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The ethics of barebacking: Implications of gay men's concepts of right and wrong in the context of HIV

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Introduction

Recent compelling evidence that HIV-positive persons on successful antiretroviral treatment are much less likely than those not virally suppressed to infect their heterosexual partners (Cohen et al., 2011; Das et al., 2010; National Institute of Allergy and Infectious Diseases, NIAID, 2011) has changed the implications of condomless intercourse and, by extension, the ethical context of “barebacking” that roiled gay communities in heated debate a decade ago. The so-called “Swiss statement” (Vernazza et al., 2008)—that successful viral suppression is tantamount to eliminating infection risk—and new evidence that HIV-negative men taking prophylactic medication prior to exposure to HIV (“PreP”) also can reduce transmission risk (Grant et al., 2010) both reflect a new set of conditions for partners with unknown or discordant HIV serology in the negotiation of their sexual practices. Because prevention messages need to be updated to remain coherent with changed conditions as both HIV-positive and -negative men acquire new options to avoid transmission, previous assumptions about ethical implications of barebacking are likely to be revisited.

Nonetheless, as long as HIV transmission is even hypothetically possible, ethical considerations about personal and shared responsibilities toward risk remain relevant. The present study investigates the issues, concerns, and beliefs of men who engage in barebacking within the notion of sexual ethics even though the men themselves may not have framed these issues, concerns and beliefs as “ethical” or as a personal, operational, ethical system. We believe ethical considerations are complex in this case in that they involve what sexual partners *surmise*, what they *ask*, what they *reveal*, and what they *do* in the sexual encounter. Although people do not strictly and consistently act upon their beliefs

about what is ethically correct, a strong belief in one's responsibility to prevent HIV transmission is associated with reduced sexual risk behavior (O'Leary & Wolitski, 2009). Altruistic appeals including implied ethical components formed part of safer-sex messages from the earliest days of the HIV epidemic [authors] and continue to be utilized today (hivstopswithme.org, 2012). We revisited how gay men conceptualize their own and others' responsibilities in risky sexual encounters by reviewing qualitative data from a large sample of men who reported "barebacking" behavior or described themselves as "barebackers."

In this paper we operationalize "barebacking" as intentional unprotected anal intercourse in an HIV-risk context (authors) to underscore the differences in ethical considerations when participants cannot rule out the possibility of disease transmission. From its earliest coining in the 1990s to the present day, the practice of barebacking has provoked a pronounced split among proponents, critics and others uncertain what to make of it (see Halperin, 2007). At the heart of the debate was critics' objection to barebacking on ethical grounds—the violation of safer-sex guidelines previously embedded in the early HIV prevention campaigns (Gendin, 1999). Given the shift in HIV prevention focus from HIV-negative men to a much greater perceived role for the HIV-positive partner (O'Leary & Wolitski, 2009), the nature and function of these guidelines are increasingly relevant. This is particularly true given the resurgence of criminal prosecutions of men for engaging in the practice or, in more extreme cases, for failing to disclose their HIV status even when barebacking did not occur (Center for HIV Law & Policy, 2012; Mykhalovskiy, 2011).

Earlier studies have looked at the habits and motivations of HIV-positive men with male partners with respect to disclosure of their infection before sex (Denning & Campsmith, 2005; Gorbach et al., 2004; Marks & Crepaz, 2001; O'Leary & Wolitski, 2009; Wolitski et al., 2007). One study found that learning of one's HIV infection status leads at least to a short-term reduction in sexual risk (Marks, Crepaz, Sennerfitt, & Walton, 2005) while others found harm-reduction strategies employed by HIV-positive men with sexual partners of a different or unknown HIV status (Parsons, Halkitis, Wolitski, Gomez, & Seropositive Urban Men's Study, 2003; van de Ven et al., 2002).

