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# “Riding Bareback”: Factors Involved in the Development of a Bareback Identity

Scott Charles Musgrove  
*Antioch University - Santa Barbara*

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“RIDING BAREBACK”: FACTORS INVOLVED IN THE DEVELOPMENT  
OF A BAREBACK IDENTITY

A dissertation submitted to the Faculty of  
Antioch University, Santa Barbara in  
partial fulfillment of the requirements for the  
Degree of Doctorate of Psychology in  
Clinical Psychology with a Family  
Psychology specialization and a concentration  
in Family Forensic Psychology

By

Scott C. Musgrove, M.A.

Dissertation Committee

---

Barbara Lipinski, Ph.D., J.D.  
Dissertation Chair

---

Ryan Sharma, Psy.D.  
Second Faculty

---

Katherine Burrelsman, MFT, Psy.D.  
Student Reviewer

---

Jeffrey Parsons, Ph.D.  
External Expert

## Abstract

### “Riding Bareback”: Factors Involved in the Development of a Bareback Identity

By

Scott C. Musgrove, M.A.

Researchers in the area of HIV prevention have long been aware of the rising incidence of unprotected sex among men who have sex with men (MSM). In recent years researchers have witnessed the emergence of the behaviors, attitudes and practices that discriminate between those of the MSM community who strictly and consistently adhere to safer sex practices, those who inconsistently practice safer sex, and those who eschew protected sex altogether. Understanding the factors that motivate the development and adoption of a “barebacker identity” in spite of serious potential for HIV infection may well help support the efforts of public agencies to provide effective psycho-education and intervention efforts designed to curb HIV transmission. This quantitative study looked at factors that motivate the adoption of a “bareback identity” and hypothesized that the predominant features in the decision to bareback were innately tied to a man’s sense of autonomy regarding his sexuality, a reaction against his perceived loss of freedom in the expression of his sexuality, a weighted alignment with male role norms, and internalized impact of his beliefs about his sexuality. The use of four inventories to ascertain these factors analyzed with survey participants’ assertion of a “bareback identity” found no significant correlation.

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Finally, my unending gratitude to a medical general practitioner from my years as an undergraduate in Birmingham Alabama circa 1981: your simple warning and concern are the reason that I am alive today to be of service to others.

## TABLE OF CONTENTS

<b>CHAPTER I – INTRODUCTION</b> .....	<b>1</b>
AIDS and Public Policy Prevention Attempts.....	<b>8</b>
Additional Factors Affecting Unsafe Sexual Behaviors.....	<b>13</b>
<b>CHAPTER II - REVIEW OF THE LITERATURE</b> .....	<b>15</b>
Terms and Definitions.....	<b>15</b>
Acquired Immunodeficiency Syndrome.....	<b>17</b>
Identity Development Models.....	<b>20</b>
Eriksonian Identity Development.....	<b>21</b>
LGBT Identity Development Models.....	<b>24</b>
Cass.....	<b>26</b>
Troiden.....	<b>32</b>
Coleman.....	<b>36</b>
LGBT Models’ Synthesis.....	<b>39</b>
Limitations to LGBT Models.....	<b>40</b>
Bareback Identity.....	<b>45</b>
Limitations to Understanding.....	<b>50</b>
Masculine Ideology.....	<b>53</b>
Reactance Theory.....	<b>58</b>
Internalized Homophobia.....	<b>62</b>
Summary	
<b>CHAPTER III – STATEMENT OF THE PROBLEM</b> .....	<b>73</b>
Main Research Questions.....	<b>73</b>
<b>CHAPTER IV – METHODS</b> .....	<b>75</b>
Description of Research Design.....	<b>75</b>
Recruitment of Participants.....	<b>77</b>
Description of Instrumentation.....	<b>78</b>
Measures	
Psychological Reactance.....	<b>78</b>
Masculine Ideology.....	<b>78</b>
Internalized Homophobia.....	<b>79</b>
Sensation Seeking.....	<b>79</b>
Bareback Identity.....	<b>80</b>
Ethical Assurances.....	<b>80</b>
<b>CHAPTER V – RESULTS</b> .....	<b>81</b>
Demographic Data.....	<b>82</b>
Data Related to the Research Questions.....	<b>84</b>

<b>CHAPTER V – DISCUSSION</b> .....	<b>86</b>
Discussion of Study Results.....	<b>85</b>
Study Limitations.....	<b>87</b>

**REFERENCES**

Appendix A: Information Sheet for Non-Medical Research	
Appendix B: Demographic Questionnaire	
Appendix C: Theoretical Reactance Scale	
Appendix D: Conformity to Male Role Norms Scale Short Form	
Appendix E: MAG–MSV	
Appendix F: Zuckerman-Kuhlman Personality Questionnaire	
Appendix G: Bareback Identity Scale	
Appendix H: Informed Consent	

## List of Appendices

Appendix A Information Sheet for Non-Medical Research

Appendix B Demographic Questionnaire

Appendix C Theoretical Reactance Scale

Appendix D Conformity to Male Role Norms Scale Short Form

Appendix E MAG–MSV

Appendix F Zuckerman-Kuhlman Personality Questionnaire

Appendix G Bareback Identity Scale

Appendix H Informed Consent

## **CHAPTER I: INTRODUCTION**

The term “bareback” implies freedom; borrowed from the lexicon of the equestrian world, “bareback” refers to the exciting and dangerous act of riding a horse without saddle or reins. It connotes romanticism, eroticism and an adventurous disregard for convention. The term “bareback”, still a relatively unknown term among heterosexuals has, in recent years, been appropriated by the MSM (men who have sex with men) community to identify the act of insertive or receptive anal sex without the use of a condom (Bimbi & Parsons, 2004; Halkitis, Wilton & Galatowitsch, 2005; Yep, Lovass & Pagonis, 2002), as well as the intentional choice to engage in unprotected sex (Goodroad, Kirksey & Butensky, 2000).

The term has become increasingly ubiquitous within the gay male and MSM community as a discriminator between those individuals who practice safer sex and those who do not. Various subpopulations have been examined in this phenomenon, including, but not limited to those who are “erotic risk-takers” and pursue higher levels of physical sensation during sex (Gauthier and Forsyth, 1999), HIV positive men who identified as sexual adventurers (Halkitis and Parsons, 2003), those seeking a sense of intimacy or spiritual connection (Yep, Lovaas & Pagonis, 2002) and individuals who utilize the internet for sexual connection (Wolitski, 2005)

or otherwise connect in a sexually heightened atmosphere (Parsons, 2005; Parsons & Vicioso; 2005, Wolitski, 2005)

The facts around HIV transmission are startling; In the past 26 years HIV is estimated to have killed over half a million individuals and approximately 415,000 are currently living with AIDS. An additional 1 million individuals are HIV infected with 40,000 new infections occurring annually in the United States alone with an 8.6% spike in transmission among MSM between 2001 and 2006 (CDC, 2008). Given these grave statistics, it is challenging for researchers to understand the motivations for the increases in barebacking behaviors. What is apparent now in the third decade of the HIV phenomenon is that presentation of safer-sex practices by health promotion campaigns as simplistic changes in behavior are insufficient to impact the complicated phenomenon of unsafe sex, and that certain members of the MSM community actively engage in unsafe practices not in ignorance of, but *in spite of their knowledge regarding HIV transmission* (Wolitski, 2005).

In Western culture, men have traditionally held a dominant position in virtually every strata of society. This dominant position, often described as patriarchy or masculine hegemony, encompasses a number of psychological / internal processes, assumptions and behaviors that affect the decision making progress of individuals, whether they are aware of

these influences or not. The adoption of a “barebacker identity” therefore, may be intrinsically linked to an individual’s perception of his entitlement as a man, his view of his sexuality and the ways in which desires to connect with others. As a model of sexual identity development, however, the process by which an individual aligns with a barebacker identity does not follow the generally accepted models of identity development proposed by Erikson (1969), Cass (1979), Troiden (1979, 1989) or Coleman (1982).

Barebacking is a behavior that has been variously described as a reclamation of sexual power (Ridge, 2004) and masculinity (Halkitis, 2001) and an “outlaw” manifestation of sexual behavior (Crossley, 2000); A behavior where the risk of infection is outweighed by what an individual considers to be psychological (Halkitis et al. 2004), emotional (Haig, 2006) physical advantages or assertion of their autonomy (Bimbi and Parsons, 2004; Shernoff, 2005).

