interpersonal communication in relationships and perceived monogamy, substance abuse, and a number of epidemic-specific variables, including safer sex fatigue, treatment optimism, and the understanding of complex issues regarding transmission. Therefore, for future community-based HIV prevention campaigns to be more successfully received by the gay community, ideally, interventions would encourage and
promote increased sexual communication and attempt to debunk myths and challenge assumptions regarding the more finite details of HIV transmission. One of the most universally-discussed factors in sensitizing oneself to perceived risk, as in the Health Beliefs Model, was the need for greater knowledge concerning the reality of living with HIV and antiretroviral ‘cocktails’ at present. However, care should be taken in this case in order to sensitively convey this reality without further stigmatizing HIV+ individuals. The results also suggest that there is still a need for HIV interventions to be more representative of the gay community at large, and of real community members as opposed to muscular, impossibly attractive print models. If possible, prevention campaigns should also engage individuals interpersonally.

Comparing the results of the present study with the literature on previous interventions, one can see a definite trend towards greater long-term success with interventions that possess more of the factors determined to most significantly impact sexual decision-making. For example, Kelly’s intervention involving ‘trendsetting’ community members who are trained to promote and communicate information about safer-sex practices to other men in the community documented significant behavioural change in sexual practices (Kelly et al., 1992). Another recent and highly successful prevention campaign focused particularly on changing or improving men’s sexual negotiation skills (Bonnell et al., 2006). Gay men responded well to this intervention, and their success in this endeavour was suggested to be a reflection of both a brief period of interpersonal interaction and the qualitative aspects of the person performing the intervention (Bonnell et al., 2006). Lastly, once more highlighting the need for different mechanisms and content in HIV prevention is the comparison of the more socially interactive community-based intervention programs described above with less interactive community-based interventions. For example, the widespread 2001 Welcome to Condom Country media campaign
was highly successful in terms of reaching its target audience and re-introducing HIV/AIDS into gay public consciousness. However, although 87% of our sample population knew of this campaign and/or had seen the advertisements, most respondents felt it was provocative, fun and ‘campy,’ but hadn’t impacted upon their behaviour. This is consistent with the literature presented suggesting informational interventions are less effective when widely perceived to be telling people what they believe they already know (Wolitski et al., 2001). In this sense, a similarly comprehensive campaign media that is interpersonally engaging, has a more diverse community focus, and conveys a novel overall message may be more effective in shifting community norms.

**Implications for the Practice of Counselling Psychology**

Finally, the results of the present study highlight a number of psychological, emotional, and adaptive functioning domains involved in sexual decision-making that are relevant to the clinical practice of counselling psychology. As is the case with community interventions, the results can inform the discipline by highlighting the most potentially significant aspects of sexual decision-making to be focused on in the context of counselling-based HIV prevention strategies. The present study can also inform the clinical practice of counselling psychology by elucidating for professionals the most salient issues in gay men’s relationships, emotional lives, and sexual practices. First-hand personal narratives of lived experience can serve as very useful and informative frameworks for understanding a population’s social and cultural norms. For example, understanding the contextual significance of community attachment for gay clients, or the high cultural standards placed on physique and attractiveness that they are subject to, allows clinicians to better appreciate and empathize with a client’s frame of reference. This can have important implications for the content of therapy sessions, and fostering a strong empathic
connection with clients when the therapist themselves has not experienced similar life challenges (Bodnar, 1997; Cadwell, 1994; Gelso & Fassinger, 1990; Harris & Alderson, 2007).

The results of the present study are also relevant to the development of therapeutic alliance (Bodnar, 1997; Cadwell, 1994; Gelso & Fassinger, 1990; Harris & Alderson, 2007). A number of participants in the current sample described themselves as experiencing a strong desire to belong, and to be loved. At the same time, however, respondents also endorsed significant issues trusting other people, the frequent experience of rejection, and difficulty connecting interpersonally with other individuals. As a result, the present results support the contention that therapeutic alliance can be slow to develop with gay and bisexual clients (Cadwell, 1994; Harris & Alderson, 2007). Additionally, this highlights the possible great emotional significance of therapeutic alliance for many gay and bisexual therapy clients, as the experience of acceptance and unconditional positive regard can be a powerfully motivating factor in positive self-esteem and success in therapy (Bodnar, 1997; Cadwell, 1994; Rogers, 1951; Rogers, 1986). This concern is amplified for HIV+ therapy clients, who more frequently experience personal rejection, social isolation, or significant individuals in their lives avoiding them (Bodnar, 1997, Cadwell, 1994). Some clients may simply become accustomed to this feeling, and therefore clinicians should be aware that therapy clients who are living with HIV or AIDS can experience severe difficulties in the development and fostering of therapeutic alliance (Cadwell, 1994). A longer phase of slowly-building mutual trust and rapport may be required before a secure therapeutic alliance is established (Bodnar, 1997, Cadwell, 1994).