Wolitski and colleagues (2007) identified four categories of how HIV status might influence sexual behavior by distinguishing whether high or low importance was assigned by the HIV-positive respondent to two separate constructs of responsibility for safe action, i.e., "perceived own" and "perceived partner's" responsibility. Van Kesteren and colleagues (2005) identified three ethical postures among HIV-positive men in the Netherlands: their own absolute or exclusive responsibility; shared responsibility with partners; and no responsibility. However, they found that these positions did not always coincide with actual behavior. Our study attempted to explore the range of participants' ideas about own and partner responsibilities and whether these competing views were congruent or incongruent with our respondents' descriptions of their sexual encounters. Furthermore, while previous studies have examined the ethical stance of HIV-positive men, the ethics of barebacking cannot be understood by examining their beliefs and practices in isolation from those of their partners, some of whom are HIV-negative or uncertain of their status. The present study adds this important perspective. [

Defining what constitutes ethical action in the context of public health is frequently a battleground for competing visions of personal and collective responsibility. Public smoking bans, playground safety rules, mandatory vaccination prior to school enrollment, seat-belt and motorcycle helmet laws, forced tuberculosis treatment, access to sugary drinks, etc.—such topics typically stir deep feelings about how autonomy in the private sphere should be balanced by the needs of the public good. When ethics are applied to the sexual realm, a

further complication is added given the highly contested issues of individual choice and social approval or disapproval of specific sexual behaviors.

Caregivers or educators seeking to resuscitate communication within gay communities about risk in a spirit of collective protection and reciprocal responsibility can benefit from understanding how barebacking men's ethical assumptions operate, especially if their beliefs are ambiguous, unconscious or contradictory or if underlying disagreements among them are irreconcilable. Our study sought to untangle these concepts in an urban setting in the U.S. We sought to discover if men who bareback believe their practice entails a sense of responsibility to self and/or partners; if these beliefs are different for HIV-positive and -negative men; and how these beliefs were consistent (or inconsistent) with their reported actions. Finally, although the present study describes a U.S. population, issues of disclosure and risky sex among homosexually active men are of worldwide concern. Findings from a recent study indicate that barebacking among HIV-positive Asian men is more common and status disclosure less frequent than among comparable U.S. populations (Wei, Lim, Guadamuz, & Koe, 2011). Our findings and their framing within a context of ethics can contribute to discussions of the beliefs and motivations of a wide range of homosexually active men in the context of persistently high HIV incidence in this population worldwide.

Related findings from this study were reported earlier and include discussions of whether "barebacking" itself was a useful construct, an analysis of barebacking Web sites, social and psychological vulnerabilities as motivators for barebacking, and a number of other issues [authors].

Methodology

Participants

For a larger study on barebacking known as [removed for review], we sought men who used the Internet to meet sexual partners and either described themselves as "barebackers" or had engaged in "bareback sex" with multiple partners met online. Other eligibility criteria were: at least 18 years of age; resident of [removed for review] or environs; reported using the Internet to meet men for sex at least twice per month; and reported intentional, condomless anal intercourse with a man met over the Internet. We identified the six most popular Internet sites used by men in [removed for review] to meet other men interested in this sexual practice and recruited 120 men from these sites for individual, face-to-face interviews (for details on site selection and characteristics, see (authors). Self-reported HIV-negative men were oversampled because our interest lay in exploring how these men understood and described their behavior given the risk of HIV infection associated with it. (A few men had never been tested and are included in the HIV-negative category for purposes of this discussion.) Recruitment goals were to obtain adequate representation from the four main U.S. ethnic/racial groups in the [removed for review] area (Caucasian, African American, Latino, and Asian/Pacific Islander), rather than data saturation. Two active recruiting strategies were utilized: instant messages were sent to men on the sites to engage them in live chats about the study and invite them to participate; we also created a study profile on some sites and sent e-mails to users through its internal messaging system. Recruiters for this study always presented themselves as researchers and included links to the study Web site in their initial contact messages. The research project was approved by the [removed for review] Institutional Review Board. Fieldwork was undertaken between 2005 and 2006.

Assessments

After completing informed consent procedures, participants responded to a structured assessment using a computer-assisted self-interview (CASI) with questions about the

participants' demographic characteristics, HIV status and testing, and sexual behavior in the previous two months. They also underwent face-to-face interviews conducted by one of three clinical psychologists from the research team. Interviewers had lengthy experience in HIV-related work both as clinicians and researchers and adopted a non-judgmental, conversational approach to elicit participants' attitudes, worldviews, and subjective understandings of their behavior in an amicable atmosphere, especially important given the sharp condemnations of barebacking current at the time (2005–2006). The interviews covered a variety of pre-established topics: use of the Internet to meet sexual partners; sexual experiences, including earliest barebacking episodes and subsequent reflection on barebacking and risk practices; understanding of the term “barebacking”; disease prevention strategies; gay community attitudes; and HIV disclosure and partner selection [authors]. Participants were told that their experiences would be elicited without judgment. Interviewers did not engage in structured risk-reduction counseling but were attentive to participants' desires to explore their motivations and their ways of gauging risk and deciding how much risk to run. Interviewers also provided resources for obtaining additional counseling and testing services. The interviews lasted about two hours for which respondents were compensated with US\$50.

