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Facilitators of Barebacking among Emergent Adult Gay and Bisexual Men: Implications for HIV Prevention

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Abstract

We undertook a qualitative study to develop a greater understanding of “intentional” unprotected anal intercourse among drug using gay and bisexual men, also known colloquially as barebacking. In our present analysis, we investigated this behavior in a subset of 12 HIV-negative men in the early adulthood stage of life to disentangle factors which functioned as facilitators of barebacking, a behavior which may place these men at risk for HIV infection. Based on thematic analysis of life-history interviews, we delineated four main themes associated with barebacking: drug use, the role of responsibility for safer sex, misunderstandings about HIV transmission, and underlying mental health issues. The data suggest that lack of knowledge about HIV transmission is insufficient in explaining risk-taking. Rather, rationalization processes may be a factor in the sexual risk-taking behaviors of young HIV-negative men, and moreover, deep intrapsychic processes, (often heightened by concurrent substance use), and the desire to please sexual partners may drive the decision-making of these men. Future intervention strategies must motivate and empower young men to seek support for the states that drive sexual risk-taking.

Keywords

barebacking; HIV; drug use; mental health; risk-taking

INTRODUCTION

Over the last decade, behavioral researchers have documented the emergence of intentional unprotected anal intercourse among gay and bisexual men; the behavior has been coined “barebacking” (Gauthier & Forsyth, 1999; Goodroad, Kirksey, & Butensky, 2000; Halkitis, 2001; Halkitis, Parsons, & Wilton, 2003; Halkitis, 2006; Mansergh et al. 2002; Rofes, 1998; Suarez & Miller, 2001; Wolistki, 2005). Despite the fact that men recognize the risks associated with barebacking (Halkitis, Wilton, & Drescher, 2005), it is still a behavior in which they engage. A variety of motivations for intentional unprotected anal sex have been documented, including more intense physical pleasure during sex, the need to feel a physical and emotional connection with partners, and the eroticization of behavior that is considered taboo (Wilton, Halkitis, English, & Roberson, 2005; Wolitski 2005; Carballo-Diequez & Bauermeister,

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2004; Mansergh et al., 2002). Men who bareback have reported using varying heuristics, often based on their partner's physical characteristics or mannerisms, to negotiate risk-taking with sex partners (Halkitis, Wilton, and Drescher 2005; Suarez & Miller 2001).

Research has demonstrated that a variety of factors influence men's barebacking behavior (Halkitis, Wilton, and Drescher 2005; Suarez & Miller 2001), including, but not limited to, AIDS-burnout/AIDS-related fatigue and the advent of antiretroviral therapy (ART) and subsequent perceptions of reduced infectivity have led to an increasing willingness among men who have sex with men (MSM) to take sexual risks (Adam, Husbands, Murray, & Maxwell, 2005; Shernoff, 2005; Crossley, 2004; Ridge, 2004; Halkitis, Parsons, & Wilton 2003; Suarez & Miller, 2001; Halkitis, Zade, Shrem and Marmor, 2004). Gay men also report that the rise in the use of club drugs, such as methamphetamine, cocaine, GHB, ketamine, and ecstasy, and ineffective prevention campaigns contribute to an increase in sexual risk-taking (Halkitis, Parsons, and Wilton, 2003; Halkitis, Wilton, Wolitski, Parsons, Hoff, & Bimbi, 2005; Wilton, Halkitis, English, & Roberson, 2005). However, a cause-and-effect viewpoint is overly simplistic and fails to account for the other factors and person-level characteristics related to barebacking behavior. (Shernoff, 2005) Similarly, the concept of safer-sex relapse fails to explain the intentional unprotected sex that occurs as barebacking. (Halkitis, Parsons, & Wilton 2003)

Many contemporary HIV prevention messages have been built upon the notion that information and education are sufficient to prevent unprotected anal sex. Fisher and Fisher (1996) however, argue that motivation is key to understanding risk-taking. Crossley (2004) points out, "Such assumptions produce an image of the individual that is overly rational and fails to take sufficient account of the complex interrelations between psychology, health issues, and the sociocultural and moral environment in which people live." In addition, Halkitis et al. (2005) suggest that we have neglected the role that emotions play in sexual transactions. Similarly, models such as the Theory of Reasoned Action (Ajzen & Fishbein) and Health Belief Model (Rosenstock et al.) fail to take into account the contexts and situations in which these barebacking behaviors occur and the ways in which MSM have reconceptualized safer sex information and education based on these contexts, situations, and heuristics (Halkitis, Zade, Shrem, & Marmor, 2004; Ridge, 2004)

Prior research into barebacking has two significant limitations. First, researchers' definitions, understandings, and interpretations of the phenomenon of barebacking may differ from the definitions, understandings, and interpretations of the individual who barebacks (Halkitis, Wilton, Galatowitsch, 2005). Second, researchers have been unable to delineate risk factors or trajectories that predispose some men to have intentional unprotected anal sex (Adam, Husbands, Murray, & Maxwell, 2005; Halkitis, Wilton, and Drescher, 2005; Halkitis, Wilton, & Galatowitsch, 2005; Wolitski 2005), and we (Halkitis, Siconolfi, Fumerton, and Barlup, in press) have argued that this is a key point to developing new and relevant prevention strategies.

