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Inner Contradictions Among Men Who Bareback

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Abstract

“Barebacking,” or intentional unprotected anal intercourse when HIV transmission can occur, emerged as a descriptive term in the 1990s and marked greater acceptance by gay and bisexual men of dispensing with condom use under certain circumstances. In an exploratory study of men who used Internet sites to meet partners and who reported recent episodes of barebacking, respondents outlined numerous strategies they deployed to avoid HIV infection instead of universal condom use. However, in interviews many participants acknowledged uneasiness with the flaws in their chosen strategies and the contradiction between their urgent desire to remain HIV-free and their sexual practices. For some, the dissonance between the conflicting cognitions could be resolved through self-justification, mental compartmentalization, or invincibility beliefs so that barebacking can continue. For this sub-population continued reiteration of cognitive-based prevention messages have the potential to reinforce rather than undermine their attachment to inadequate strategies for disease avoidance.

Keywords

sexuality; gays and lesbians; HIV/AIDS; cognition; Internet

“Ordinary life is full of contradictions; ordinary people are used to accommodating them.”

(Coetzee, 2007, p. 18).

The popularization of the term *barebacking*, defined as intentional condomless anal intercourse when risk of HIV transmission is present (Berg, 2009; Carballo-Diéguez, 2001; Carballo-Diéguez et al., 2009; Suarez & Miller, 2001), signaled an important change in the conceptualization of sexual risk for gay and bisexual men. Instead of incidents caused by condom inaccessibility, poor planning, sexual excitement, or other accidents, the new coining implied that at least some men were declaring a conscious choice rather than experiencing “slippage” from intended precautions or relapse into disavowed behavior, terms that indicated momentary displacement of widely accepted norms. The adoption of the term *barebacking* and its incorporation into Web sites and dating profiles suggested a paradigm shift in sexual risk-taking (Berg, 2009; Van de Ven et al., 2002) and broader acceptance of different approaches to disease avoidance (Morin et al., 2003) in which condoms were merely one prevention tool among many, and sexual risk was no longer to be strictly avoided, such as in the earlier “use a condom every time” campaigns (Suarez & Miller, 2001).

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The barebacking coining and controversy occurred as unprotected anal intercourse (UAI) was increasing among HIV-negative gay and bisexual male populations in North America and Europe (Crepaz et al., 2009) while HIV infection rates ended their gradual decline and began to edge upward (Centers for Disease Control and Prevention, 2011; Grulich & Kaldor, 2008; Sullivan et al., 2009). Some saw the reversal in the downward trends achieved in both UAI and HIV incidence as the lamentable end of an extraordinarily successful public health intervention—safe sex among gay men, based on an explicit, community-wide shift of sexual habits (Becker & Joseph, 1988; Dowsett & McInnes, 1996).

The initial dismay in the public health community over gay men openly disputing safer-sex guidelines despite the devastation wreaked by HIV obscured the continuity between the “invention” of safe sex (Patton, 1990) in the 1980s and its multiple reinventions from the onset of the AIDS epidemic into its third decade. In the first years of the HIV outbreak, many men feared that the new disease might lead to a reaction more deeply stigmatizing homosexual practices and were thus favorably disposed to accept and adopt the guidance emerging from the new AIDS information and advocacy groups as trustworthy, gay-friendly advice (Junge, 2002; Shilts, 1987).

Sheon and Crosby (2004) argued that safer sex became normative largely because it was seen as a “temporary inconvenience” (p. 2106) based on the broadly shared hopes—encouraged by official pronouncements—that either a cure or a vaccine would soon arrive (Markel, 2005). As this did not occur and safer sex became institutionalized, condomized intercourse gradually evolved into the presumed standard for homosexual intimacy (whether or not it was consistently observed in practice), with unprotected sex treated as a distortion of it, except for some monogamous couples (Suarez & Miller, 2001).

Nevertheless, as HIV became a permanent feature of the sexual environment, more explicit challenges to the presumed desirability or feasibility of universal condom use inevitably occurred, sometimes described as a backlash against relentless condom promotion (Wolitski, 2005). Thus, some ambiguity and even contradiction emerging from men’s decisions about barebacking should not be surprising given the need to avoid infection and to balance caution with sexual satisfaction over several decades. Like their heterosexual peers, many gay and other men who have sex with men (MSM) gauged how much risk was in fact really risky, and some continued to engage in UAI with male partners despite the knowledge that condoms provide an effective barrier against HIV infection (Dukers et al., 2002; Halkitis, Parsons, & Wilton, 2003).