Until the late 1990’s, unprotected sex between MSM was understood to be an unintentional result of chance, inconsistent safer-sex practices or a reversion to unsafe sex behaviors; there was little distinction between intentional and unintentional unprotected sex. The evolution of the term has taken a convoluted journey from its origins as a radical pop-reference (Scarce, M. 1999) to subpopulation identity marker. In 1997, the term “barebacking” first appeared in print in a magazine devoted to

individuals with HIV. The article prompted other articles penned by activists and journalists within the LGBT community, as well as editorial commentary from readers. Even with this burgeoning conversation, the term “bareback” was still not definitively tied to intention vs. chance. Early into the 21<sup>st</sup> century, the term remained ambiguous among some researchers, denoting any variance of unprotected or unsafe sex that connoted intention (Adam, 2005) and this complicated not only the evolution of the term, but quantitative research as well.

The earliest researchers have defined the term with subtle distinctions, and then made a presumptive leap from behavior to identity. Parsons and Bimbi (2007) illuminate the problem that this leap generates within the research community by pointing out that researchers imply a “bareback identity” among various lumped together sampling pools, without confirming if their participants held the same perspective. Lack of this discernment among study participants has led to wildly different results in the prevalence of unprotected sex among HIV negative and HIV positive MSM.

In the following years as research became more available from Internet sources such including websites, chatrooms, listservs and online social networking venues, researchers began to define the term more narrowly as a number of not-necessarily connected motivating factors

emerged such as increased sensation, erotic risk – taking, sexual adverturism, sexual compulsivity, and substance abuse (Parsons and Bimbo, 2007).

As a phenomenon that was once believed to exist only on the fringes of the MSM community, barebacking has grown in epic proportions over the past 12 years (Bimbi and Parsons, 2004, Halkitis, Wilton and Drescher, 2005), particularly in the latter half of the 1990's (Eckstrand et al., 1999) in spite of the severity of the consequences of HIV infection. A 1999 CDC study that looked at sex practices among MSM found startling shifts in behaviors; The percentage of men who claimed to consistently use condoms decreased from 69.6% in 1994 to 60.8% in 1997, with the most significant decline emerging among men between the ages of 26 and 29. Additionally, the numbers of MSM who reported increased unprotected anal intercourse and multiple sex partners increased to 33.3% in 1997 from 23.6% in 1994. The CDC study found that this upsurge corresponded with increased availability of effective antiretroviral therapies for HIV, thereby implying that MSM may well assume that HIV infection can be efficiently managed by medication. Data gathered by the Multi-center AIDS Cohort Study showed that in a 24-month period, 44% - 47% percent of individuals returned to UIAI (unprotected insertive anal intercourse) and URAI (unprotected receptive anal intercourse) after

previous periods of safer sex practices (Wolitzki, Valdiserri, Denning & Levine, 2001).

How are we to understand the choice that individuals make to engage in this practice? Is it an act of rebellion or risk? An internalized rejection of one's sexuality that manifests in what some would rationally describe as a self-destructive act? Is barebacking an expression of identity development in a marginalized population seeking to reclaim a sense of self-efficacy, interpersonal congruence, and social unity that is inconsistently offered by the MSM community? While each of these factors may play a role, it is more likely that this phenomenon is a manifestation of masculine hegemony emerging from a heteronormative culture that values the freedom and autonomy of manhood over the potential consequences of the individuals' actions, particularly when it comes to sexual behavior and choice.

Various private organizations have created and maintained massive outreach programs to educate American society about HIV/ AIDS. Each major metropolitan area in the United States has an AIDS organization that provides testing, low cost referrals for medical treatment, educational materials, and a host of social services. Celebrities have supported dissemination of educational materials and promoted the de-stigmatization of HIV/ AIDS, and in isolated cases, even come forward

to reveal their struggle with HIV, most notably former NBA player Magic Johnson.

What might be considered common knowledge regarding HIV is inconsistent: 43% of participants in a recent study representing a broad section of the U.S. population mistakenly believed that HIV could be transmitted through non-sexual and non- blood contact means (Kaiser Family Foundation, 2006), and among a broad sample of MSM populations with a great deal of access to information about HIV, little or no correlation has been found to changes in behavior that might facilitate transmission of the disease (Yep, Lovaas & Pagonis, 2002). Between the years of 2001 and 2006, male-to-male sex continued to be the main method of transmission of HIV infection within the United States (CDC, 2008).

How then do we effectively address this most integral factor of HIV transmission if we know that the major source of it occurs between men, regardless of how they individually define their sexual orientation or sexual expression? Just as the anti-drug message of the 1980's "Just Say No," and current public school sexual abstinence programs have produced little if any impact on drug use or sexual activity among teens (Hauser, 2004; Lynam, Milich, Zimmerman, Novak, Logan & Martin, 1999), various public health models have attempted to stem the tide of new

infections by addressing what was assumed to be a general lack of information available to the general public regarding the transmission of HIV (Halkitis, Wilton & Drescher, 2005).

#### AIDS and Public Policy Prevention Attempts

Early attempts by organizations produced significant, but short term success in stemming the rates of infection by the use of slogans such as “We All Have AIDS” (Kaiser Family Foundation), “No Glove, No Love” (Center for Disease Control) and “Get Tested Now” (AIDS Healthcare Foundation). It is likely that the successes of these efforts were limited because they provided overly simplistic responses to an action that is complex and driven by multiple factors (Crossley, 2002, Wolitski, 2005). It is notable that one of the most powerful and successful early campaign choice of message delivery was generated by the provocative slogan “Silence = Death” (Greenberg, 1992). The slogan, emblazoned upon an inverted pink triangle on a black background, was a potent and arresting political symbol that captured public attention as a reclamation of gay identity by appropriating a symbol utilized by Nazi Germany during World War II to identify homosexuals in prison camps. The “Silence = Death” message appeared at a time in the mid-1980s when the height of fear and anger in the gay community was coupled with the lowest level of

knowledge of the disease and lowest government acknowledgement of the crisis.

It is likely that the success of this early effort was born of a backlash in the gay community to a political and social environment that refused to acknowledge the threat that HIV infection posed (White, 2004), thereby appealing to the threat to an individuals' sense of civil liberty (Wolitski, 2005) rather than an impingement upon their sexual identity. With a dearth of support from public agencies or the government, individuals within the LGBT community created massive and successful grass roots efforts to educate the public with information that was available, resulting in a significant reduction in HIV transmissions within the gay community.

In the early years of the AIDS crisis, messages regarding HIV transmission and prevention among the LGBT community were decidedly gay-affirming and sex-affirming (Shernoff, 2005), and therefore aligned with important identity aspects of the community. Implied messages from the government, however, were unresponsive at best, and at worst, negligent. It was not until 1987 that United States President Ronald Regan actually used the word "AIDS" in a speech delivered to the public. By that time, 41, 027 individuals had died from the condition and another 71, 176 were diagnosed with AIDS (ACT UP, 2009). At this time, CDC studies of

HIV were chronically under-funded despite numerous requests to the government by leading medical researchers.

The LGBT community during this time received contradictory messages; from their own activists and grassroots organizations, they were given education, promotion and support of safer sex practices. From the government however, steps were taken to actively impede such education and support to the entire country, as exemplified by Senator Jesse Helm's amendment to a federal appropriations bill to ban HIV/ AIDS education endeavors because that would "encourage or promote homosexual activity (Bronski, 2003).

Although much has changed in the past two decades in regards to funding and research of effective treatments, there is concern that as AIDS has reached global proportions and spread into other communities, the message of education and prevention may have been diluted to reach a wider audience, and has thereby lost its potency for all of the intended recipients (Crossley, 2004 ; Shernoff 2005, : Wolitski, 2005). What is apparent now in the third decade of the HIV phenomenon is that presentation of safer-sex practices by health promotion campaigns as simplistic changes in behavior are insufficient to impact the complicated phenomenon of unsafe sex, and that certain members of the MSM

community actively engage in unsafe practices not in ignorance of, but *in spite of their knowledge regarding HIV transmission* (Wolitski, 2005).

While use of the term “barebacking” has been generally understood as a description of the behavior of condomless, anal-insertive sex, researchers in recent years (e.g., Halkitis, Wilton & Galatowitsch, 2005) have found notable differences in behavioral practices. Such practices are those between HIV positive individuals and their HIV positive partners, reflecting findings in earlier research that have been named “negotiated safety” (Parsons and Bimbi, 2005, p. 278). “Negotiated safety” presumably reduces the likelihood of infection in HIV negative / seroconcordant couples as they have declined the use of condoms only after consistent condom use and repeated HIV testing (Halkitis & Parsons, 2003; Halkitis, et. al., 2004; Mansergh, et al. 2002).