Thus, we need to develop a holistic understanding of the facilitators of barebacking behavior among gay and bisexual men. This understanding is particularly relevant among men who are uninfected with HIV and moreover, came of age long after AIDS was known to the world. To address these matters, we conducted an in-depth thematic analysis of the life history interviews of 12 HIV-negative gay and bisexual men in their twenties. Through using men's own accounts of their barebacking behaviors, we sought to create a framework for analysis that would elucidate the contextual factors and facilitators at play.

METHODS

Design

Project B2B implemented a cross-sectional design combining qualitative and quantitative components to examine the facilitators, or antecedents, of barebacking behavior in adult emergent gay and bisexual men who identify as barebackers and live in New York City. Studied components included the developmental, behavioral, psychological and contextual lives of the men with following goals: (1) to characterize the meanings and definitions of barebacking according to gay and bisexual men; (2) to assess the associations of attitudinal, normative, behavioral, developmental, psychological, and social or contextual antecedents with gay and bisexual men's barebacking behaviors; (3) to disentangle the relationships among an individual's barebacking identity, perceptions and attitudes of barebacking, and barebacking behaviors. Components from each of the goals are discussed within this paper.

Sampling Framework

Using passive and active recruitment methods, we recruited 102 gay and bisexual men into the study. Most of the men, 92.2% ($n = 94$), were recruited through passive measures, such as flyers posted throughout New York City's predominant gay locations and mailed to gay or bisexual participants from the research center's previous studies. Internet postings of the study were also utilized. A few of the participants, 7.8% ($n = 8$), were actively recruited; recruiters approached individuals in targeted venues to encourage participation and provide basic information on the study.

As a result of the recruitment strategies, a total of 224 men called our center to be screened into the study via telephone interviews. Via phone, a trained research staff member briefly described the study and determined eligibility of potential participants. Individuals were deemed eligible if they met specific requirements, which would aid in our efforts to contextualize and define the facilitators and meanings of barebacking in gay and bisexual men. The study requirements included: (1) 18 years of age or older; (2) self-identify as gay or bisexual; (3) familiarity and identification with the "barebacker" term (i.e. "Do you consider yourself to be a barebacker?"; "Are you familiar with the term barebacker?"); (4) at least one self-disclosed barebacking act in the past three months (i.e. "When was the last time that you had anal sex with another man that you would define as barebacking?"); and (5) at least two barebacking acts in the past year (i.e. "How many times in the last year did you have anal sex with another man that you would define as barebacking?"). In addition, defining the term "barebacking" was not included in the screening process, as gathering unbiased participant definitions of this construct was part of the study. Finally, previous research demonstrates that there is a strong association between club drug use and barebacking among some gay and bisexual men (Gorman, Nelson, Appelgate, & Scrol, 2004; Halkitis, et al., 2001). Participants, therefore, were also screened for their use of club drugs, specifically ecstasy (MDMA), ketamine, methamphetamine, powdered cocaine, or GHB. Eligible individuals must have reported that they used any of the listed drugs at least six times in the last year, at least once in the last three months, and at least once before or during sex in the last three months. Of the 224 men initially screened for the study, our final sample yielded 102 participants.

Procedures

After individuals were screened and deemed eligible, they were scheduled for a single assessment appointment. During the appointment, each participant provided an informed consent in the presence of a trained researcher. Next, an initial self-administered, quantitative survey was administered using an *Automated Computer-Assisted Self-Interview* program (ACASI). A research associate followed with a qualitative life history interview. Participants received a monetary incentive of \$50 and an informational packet containing community

referrals for health and psychological services and resources. The authors' academic institution granted IRB approval. The quantitative analyses are presented elsewhere (Halkitis, 2007), while the qualitative data provided the basis for our present analysis.

Measures/Qualitative Protocol

We collected our data using the life-history method (Connell, 1992; Elder, 1985; Gerson, 1985), which is a well-designed interview schedule that systematically incorporates the independent variables of theoretical relevance to the study. This qualitative method has been used extensively to understand aspects of gay and bisexual men's lives, including their sexual lives (Browser, 1992; Connell 1992; Dowsett, 1996), and was ideal for our investigation of the factors facilitating barebacking identification and behavior. For the purposes of this project, the interview schedule tapped into five principle dimensions of inquiry: the psychological, the cultural/institutional, the symbolic, the behavioral, and the drug-using. The interview schedule was divided into phases of the life-course (i.e. childhood (0–12), adolescence (13–17), emergent adulthood (18–23), early adulthood (24–29), adulthood (31–39), and early-middle adulthood (40–49) on the basis that sexual behaviors are likely to vary across the life-course and across individuals. These life course classifications were used as sensitizing concepts designed to provide a general theoretical focus in each time period. Questions concerning familial relationships or early sexual experiences, for instance, were employed in the section of the interview schedule covering childhood and adolescence, while questions concerning the onset of sexual identity, use of club drugs, struggles with HIV/AIDS infection, conceptions of barebacking, and preferred sexual practices were implemented in the adulthood section. In anticipation of each life-history having unique variations, the schedule was purposefully flexible to allow for the reconstruction of the life-course phases per interview. The interview was semi-structured, combining a pre-established range of theoretically informed questions with flexibility in prompts that permit discovery. Thus, the interview process remained focused while encouraging exploration of unique or unforeseen experiences and facilitators within each participant. The interplay of data collection and analysis established a fluid relationship between inductive and deductive approaches, ensuring empirical “grounding” for emerging theory-building while sustaining a focused, theoretically informed inquiry (Strauss & Corbin, 1998). Specific questions about barebacking explored the participants' understanding of this construct, behavior related to the construct, identification as a barebacker, and roots, or facilitators, of barebacking behavior.