One question included in the in-depth interview specifically addressed ethical concerns: “What are your feelings regarding what is right or wrong around HIV risk?” The interviewer later introduced the terms “responsibility” and “ethics” or “ethical” into the conversation if the participant had not already employed them. Further comments were elicited by asking if the respondent saw his sexual milieu as “every man for himself” and whether he assigned greater responsibility to the HIV-positive or the HIV-negative man in the barebacking environment. If the topic of disclosure had not been mentioned, the interviewer raised it by asking, “Overall, what are your expectations regarding disclosure of HIV status between sexual partners?”

Analysis

The interviews were audio-taped, transcribed and verified for accuracy. Six researchers involved in the design and implementation of the study developed a preliminary codebook based on the interview guide. Transcripts were coded using NVivo qualitative data analysis software by two coders who then resolved discrepancies through consultation. We initially reviewed transcripts coded under “ethics and responsibility” and performed thematic analysis, identifying several recurrent themes: responsibilities of HIV-negative versus HIV-positive men; individual versus shared responsibilities; and disclosure issues and communication about HIV serostatus. We developed sub-codes using these themes. As “disclosure” and “serosorting” (i.e., choosing partners with the same HIV serostatus) had been coded separately but were topics that appeared repeatedly in the ethics and responsibility code, we reviewed these codes as well and added new themes to our analysis: openness about serostatus; hostility and rejection; indirect disclosure techniques; and “don't ask/don't tell” strategies. Finally, to explore how broader community attitudes and other underlying assumptions may have further influenced men's understandings of ethical responsibilities, we examined material coded as “bareback community,” “sexual norms,” and “disease prevention strategies.” Additional themes emerged from this analysis: norms of HIV sero-discordancy; the public health focus on preventing HIV transmission versus individual well-being; perceived attitudes among barebackers versus non-barebackers; and attitudes toward the practice within the larger gay community. Finally, we chose quotes to illustrate the main themes identified, including not only the most common attitudes but also their full range, including those that disagreed with or deviated from the more frequently expressed opinions.

Results

Participants were 120 men recruited in the [removed for review] area including roughly equal numbers of Caucasian (n=35), African American (n=28) and Latino (n=31) men with a smaller percentage of Asians/Pacific Islanders (n=17) and some self-described “other” or mixed race men (n=9). They reported frequent unprotected anal intercourse (mean=5.37 receptive occasions and 7.72 insertive occasions in past two months) and an average of 13.6 partners in the last year (median=9). Approximately one quarter (n=31, 26%) were HIV-positive. Six of the remaining 89 had never been tested. In the discussion that follows, quotations for participants include a brief descriptive phrase listing race/ethnicity, age and HIV status to distinguish among participants.

We address the ethical implications of the interview data under the following categories of frequently expressed beliefs: (1) That personal responsibility is part of the sexual encounter; (2) That HIV-positive men bear a greater ethical burden to prevent disease; (3) That HIV-negative men bear a greater ethical burden for self-care; and a final summary category (4), “Easier said than done”—and not easily said.

(1) Personal responsibility is part of the sexual encounter

When asked to consider the ethics of risk and the possibility of HIV transmission taking place as a consequence of their own and others’ behavior, participants overwhelmingly concurred that people do have responsibilities in this area and attempted to describe them. Frequently, their initial response to the question framed the issue in terms of individual rights and the choices made by free, autonomous adults.

Everyone is an individual. And everyone has a right to make an individual consent. And, you know, it is an adult decision that you make. If you know that HIV exists, and you don’t want to use condoms, you don’t want to use any kind of protection, that’s your decision.

[African American, 41, HIV–]

This typical response asserts a personal, rights-based outlook with the caveat that people are also individually responsible for the outcomes resulting from their choices. A two-part formulation of this sort was very common among participants.

And the minute you decide not to [use a condom]—nobody’s forcing you—the minute you decide not to, that’s a personal choice. You made that choice. It has nothing to do with that other person. That’s you.