A significant precursor to negotiated safety then, is “sero-sorting”, which is the self-directed pairings of casual sexual partners into seroconcordant couples, that is, choosing a sex partner who shares their HIV status (Halkitis, et. al, 2005). This partnering with another individual who shares the same HIV status reflects a cognitive strategy to avoid HIV infection, albeit one fraught with assumptions depending on the level of communication between partners. This strategy presents a number of problems based on what might be limited communication and

extraordinary assumption between casual sex partners, however, in a relationship committed to open communication regarding the expression of sexuality and adherence to agreed upon protocol, negotiated safety may well be a successful way to avoid HIV infection.

In synthesizing research from several different studies of how HIV positive men disclose their status to potential sex partners, Parsons et al (2005) reveals a complex set of phenomena. Relying on an individual to accurately share his HIV status with a potential sex partner presents a challenge for those who feel stigmatized by their serostatus as well as the possibility that such revelation may then lead to rejection. Such an intense focus on disclosure as the arbiter of HIV transmission then minimizes consistent safer sex practices used by individuals to protect themselves and their partners. HIV disclosure as means of facilitating a reduction in infection presupposes that serodiscordant individuals will not engage in unprotected sex. In a study that looked at the sexual activities of HIV positive men, no difference was found in the rates of unprotected anal sex when looking at those who reported consistent disclosure as compared to those who did not reveal their HIV status to their sex partners. This implies that some individuals will persist in practice of unsafe sexual practices even when they disclose to a sero-discordant partner and

some individuals who avoid any disclosure will reliably avoid unsafe sexual practices (Parsons, et. al, 2005).

Another mechanism utilized by individuals seeking to minimize the transmission of HIV is described by the term “strategic positioning”. Strategic positioning, is in effect, the negotiation of the role each sex partner takes in the context of the sexual act being practiced. An example of strategic positioning used in the context of unprotected sex is illustrated by an HIV negative anal insertive (“top”) engaging in anal intercourse with an HIV positive anal receptive (“bottom”) individual, or an HIV negative oral insertive engaging in anal intercourse with an HIV positive oral receptive individual. In both of these scenarios, the transmission of HIV is less likely to occur, but it is by no means a way of absolutely avoiding HIV infection.

#### Additional Factors Affecting Unsafe Sexual Behaviors

There are a number of factors at play in the practice of unprotected sex among MSM, including an increase in the use of disinhibiting recreational drugs, the Internet as a means of connection for sex, a decrease in HIV educational funding, HIV status, loneliness and desire for intimacy (Parsons, et al, 2005, Shernoff, 2005), as well as assumptions made by individuals regarding the severity of infection in light of the current arsenal of medical treatments (Halkitis, Wilton &

Drescher, 2005). Individual factors such as these however, are representative of influences from the individual's environment, and do not necessarily reflect the internal psychological processes involved in decision-making that may have more to do with adaptive processes that are intrinsic to the individual (Shernoff, 2005). A more profound understanding of the motivating and intrinsic personality factors involved in the decision to engage in unprotected sex may serve a vitally important role in looking at the way AIDS education and HIV prevention is presented to the public. There is also a need to understand why some members of the MSM community engage in bareback behaviors, while others do not (Halkitis, Wilton & Drescher, 2005).

## **CHAPTER II: REVIEW OF THE LITERATURE**

This literature review will attempt to lay a foundation for understanding the concepts of identity formation and factors that play a role in the adoption of a “barebacker identity”, as well as explicate terms and definitions that this study will make reference to. First is a discussion of Erikson’s heteronormative identity formation model on which current LGBT models are based and the limitations inherent in their conceptualization. Current literature regarding other factors such as masculine ideology, internalized homophobia, reactance, and sensation seeking will also be explored regarding their impact on the MSM community, as well as contradictory findings in the research. This information will be used in an attempt to contextualize the choice of certain MSM who intentionally engage in unprotected sex in the formation of a “bareback identity”

### **Terms and Definitions**

The acronym “MSM” refers to “men who have sex with men”, and is intended to include males who identify as gay, bisexual, sexually fluid, or heterosexuals that engage in homosexual sex. It is an attempt to identify a certain population of males without restricting the definition of that population to their sexual behavior.

“Bareback”, or “barebacking”, still a relatively unknown term in heterosexual community, refers to the activity of receptive or insertive anal sex between MSM without the use of condoms, however, it does not necessarily imply a “bareback identity”, which is the focus of this study. Additionally, “barebacking” in this study is differentiated from the concept of “negotiated safety”, wherein two sero-concordant partners choose not to use condoms within the confines of their relationship (Parsons and Bimbi, 2006).

“Sero-sorting” refers to the act of differentiating between potential sex partner’s HIV status in order to ascertain HIV congruence in preparation for unprotected (condomless) sex.

“Heteronormative” refers to the traditions and customs that justify and sanction the privilege of heterosexuality and heterosexual relationships as essential, elementary, and innate within the social order. It is form of class suppression that illuminates the importance of sexuality along with expansive structures of power that impact race, gender and socio-economic status (Cohen, 2005).

This paper will utilize the following acronyms to facilitate comprehensive discussion of the sexual preferences of study participants: URAI (Unprotected Receptive Anal Intercourse) and UIAI (Unprotected Insertive Anal Intercourse). The acronym “LGBT” refers to an umbrella

term known as “Lesbian, Gay, Bisexual and Transgendered”. Although this study focuses on the MSM community who may not identify as gay or bisexual, the vast majority of research on same-sex interactions deals with and is drawn from studies of the LGBT community.

### Acquired Immunodeficiency Syndrome

Acquired Immunodeficiency Syndrome (AIDS), a viral infection that systematically destroys the human immune system, was first identified in the United States in 1981 (Center for Disease Control, 2008). The virus blossomed into destructive power in the early 1980s. In its early years, the virus decimated the gay populations of major urban areas in the United States while slowly spreading to smaller communities. In the past 26 years, the virus gained a foothold into virtually every strata of American society, and is estimated to have killed over half a million individuals. In spite of massive educational and promotional projects and the advent of effective medical treatments, at the end of 2004 there were an estimated 1 million individuals infected with HIV in the United States. The current number of individuals in 2008 actually living with AIDS estimated to be somewhere around 415,000 (CDC, 2008).

While the number of AIDS cases peaked in the early 1990’s to around 80,000, and options regarding the prevention, treatment and diagnosis of HIV continue to be discovered, there are 40,000 estimated

new infections each year (CDC, 2008) in spite of the execution of numerous education and awareness programs (Halkitis, Wilton, & Drescher, 2005). Fifty-three percent of new HIV infections in 2006 were among MSM. The highest rate of new HIV infections occurred in men in their 30's followed by those men in their 40's. The CDC (2008) ascribes this phenomenon to already significant numbers of HIV infected men in those age groups.

The earliest infections appeared primarily in Caucasian men in metropolitan areas, however HIV has exploded into the communities of color with approximately 46% of the AIDS diagnoses in 2006 occurring within the African American community (CDC, 2008). The high incidence of infection rates within the male African American population of the United States has been attributed to “the down low”, or the practice of men having sex with men without identifying as gay or bisexual; sexual orientations that are highly stigmatized within many communities of color. Many of these individuals have wives, girlfriends or female sex partners who are unaware of their partners' extra-relational sex, and consequently, may then be at risk of HIV infection themselves, which increases the spread of the virus into the heterosexual community.

The research and funding dedicated to AIDS over the years has failed to produce an effective and reliable vaccine for HIV but there are

promising treatments that include microbicides (Center for HIV Prevention Research, 2008) and “combination prevention”, which is the amalgamation of current effective medical treatments, microbicides, vaccines and condoms in those already infected to limit the spread of infection (International AIDS Conference, 2008). More promising information includes the potential immune response to HIV in the saliva of men who have engaged in oral sex regularly with HIV positive partners (Hasselrot, Saberg and Hirbod, et. al., 2009) and the extremely low incidence of “superinfection” of already infected individuals (Willberg, McConnell, Erikson, et al., (2008). Recent groundbreaking treatment of HIV has shown an extraordinarily successful but financially unrealistic, medically dangerous “cure” for HIV by the replacement of a patient’s immune system through bone marrow transplant and chemotherapy (McNeil, 2008).