As HIV/AIDS evolved into a permanent feature of gay life, adjustments to the 100% condom rule began to emerge. Monogamous partners sometimes relied on “negotiated safety”, i.e., sexual exclusivity sometimes modified to permit condom-protected sex with third parties (Crawford, Rodden, Kippax, & Van de Ven, 2001; Guzman et al., 2005). Other risk-reduction approaches included “dipping” (Hoff et al., 2004), “strategic positioning” (Van de Ven et al., 2002), and “serosorting” (Jin et al., 2009). Unfortunately, the new prevention techniques did not keep incidence rates down (Katz et al., 2002). Given the continuing high prevalence of HIV infection among urban gay populations (Centers for Disease Control and Prevention, 2010) and the risk involved in barebacking, the practice has generated a number of attempts at explanation.

One early interpretation merged barebacking with another phenomenon colloquially termed “bug-chasing” or seeking to become HIV-infected as an act of rebellion, of control over the infection event, or as a ritualized pursuit of group membership (Dean, 2009; Gauthier & Forsyth, 1999). However, most researchers report that the vast majority of men who bareback wish to avoid HIV infection and are far from indifferent to this possible outcome

(Adam, Husbands, Murray, & Maxwell, 2005; Balan, Carballo-Diéguez, Ventuneac, & Remien, 2009; Davis, Hart, Bolding, Sherr, & Elford, 2002; Ridge, 2004).

In attempting to understand the barebacking phenomenon, researchers have examined the rise of Internet-based sexual networking and its effect on MSM sexual habits (Elford, Bolding, Davis, Sherr, & Hart, 2007; Grov, 2006; Ross, Rosser, McCurdy, & Feldman, 2007). Similarly, the availability of successful clinical treatments that check viral replication and reduce morbidity could affect concern about HIV infection (Adam et al., 2005; Brennan et al., 2010; Sullivan, Drake, & Sanchez, 2007; Vanable et al., 2000). On the individual level, researchers have found correlations between barebacking and HIV-positive status (Mansergh et al., 2002), crystal methamphetamine consumption or heavy drinking prior to or during sex (Halkitis & Parsons, 2003; Mansergh et al., 2002), and Internet use for sexual contacts (Berg, 2008). Other factors have also been linked to barebacking such as sexual sensation-seeking (Berg, 2008; Halkitis & Parsons, 2003), defining masculinity through sex (Halkitis & Parsons, 2003), and romantic obsession (Grov et al., 2007), as well as the impact of social vulnerabilities such as racism, loneliness, and homophobia (Bauermeister, Carballo-Diéguez, Ventuneac, & Dolezal, 2009).

Despite these varying explanations that incorporate a range of non-rational influences, prevention strategies and interventions still tend to rely on cognitive behavioral change models that emphasize the role of motivations, skills, and intentions and focus on an individual's progression from lower to higher states of readiness and capacity to carry out the desired behavior. However, amid the data on motivations, influences, strategies, and beliefs about barebacking among those who practice it, little attention has been paid to how men understand the tension between their expressed desire to avoid HIV infection and engaging in a behavior that could cause it. We addressed this issue in the present study and sought insights into the explanations proffered by men who bareback for the inner contradictions that they sometimes manifested and even acknowledged.

Well before the public debate around barebacking, Gerrard, Gibbons, and Bushman (1996) questioned the "motivational hypothesis" underlying many health behavior models utilized in the HIV prevention field, i.e., that perceived vulnerability motivates subsequent precautions. They observed that evidence for this link was often found in activities such as vaccinations and preventive screenings and argued that HIV-related risk might operate differently because of the emotions associated with sex, the impact of sexual arousal on decision-making, low infection probability per act, and the disease's long latency period. In addition, they surmised that individuals' estimates of their relative vulnerability to HIV infection might not motivate but rather reflect their risk and precautionary sexual behaviors, at least for high-risk populations.