[African American, 29, HIV–]

Within the range of opinions on what constituted an ethical action, HIV-positive and HIV-negative participants both frequently emphasized the individual nature of the rights and responsibilities and that everyone, themselves explicitly included, had to shoulder the burdens of his own freely chosen actions. They sometimes used comparisons and metaphorical illustrations:

It’s your life and how you take care of your body and what you put into your body from the food you eat to, you know, whatever you drank or whatever drugs you take. These are all individual choices people make.

[Caucasian, 44, HIV–]

You are the captain. You own your body. You educate yourself, and you make your own decision.

[Asian/Pacific Islander, 38, HIV+]

Many participants acknowledged that unpleasant consequences might result from freely exercised choices as expressed in the recurrent phrase, “You have no one to blame but yourself.” Some mocked those who bemoaned the results of their behavior after engaging in it.

You should really be responsible. If you do barebacking, you should be responsible about it, not like doing it and then, oh, oh, oh, oh dear!

[Latino, 41, HIV+]

And if you do get [HIV], who else can you blame but yourself? One hundred percent.

[Latino, 24, HIV–]

The sense of individual responsibility persisted even when respondents suspected that they had acquired HIV through the conscious indifference of a former partner.

Interviewer (I): So how do you feel about that?

Respondent (R): Uh, probably angry. But, no, not really. Uh, it’s too late, you know? Angry that it happened, but I put myself there.

[Caucasian, 58, HIV+]

These strongly individualist comments reflect a view of sexual interaction between independent persons who enter into a consensual, quasi-contractual agreement knowing the terms and potential consequences—a *caveat emptor* (“buyer beware”) perspective congruent with Adam’s “neoliberal sexual actor,” (2005) i.e., “rational, adult, contract-making individuals in a free market of options” (p. 344). The early emphasis on individual responsibility in safer-sex campaigns, such as those that encouraged people to assume that all partners were HIV-positive, fits neatly into this paradigm.

However, the stark individualism expressed in the concept of exclusively personal responsibility also carried a paradox: if one is individually responsible for one’s conduct and its consequences, then one’s partner is equally individually responsible. Even the shared experience of sexual intercourse was viewed in strictly individual terms as occurring between independent adults choosing to run a risk; therefore, the “buyer beware” approach meant that each party was expected to know what he was doing and to assume exclusive responsibility for the outcome:

In America, I feel that the responsibility lies with each one of us for our own decisions. And so if the guy who didn’t want to have sex with me the other day when I brought up the fact that I was positive, was making—that was his decision.

[mixed race/other, 50, HIV+]

At the same time, the feeling that the individual was responsible for what he could bring upon himself did not preclude recognition of the harm that could result from barebacking, and some participants added the requirement that one also should consider it. This requirement sometimes was applied to the actions involved (barebacking); other times, participants extended the caution to the issue of disclosure.

To go out and do this kind of stuff with yourself, that’s you, yourself, and your responsibility. When you’re out doing this behind somebody else’s back and then going home and having sex with your wife? Hello! That’s somebody else’s life you’re screwing with now.

[Caucasian, 41, HIV+]

As long as you do not hurt somebody else in the process, then you're entitled to your own happiness. My problem would be where you know you're HIV-positive and you do not say anything.

[African American, 25, HIV–]

Therefore, while the men in the sample generally accepted ethical responsibility in the sexual encounter, they often individualized it in ways that subtly shifted the burden of caution to the partner while reiterating that potential harm to others also had to be taken into account. Hence, a classic “neoliberal” and individualized ethical position cannot be easily bounded and held certain when care of the other has a long history in Western culture and lies beneath the surface of most human interactions, particularly intimate interactions such as sex. This potential predicament calls for an attempt to understand how these men try to resolve the problem. They do so through a number of maneuvers.

(2) Belief that HIV-positive men bear a greater ethical burden is widespread

Participants tended to perceive the respective responsibilities of HIV-positive and HIV-negative men differently, according to the serostatus of the speaker. After introducing the topic and eliciting a first reaction, the interviewers invited respondents to elaborate specifically on who bore the *greater* burden of responsibility to avoid HIV transmission: men who were HIV-positive or those who believed themselves to be HIV-negative. Here, the responses typically followed a pattern: the men usually first said both parties were responsible, often describing it as an equally shared burden. Pregnancy was sometimes mentioned as an apt parallel.