Since 1995, the introduction of new medication therapies such as Highly Active Anti-Retroviral Treatments (HAART) have allowed many of those infected with HIV and access to medication to live with the presence of AIDS in their lives as a chronic but manageable condition. It is an uneasy balance however, as the long term efficacy of current retroviral medication “cocktails” for the entire population of infected individuals is not known. The medications do not work equally well for everyone and

while there are individuals for whom the medications work effectively, there are also individuals for whom the trade-off in side effects severely impacts their quality of life. Older HIV infected patients may respond well to HAART regimes (Greenbaum, et al., 2007) but the recipients experience a host of other challenges brought on by not only their weakened immune systems but also the toxicity of long term medication use and rapid onset of health conditions including anal, lung and colon cancers, osteoporosis, and cardiovascular disease (Hardy, 2009) as well as impaired renal and hepatic function usually seen in elderly or chronically ill individuals (Casau, 2005).

### Identity Development

An individual's sense of identity may be seen as a construct comprised of aspects of their social and psychological interactions; it is complex, varied, layered and multi-dimensional. "Identity" may contain characteristics of the individual's biological traits, regionality, ethnic background, psychosocial needs, expression and experience of sexuality, physical and sexual identity, as well as constantly evolving religious, spiritual, and political beliefs (Collier & Thomas, 1990; Erikson, 1968). Identity provides a balance between a person's sense of individuality and social unity with an inner sense of linear sameness and permanence, while allowing for a continual synthesis of new experience to contribute to a

holistic sense of being (Fadim & Frager, 1993), forging what identity development theorist Erik Erikson called “a selective, integrating, coherent and persistent agency central to personality function” (Erikson, 1964, p. 137).

In an attempt to understand the foundations of bareback identity, this study will look at the widely accepted identity development stage models. Erikson’s identity development model and the most widely accepted models of LGBT identity development that emerged from his may have useful as initial query into this area, but they carry numerous underlying assumptions that impede an understanding of the bareback identity phenomenon.

### Eriksonian Identity Development

Erikson’s eight-stage model posits a linear process of development for human personality growth and identity development throughout the lifespan. His model offers opportunities for the individual to occasionally reevaluate and modify facets of their identity as necessitated by life circumstance. Each stage contains developmental tasks, takes place within a chronologically optimal period in the individual’s life and, if completed successfully, manifests in psychosocial strengths that assist the individual through the rest of the developmental phases (Boeree, 1997). Erikson saw identity as “a configuration of

gradually integrating constitutional givens, idiosyncratic libidinal needs, favored capacities, significant identifications, effective defenses, successful sublimations and consistent roles” (Erikson, 1969, p. 116).

As a contrast to this image of a holistic, unified sense of personal self, a deficit in the individual’s sense of identity can result in fragmentation (Minton and Macdonald, 1984), or a skewed, antagonistic view of existing norms, available values, and socially oriented interactions. The individual, unable to adhere to what he believes are the markers of a positive social model, may opt to align with one that appears negative, or creates one that suits his perceived needs (Fadim and Frager, 1993).

Erikson’s model posits an “either / or” scenario to illustrate the dynamic polarity between what is considered the successful or unsuccessful completion of each stage. In infancy, the model begins with basic trust vs. mistrust in a child’s perception of his environment. According to this model, the individual’s development of a sense of trust is primarily reliant on the success of the maternal relationship, followed by stages well known in psychological literature by their “positive attribute vs. negative attribute” labels: autonomy vs. shame and doubt, initiative vs. guilt, industry vs. inferiority, identity vs. role confusion, intimacy vs. isolation, generativity vs. stagnation and ego integrity vs. despair. Each stage’s successful completion is predicated by the successful completion of

intrinsic markers of the prior stage much like the biological phases of embryonic development.

Unlike embryonic development however, Erikson posits that each stage maintains an active tension between two poles, with the marker for healthy and successful completion held in a middle ground (although success is often defined by the weight of what would be considered more positive attributes than negative). Increased self-efficacy, inner cohesion, and the functional capacity of the individual results from successful resolution of each of the stages. Movement forward into the next stage is confirmation of the successful completion of a challenge or crisis that allows for the integration of new aptitudes and strengths by the individual that are enhanced by the individual's perspective of their enhanced value.

"Epigenetic" is a term often used to describe Erikson's model, but not necessarily understood in the true definition of the word. Erikson's use of the word refers to the ongoing process of development, unfolding or evolving according to a pre-determined plan where interference with that process may ruin the final product (Boeree, 1997). A broader and perhaps more appropriate definition of the term encompasses a sense of evolution or mutation through the stages into a new form that may have characteristics radically unlike those in the prior stages. Movement through the stages of identity development is not simply a matter of

layering more and more information and experience, but instead, altering the individual's capacity to interpret that information and consequently, the process by which meaning is constructed (Kroeger, 2000).

It is important to note at this point in the research however that Erickson, as the progenitor of a linear operationalized and systemic identity development model, has been criticized for the lack of statistical research to support his model (Fadim & Frager, 1993). Erikson himself fully admitted the challenges in operationalizing and illustrating such a multidimensional and personal construct (Erikson, 1980). This is an important distinction, as many models, including the following, have been based on Erikson's concepts.

#### LGBT Identity Development Models

Beginning in the mid 1970's approximately a dozen theoretical models were constructed to explain the development of gay identity (Cass, 1984), with three emerging as the most salient (Cass, 1979; Coleman, 1982; Troiden, 1989). Erikson (1993) emphasizes the importance of the individual's sense of personal, internal solidarity with the principles and expectations of the subgroup to which they are drawn, and that this perspective is reflected back to them. Like Erikson, theorists attempting to conceptualize a model for homosexual identity development have suggested progressive stages based on the successful completion of prior

challenges. However, they emphasize the process by which the individual shifts from identification with the dominant heteronormative culture to that of a minority or sub-culture. Cass (1979), Coleman (1982), and Troiden (1979) all posit that the development of sexual identity is mutable and ongoing while being also affected by environmental factors such as sociopolitical climate, family of origin, and genetics. As with Erikson however, they are limited by their ability to fully encompass the enormous impact that all of the previous factors will have on sexual identity.

Erikson's model asserts that positive identity formation is dependent upon the extent to which the individual has successfully navigated the prior stages of psychosocial development. The understanding of this process within LGBT models however, has been built upon heteronormative foundations and understanding of identity (Diamond, 2006). Theorists focusing on LGBT models of identity development have attempted to address the process by which LGBT individuals living within this bias move along their lifespan trajectory as a result of sociocultural influences. This perspective then implies that these models are built on a dichotomizing factor of sexual identity, however, all individuals, not only those of the MSM community, attain their sexual identities in distinctive ways based upon how they reconcile the greater whole of their identity within the parameters of sociocultural influences.

(Ritter and Terndrup, 2002). In light of this, it appears that the widely accepted and largely static LGBT models (as well as stage models for heterosexual populations) lack the ability to take into account the rapidity with which other dynamic factors such as social acceptance, assimilation, and cultural oppression whether real or perceived can have on the individual's development of sexual identity.

#### Cass's Model of Homosexual Identity Development

Cass (1979, 1983/1984), like Erikson, proposed a six-stage, linear theoretical model of development for gay women and men where identity is obtained through a developmental procedure. Cass assumes however, that the foundation of the individual's experience is comprised of the individual's parental heteronormative assumptions regarding sexual orientation. Therefore, Cass's model begins with the individual experiencing incongruence between the heteronormative behaviors and their same-sex attractions (Ritter & Terndrup, 2002). This incongruence leads to the first stage that Cass names "identity confusion" and progresses through "comparison", "tolerance", "acceptance", "pride" and "synthesis" (Cass, 1979, 1983/1984).

#### Identity Confusion: Stage One

Uncertainty in identity is the origin point of Cass's (1979) development model, wherein an awareness emerges in the individual that

their knowledge in respect to same-sex attractions may apply to them. During the process of integration of this information, heightened levels of confusion, distress or anxiety may emerge as a result of the clash between their already internalized heteronormative experiences and their new experience of alignment with same-sex desire.

Within Stage One, Cass asserts that individuals will attempt to resolve their internal conflict by assessing the veracity and adequacy of this new self-perspective in several different ways (Cass, 1979; Ritter & Terndrup, 2002). The individual may see their same sex attractions as “correct and acceptable” (p. 91), facilitating movement that reduces confusion and internal discord between the former identity and that identity that is currently emerging. There is also the possibility that the individual will perceive this new information as “correct but undesirable” (p. 91) or “incorrect and undesirable” (p. 92), and that this attitude will impede or negate the course of identity development.