Data Analytic Plan

Our data analysis was guided by interpretive phenomenological analysis specified for the study's qualitative data (Chapman & Smith, 2002). The analysis process entailed using thematic coding on a case-by-case and across-case basis by a coding team of four researchers. Thematic coding was undertaken as per procedures outlined by Miles & Huberman (1984), Patton (1990), and Chapman & Smith (2002). As such, data from the audiotapes were transcribed and then compared to the audiotapes to verify accuracy. A coding team, led by the PI, formed a codebook. Through numerous iterations, the codebook was finalized and applied to the existing narratives indicating the presence of codes in the narratives via an alphanumeric coding system. Data were coded for content analysis to identify themes and factors associated with club drug use, unprotected, barebacking and protected intercourse, the intersection of these behaviors, contextual factors (venues/environments and drug using experiences), as well as current psychological, emotional and behavioral factors which may facilitate participants' barebacking identity and behavior. Each distinct theme was coded, recorded and defined in a common codebook. Reliability was maintained through the use of multiple coders who discussed and revised inconsistent codes until coders achieved 90% agreement levels. The QSR N5 (NUD*IST 5) software package was utilized to facilitate the qualitative data analysis.

Analytic Sample

Our sample of 12 HIV-negative young men (defined as ages 18–29) was drawn from a larger investigation of barebacking among 102 men who have sex with men, identify as “barebackers,” and live in the New York metropolitan area. In the full sample ($N = 102$), participants ranged in age from 21 to 61 with a mean age of 35.48 ($SD = 8.28$) and a median age of 34. In terms of race and ethnicity, 46.1% ($n = 47$) identified as White, 29.4% ($n = 30$) identified as Latino, 10.8% ($n = 11$) identified as Black, 5.9% ($n = 6$) identified as mixed race, and 7.8% ($n = 8$) were from other racial/ethnic backgrounds.

The sample for this study consisted of 12 randomly selected men who were self-reported as HIV-negative and were between the ages of 18 and 29 (emergent or early adulthood). Stratified by race/ethnicity, the participants were selected with three randomly chosen from each of the four represented racial/ethnic groups (White, Latino, African American, and mixed race/ethnicity). The resulting subsample ranged in age from 21 to 29 with a mean age of 26 ($SD = 2.42$) and a median age also of 26. Three of the participants had attained a high school diploma or the equivalent, five had some college education, three had earned a Bachelor of Arts degree, and one had attained a graduate degree. Participants within the subsample reported a mean of 25 ($SD = 31.72$) male sexual partners in the past year with a range of 1 to 104 partners. Lifetime male sexual partners varied as well, with participants reporting a mean of 138 ($SD = 185.66$) lifetime male partners, ranging from 2 to 650 partners. The mean age for onset of sexual activity with other men was 15 years old ($SD = 4.46$), with a range from 9 to 21 years old. The twelve men are described in further detail elsewhere, including childhood and young adult histories (Halkitis, Siconolfi, Fumerton, & Barlup, in press).

RESULTS

Our analyses yielded several behavioral and psychological facilitators of barebacking among the men in this sample. These included drug and alcohol use and abuse, risk despite knowledge, misunderstandings and mythologies about safer sex, HIV testing as an enabler, and deferring to partners in regard to condom use or HIV status disclosure. In addition, many of the men evidenced mental health issues, such as depression, low self-esteem, feelings of isolation and loneliness, as well as a tendency towards sensation seeking and risk-taking. These themes are described further, and participants are assigned fictitious names. Racial/ethnic identification and age are provided for each participant the first time he is quoted.

Drug/Alcohol Use

All of the men in our sample (100%, $n = 12$) described current substance use, and reported using alcohol, cocaine, ecstasy, methamphetamines, ketamine, GHB and marijuana, often in combination. The nature and frequency of this substance use varied among these men, with some, like Chris (White, 21 years-old), reporting “recreational” use. Others, including Michael, (Latino/White, 27 years-old) and David (White, 27 years-old), described drug use once or twice a week, and some reported severe abuse, like Jack (mixed race, 26 years-old), who describes himself as “a drug addict.”

A theme that resonated throughout the narratives of these men was their use of drugs to help them “escape from reality,” and “forget about everything,” as Michael explained. Paris (Latino/Black, 24 years-old) also recognized this effect, especially with ecstasy:

Yeah, it just makes you feel, like it makes you feel good. It makes you feel like so so happy about everything. You know you could think about your worst problems in the world, like, 'Oh well, who cares?' You know, smile about it... You know, you don't care.

David acknowledged using drugs in this way as a coping mechanism during difficult times throughout his life. He described his “drug use as more of an escape, you know, I stay stoned, I don't really have to deal with it.”

Drugs were also widely used by the men in this sample as a way to enhance their sexual experiences. Anthony (Latino, 28 years-old) explained, “drugs make you more horny,” and described a sexual fantasy of “getting fucked and doing coke at the same time.” Paris also said that drugs increase his sexual desire, especially certain types of ecstasy that “make you feel like you want to fuck everything you see.”

Michael indicated that drugs “make sex more enjoyable.” Jack used cocaine during sex to “enhance the sexual arena” as well as his feelings of masculinity:

When I'm doing coke, being that it keeps up all night, I tend to actually ejaculate more. I find that kind of like invigorating to my ego, I guess you'll call it. I feel like it makes me more of a man when I come like 3 or 4 times in one night, in just a span of like 8 or 6 or 12 hours, or something. And my lover loves it when I do that.