To gain an understanding of how the desire to avoid HIV infection coexisted with awareness that one's sexual practices opened the door to this outcome, we examined interviews of men who had been recruited for a study on the barebacking phenomenon to see how they explained and characterized their actions. We found that Festinger's cognitive dissonance theory (1957) was a useful framework to organize some of our findings. Festinger posited that conflicting cognitions about beliefs and behaviors (e.g., "I want to remain HIV-negative"; "I am engaging in risk that could result in HIV infection") produce discomfort and motivate individuals to resolve the tension by bringing the two cognitions into agreement, "especially if this action threatens the individuals' self-concept of being a decent or rational person" (Aronson 1999, p. 876). Festinger categorized the mechanisms used to bring about this resolution as denial, distortion, and self-justification. When individuals want to continue the behaviors or find them difficult to change, they are stimulated to modify their beliefs or to incorporate new beliefs to reduce the dissonance and restore consistency.

In a similar vein Gold and Rosenthal (1998) postulated that thought processes about AIDS that occur during sexual encounters differ in important ways from thinking that occurs “in the cold light of day” (p. 208). They characterized this dichotomy as the difference between “online” and “offline” cognitions and used this Internet metaphor to argue that cognitive shortcuts are more likely to occur during the sexual encounter (online) than in anticipatory reflections on behavioral intentions or in later explanations of what happened (offline). Both these contributions support our finding that when questioned about barebacking in the research interview, many men who practice it offered a perception of their own risk that fit the behavior engaged in. That is, the barebacking behavior of men in our sample appears to influence their construction of risk-avoidance postures that are consistent with continuing the practice. This is quite different from the assumptions of behavior change models that address perceptions of risk as a precursor to risk modification.

Researchers have used cognitive dissonance theory to address adolescent dating aggression (Schumacher & Slep, 2004), eating disorders (Mitchell, Mazzeo, Rausch, & Cooke, 2007; Stice, Rohde, Gau, & Shaw, 2009), children’s playground safety (Morongiello & Marks, 2008), and online gambling (Chiou & Wan, 2007). The interventions often involve techniques that compel participants to advocate behaviors to third parties that the participants themselves do not practice, thereby leading them to reexamine the behavior and their beliefs about it. In the realm of sexual behavior, researchers studying college students’ risks of unwanted pregnancy despite ample knowledge of risks (O’Sullivan, Udel, Montrose, Antoniello, & Hoffman, 2010) found that students explained the inconsistency between their knowledge and their practices through biased evaluations of risk, dismissal of risk or a focus on poor alternatives—all responses consistent with Festinger’s categories of denial and distortion.

Similarly, Dilley and colleagues (2002) developed a one-hour counseling intervention for gay male patients at a sexually transmitted infections clinic that decreased future episodes of unprotected intercourse by shifting the focus to participants’ justifications rather than the danger of negative outcomes, thereby taking advantage of potential inner contradictions to reframe the behavior. Because nearly all of the barebacking men in our study described strategies to lessen their risk of HIV infection, we explored the possibility that contradictions between their stated desires and their actions were being resolved through the cognitive mechanisms described by Festinger. Although the elaboration could have occurred during the research interview itself, some participants described their precautions as inadequate. How then did they explain their attachment to these strategies? How consistent were they in carrying them out, and how did they explain their failures to do so? Were distortions or self-justifications present in their descriptions as implied by Festinger’s construct?

Methods

For a larger study known as Frontiers in Prevention (FIP) that explored reasons for bareback sex, we identified the six most popular Internet sites used by men in New York City to meet other men interested in this sexual practice (Carballo-Diéguez et al., 2006) and recruited 120 men from these sites for individual, face-to-face interviews. All men approached on the sites were informed of the research immediately upon initial contact. Additional contact depended upon participants agreeing to learn more about the study. Screen names were logged to prevent more than two contact attempts. By study design we sought to oversample HIV-negative men who reported having had unprotected receptive anal intercourse because this practice carries the highest degree of risk for HIV infection. Given the importance of race and ethnicity as social constructs in the United States, we recruited roughly equal numbers of White, African American, Latino, and Asian/Pacific Islander participants. Men

were recruited in 2005–06 who fulfilled the following eligibility criteria: (a) were at least 18 years old; (b) lived in New York City or its environs; (c) reported using the Internet to meet men for sex at least twice per month; (d) self-identified as a “barebacker” or as someone who “practices barebacking”; (e) had intentional, condomless anal intercourse with a man met over the Internet; and (f) had met sexual partners using at least one of the six Web sites we identified. Two active recruiting strategies were utilized: researchers sent instant messages to men on the sites to engage them in live chats about the study and invite them to participate. In addition, we sent emails to men who had posted profiles on the sites used for sexual contacts and allowed users to initiate contact with us via a Web page. (For more information on the sample, see Carballo-Diéguez et al., 2009).