#### Identity Comparison: Stage Two

The hallmark of Stage Two appears in the individual’s recognition of the possibility that they may be homosexual. Confusion at this stage is minimized to a degree by the individual’s ability to acknowledge that they are homosexual. As this new perspective emerges the individual may feel isolated from peer groups and family (Cass, 1979). In the attempt to

mitigate this sense of isolation, individuals may engage in four strategies. The individual's choice of strategy is directly related to the level of comfort with their sexual orientation and their perceptions of themselves. Cass outlines four strategies that attempt to reduce or diminish the individual's view of themselves or others, inhibit their perception of the importance of a gay self-image, regulate negative reactions within their social environment and overvalue heteronormative values (Cass, 1979: 1990).

#### Tolerance: Stage Three

Acknowledgment of the probability that one is gay marks the third stage of this development model. At this point, there is likely to be a reduction of confusion regarding sexual orientation and the individual is able to comprehend their needs in areas regarding social, emotional and sexual interaction. This is a period however, where the dissonance between the individual's self perception and their assumption of how others see them may actually increase feelings of discomfort or alienation, propelling them to seek out aspects of the gay community, role models and other individuals (Ritter & Terndrup, 2002).

The impact of Stage Three's importance relies upon the quality of emotional fulfillment that the individual is able to glean from these contacts. Cass (1979) asserts that these contacts must be constructive in order for positive movement in the individual's identity development. If

these interactions are not perceived as positive, the individual may retreat from contacts within the newly identified community as well as experience lowered self-esteem and value for the gay subculture.

#### Identity Acceptance: Stage Four

Stage Four is characterized by continued and progressive interactions with other members of the gay community that authenticates the individual's emerging identity and encourages acceptance of gay self-image. This is a significant transition to *acceptance* from *tolerance* that allows the individual to explore further their preferences within the subculture. Critical to this stage is the influence projected by the gay subgroups with which the individual aligns; he may immerse himself fully in the belief that his same-sex orientation is valid both publicly and privately, or engage in a "partial legitimization philosophy" (Cass, 1979; Ritter & Terndrup, p. 95) where private acknowledgment of one's identity is considered valid, but is inappropriate to share with the rest of society.

Strategies for constructing a partial legitimization philosophy include *passing* as heterosexual, thereby diminishing the possibility of negative reactions from others, *limiting contact* in the attempt to reduce feelings of alienation from the dominant culture and *selective disclosure* to significant heterosexual others in the attempt to ease feelings of incongruency with a heteronormative dominant culture (Cass, 1979; Ritter

& Terndrup, p. 96). Progression to the fifth stage of this model requires successful full legitimization that supports and validates the individual's identity development. Full legitimization then may be facilitated by the individual's frustration with unsuccessful attempts at the former strategies that only serve to highlight their experience of living within a heterosexist and homophobic culture (Cass, 1979, 1990).

#### Identity Pride: Stage Five

An immersion into the gay subculture characterizes Stage Five, as the individual begins to diminish the importance of heterosexuals and appreciate or exaggerate the importance of their same-sex oriented compatriots. According to Cass, this shift emerges from the individual's perception of the contrast in the affirming way in which they view themselves juxtaposed against a heteronormative society's oppression of their identity. Individuals in this stage now favor their new identity over their previously held heterosexual self-image and, driven by anger or the threat of alienation, become activists for the gay and lesbian community and use disclosure of their sexual identity as a means of coping with these negative feelings (Cass, 1979).

Cass again asserts the possibility of identity development foreclosure during Stage Five if the individual experiences critical, offensive or deprecating responses from others in the process of disclosing

their sexual identity. If the individual anticipates derogatory interactions with those around him and receives positive affirmation instead, cognitive dissonance may occur thereby driving him to the sixth and final phase of identity development, “Identity Synthesis” (Cass, 1979, 1990; Ritter & Terndrup, 2002).

#### Identity Synthesis: Stage Six

As the individual begins to socially differentiate and focus on where they may garner emotional support and validation rather than interactions based on peer sexual orientation, the perception of an alienating dichotomy recedes, and feelings of pride and anger are less inundating and salient. Cass asserts however, that as higher levels of confidence are placed in the relationships that the individual has with compassionate and approving heterosexuals (1979), “unsupportive heterosexuals are further devalued (p.234).

Stage Six also marks the ability of the individual to integrate the possible commonalities and disparities between themselves and the heterosexuals in their orbit. With greater levels of comfort in incorporated identities, disclosure is at the forefront of social interactions. The resulting solidarity in this process then allows for the individual to progress into “the typical developmental tasks of adulthood” (Ritter & Terndrup, 2002, p. 97).

### Troiden's Model of Homosexual Identity Formation

In contrast to Cass's concept, Troiden (1989) proposes a non-linear, recursive, overlapping four-stage model with steps that are likely to align with developmental points in the individual's life history. His model also describes potential coping mechanisms for the anxiety that may manifest from the process of identity formation.

#### Sensitization: Stage One

Troiden's first stage of "Sensitization" originates in childhood when the individual gains an awareness of otherness that may be more concerned with gender identification rather than awareness of same-sex attractions that typically assert in puberty. The individual may experience marginalization directly or indirectly and lay a foundation for an internalized negative self-concept.

#### Identity Confusion: Stage Two

The second stage, "Identity Confusion" is driven by the individual's feelings of incongruence or instability with peer norms, and the onset of feelings and behaviors that could be categorized as homosexual. Troiden asserts approximate age onsets of 17 for females and 18 for males and characterizes a shift in focus to the individual's sexuality. This second stage of adolescent development is characterized by limited identification with others in the subgroup that could provide a sense of

solidarity as well as the possibility of developmental arrest due to the individual's restricting of emotional expression and contact with others (Troiden, 1989).

Within Stage Two, dissonance occurring from the conflict between childhood and adolescent permutations of identity may be addressed with various coping mechanisms. "Denial" occurs when the individual declines the significance of same-sex attractions, behaviors or desires. The strategy "repair" is characterized by the individual attempting to eradicate same-sex attractions, behaviors or desires with professional help. "Avoidance" may emerge as the individual attempts to inhibit behaviors that might influence perception of their sexual identity, diminish interactions with the opposite sex, and evasion of information that might confirm their sexual orientation (Troiden, 1989).

Additionally, the "avoidance" strategy may manifest into the individual's implementation anti-gay attitudes and behaviors towards other gays, or the avoidance of homoerotic impulses through substance use. "Redefinition" mirrors Cass's (1979) mechanisms in her Stage Two, where the individual is driven by alternative motivations that may involve factors such as situational context, "special case" strategies, "personal innocence" perspectives or "temporary identity" tactics (Troiden, 1979, 1989; Ritter & Terndrup, 2002).

A final strategy, “acceptance” may be utilized by the individual when recognition and tolerance of belonging to a social group reduces their perception of alienation and isolation. This may propel the individual to explore more information regarding the newly recognized aspects of their sexuality and then lead to Stage Three.

### Identity Assumption: Stage Three

Stage Three, “Identity Assumption” is characterized by an increase in socialization with others that identify as LGBT, with the primary developmental task being the management of social stigma. Troiden contends that the individual’s lack of a supportive family environment during this phase may encourage coping strategies echoing Humphrey’s (1972). “Capitulation” occurs when the individual internalizes and submits to non-affirming views of their sexuality that result in the avoidance of same-sex behaviors. “Minstralization” is the adoption of behaviors that align with broad cultural stereotypes of gays. “Passing” is the attempt to draw distinction and separation between behaviors and interactions in the individual’s dichotomous social environments, in effect living a “double life” (Ritter & Terndrup, 2002, p. 100). Finally, in “Group Alignment” the individual may totally submerge himself in the gay subculture and opt to avoid all situations where they might experience heterosexual stigma.

### Commitment: Stage Four

The final stage, “Commitment” is characterized as a “state of being” (Ritter & Terndrup, 2002, p. 100) with increased levels of interpersonal contentment and functioning, where the individual is less inclined to use previous coping strategies and homosexuality may take less relevance in their overall identity. Settling into this “state of being” is driven by the discomfort and difficulty that the individual experiences in his attempts to function in a heterosexual identity. Troiden (1979, 1989) outlines internal and external markers of Stage Four that the individual will experience: Internal markers include an integration of sexuality and emotional expression, a shift in understanding their sexuality from behavior to identity, increased satisfaction in this new identity, unwillingness to relinquish this new identity and an increase in personal contentment as this new sense of self is clarified.