Chris described how he used “crystal, ecstasy, cocaine and marijuana” all “before sex.”

Many of these men recalled sexual experiences in which they would not have participated without the influence of drugs:

In the locker room, you know, there's rows and rows of showers that I have known about for years. You can go at it, join in a group sex and everything, there in the locker room, and you can go in one of the bathrooms in the student union and there's somebody who is always in there ballin' or getting their dick sucked, you know...I never do that unless I was coked up.

Further, they explained that they are more likely to bareback while under the influence of drugs. Notably, the majority (67%, $n = 8$) of the men specifically described this relationship between drug use and barebacking. Many cited a lack of judgment that caused them to bareback while high. For example, Joseph (Latino, 26 years-old) explained, “Sometimes when you're messed up you don't really think about using a condom, so you just go right ahead.” Similarly, Paris says “...especially when I'm high I don't really pay attention to condom, you know. It's like I don't want to hear nothin' about no condoms and, um, I pretty much go with the flow.”

Chris pointed out the dissonance between his knowledge of the risks of barebacking and his drug-influenced behaviors:

I am also aware of the dangers while sober, and like, being conscious of them while you're screwed up is two different things. Especially seeing all the literature about it now makes me think, like, 'Oh geez, what am I doing?'

For example, he recalled a sexual partner who “insisted I take my condom off and I'm like... ok fine, your choice. And that was only because I was twisted on crystal and ecstasy. Ordinarily, I would be like, “Absolutely not.” He pointed out that his partner “was twisted on crystal and ecstasy, too.” Similarly, John (White, 29 years-old) acknowledged, “most of the time I have bareback sex, though, I am on drugs. Sounds horrible, but the feeling—I know I am not making the most rational decisions.”

Several men described the specific cognitions that lead them to bareback while under the influence of drugs. David said that he engaged in bareback sex when using cocaine because it made him “invincible, you know, like I don't care, you know nothing is going to happen to me.” John explained that drug use increases the likelihood of barebacking by causing him to

focus on the momentary sensation in the present, as opposed to the potential long term consequences:

I think it just takes away my reasoning, my initial long term reasoning, and the way I value my life versus initial sex, cause sometimes I am high, with no condom and I just wanna get fucked, like 'fuck me' and I don't care...It's like wanting the initial pleasure versus the long term effects.

Because of the effects of drug use on his judgment, and the strong propensity this creates for barebacking, Chris suggested, “I sort of fear crystal meth and ecstasy.” He acknowledged the risk involved, and described his concern for his safety:

I sort of don't trust that someone else would have that same...consciousness of my safety if I was like twisted, you know. If I'm like ladeedadeeda, ecstasy rolling, feeling good, the whole nine yards, you know and having someone else just interested in their penis solely and not necessarily about me—which is a very real possibility, which is why I fear it.

Risk Despite Knowledge

All of the men ($n = 12$, 100%) elaborated on their willingness to continue barebacking despite cognizance of the potential for HIV infection. Often, a dissonance existed between their understandings of and desires for safer sex and the riskier behaviors in which they actually engaged.

Anthony, who has lost friends to AIDS, found it difficult to start using condoms after having had experiences with condomless sex, and attributed his desire for unprotected intercourse because the sensation was more pleasurable. He continued to bareback after a gonorrhea infection. Because of that experience, he is aware of the risk that barebacking entails:

Condoms were not really a question because I was so used and accustomed [to not using them]... which is probably a poor, lame, and irresponsible excuse, in my opinion, as an individual, someone who has lost friends from HIV and who has other friends who encountered STDs... It's there, and it only takes one time. So you know, I should kinda put that before my “Oh well, I'm not really comfortable using condoms because throughout my life, you know, I never used them.”

Similarly, Jack described his thoughts after contracting Chlamydia from his partner on two occasions. “Wow, I could probably die by fooling around with this guy.” It's not any fun to think about that.” He also indicated his reaction to people he passes on the street who he perceives be to living with HIV:

I don't know, if I see someone that looks really sick on the street, I'll be like, “Damn, that sucks, this guy has HIV. Why didn't he wear a condom?” Thinking about it now, I'm like “Why don't I wear a condom?” I'm like, “Whoa, I never want to be in this situation.”

Further, he remembers his godfather, a house attendant in a hospice for people living with AIDS, returning home daily with stories of men who had succumbed to the illness.

Rick (Black, 25 years-old) explained that he continues risky behaviors despite having an ex-boyfriend who seroconverted while in their open relationship. He notes that when he cruises for partners on the Internet, he avoids men who advertise as barebackers. Yet, “the ones [men] that I do go after, eventually, you know, one thing leads to another and you're just like, ‘Ok, forget about it, let's just do it or whatever.’” Other men shared similar experiences, in which they made impulsive decisions they later regretted. John described “wanting the initial pleasure versus the long-term effects.” Paris, although he described barebacking as “dangerous as all

hell,” recounts a sexual encounter during which he held a condom in his hand throughout a sexual encounter which involved unprotected anal sex. He explained, “...the heat of the moment can definitely get you.”

Peter (Black, 26 years-old), however, attributes his willingness to take sexual risks to the seeming-inevitability of HIV infection:

It just scares the living shit out of me.... I think a lot of people are that way too, you know. And that's just like, I know it's [HIV] real. I definitely know that it exists, but it's also such a big fear that it kinda has this whole boogie man element...like this whole Satan thing...like the HIV Man is going to get you, you know, even if I used condoms every day of my life, I'd still be horrified because it's such an oppressive idea.