Data for this article were drawn from individual interviews with 89 men (74% of the sample) from each of the four racial/ethnic groups who reported being HIV-negative (see Table I); data from HIV-positive men ($n=31$, 26%) were not included in the analysis as their concerns about barebacking did not include avoidance of primary infection. Among the questions asked during the interviews were: What are your concerns related to sexually transmitted infections and HIV? Do you know of strategies used to reduce one’s risk of getting HIV? What are your feelings regarding what is right or wrong around HIV risk? When do you discuss HIV status with new sex partners? What are your expectations regarding disclosure of HIV status between sexual partners?

Measures

After completing informed consent procedures, participants underwent a face-to-face in-depth interview conducted by one of three clinical psychologists and completed a structured assessment using a computer-assisted self-interview (CASI) with questions about the respondent’s demographic characteristics, HIV status and testing, and sexual behavior in the previous two months. The interviews lasted about two hours, and respondents were compensated with US\$50 for their time. This study was approved by the Institutional Review Board at the New York State Psychiatric Institute.

Analysis

The interviews were audiotaped, transcribed, and verified for accuracy. A six-person team of researchers involved in the design and implementation of the study developed a preliminary codebook based on the interview guide. Each transcript was coded using NVivo qualitative analysis software (QSR International, 2002, 2006) by at least two coders who then resolved discrepancies through consultation.

During the course of the interviews and review of the transcripts, we observed contradictions in some men’s narratives between their wishes to avoid HIV infection and their simultaneous acknowledgement of the risks involved in their barebacking practices. Although some men described pre-set risk calculations and their adherence to them, others offered explanations for their behaviors that were internally inconsistent and sometimes explicitly recognized as such by them. Festinger’s cognitive dissonance theory was not used to guide the interviews, but it provided a framework for a second-level codebook that was created to organize the responses that emerged.

We examined texts coded under “condom use,” “disease prevention strategies,” and “ethics and responsibility.” Subcodes included attitudes toward the gravity of HIV infection; mental compartmentalization isolating risk thoughts from sex; belief in personal immunity to HIV; heuristics utilized by participants to detect whether a partner was HIV-infected (both those believed reliable and those deemed unreliable); and characterizations of sexual sensation as overwhelming. Four researchers independently coded these texts to verify concurrence. We

then identified the most common as well as the full range of responses and selected extracts from the interviews to illustrate both the main themes and the variety of comments obtained.

Results

Some respondents described their adherence to established disease avoidance strategies and stated that they accepted the risks involved as the cost of sexual fulfillment. For example, participants might have relied on HIV-specific knowledge such as the relatively lower risks of insertive versus receptive anal intercourse or the reduced infectiousness of individuals on successful antiretroviral treatments. As one participant stated,

I think, for me personally, I understand the risk as an assertive top not using a condom. You know, I always try to be [inaudible], you know like, not have no cuts or sores or lesions, you know, on my penis.

These individuals felt they were proceeding in a coherent fashion and did not describe or exhibit tension between their beliefs and their behavior.

But a majority did describe a contradiction between their stated strong concern to remain HIV-uninfected and simultaneous awareness that their behavior exposed them to infection. Their ways of dealing with this contradiction can be grouped in four broad categories: (a) self-justification; (b) mental compartmentalization; (c) invincibility beliefs; and (d) acknowledgment/acceptance of the contradiction.

Self-justification

Some participants described intense sexual sensations that overwhelmed their calculations about risk (Carballo-Diéguez et al., 2011). Those who offered this type of explanation simply admitted that they were unable to carry out their prior intentions; however difficult such an acknowledgment might be, the posture permitted the participant to reaffirm the validity of his original intentions without denying or distorting the level of risk involved.