External markers of Troiden’s Stage Four include experimentation with relationships that reflect the integration of sexuality and emotional expression with a need to reveal their sexual identity to their heterosexual peers. In attempts to manage potentially stigmatizing experiences, the individual may shift earlier passing and group alignment tactics to assimilating with heteronormative standards in order to retain respect from social peers while at the same time revealing their sexuality

to selected people. The individual may also compartmentalize their sexuality away from social interactions, neither denying or revealing this aspect of identity in the belief that sexual orientation is not germane to those relationships. Another option is the morphing of the sexual identity to a mark of dignity and self-respect from that of a shame – based perception (Troiden, 1979, 1989).

#### Coleman's Model of Homosexual Identity Development

Coleman's (1982) five-stage model of lesbian and gay identity development offers a conceptual approach that is not necessarily tied to the age of the individual. This model allows for individuals to enter and exit the process of identity development at different markers while not necessarily experiencing each stage in a linear fashion. Additionally, not all individuals experience each stage of Coleman's model depending upon their own unique development histories, or they may experience various aspects of multiple stages simultaneously.

#### Pre-Coming Out: Stage One

The preconscious state of "Pre-coming Out" describes when the individual becomes aware of being different without necessarily being able to pinpoint the nature of the differences between himself and his peers. He may repress or reject same-sex attractions. In children, this experience may result in the individual experiencing feelings of isolation, alienation

and a sense of being different from their peers. The self-esteem of the individual may be negatively impacted at this stage and attempts to mitigate these experiences may result in the use of classic defense mechanisms such as rationalization, sublimation, denial, repression and reaction formation (Coleman, 1981, 1982). During this time, individuals may be challenged by “behavioral problems, psychosomatic illnesses, suicidal attempts or various other symptoms” (p. 33) in their attempt to express their experience of inner discord. The conscious awareness of same-sex desire breaking through such primitive defense mechanisms will then allow the individual to move to the next stage of development.

#### Coming Out: Stage Two

The second stage, “Coming Out” is the initial exploration of acceptance and understanding one’s same-sex attractions that may be confusing: while there is burgeoning awareness, there is not likely to be clarity in the understanding of what it means to be gay. The sharing of the individual’s self – awareness with others may be a positive experience, leading to increased comfort and further disclosure. During this stage, heteronormative standards are still held as preferable, so recognition and acceptance from selected heterosexual peers may serve as positive reinforcement to the still fragile identity formation of the individual, while acceptance from gay peers may not be significant. If disclosure to peers is

a negative experience, developmental regress to Stage One can occur (Coleman, 1981, 1982).

#### Exploration: Stage Three

“Exploration”, the third stage is characterized by exploration and experimentation with a new social and sexual identity. Coleman asserts that promiscuity, obsession, and romantic pursuit are likely to be the hallmarks of this stage, which may pose challenges in the form of shame to the post-adolescent or post-teen adult. Again, difficulties at this stage may result in a reversion to a previous state (Coleman, 1981, 1982).

#### First Relationship: Stage Four

The stage “First Relationship” is comprised of a longing for more consistent and profound interpersonal and intimate relationships that is supported by the individual’s sense of competency regarding their sexual abilities. Coleman’s use of pejorative terms for this stage include descriptives such as “intensity”, “possessiveness”, and “desperation” (p. 38) with the implication being that these emotional experiences are exclusive to the same-sex oriented population. Rebellion at this stage may result in the pursuit of sexual connections outside of the primary committed relationship (Coleman, 1981, 1982).

### Integration: Stage Five

In the final stage, “Integration”, the individual’s perception of themselves is no longer fragmented, but rather they see themselves as a fully functioning member of a larger society where their personal and public selves achieve union. The hallmarks of this stage are increased self-efficacy, increased resiliency against rejection, increased relationship stability and a decrease in doubt and fear of loss (Coleman, 1981, 1982).

### LGBT Models’ Synthesis

The previous models present a logical and linear progression from awareness to immersion to integration of sexual identity (Bilodeau and Renn, 2005). They begin with a phase where individuals engage in the use of varied defense mechanisms to halt the detection of same-sex attractions. The defense mechanisms are used in the attempt to reduce the individuals’ homosexual feelings for a period of time that may vary from person to person. This approach can have negative consequences in regards to emotional health for the individual stemming from the psychic energy required to contain the structure of such defenses.

According to the models, the eventual acknowledgement of non-heterosexual orientation emerges from an incremental recognition and provisional acceptance of same sex-attractions and feelings. These stage models assert a period of tentative emotional and behavioral testing with

members of the same sex that generally follows the acknowledgment of attraction that then transitions into an increasing sense of “personal normalcy” (Bilodeau and Renn, 2005, p. 26). Each of the models assert that identity crises may occur as a result of the end of a first relationship, thereby reinforcing former negative perspectives of same-sex attractions. Additionally, the models propose that final integration and an affirmative, accepting view of self occurs when same-sex attractions are once again accepted.

#### Limitations to LGBT Identity Models

Stage models present a number of challenges in their usefulness for current understanding of sexual identity development. The assumption and subsequent implication in the majority of current research on stage gay identity models is that they accurately represent the development process. This assumption presents a challenge in providing empirical validity, as they were primarily developed with small samples, and sometimes without empirical data. They are limited in the same way that their perspective of the individual is limited, and this may be a reflection of the era from whence they emerged: In the late 1970’s through the 1980’s the shift from pathology to sexual orientation within the psychological community was still relatively new. In these models, it is as if the same-sex attracted person does not exist as a fully rounded being outside of the

singular facet of their sexuality, and that the development of one's identity is, in essence, a ricochet effect of feeling apart or different from existing heteronormative standards.

The models suggest a fixed, integrated and significantly valuable final point that does not accurately describe the perspective of many people, whether they are same-sex attracted or not. Cass, Troiden and Coleman all hold up the individual's realization of that integrated endpoint as a marker of healthy sexual identity (Bilodeau and Renn, 2005). While Cass does propose that congruency or incongruency of the individual's sense of self is directly related to stability, changes and adaptation (Ritter and Terndrup, 2002) all of the models are limited by a static framework that does not take into consideration rapid changes in culture, the devastating impact of AIDS on multiple generations of our society and much less, the influence of patriarchal culture on men's decision-making processes. The models do not address the concept that LGBT identities have different names and often conflicting meanings when viewed through a multicultural lens: The concepts of gender identity, culture and sexual orientation that originated from a Eurocentric perspective are obfuscated, deconstructed and rebuilt based on the identity needs of different cultural and ethnic groups (Bilodeau and Renn, 2005).

The theorists admit that the process is generally more fluid and recursive than a true phase / stage model permits (Cass, 1979, 1984, Troiden, 1979, Savin-Williams, 1990), but it is likely that they don't emphasize it enough. As is the challenge with all theory firmly rooted in a particular age, perhaps the writers could not have anticipated what would develop over the following decades, or even the speed at which these multiple factors (HIV, political movement, partial social acceptance, the resurgence of the fundamentalist Christian movement) would increase.

Problematic also is that the vast amount of data used to formulate these stage models of gay and bisexual identity development was drawn from adults reflecting back on their experiences that may have begun decades earlier, thereby heavily influenced by the plasticity of memory (Ryan and Futterman, 1998). Looking backward in this way may help our understanding of identity development, but it will lack the ability to account for rapid change.

Many of the Cass, Troiden and Coleman's assertions can appear archaic by their implicit judgment by the use of terms such as "pride" (Cass, 1979, 1983/1984) "minstralization", "avoidance strategy" (Troiden, 1989). References to extra-relational sexual connection as act of rebellion (Coleman, 1981, 1982) fail to respect a broader and less heterosexually oriented template for relationships. The impetus of progression through

several points of Cass and Troiden's models appears to be the stigma that the same-sex attracted individual perceives regarding his feelings. While this may be accurate, it likely holds much less effect on the individual in 2009 than it did 25 years ago.

Coleman's third stage, "Exploration", is characterized by exploration and experimentation with a new social and sexual identity. Coleman asserts that promiscuity, obsession, and romantic pursuit are likely to be the hallmarks of this stage, which may pose challenges in the form of shame to the post-adolescent or post-teen adult. It appears that little attention is paid to the wide variance interpersonal relational skills that would stem from the various influences of ethnicity and culture, or even the diversity of parenting styles.