(I): Some people say that for example it's the people who are positive that have the responsibility because they're the ones that have something that's lethal.

(R): It's almost like telling the man is responsible not to get the woman pregnant. There really is no one person, both people are technically responsible, but it's not up to one or the other.

[Caucasian, 51, HIV–]

However, as these discussions progressed, the strict equality of responsibility in the minds of HIV-negative respondents tilted toward the HIV-positive partner, at least in terms of the requirement to disclose the fact.

I mean, I think there's responsibility on both parts. Everyone knows they're taking a risk when they don't use condoms. It's a personal decision, but I feel like if you're positive, you owe it to me to let me know that you're positive.

[Latino, 20, HIV–]

I think both [bear responsibility]. I think it's like 50-50. But if they're positive, I think they should tell.

[Asian/Pacific Islander, 27, HIV–]

As reflected in these replies, the discussion on responsibility quickly moved from sexual behavior *per se* toward the conversation partners might or might not have beforehand. While the HIV-positive partner was usually charged with the responsibility of *revealing* his HIV status, a trickier question arose as to who should do the *asking*: some assigned greater responsibility to the HIV-positive partner while reiterating the contrary assertion that it was an equally shared burden.

I think it's both people's responsibility. Somebody has to ask, and somebody has to tell. [...] It doesn't matter who does it first. And if one person knows they have HIV, and they're just having sex without saying, 'Uh, before we get down to

business, I should let you know I'm kind of positive,' yeah, that person should probably be arrested.

[Latino, 24, HIV-]

Despite the initial claims that individual responsibility is equally shared by both partners, most HIV-negative men in the study eventually expressed that they believed those already HIV-positive were ethically charged both with disclosing *and* with initiating the conversation about HIV status.

I think that it's definitely both of their responsibility, but it's also under control of the person with the disease.

[Caucasian, 24, HIV-]

As will be seen in the next section, some HIV-positive men shared this view but added significant caveats of their own.

(3) Belief that HIV-negative men bear a greater ethical burden for self-care is also common

Some HIV-positive men assumed the responsibility that they perceived corresponded to their serostatus and insisted upon initiating the conversation if the partner remained silent. Frequently, however, HIV-positive participants placed the responsibility on the negative partner to ensure the latter's own well-being. Once again, the focus of the comments was on personal choice and accepting the consequences afterward.

I do like the new HIV campaign that's out there: 'HIV stops with me.' You know, putting the onus on people with HIV to, sort of, you know—what do you call it? I mean, I do like the notion of that. But I feel, I still feel there needs to be a higher responsibility that people need to, you know, take responsibility for their own health, their own, you know, selves, their own bodies.

[African American, 32, HIV+]

Some HIV-negative respondents agreed.

It's kind of like, if you'd go out and buy a car, you see it has four wheels, you know it has an engine, you know you like the paint color. But I think when you buy the car, you want to ask them, does the car have brakes? You know, you don't skip that part. You—there are things you just don't skip.

[Latino, 24, HIV-]

While HIV-positive men expressing this point of view often acted preemptively by disclosing their status even when not asked, they also reported amazement or exasperation at how frequently they were expected to carry the entire burden of avoiding harm. One participant offered this analogy:

If you don't want somebody to come over to your house and party, you have an obligation to tell them that. I actually have a friend who's a police officer, and somebody literally came over and started cutting lines [of cocaine] out on his coffee table. He arrested the guy! And I was like, 'Dude, did you bother to tell him that you didn't want anyone partying?' [...] I'm like, 'You had just as much responsibility on that as he did.'

[Caucasian, 32, HIV+]

This participant's story implied that persons who wished to avoid HIV infection actively had to seek out the information about the partner's status, and that those who did not do so were responsible for the outcome (or "had only themselves to blame"). From this perception of a

shared burden of persons being individually responsible for their own actions and well-being, some eased into a defense of non-disclosure.

I shouldn't have to feel like I'm the patron saint of self-protection, like I have to jump in front of the car to protect this person from something that they should be knowledgeable enough to protect themselves from.

[African American, 29, HIV+]

Sometimes, the interplay of concepts of personal choice and equal responsibility led to ambiguity or inconsistency. For example, an HIV-negative participant could start with a general notion of individual responsibility, ...