Rationalizations and Mythologies

The majority of the men ($n = 11$, 92%) provided narrative that indicated misinformation regarding HIV transmission. These misunderstandings were either rationalizations or mythologies surrounding what constituted high-risk sex, utilizing heuristics that involve age, physical appearance, proximal behaviors, and social circles of partners. Mythologies were also related to the participants' own personal characteristics.

Some of the mythologies were based on perceptions of risk and sexual behaviors. A third of the men ($n = 4$, 33%) believed they were preventing HIV infection by avoiding ejaculation inside their partners, or not allowing partners to ejaculate inside of them. Peter describes the rationalization of his sexual risk-taking to others:

I know they are asking me, “Well, did you use a condom?” And I'm thinking, “Sure, I was safe. Because I might not have used a condom, but I know I didn't ejaculate in that person, or, you know, like I made sure they were lubed up, I was lubed up, whatever.”

Furthermore, a number of the men perceived levels of risk based on their partner's physical or social characteristics. Several men explained that in their eyes, younger men were less likely to be infected with HIV. Both David and Chris indicate that they believe younger men are less likely to be infected than older men, and for this reason they are more likely to bareback with younger partners.

Conversely, Jack perceives himself to be at low risk because of his partner's older age and physical appearance, despite having contracted Chlamydia from him on two occasions:

I kinda use a false pretence to strengthen my belief that I'm doing the right thing, because he's an older guy. He doesn't have that many — he never had that many partners, and like, “Look at his old ass. He can't even fuck anybody else, he's lucky he has me,” or something. So one of my best friends [asked] “Do you guys ever use condoms?” I'm like “So what? I'm young. He's old.”

Jack also described a local bartender who he believes is HIV-positive because he has a certain “look in his eyes.” Jack explained that he would not have sex with anyone in the bartender's social circle, even with a condom, because he believes they also are likely to be infected:

I don't hold it against him for having it, but at the same time I wouldn't want to be around him sexually, or in any other way.... You can catch it different ways.... And through him sleeping with somebody else, that person sleeping with somebody else, and me sleeping with the last person in the group with or without a condom. I'd still feel at risk so I wouldn't. I find myself moving away from his group... I don't feel like I should be around that person or his group of friends.

Anthony bases his perception of risk on the appearance of his partner and the “vibe” he gets from their initial encounter:

If he was a really hot and good-looking masculine guy that I was really attracted to. Or if he was someone that I knew maybe just came out recently and didn't have any experiences. [It's] probably someone like that I would bareback with, as opposed to maybe someone who I know has been around.

Rick, who seems to be unaware that he himself is a casual encounter for his partner, determines whether he is willing to bareback with a partner based on how casual his partner appears to be with his sexuality:

We just discuss a variety of things. I like to see how they think... I like to see if they just run around and do this with anyone.... I like to know. I really like to know if they just run around and do this with anybody, because if they run around, I don't like people who just run around and just do it [with] anybody. Although I do [have casual sex], it's like I don't like the person I'm being intimate with to be like that.

Some of the men believe that their partners' general demeanors are a metric for gauging their likelihood of being HIV infected. Chris believes that his boyfriend is not at risk for infection through sex outside of their relationship because he is a “militant top.” Paris, who explained that he does not know “how the virus is formed if two people don't have it,” (indicating a significant misunderstanding of HIV infection), further proposes that his partner, who avoids smoking, excessive drinking, and marijuana use is not a risk-taker and therefore unlikely to be infected.

Other men attributed their own personal characteristics to their reduced risk for seroconversion. Michael knows peers who have been infected through injection drug use, and because he does not engage in this specific behavior, believes himself to be at lower risk despite his barebacking behaviors. Lastly, John, who feels “spiritually connected to God,” does not believe his sexual activity is putting him at risk. “I don't think God's plan is for me to die of HIV.”

The Role of HIV Testing

Half of the men ($n = 6$, 50%) elaborated on the role that HIV testing played in their sexual decision making or general anxiety about HIV/AIDS. Both Chris and Rick used HIV testing and serostatus disclosure to determine with whom they barebacked. Chris used “November test results” to prove seroconcordance with his partner so that they could engage in condomless sex in December. Rick, whose partner seroconverted during the course of the relationship despite previously testing negative, still used his own “negative” test result to legitimize future barebacking behavior. Paris describes his anxiety around testing and waiting for results, echoed by other men:

The negative consequences the next day or right after... the worry, the wait for the test. It's like, you know, fear. Tremendous fear... you just feel that fear until the tests come back negative and it's like “Wow.” You breathe a sigh of relief. “I got lucky one more time.” I mean sometimes, I think this is going to be the death of me.

For these men, testing negative for HIV antibodies acted as an enabler for their barebacking. They described continuing through a cycle of risk behavior, anxiety about testing, receiving a negative result, and relapsing into risk behavior.

Acquiescing Responsibility for Safer Sex

When discussing the details of their sexual behaviors, the majority of participants (83%, $n = 10$) stated they did not actively seek to have unsafe sex. Instead, barebacking “just happens.” Generally for the participants, protected sex and disclosure of serostatus occurred only if

initiated by the partner. Many of the men in this group did not take the initiative to discuss or decide upon condom usage or serostatus, leaving the level of risk in the hands of their partners. Derek (Black, 28 years-old) explains:

Sometimes it [barebacking] is discussed, but most of the time, you just want to get in there and have sex...you throw caution to the wind A lot of times though, most people won't forget the condoms...It's like, okay, you are hot and horny, and I am hot and horny. Let's go do this!