Lastly, the results of the present study can be helpful in devising behavioural interventions in individual counselling psychology. For instance, with some gay or bisexual clients there may be a need to address factors like self-esteem or self-efficacy, etc., by addressing
more fundamental meta-variables related to interpersonal connection and loneliness. This could guide certain kinds of cognitive-behavioural therapeutic interventions or homework tasks utilized with clients, for example, requiring clients to seek out community engagement and social groups, etc. As an example, an AIDS Committee of Toronto (ACT) study looking at aging and HIV risk, found that older gay men endorsed greater feelings of isolation from the community (Murray & Adam, n.d.). The outcome of this research involved the creation of a series of Friday evening HIV prevention and social discussion groups for older gay men. These discussion groups were a success and quickly became so popular that two members of the group, with the support of ACT, were motivated to begin facilitating a larger-scale six week support groups for older gay men focusing on issues related to mid-life (Murray & Adam, n.d.).

**Concluding Remarks**

**Limitations of the present study.** Research on sexual decision making HIV risk behaviour in gay men is challenged by vast methodological and interpretational issues, partially due to the cultural complexity and socially-entrenched nature of the behaviours of primary interest, and the fact that those critical behaviours occur privately. As in the present study, it also necessitates that men honestly and accurately self-report their own practices. There were certain limitations to the current study. Foremost, the small sample size (N=15) precluded a more cohesive representation of other ethnic groups, younger men, and HIV+ individuals in the sample population. The sample size may be the reason certain commonly-found trends in the literature are not replicated in our results. For example, young gay men have been found on average to have higher rates of party drug use (particularly crystal methamphetamine) as well to endorse high rates of unprotected anal sex (McAuliffe, Kelly & Sikkema, 1999; Mansergh & Marks, 1998). In contrast, the few young participants in the current study reported relatively
conservative personal preferences, were engaged in time-consuming and/or challenging academic study, and largely denied drug or alcohol use. Furthermore, it is interesting to note that 43% of young gay men (defined as less than 30 years of age) in our sample had never had unprotected anal sex ever, whereas 100% of men over 30 in our sample had barebacked at some point.

**Directions for future research.** There is a call for greater research on community-based, psychological HIV prevention interventions in the population of gay and bisexual men. This is particularly the case for those community interventions most likely to influence social norms and attitudes. The present study has highlighted a number of variables fundamental to safer-sex decision-making in order to help guide future intervention efforts. Important directions for future research could include further, expanded, qualitative research on the lived experiences of gay men in the same vein as the current study. A greater sample size and the inclusion of a more diverse sample population in terms of age and ethnicity could also allow for increased understanding of the range of experiences of different gay and bisexual men. For sustained prevention, further research should attempt to tap social norms and attitudes.

**Summary and conclusions.** A challenge in the field of psychology is the development and implementation of HIV prevention interventions that will reach a large number of gay men and do so effectively, increasing knowledge, changing behavior, and in particular, altering social norms and attitudes. The present study was designed to identify the most relevant psychosocial factors in the sexual decision-making process, and the psychological implications of these factors for overall mental health and well-being of participants. The results suggest that three core factors, which include self-efficacy, sexual communication and/or negotiation, and individual assessment of risk, are most relevant to norms of sexual decision-making for gay/bisexual men.
The development of a greater variety of novel community-based psychological interventions emphasizing communication, personal efficacy, and the realities tied to living with HIV is strongly recommended in order to attempt to widely augment social norms and attitudes central to HIV prevention in the gay community. This may be central to sustained behavior change in the long-term, and thus contribute to the emergent need to reduce the overall rate of HIV incidence for the population of gay and bisexual men.
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Differences, 19, 713-723.