I see it as just every man for themselves because you know, you know what you're doing... I speak for myself. I like to bareback, and I like to do it, and I know—if I ever come out with anything [become HIV-positive], I'll deal with it. Because that was my choice in doing that.

... add a caveat that the burden of *disclosure* is not in fact equally shared ...

But they [HIV-positive partners] should at least tell us.

... and elide entirely the question of who does the asking, thus concluding nonetheless that:

Anyone that gets an STD or turned up positive, it's not the other person's fault. It's your fault.

[Latino, 27, HIV-]

The practical difficulties in following their own guidelines led some men to acknowledge internal struggles.

I've had a scare before with it, and, um, you know, I'm still friends with the guy who had sex with me and didn't tell me about his poz—you know, being positive. And the reason I did is because I didn't ask him.... I couldn't be upset with him because I didn't ask.

[African American, 29, HIV-]

(4) Easier said than done—and not easily said

As we have seen, serostatus often affected respondents' views of where the ethical responsibility lay. However, HIV-positive men faced unique pressures. For example, even though participants in the study were recruited through gay-oriented Web sites where barebacking was either explicitly alluded to (e.g., in the Web site's name) or where a subpopulation of site users actively sought partners willing to practice it, those men who frankly acknowledged their HIV-positive status on the sites sometimes attracted hostility.

You get a lot of hate mail when you put 'positive' in your profile [...] because I'm positive and bareback [...] that you're—you know, you're a sick faggot and you're infecting the world and you're destroying the game, you know. And, you know, you're spreading the plague, and you are the plague, and you should be killed and, you know, all that stuff.

[Caucasian, 58, HIV+]

Even the invitation to serosort implied by posting one's HIV-positive status on a public site did not deflect hostile reactions. Some HIV-negative respondents agreed that people who exposed others to risk were guilty of unethical, even criminal, behavior:

I know that the people that do carry the virus, you know, they're angry because they have the virus, and, you know, they just want to spread it to everybody.

[Latino, 38, HIV–]

Although these sentiments represented a minority view among HIV-negative participants, they were frequent enough to confirm that HIV-positive men who engage in barebacking do encounter considerable opprobrium from within the “barebacker” scene. As a result, while respondents largely agreed that disclosure is important and sometimes ethically mandated, they also recognized that it was far from easy and, in fact, often did not occur. Individuals who did disclose their HIV-positive status faced rejection or loss of sexual possibilities:

I’ve met one guy who actually volunteered that information. [...] He’s now dead, rest his soul, but he was such—you know, he was very responsible and you know, very mature about it. Most of the guys I’ve met feel that they like me and so they don’t want to ruin it by, you know, bringing that up.

[African American, 39, HIV–]

Yeah, people who have it should be open about it. They should feel that it’s okay to be open about it. Even though I won’t have sex with them! [laughter]

[Caucasian, 24, HIV–]

As a strategy to avoid discomfort, some respondents said they used indirect disclosure methods. However, since even the broadest hints did not guarantee that the recipients understood the intended message, participants still had to make choices that reflected their perception of where the responsibilities lay and sometimes used hints and clues or relied on the explicit information in their online profiles:

One day, we were having sex, and we were both drunk, and we had unprotected sex. And then he gets around to seeing my profile. How come I didn’t tell? Well, I explicitly asked you whether or not you had read my profile. The fact that I’m HIV-positive is in there. It’s in bigger, bolder type than anything else in my profile. And he was mad at me. He thought he was mad at me. He was mad at himself. He made a choice that he knew to be poor.

[Latino, 35, HIV+]

These comments illustrate the limitations of applying *caveat emptor* to ethical responsibilities as the assumptions of informed consent between autonomous actors allow no room for naïveté, impulse, differential power relations, yearning for affection, impairment, confusion, or other sorts of vulnerability. However, some adherents to *caveat emptor* also reported that they are influenced by the attitudes displayed by partners, which could have implications for prevention strategies:

My feelings are, if you know that you’re HIV positive, then you should serosort and only have sex with HIV-positive guys if you’re barebacking. If you don’t know your status, and you’re barebacking, then you should have sex only with those people who either don’t know or don’t care. But a person who expresses concern about the status and, and you don’t know, I think that you should, sort of, back off.

[African American, 47, HIV–]

Although the problems associated with disclosure might lead to avoidance of the topic, this comment illustrates how breaking the silence may influence the sexual repertoire. When this participant’s partners stated that they were HIV-negative or expressed concern by asking about his own status, he felt greater responsibility to limit the risk behaviors that followed.