Something happens. You know, you get to a point, it's as if being sexually turned on—you know, they talk about how your judgment is impaired when you're on drugs. I don't need drugs. All I need is to be with a hot guy, and a good deal of my judgment gets put on hold.

An individual acknowledging powerlessness over sexual desire might regret his behavior or dislike the suggestion of weakness, but his explanation for it would remove the need to reconstruct or distort the experience as not really risky. Nonetheless, an element of self-justification often crept into these accounts:

But somewhere after you—after you make the choice [to bareback], you submit to the experience, and you get wrapped up into the experience.... How do you make your way back once you, once you, once you've made that agreement? It's like signing a contract.

The contract metaphor implied an interpersonal dynamic that trumps individual decision-making, suggesting that once the speaker had taken the initial steps towards engaging in bareback sex, he no longer believed himself to be at liberty to place additional limits on the interaction. The common thread through this type of explanation of how barebacking occurs is the acknowledgement that the participant's concerns about HIV acquisition repeatedly are sidetracked or overwhelmed and not just under rare circumstances involving unusual factors. Rather, the men used present tense to indicate a recurrent or habitual situation, an outcome that is almost justified by the forces at play, i.e., in the presence of A, I acknowledge that my behavior is B.

Other participants extrapolated from past successes to fortify their belief that the desired behavior was not, at least in their case, all that risky. Frequently, however, the comments included expressions of doubt about the reliability of the explanation offered.

You know, if you do an enema, then that kind of washes everything around, so, um, [a doctor] said that's not, not always, you know, a sure way to make sure that even if someone does come inside you, to get that out, so, you know [inaudible] risk is still high.

Other participants expressed similar doubts: "Usually if I'm with somebody for the first time, I'll always, always wear a condom.... But I guess it's more of a psychological thing than anything else." "I know that pre-cum has HIV in it too. So you really don't protect somebody by pulling out. But it's kind of a pretense toward that." In addition to recognizing that their approaches—use of enemas, delaying barebacking to a later encounter, selection of partners by physical characteristics and the like—were not entirely reliable, the men often acknowledged that they did not strictly adhere to them in any case.

Interviewer (I): So at the point that you didn't use [condoms], was that, kind of a conscious decision?...

Respondent (R): Mmm, I don't know. I guess that really depended on the person, because sometimes if they're the right person, it was just like, you know what? I don't want to use them with you. Then we'll just be natural.

These descriptions implied that the strategies did not drive or set boundaries to the individuals' risk behavior but might have served to reassure the speakers about the behavior in which they had and would continue to engage.

Compartmentalization

Although some participants described their actions as resulting from weakness, most resisted explanations that implied irrationality, lack of control, or other personal shortcomings. Instead, they often described a process of mental or temporal compartmentalization of the conflicting ideas. Some managed the contradiction by separating the risk from the behavior and addressing the two independently, in effect suspending the contradiction for the duration of the sexual encounter: "[U]sually if I want to be with someone, I think they're already hot. So I'm not even thinking about condom use."

This separation was sometimes expressed as an act of cognitive will: "But there's always the idea that, you know, okay, I'm having sex with someone, and I still don't really know, you know? So, for me, it's about, out of mind, out of sight." At other times, the separation was described in temporal terms.

If someone doesn't put [the condom] on, then I actually get a little more excited, that, oh my god, he's actually going to fuck me without a condom. And at that time, it doesn't really come in my mind that, oh, I should talk to him first if he's negative, or...like, the risks involved, or does he do this often? Like, any of that stuff. I'll say, like, no, no, no, it will just kill the moment. Let's just do all that later.

Whether segregating the two cognitions by postponing one until later or by mentally shoving the intruding idea away, the irreconcilable nature of the two competing positions sometimes would lead to virtually simultaneous contradictions: "I don't always necessarily have unprotected sex on the first time. In fact, I never do. There's been a few times." Or as this participant explained:

Now granted, if, you know, a guy comes, and he fucks me, and I don't have any other previous experience with him, nor do I know whether or not he's taken loads,

then I don't know. So I know I'm at equally high risk, but I don't know that I'm at that risk. Does that make sense?

Others perceived and described the compartmentalization as necessary to separate sex and/or the sexual partner from thoughts of disease and death.