Though no one model can capture the entire spectrum of identity development within the LGBT community, at this stage in Western culture, it is generally accepted that the awareness of one's same-sex attraction is likely to place the individual at odds with a heteronormative society when some universal and persistent themes are evident. Caution should be urged when taking a narrow perspective of any one individual (Martell, et. al, 2004), let alone one who is impacted by multiple and society influences in the journey through resolution of their sexual identity. Research within the LGBT population consistently demonstrates

the mental health benefits of accepting a gay identity, resulting in generally higher levels of functioning, increased ego strength and increased self-esteem (Brady & Busse 1994; Miranda & Storms, 1989; Walters & Simoni, 1983; Wells & Kline, 1987), possibly illustrating the importance of internal identity solidarity that pushes back against perceived oppression.

Understanding identity with the MSM population necessitates a broader respect for non-homogeneity within a group, as no term would sufficiently include the diversity of individuals from all cultural, racial or ethnic groups who express sexually through MSM activities (Martell, Safren, Prince and Goldfried, 2004) and that individual identity development must not be necessarily equated with the process of group identity development. Further, Martell asserts that an understanding of sexual identity must be distinct from that of sexual orientation; the author stresses that there is not always a parallel between sexual behavior and sexual orientation or identity.

Yep, Lovaas and Pagonis (2002) offer that while the foundation of gay identity is sex, a “gay sexual identity” (p.3) is not homogenous. A same sex-oriented sexuality encompasses the same diversity that describes other “sexual-object choice” populations and is subject to the same disagreements, strains and dissections that plague the gay community on

the basis of socio-economic status, age, race, culture, and ethnicity. For the MSM community, sex is an integral part of identity foundation and the act of barebacking supports this identity with a resistance to norms imposed by a heteronormative culture (p. 4). A more longitudinal perspective aligns unprotected sex as emerging from Western cultural values of an individual's choice and responsibility (Parsons and Bimbi, 2006). A choice for many that would be unimaginable becomes a necessary and perhaps valuable part of one's identity in this context.

#### Bareback Identity

While unsafe sex is irrational for the greater population, a process of rationalization takes place in the formation of a bareback identity that is likely fraught initially with cognitive dissonance. Decisions weighing the benefits versus perceived threats of unsafe sex are not necessarily irrational (Suarez and Miller, 2001). This cost / benefit analysis which combines potential harm-reduction tactics such as strategic positioning and serosorting with reinforcement of sexual and masculine autonomy and may well outweigh any perceived threat of HIV infection.

Therefore, the methods through which an individual finds relief may parallel journey to a holistic sexual identity, where an "us vs. them" dichotomy (Ritter and Terndrup, 2002) is solidified as the individual perceives negative or diminishing actions and attitudes that confirm the

individual's preconceptions of the other. In this case, the "other" being those that affirm safer sex practices. This movement "redefinition", reflects what Troiden (1989) describes in step four of his model as a critical stage for the final point of "acceptance" where "the process of labeling themselves as belonging to a social category diminishes their sense of isolation" (p. 99)

A subculture that perceives itself "other" such as the MSM community, still must deal with the impact of homophobia from the greater population, as well as internalized aspects of that homophobia. In his discussions on adolescent development, Erikson (1969) asserts that conflicted individuals are drawn toward re-integration of aspects of the fragmented self, therefore, the choice of an identity presented as undesirable or dangerous is yet still preferable to an identity without substance, or that is oppressed (Martell, Safren, Prince and Goldfried, 2004). The individual's construction of an integrated identity, regardless of incongruencies or biases, may well hold benefits for the individual that they perceive to outweigh the risks. They may believe that unprotected sex is more physically intimate or that it feels reinforces their autonomy as a man. Cole (2006) points out that individuals are likely to choose an intrinsically personal tactic to minimize their experience of stress or threat, thereby illustrating how decisions arising from the individual's

behavioral social identity act as mechanisms for this part of the development process. Integral to this process however is how that particular strategy is influenced by the threat of social rejection.

The generally accepted view of public health models is that individuals take part in dangerous activities due to a lack of specific knowledge of that danger through ignorance or lack of education. As a result the approach for most programs focused on HIV prevention is based on the assumption that information regarding consequences to certain actions will avert risk-seeking behaviors (Parsons, Halkitis, Bimbi, & Borkowski, 2000). In spite of a broad spectrum of available information regarding the dangers of nicotine, and fatty foods and excessive alcohol on one's health, many individuals continue to engage in these activities (Fogarty & Youngs, 2006; Fogarty, 1998; Walker, M., Laresen, R., Zona, D., Govindan, R. & Fisher, E., 2004).

For researchers familiar with the historical advent and scope of the AIDS epidemic, there is disbelief and disappointment in the attempt to understand how some individuals can choose to intentionally engage in unsafe sex (Halkitis, 2005), and a grudging acceptance that efforts at risk – reduction behavior has small impact, if any (Yep, Lovass and Pagonis, 2002). This acceptance has perhaps come with the understanding that efforts made by public health agencies must understand the impact of

those efforts on the individual's sense of personal power, autonomy, dignity and values (Martin 2001).

Understanding the choice among MSM to engage in unprotected sex at this particular point in time in the history of HIV is a challenge that has begun to garner a great deal of attention among researchers in recent years. Unprotected sex includes facets of how some MSM define themselves, although the processes by which the mechanisms of barebacking and the formation of a bareback identity (Yep, Lovass and Pagonis, 2002) are conflicting and not well understood (Halkitis, 2007; Halkitis, Wilton and Drescher, 2005; Halkitis, Wilton, Wolitski, Parsons, Hoff and Bimbi, 2005; Mansergh, 2002; Shernoff, 2005; Wolitski, 2005).

The adoption of a bareback identity is complex and multilayered and may hold varied and multiple meanings for the individuals engaged in the behavior. These multifaceted and sometimes contradictory motivations may themselves emerge from radically different aspects of the individuals' culture, as well as an already existing sense of identity, which itself is borne of multiple and conflicting factors. The difficulties in identifying a newly emerging epidemiological or behavioral movement may stem from a seemingly insignificant rise in dangerous actions or disease occurrences that symbolize a relatively dramatic shift (Wolitski,

2005). This dramatic shift may then affect a huge portion of the population, or in this case, subpopulation.

The practice of unprotected sex, aside from that of a barebacker identity has been discussed as “both a symptom and a cause of broader changes in the ways that MSM think about HIV, their risk of becoming infected, or infecting someone else” (Wolitski, 2005, p.11). The act of barebacking is seen as a symptom in that it results from the availability of effective medications, ongoing transitions within the gay community and changes in how prevention programs are conducted. Additionally, the act of barebacking among MSM may act as casual factor in increased risk by providing a “social identity” (p. 11).

Herek asserts “minority groups come together because of characteristic features that are devalued by dominant segments of society” (Ritter and Terndrup, 2002, p. 89). As the MSM is not a homogenous group by any means with regard to need for social acceptance or presentation of personal identity, any kind of sexual prejudice, even from within the MSM community can provoke a range of psychological and behavioral stress responses and discernment of personal hazard (Cole, 2006). All individuals experience a dissonance in how society views them and how they view themselves. They may use a dichotomizing tactic to mitigate “feelings of anger born of frustration and alienation” (Cass, 2002,

p. 79). She offers that this rage will combine with the individual's sense of self – respect and thereby manifest in motivation for activism. But what if there is another result? What if the experience of anger at perceived oppression by public health policy combines with other factors such as a desire for physical intimacy results in actions taken against the self?

### Limitations to Understanding

As Ritter and Terndrup (2002) note, the examination of individual identity development within broad identity development models is limited by consistently sound methodological and longitudinal research. Diamond (2006) presents an exhaustive list of the limitations of existing models of LGBT identity development citing a primary difficulty of the use of individuals' self-definition across divergent and varying model constructs. How then can researchers accurately represent individuals in the first stages of sexual identity acquisition or development, when they may not yet see themselves as LGBT?

By far, the majority of studies of MSM development have been generated from data on White, middle-class men under the age of 45, a population that in general, tends to represent a higher socio-economic status, and higher levels of parental education. This is a group that does not necessarily represent all individuals who fall into a sexual minority category. This precludes a deeper understanding of the differences in

sexual orientation between various peoples of color (Diamond, 2006; Martell, Safren, Prince & Goldfried, 2004) and is additionally limited by potential sampling errors that may result when studying any obfuscated, oppressed groups that experience stigmatization or who do not take an active role in the subculture.