Discussion

Although few would disagree that the underlying imperative is to avoid harm, HIV prevention discourse among gay men has embodied competing traditions, simultaneously endorsing the legitimacy of personal sexual fulfillment while also appealing to a sense of community solidarity and the duties implied in adhering to it. The very idea of “safe” or “safer” sex originated in a deeply collective ethos that included explicit appeals to join a community effort for self-care and group welfare, all in the context of a gay community under biological and political threat (Berkowitz & Callen, 1983; [authors]; Watney, 1994). At the same time, educators—with considerable variation country by country—often shaped HIV prevention campaigns to strengthen individuals’ capacities to act safely by linking it with a defense of their hard-won sexual emancipation in an “empowerment” paradigm that echoes modern consciousness of the self as an autonomous individual, freely interacting with others on the basis of informed, consensual decisions for which each person assumes sole responsibility (Adam, 2005).

In our sample of men who engage in bareback sex with multiple partners, respondents clearly acknowledged ethical obligations associated with the decision to engage in a behavior where HIV transmission cannot be ruled out. As might be expected in a society like the U.S. permeated with strongly individualistic assumptions, the common opinion was that each person is responsible for his own decisions and the consequences that follow from them.

At the same time, a “do no harm” second tier of responsibility also was frequently acknowledged. Nevertheless, the burden of responsibility on how to avoid harm tended to fall on the “other,” the person with a serostatus different from one’s own. HIV-negative men generally thought that positive men bore more responsibility and should disclose their status or restrict their barebacking to other HIV-positive men. By contrast, HIV-positive men tended to consider that the negative partners bore at least some responsibility to care for themselves and should seek the relevant information actively either by asking or by examining online profiles carefully.

A dilemma arises in the intersection of the two strong tendencies that historically underlie Western ethical thinking, particularly as it is enacted in the U.S. There is an inherent tension between a recognized social benefit (stopping HIV transmission) and an individual’s right to determine one’s own fate and to act according to one’s own judgment of self and others. HIV/AIDS has thrown up significant difficulties for this ethical intersection because its early history invoked discrimination and stigmatization related to sexuality and in particular to homosexuality. Gay communities around the world enacted a collective response by creating a “safe[r] sex culture” despite this distorting environment (authors; Patton, 1990) dedicated to stopping HIV—that is, to the common (gay) good. The safer-sex culture of the early years of the epidemic has evolved into something quite different in this “post-AIDS” era (authors) where all gay men no longer share a common relation to and experience of HIV and AIDS, even if condom use is still normative. Where do men like those in this study turn to receive the best advice available on how to behave or to consider their comportment in relation to self and others? Our earlier analysis of barebacking Web sites (authors) reveals inconsistent positions and contradictory advice. What ethical stance guides such advice: *caveat emptor* or “HIV stops with me”?

HIV prevention messages that allude to an earlier, more collective response to the epidemic are valid reminders that sexual conduct has an ethical dimension. Our findings suggest, however, that while gay and other men who have sex with men generally will endorse these messages, their agreement may have little effect in practical terms. The intention to act

ethically does not always produce the best result in terms of the risk of HIV transmission. While encouragement of a sense of responsibility among HIV-positive people is certainly appropriate, such campaigns brought into the public sphere may reinforce for some the idea that HIV-positive persons are primarily or even exclusively responsible for vigilance around sexual safety. This could further strengthen the tendency described here among HIV-negative men engaged in barebacking, i.e., that the “other” bears the principal burden—not oneself.

Discussion of the ethics of unprotected sex regularly resurfaces when prosecutions of HIV-positive men for allegedly endangering sex partners occur and receive broad media coverage (Center for HIV Law & Policy, 2012). These high-profile cases reawaken latent fears of HIV-positive men as irresponsible or even vengeful individuals indifferent to others’ well-being or intent upon harming them (Strub, 2012). A majority of respondents to one opinion survey supported vigorous prosecution of HIV-positive individuals for unsafe practices or for failure to disclose their status to partners, whether or not the behavior was consensual or harm could have resulted from it (Horvath, Weinmeyer, & Rosser, 2010). In the same study, gay male respondents who were HIV-negative endorsed these ideas at virtually the same rate as the overall, general population sample.