If you're going to [take an HIV test], then let's do it, and then we can enjoy the sex fully, and not during the whole time [be] going, "Am I going to die? Am I going to die?" "Oh this feels good. Is this person positive?" ...Sometimes I just try to push it out [of my mind] so I can enjoy the sex because that's what I'm there for. I'm not there to freak out about my status.

It was, it was kind of like a choice, almost made out of desperation, hoping that through some kind of faith or hope, that I could make the world a place I could be—that wasn't sex-equals-death, that, you know, assume-everyone-is-going-to-kill-you kind of shit that I had been hearing. Because I just didn't want—I mean, I didn't want to touch somebody with that attitude, that they were going to give me a disease.

Invincibility beliefs

A number of respondents expressed confidence in their ability to remain HIV-uninfected based on their success in doing so to date. They described how they estimated the riskiness of a given act with a given partner or type of partner. In other cases they relied on inaccurate information, individual heuristics, intuitions or philosophical beliefs. Often, men described a feeling of invincibility based on their extensive history of sexual risk without acquiring HIV—a "so far, so good" posture as expressed in the following comments: "Either I'm immune, or what I do doesn't expose me to risk." "I mean, I always always tended to go with the gut feeling. With the gut feeling. And in the 25 years I've been on this earth, it has never led me wrong." Or as this participant said:

I don't think I'm going to be able to catch it if I'm just putting my cock in someone's ass raw. That's what I think. That's what I'm thinking.... But I still, in this own little world of mine, this non-reality, I think I'm invincible, you know.

By extrapolating from past success, these men fortified their belief that the desired behavior was not unacceptably risky and could be pursued in the future.

Acknowledgment/acceptance of the contradiction

Some respondents viewed the inconsistency between their intentions and their behavior as insurmountable and simply stated that they were unable to reconcile the two.

I: How big a concern are STIs?

R: They're a huge concern.... And, you know, if I get a disease I can't do anything about, that's fine, but the idea of having HIV or AIDS, something that I could have prevented, you know, that scares me...

I: And how does that jibe with the barebacking?

R: [laughs] Again, this really contradicts itself completely.

Yeah, it's, um, it's an oxymoron. Um, but life is filled with contradictions.... I suppose I'm contradicting myself by saying that I'm super-concerned. I am. Granted, I am very concerned. But then, if I'm so concerned, why do I have unprotected sex? I honestly don't know.

On occasion, respondents who acknowledged the contradiction bluntly described their discomfort in doing so. As Gold and Rosenthal (1998) suggested, questions raised about risks during the research interview (an “offline” moment in their metaphorical taxonomy in contrast to the “online” thought processes that occur during the sexual encounter) frequently generated tension. The following two exchanges are typical of many that took place as respondents explored their decision-making process:

R: You know what? I usually assume everyone is positive. Which makes it seem even more stupid of me to fuck without a condom, but I do it.

I: Does it trouble you?

R: Eh, I tend not to over-process that sort of part.

R: Yeah, it makes me look like a shit for not asking people about their HIV status, doesn't it?

I: Really?

R: I think so.

I: Why?

R: I think in the course of your questioning it makes me feel kind of like, oh you know what? I guess I should be asking more people about their HIV status, but I'm not.

These comments suggested that the participants' sensations associated with contradictory cognitions around risk were unpleasant. The exchanges also highlighted the role of the research interview itself in generating an explanation for behaviors that participants might not have often considered or discussed in other settings.

Some participants described a safety strategy that included barebacking practiced under clearly defined and limited circumstances. For those whose behavior was anticipated in the risk calculation, the kinds of psychological stress reflected in many of the comments above is unlikely to arise. Just as often, however, such calculations described an ideal rather than a lived experience:

So it's not something that you would just do with somebody that you just spoke to online, right, then and there,...But shit like that just happens. It's not like it never happens.... [F]or the most part, I don't push—I don't try to go ahead and do the bareback thing. It happens. It happens more than once or twice.

Discussion

Respondents in the FIP barebacking study were aware of their enhanced risk and also described recapturing the exhilaration and thrill of sex after years of associating it with disease and loss. Some of the men had established safety boundaries that might include barebacking and accepted the estimated risks; many others acknowledged that their prevention strategies were not entirely reliable and/or that they did not practice them consistently. When asked to explain this contradiction, their replies varied: some described their inability to carry out a protective strategy; others manifested a belief in their invincibility based on past experience or compartmentalized the conflict between their concerns and their actions, either temporally or psychically. A few simply recognized the paradox and accepted the associated discomforts.