If a potential partner prefers condoms, however, a condom is used, suggesting that all ($n = 12$, 100%) of our participants are, at the very least, influenced by their sexual partners on the level of safety or risk they take. For Jack, his sexual experience began with his godfather, who never used condom when they had sex, "And it's just been like that ever since. Yet, anybody I have sex with, if it bothers them, I wear a condom."

Defaulting to partners' wishes as Jack does is a common theme in the participant narratives. Four of the men in our study (33%) almost always forgo their own health for the sake of their partners. Simply stated by David, "I just want to please them." Ensuring the pleasure of their counterparts is an important criterion for determining the level of intimacy during the sexual encounter as well as their assessment of their own performance. So much so, that they are willing to bareback, even if they feel "violated" as Anthony stated, or "like a whore," as David expressed. David placed no blame on his partner, because he "should have taken responsibility and said, 'No.'" He continues deferring to "cute, young" guys, however; suggesting the need to please his partners and barebacking is an ever present dilemma for him.

After three months of "badgering" from his boyfriend, Chris began barebacking. A few months later, Chris barebacked when they included a third person, again at his boyfriend's wish:

We drug [sic] someone home from there [the party] and they [boyfriend and third person] insisted I take my condom off, and I'm like, 'Okay fine, your choice.'"

Half of the participants ($n = 6$) described situations where responsibility was clearly stated that the beginning of their stories, which was then dismissed as the encounter was further described. Statements such as "I usually ask" or "I usually wear a condom" began the conversation, but as specific stories and actual events were told, the theme of deferring to partners arose. Rick, for example, searches for partners online, selecting only those who use condoms. Once face-to-face, both typically forgo the condom:

It's like some people would say that they don't do it [bareback], but it's like the opposite or whatever. The people [sic] who says they don't do it is like the ones that I do, like, go after, and then eventually, you know, one thing leads to another and you just, like, okay, forget about it. Let's just do it.

Most ($n = 8$, 66%) of the participants were also unlikely to question their partners' serostatus. For example, Chris's current boyfriend did not feel comfortable asking about his partner's serostatus because, "It seemed like a mood killer."

Mental Health Issues

Many of the participants in our sample reported experiencing symptoms of depression, including profound sadness, low perceptions of self-worth, and feelings of isolation and loneliness. In total, 42% ($n = 5$) reporting these feelings, and two men even reported previous suicidal ideation. David, for example, described his current emotional state as "just generally depressed...everything that I have ever done has been wrong." He acknowledged his "lack of self-confidence," and similar thoughts were reported by 33% ($n = 4$) of the men in our sample.

Some men described negative feelings about themselves specifically related to their sexual identities which, often in combination with reduced self-esteem, contributed to feelings of isolation and loneliness. In fact, 67% ($n = 8$) of these participants reported feeling disconnected in some way from others. As Jack explained, "I just feel like a lot of groups I don't fit into, so I don't even hang out anymore...I feel like I'm an outcast or something." Similarly, David said, "I have always been an outsider," and Peter, when asked if he experienced feelings of isolation as an adult as he did as a child, reported "Oh, I mean, yeah, it's still tough. I mean, I guess the difference is you kind of expect it out of like, adults that you ain't gonna make friends, you know what I'm saying." Paris also described feeling alone. "You know, 'cause everybody else isn't with me you know. Everybody else doesn't have to lay there and stare at the ceiling and you know go through the things that I go through." For Joseph, these feelings stemmed in part from his inability to reveal his sexual orientation to others:

...It's a secret, nobody knows...I feel that I have to [keep it a secret] cause I don't want nobody--I feel that if I tell anybody that they're not gonna like me or they're gonna like not hang out with me no more.

Paris expressed similar feelings:

I'm bisexual, but it's like I'm still not even comfortable with it yet you know. I can't tell people about it...I feel like um I don't know it's sinful, it's lustful, it's wrong, um it's just like completely opposite from like what I'm supposed to be using and putting forth, you know...

Other men described decreased self-esteem related to feelings of sexual inadequacy. As Jack explained:

I remember going to the baths a few times out here in New York. And like, people just walking by me, whatever. My dick wasn't really that big for them, like it wasn't big enough. My ass wasn't tight enough, whatever. It's not like it was a sexual thing, but it's really uncomfortable when you go there and you can't even find a piece of ass or whatever.

Reports of difficulty coping with and expressing these negative emotions and thoughts were common among these men. For example, Anthony described feeling unable to express himself to others, and of lacking psychological and emotional support:

I was so angry and I had so many things bottled up inside that I had no way of expressing it. There was no counseling. Where were the guidance counselors? Who knows? At school?

Paris also described his inability to effectively cope with his emotional struggles, and the some of the resulting behavioral effects:

Yeah, I never really I never really like had somebody to talk to, and all of that, you know. like somebody, except for my best friend, and there was some things I couldn't tell him, you know, 'cause I didn't think he'd understand. And it was like I don't know sometimes it was I don't know, I just keep it inside and you know. I think about it. I cry about it, um I break things, you know...

Many of these men reported that barebacking sometimes functioned as either an embodiment of or a treatment for these mental health symptoms. For example, David stated:

"I maybe, just wanting to be accepted and I was willing to do whatever, you know, just to have someone notice me or whatever, so I was willing to do it without a condom."