At the same time, recent biomedical advances reframe the ethical questions pondered by our participants as disclosure expectations and/or intentions might not be the same as when HIV infection was a more likely outcome of bareback sex. The scientific environment is greatly altered by successful HIV suppression through treatments and now the advent of “PreP.”

The conditions of the 1980s that generated the unique initial response to AIDS—a strong sense of “community self-governance” (Adam, 2005, p. 334) in the face of multiple dangers—are now radically altered as well. As a result, attitudes about HIV status disclosure are not likely to reflect the special environment that grew up around the AIDS epidemic in its early years but rather the same beliefs about collective responsibility and personal rights that are current in other areas.

In addition, the legal environment has shifted significantly since the data were gathered in 2005–2006: now, barebacking by HIV-positive men is not merely a socially stigmatized behavior but a criminal act in 36 of the 50 states of the U.S. (Center for HIV Law & Policy, 2012; Strub, 2012), and prosecution for non-disclosure of HIV status is on the rise. Continued criminalization of the sexual lives of people with HIV could resuscitate the barebacking controversy in a far more hostile media and judicial environment. The tendencies reflected in our study to shift somewhat unconsciously the responsibility for safety to the “other” will be reinforced if criminal prosecutions involving HIV-positive persons increase.

Nonetheless, the present study illustrates that merely expressing concern for one’s own health and a desire to stay HIV-free might influence the precautions taken by a partner because nearly all people have ethical concerns and do not wish to perceive themselves as being indifferent to the fate of others. Reinvigorating the ethical component of safer-sex discussions, therefore, could aid in inhibiting actions that are likely to cause harm. At the same time, in sexual scenarios where participants value silence as a masculine trait (Haig, 2006), such advice to individuals makes little sense; a more collective approach is needed.

Limitations

The data for this study were collected in the 2005–2006 when barebacking was still a relatively new addition to HIV jargon and a novel source of erotic charge. Some of the Web sites that were utilized for participant recruitment prominently featured the term in their

outreach to site users and celebrated the practice in defiant or libertarian terms; some have been taken down since then. Both the initial negative connotations of barebacking and its corresponding allure as a transgressive practice are probably weaker today than when the participants were interviewed. Furthermore, the biomedical advances mentioned above have recalibrated ethical considerations. Nonetheless, risk remains, and choices with ethical implications continue to be made.

Recommendations

Exploration and discussion of the ethical dimensions of gay relationality, so much a part of the early debates on “how to have sex in an epidemic” (Berkowitz & Callen, 1983), are now focused much more on issues like same-sex marriage than on sex itself. But the explosion of new scientific findings bearing on HIV risk calculus offers an intriguing hint of where a sex-focused ethical discussion could take place. Gay men have been absorbing and applying new scientific information for years (Race, 2003) and modifying their sexual repertoire with it by pursuing options for condomless sex under a variety of labels (negotiated safety, serosorting, strategic positioning, and barebacking); therefore, they might value opportunities to learn more in nonjudgmental settings. HIV prevention promoters eager to see a more explicit ethical discussion might address the quotidian dilemmas of men such as these respondents by disseminating scientific knowledge in fora—using the gay and lesbian press, gay community centers, or AIDS service organizations—structured to stimulate a fluid discussion without medical domination. Such initiatives might be potent vehicles for resuscitating shared concerns and exposing the unrecognized and unquestioned premises of the modern rhetoric of individual consent and responsibility.

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Table 1

Demographic characteristics of the study participants (N=120)

Characteristic	Mean (SD)	Range
Age	33.57 (9.63)	18 – 63
Years of Education	14.78 (2.90)	2 – 20
	Median (IQR)	Range
Income	\$25,000 (10,000–40,000)	0 – 100,001
Prior HIV tests	5.00 (2.00–12.00)	0 – 99
Number of male partners, 2 months	9.00 (5.00–19.00)	0–150
		n (%)
HIV+		31 (26%)
Race/Ethnicity		
Latino		31 (26%)
African-American		28 (23%)
Asian/Pacific Islander		17 (14%)
White/European-American		35 (29%)
Native American		3 (3%)
Other		6 (5%)
Sexual Identity		
Gay/homosexual		104 (87%)
Bisexual		11 (9%)
Straight/heterosexual		2 (2%)
Gay and bisexual		2 (2%)*
“Don’t know”		1 (1%)

* participants could select multiple categories