We found that Cognitive Dissonance theory offered helpful insights to our findings. Festinger (1957) postulated that the uneasy sensation associated with a belief/behavior

contradiction stimulates a movement toward greater consistency either through a change in the contradicted belief or a change in the contradicting behavior. However, amelioration of the dissonant tension does not require that the movement proceed toward reduced risk. Our results suggest that traditional HIV prevention messages involving reiteration of risks can aggravate some men's reliance on compensatory mechanisms in the face of powerful non-rational factors. By reinforcing the focus on reasoned behavior guided by individual choices, such repetitions could intensify, not weaken, their attachment to problematic strategies.

The interventions cited in the introduction suggest that merely increasing awareness of negative consequences is less effective than converting participants into active advocates for a position that is inconsistent with their own conduct. But these successful interventions presuppose a social vehicle through which to engage in advocacy or dialogue with others, and ironically such a vehicle might not be readily available for gay and bisexual men to address HIV-related issues, especially given the pronounced decline in the sort of community-based dialogue and collective invention that brought the concept of safer sex into being in the first place (Dowsett, 1990). In this regard it is striking how often our research volunteers commented that the interviewer's questions provided a rare and welcome opportunity to consider and reflect upon their sexual behaviors, attitudes, and needs.

Where decisions to take precautions once fit within a consciously self-protective community, later departures from the universal condom message like barebacking, serosorting, and other strategies were more individual or dyadic in nature or emerged from sexual networks with at best ambiguous support and often vigorous opposition from public health and gay communities. As opportunities for the shared processing of decisions about sexual risk and satisfaction decline, individuals relying on their own emotional and intellectual resources naturally will seek plausible explanations for their individual behavior. In a social environment emphasizing exclusive personal responsibility, individuals will experience additional pressure to find a credible explanation for his actions if they see these actions as strictly individual choices. It is thus not surprising that the responses generated by questions along the line of, What lies behind your behavior? should evoke the tension predicted by Festinger's theory. Indeed, the paucity of dialogue on sexual intimacy and HIV risk within an identifiable gay community could intensify the dissonant tension among individuals struggling to achieve sexual and relational satisfaction, preserve their health, and sustain a positive concept of self, all while aware that they are interacting with a population in which one in five of their peers is likely to be HIV-positive (Centers for Disease Control and Prevention, 2010).

Limitations

The study was based on a sample restricted to the New York City area comprised of men who reported engaging in bareback sex and having sought a partner via the Internet for bareback sex in the preceding two months. While this procedure excluded participants who practiced unprotected anal intercourse in other contexts, we were not seeking to estimate the prevalence of these beliefs or cognitive strategies. Rather, we sought to shed light on the attitudes and beliefs associated with barebacking, and our relatively large, multi-ethnic sample provided a broad range of relevant experiences.

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Table I**Demographic & Behavioral Information**

n = 89		
	M (SD)	Range
Age (in years)	32.03 (9.83)	18–63
Annual income (in dollars)	30,594 (25,034)	0–100,000
Sexual behavior in the prior two months		
URAI ¹ occasions	5.37 (6.09)	0–30
No. partners with whom practiced URAI	4.30 (4.97)	1–30
UIAI ² occasions	7.72 (10.91)	0–54
No. partners with whom practiced UIAI	6.23 (7.87)	1–40
	n	%
Education level ³		
Partial high school	4	4.5
High school graduate	11	12.4
Partial college	32	36.0
College graduate	40	44.9
Ethnicity/Race		
African-American	19	21.3
Asian/Pacific Islander	16	18.0
White	24	27.0
Hispanic/Latino	22	24.7
Other	8	8.9
Employment status ⁴		
Employed full-time	48	53.9
Employed part-time	22	24.7
Student (full-time)	17	19.1
Unemployed/disability	9	10.1

¹URAI = unprotected receptive anal intercourse

²UIAI = unprotected insertive anal intercourse

³Two participants did not respond to this question.

⁴Totals are greater than 100% because some reported both student and employment status.