Barebacking was often described as a means of combating feelings of isolation and loneliness. In total, 58% ($n = 7$) of the participants in this sample indicated that having sex without a

condom was more intimate than engaging in protected sex. This was especially true within a committed relationship. Rick provided the following explanation:

I would say, it's like, it does make it more intimate. If you ain't in a relationship with somebody, it is actually more intimate that having sex with a condom if you're not with somebody, but even so if you are in a relationship with somebody, it makes it even more intense because it's like, um you fucking this person without a condom and them and then you cumming inside of them so it's like, it's kind of like, it's a more intimate thing going on.

Within a relationship, barebacking was seen to provide a means by which to show love and affection, and to infuse more meaning into the sexual experience. Louis (White/Latino, 25 years-old) described it as follows:

...A matter of love, but I think it's very different if you do it with your partner than if you do it randomly 'cause people that do it randomly, I think they're impulsed by sexual feeling. I mean, how it feels... the cock's skin feels against your ass's skin, I think that is what you're triggered by, but when you are in a relationship it's about trust and um it's sort of by love, that's it.

Peter also described barebacking within a relationship as “meaningful...I mean it's best when you're with somebody.” Anthony further explained the sense of physical connection obtained while barebacking. “Intimacy, just feeling, you know, being able to love, or being with your partner, like experi-, you know exploring the insides of each other and shooting your love juice all up in there.” As Louis said, “You're, like, kind of fucking the real thing.”

So, while barebacking was described as a means of increasing intimacy between partners, engaging in protected sex also functioned as a method of preventing a deeper connection. Peter understood the intimacy as follows:

It seems that, you know, with condoms, you know, there's still...you could still like maintain, you know, this level of respect and it could still feel good and everything. But, you know that, you know at least I know that there's something like keeping us from being intimate with each other.

While these men evidenced certain struggles with mental health issues, there was also a theme of sensation seeking and a tendency toward risk-taking. For some of the men, this took the form of sexual adventurism. Chris explained, “I like bondage and kinky sex you know. Normal butt fucks are boring.” Louis also reported that “uninhibited” sexual behaviors brought him the most pleasure. “Like somebody who's not afraid to take...I wouldn't say risks, but who's not afraid of like exploring other stuff.” Peter described an “adventure element” that he enjoys in general in his life. Further, Michael specifically described the connection between risk-taking and barebacking. “I just know that I enjoy sex better and sometimes to me I like taking risks.”

DISCUSSION

In this analysis we examined facilitators of sexual risk-taking among young adult gay and bisexual HIV-negative men who identified as barebackers. As expected from our sampling criteria, all of the participants in our sample reported using drugs and alcohol, and specifically reported barebacking while under the influence of substances including cocaine, ecstasy (MDMA), methamphetamine, ketamine, GHB and marijuana. This association between drugs and sexual risk-taking is well supported by previous research (Halkitis, Fischgrund & Parsons, 2005; Halkitis et al., 2003; Halkitis et al., 2001; Gorman et al., 2004). Further, Halkitis et al. (2005) found that men who identify as barebackers are more likely to use drugs in general, and specifically during sexual encounters, than men who do not identify as barebackers.

The men whose narratives we analyzed described several key reasons for their substance use that have also been reported in previous research, including the desire to escape from unpleasant realities and enhance sexual experiences (Halkitis et al., 2005; Halkitis et al., 2003; Halkitis et al., 2001; Palamar & Halkitis, 2006). They also reported that drugs and alcohol diminished their inhibitions and reduced their judgment and reasoning abilities, facilitating sexual experiences, including unprotected anal intercourse, in which they would not normally have participated (Halkitis et al., 2005; Gorman et al., 2004; Wilton et al., 2005). Notably, these men acknowledged the risks associated with their substance use, and reported concern for their safety because of the increased likelihood that they will bareback while high.

Many of the men in our sample reported mental health issues, including depression, low self-esteem and feelings of isolation and loneliness, and described barebacking as a either representative of or a treatment for these emotional symptoms. Previous research has also indicated an association between depression and low self-esteem and barebacking (Halkitis & Wilton, 2005; Odets, 1994; Shidlo, Yi & Dalit, 2005; Preston, D'Augelli, Kassab, Cain, Schulze & Starks, 2004). Especially salient for these men was the use of barebacking to alleviate painful feelings of isolation and loneliness, particularly as a means of achieving intimacy and emotional connectedness with sexual partners. This function of sex, and barebacking specifically, is also supported by prior research (Halkitis & Wilton, 2005; Wilton et al., 2005; Halkitis et al. 2003). Barebacking also functioned as an outlet for sensation seeking and risk-taking in some of these men, who saw sex without condoms as a form of sexual adventurism, a connection that has also been previously reported (Halkitis & Parsons, 2003; Bancroft, Janssen, Strong, Carnes, Vukadinovic & Long, 2003).

The men also detailed the ways they attempted to rationalize their decisions regarding risk-taking. They reported using heuristics based on their partner's physical characteristics, including overall bodily appearance and age. Several of the participants felt that younger partners were less likely to be HIV-positive and therefore safer to bareback with. Additionally, some of men felt that they could determine their partners' serostatus based on his mannerisms, prior acquaintance with the partner, or simply trusting their own "instinct." Previous research on sexual risk-taking has focused on gay and bisexual men's beliefs about their own physiological or spiritual resistance to HIV infection (Halkitis, Zade, Shrem, & Marmor, 2004); however, these men appeared to project beliefs about non-infectivity onto their partners. Additionally, all of these heuristics replaced any form of serostatus disclosure.