Appendix A: Demographic Questionnaire

1. Age in Years: ______________________
2. Gender: ______________________
3. Ethnic/Racial Background (please specify): ______________________
4. Sexual Orientation: ______________________
5. Current Relationship Status (please specify): ______________________
6. Have You Been Tested for HIV:
   
<table>
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<th>Yes</th>
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7. If tested, HIV status at last testing: HIV- HIV+ Don’t Know
Appendix B: Interview Questions

1) **Relationships**

- What are the most important issues in your life at the moment?
- How important is it for you to have a lover/partner?
- What are some problems today with finding/maintaining a relationship?

2) **HIV Awareness**

- How can someone get infected with HIV?
  - Unprotected sex?
  - Which acts?
- Can you tell if someone is infected?
  - If so, how?
- On a scale from 1 to 10, where 1 is not at all concerned and 10 is very concerned, how concerned about HIV are you?
- What is the average lifespan of an individual with HIV/AIDS?

3) **HIV Prevention Advertising Campaigns**

- Do you know of any safer sex or HIV prevention campaigns?
- How about the “Condom Country” campaign ads?
  - What do you think of these ads?
  - What’s the message?
  - Do you think it’s effective?
- What would an ideal HIV prevention campaign look like?
- What do you think people need to hear?

4) **HIV Treatment Optimism and Safer Sex Fatigue**

- Are men who have sex with men more or less likely to practice safer sex than say, 5 or 10 years ago?
  - Why or why not?
- Are men who have sex with men more or less concerned about HIV than 5 or 10 years ago?
  - Why or why not?
- How do new treatments like HAART, AIDS ‘cocktails’, or protease inhibitor drugs affect gay men’s concern about HIV and AIDS?
- In your opinion, will there be a vaccine or a cure?
  - When?
- When you first heard about AIDS, could you envision still having to use condoms today?
- Have condoms become easier to use or just more a part of your sexual routine?
- Are gay men just getting tired of using condoms?

5) Sexual Practices and Sexual Negotiation

- Have you heard of the term ‘barebacking’?
  o Have you done it?
  o Can you tell me about it?
  o How do you feel about that?
- Is sex better with or without a condom? Why?
- Have you heard of the term “Negotiated safety”?
  o What does it mean to you?
- Is there a point in a relationship when men stop using condoms?
  o If so, when? And under what circumstances?
- Do you bring up the topic of safer sex with a new partner?
  o If so, how?
  o If they refuse, what do you do?
- If someone allowed you to penetrate them without a condom, would you make any assumptions about their HIV status? What would that assumption be?
- What if someone asked or attempted to penetrate you without a condom? Would you make any assumptions about their HIV status? What would that assumption be?
- How do you feel about HIV+ men having sex without practicing safer sex?
- How do you feel about having sex with HIV+ partners?
- Is there a difference between knowing and not knowing someone’s HIV status?

6) Alcohol and Drug Usage

- Do drugs and alcohol affect how some gay men practice safe sex?
  o If so, how?
- Do drugs or alcohol make practicing safer sex more difficult for you?
  o Can you think of an incident where this happened?

7) Self-Esteem and Related Issues

- Compared to the general population, how is the self-esteem of most gay men?
- Do you think there is a perception of the ideal gay man – in terms of, age? Ethnicity? Height? Weight? Muscularity?
- Thinking about these ideals for a moment, for men who don’t fit the stereotype, could they in any way, cause someone to practice more risky sexual behaviour?
Appendix C: Glossary of Terms

Terms as used in the context of this report (ACT, 2008):

Barebacking  Unprotected anal intercourse.

Bottom  A term used (as both a noun and verb) to refer to receptive anal intercourse, or the receptive sexual partner.

Gender Identity  Whether an individual identifies as male, female, both, or neither.

MSM  Men who have sex with men. This category is general, however, and does not indicate sexual preference. For example, MSM may not all identify as gay or bisexual.

Polyamorous  Describes the practice of having a more than one devoted, intimate, primary partner relationship at a time with the full knowledge and consent of everyone involved.

Protease inhibitor  A class of medication preventing viral replication used in the treatment of HIV.

Queer  A wide-reaching term describing any identity that transgresses from conventional societal principles of gender and sexual orientation.

Sero-positive  HIV positive status.

Sero-negative  HIV negative status.

Sero-concordant  A term indicating two individuals of the same HIV status.

Sero-discordant  A term indicating two individuals of different HIV status (i.e.: a sero-discordant relationship).

Top  A term used (as both a noun and verb) to refer to insertive anal intercourse, or the insertive sexual partner.
Two-Spirit  

A form of North American First Nations cultural identity that denotes features of both the male and female spirits in one individual (this may relate to sexual orientation and/or gender identity).