Despite the fact that viral load is extremely high after initial infection during which time antibodies are not easily detected (Jacquez, Koopman Simon, & Longini, 1994; Koopman, Jacquez, Welch, Simon, Foxman, & Pollock, 1997), several of the men detailed using HIV antibody testing as a way of affirming their ability to continue taking risks. These men experienced cycles of fear of testing HIV-positive, actually testing HIV-negative, and resuming risky behaviors.

All of our participants deferred to their partners' requests during sexual acts, including deciding whether to bareback or use condoms. Barebacking has commonly been defined as "intentional" unprotected sex (Halkitis, Wilton, & Drescher, 2005), yet through our study we found that most of the self-identifying barebackers do not intentionally plan to bareback. Instead, "it just happens," as supported in previous work in which the intention varies amongst barebacking individuals (Halkitis, Wilton, & Galatowitsch, 2005). Only two participants claimed to actively seek unprotected sex, and even they used condoms when preferred by the partner. Notably, all of the men were strongly influenced by their sexual partners, especially during the interaction, reminding us again that prevention efforts focusing on education alone will not suffice.

The study participants were willing to continue intentional risk-taking behavior despite clear knowledge or personal experience of the possible consequences, ranging from HIV infection to exposure to other sexually transmitted infections, such as Chlamydia or gonorrhea. They often expressed a desire to change their behaviors despite a seeming inability (as demonstrated by continued risk-taking) to implement safer sex practices, such as serostatus disclosure or condom use. Consistent with previous research (Crossley, 2004; Ridge, 2004; Adam, Husbands, Murray, & Maxwell, 2005), this lends credence to the notion that sexual risk-taking is a complex behavioral phenomenon, and prevention efforts formulated on basic education are overly reductive and mostly ineffective in addressing barebacking in particular.

Limitations

First and foremost, we acknowledge that our analytic sample of 12 men was drawn from a recruited sample of 102 high-risk gay and bisexual men. Specifically, we recruited men who were self-identified barebackers and club drug users; thus, while this represents a segment of the population it certainly is not representative of the totality of the gay and bisexual male community. An abundance of gay and bisexual men do not identify in these manners, and moreover develop adaptive behaviors in young adulthood. Thus, generalizations to gay populations are highly cautioned. The risk bases and associated maladaptive behaviors described in our sample of 12 men are likely very specific to a subset of gay culture. Secondly, our focus was on young gay men, those in emergent adulthood, and specifically ages 20 to 29. As historical and societal shifts have had profound effects on the gay community as a whole, it is important to note that these men were born between the mid-1970's and mid-1980's and were not sexually active as self-identified adult gay men until after the initial explosion of AIDS in the early 1980's. It is in this historical context that their behavior should be considered, and thus contrasted to those men who were sexually active either before the initial stages of gay liberation in the early 1970's (the "pre-Stonewall Generation") or slightly thereafter in what some have coined the "AIDS Generation." Finally, we chose to analyze the interviews of only 12 of the 23 men ages 20 to 29. While our coding and analysis led to saturation in themes, we nonetheless expect that perhaps other risk bases were excluded because they were not evident in the interviews we considered. However, our random selection of more than 50% of the sample in this age range and stratification by race/ethnicity does provide some assurance that at minimum the most salient themes emerged.

Conclusions

The term barebacking is one that has appeared frequently in the HIV literature in the last several years. Despite efforts to fully understand what this construct actually means, much of the research has yielded estimates, albeit inconsistent ones, about the prevalence of this behavior, and offered limited explanations for what motivates young HIV uninfected gay and bisexual men to engage in high risk behavior, in this the third decade of AIDS. What becomes apparent in our analyses is that sound cognitive reasoning are insufficient in explaining sexual risk-taking, despite the fact that a multitude of social cognitive models base their explanations of risk behaviors on thought processes and rationale decision making. What is apparent in the narratives that we considered is that misinformation may be a factor in the sexual risk-taking behaviors of young HIV-negative men, but moreover, that deeper intrapsychic processes, including low levels of self-esteem, elevated levels of depression, as well as other emotions (often heightened by concurrent substance use), and the desire to please sexual partners may drive the decision making of these men which may some eventually lead to HIV seroconversion.

To this end, intervention strategies need to also delve more thoroughly into these realities and empower young men to seek support for the states that drive their risks—both sexual and drug using. Solutions for these risk behaviors must be addressed beyond the behaviors themselves

and with regard to the facilitators that exacerbate the taking of risks. The results of our investigation suggest that prevention and intervention programs that are multi-faceted and address the psychological, emotional and behavioral aspects of barebacking, in addition to educating individuals about the mechanics of disease transmission and safer sex practices, will have an increased potential for effecting change in the lives of individuals who continue to put themselves at risk for HIV through unprotected sex. Programs that screen for and address mental health issues and substance use are imperative, as some men seem to be using barebacking as a way of coping with difficult emotional and psychological issues. Further, programs which help men develop both motivations and skills (e.g., partner negotiation) to stay HIV-negative may help prevent seroconversion in the interim of mental health treatment. Additional focus placed on the individual's self-esteem and awareness (Shernoff, 2005), along with tools to help men communicate with sexual partners, may also help men keep unprotected sex from "just happening."

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