Classic models of identity development present a linear, largely non-recursive template, and assert that the result is final or immutable; this may be the exception rather than the rule, particularly for the LGBT community. An important criticism of the existing sexual identity models is that they all suppose an end stage where there is a clear lesbian, gay or bisexual identity that is the necessary foundation for future healthy development. She points out that ambivalence regarding a label comprised of any of these facets is likely to be seen by the mental health community as a sign of internalized homophobia and further self-stigmatization (Diamond, 2006).

Erikson, Cass, Troiden and Coleman all acknowledge that identity development is informed by contextual factors such as the political climate or the individuals' own journey of self-discovery, however, it is unlikely that any of the models could have predicted the radical impact that AIDS would have on the MSM community both positive and negative. On the positive side, emergence of AIDS into the LGBT community inspired

solidarity on many fronts and cemented the efforts of grass-roots organizations. On the negative side however, misinformation, nascent medical research, poor government response and cultural immaturity on the part of the larger society resulted in an explosion of HIV-related stigma and fear that may well have set back the achievements of those in the LGBT communities.

Sexual identity, particularly for the MSM community, may continue to evolve due to contextual factors such as political climate, or the individual's own journey of self-discovery. In our understandable haste to stem the devastating effects that HIV continues to exert on our population, we may be missing valuable components of the driving mechanism, particularly when studies (Meyer, 2007) show that our understanding of adult development in sexual minority peoples of color are vastly underrepresented in research. Comprehending the phenomenon of barebacking identity will require more than the outdated and narrowly defined stage-development models that have been accepted over the past three decades. It is this author's assertion that the adoption of a "bareback identity" is intrinsically tied to a man's perception of his sovereignty regarding the expression of his sexuality, his conscious and unconscious beliefs about his sexual orientation, and most importantly, the impact of his entitlement in a male-dominated society.

As previously noted, researchers in HIV transmission have endeavored to look at what incremental and statistically sound information that can be gleaned from studies that focus on quantifiable factors. While these studies are absolutely necessary and play an integral role in treatment, advocacy and prevention policy, they miss the larger and sometimes more nebulous static characterological factors that are involved how individuals choose to express their sexuality.

For the vast majority of known cultural history around the world, men have traditionally held a relationally and societal dominant position in virtually every strata of society regardless of their socio-economic status. This dominant position, often described as patriarchy or masculine hegemony, continues today in Western culture and encompasses a number of psychological / internal processes, assumptions and behaviors that affect the decision making progress of individuals, whether they are aware of these influences or not. A closer look at how MSM (with the emphasis on *men*) adopt a “barebacker identity” will show how sexual choice is linked to an individual’s perception of his entitlement as a man, his view of his sexuality, and ways in which desires to connect with others.

### Masculine Ideology

Masculine ideology, a norm conceptualization of the male gender role that has been extensively studied in heterosexual psychosocial

literature, has been described by Levant (1996) as a “complex and problematic construct” (p. 260). Originally coined by Thompson and Pleck (1995), the paradigm is a radical departure from earlier rigid and archaic models of gender orientation and instead focuses on the influence of societal pressure on the development of male gender norms. Pleck asserts that there are definitive markers of prevailing criterion and beliefs regarding traditional male gender norms despite the cultural and psychosocial diversity in the U.S. (1995). His attempts to categorize masculine ideology for a more current understanding resulted in a tripartite model, naming the inability of one to achieve congruence with an internalized ideal of male maturity “discrepancy-strain”. When the individual has been able to achieve said congruence but experiences negative side effects, this has been coined “dysfunction-strain” and the traumatic impact of the process of achieving the masculine ideals has been named “trauma-strain” (Levant, 1996, p. 261).

What is generally accepted as a precept of masculine ideology is that the individual considers himself masculine if his beliefs regarding how men should act are congruent with the norms within his culture, regardless of how congruent his actions are with that belief (Doss, 1998). While the emphasis in Pleck’s model asserts that the manifestations are socially constructed, there is little doubt that men are subject to normed

characteristics such as aggression, hostility, independence, toughness, and anti-femininity (Noar & Morokoff, 2002; Thompson & Pleck, 1986). An alignment with traditional norms of masculinity are predictive of sexual risk-taking (Amaro, 1995; Noar & Morokoff, 2002; Pleck, Sonenstein & Ku, 1993) as well as increased sexual behavior in heterosexual adolescent boys; higher numbers of sexual interactions, higher numbers of sexual partners and less consistent condom use (Parsons, Halkitis, Bimbi & Borkowski, 2000; Gillen & Lefkowitz, 2005; Pleck, Shearer, Hosterman, Sonenstein & Ku, 1993). In light of the power that masculine ideology has on the individual and the sexual scripts to which he adheres, the predominant identity development theorists, including Erikson, have missed a vital component in their models; gender.

Gender role norms exert a powerful effect on sexual behaviors as well as the dynamics that may occur within a sexual dyad. Hypotheses regarding safer sex behaviors that only consider thoughts and convictions are likely to miss integrally vital contextual variables such as the impact of consciously or unconsciously accepted male sexual category roles (Noar & Morokoff, 2002). Erikson, Cass, Troiden and Coleman in their attempt to standardize a linear model of identity development failed to incorporate the significant impact that masculine ideology has on the individual. Most importantly, alignment with traditional male gender roles can inhibit the

range of perceived behavior choices available to men and result in pressure and stress when conflicts arise as a result. In the heterosexual model of interaction, the “scripts” manifested by traditional gender roles reinforce men as sexual aggressors and customarily accepted male gender roles have a major impact on attitudes regarding safer sex and sexual behavior that put both men and women at risk for sexually transmitted infections.

In gynocentric studies of this phenomenon, it has been noted that prescribed gender roles of both men and women contribute heavily to sexual risk-seeking behaviors (Amaro, 1995; Edgar & Fitzpatrick 1988; Metts & Fitzpatrick, 1992) including higher levels of endorsed masculine ideology and its relationship to negative attitudes regarding condom use (Noar & Morokoff, 2002). The impact of the male gender role also places the women in the position of being an arbiter of sexual action (LaPlante, McCormick & Brannigan, 1980; McCormick, 1979; Simon and Gagnon, 1987).

What happens then in a connection between two MSM with no prescribed gender role as the sexual limit setter? As it has been observed, in the heterosexual model, higher levels of endorsed masculine ideology results in men who hold less conviction that they are responsible for pregnancy prevention, that pregnancy validates their masculinity, that

sexual interactions are antagonistic in nature, and that they rarely use condoms when the choice is theirs despite the fact that they are likely to be the ones that most often initiate sexual interactions (Noar & Morokoff, 2002). A reflection of this in the MSM community “suggests that men who identify themselves barebackers are more likely to perceive that responsibility for safer sex rests with their partner and not themselves” (Halkitis, Wilton, Wolitski, Parsons, Hoff & Bimbi, 2005, p. S33).

Men within the MSM community, regardless of how they identify the expression of their sexual desires, are subject to many of the same pressures to conform to gender stereotypes by authority figures, family, or their perception of the world around them (Martell, Safren, Prince & Goldfried, 2004). While an individual may recognize consciously or unconsciously his same-sex desires early in development, he is still subject to the pressures exerted through cultural context that contribute to the individual’s sense of his masculinity (Cronan, 2007). Those that engage in bareback sex may well operate within norms that emphasize “hyper rational, masculine, competitive individualism” (Adam, 2005, p. 345) that not only encourages them to push back against perceptions of behavioral constraint, but also allows them to engage in behaviors that problematic perception of what constitutes physical intimacy.

### Reactance Theory

According to Psychological Reactance Theory (Brehm, 1966, Brehm & Brehm, 1981), an individual will experience “psychological reactance”, described as the experience of an uncomfortable motivational state of pressures to re-establish a threatened or lost freedom, when the individual feels that their freedom to engage in a particular action is endangered or removed. The theory proposes that the higher-valued that particular freedom is to an individual, the higher the individual will experience reactance when he feels that the freedom is threatened or removed. An individual may then attempt to restore the perceived lost freedom by determinedly engaging in the activity that is threatened.

It has also been proposed that the “reactant response” may be triggered by the perception of a lost freedom, but also by the individual’s perception of when and how they desire to engage in that behavior (Seeman, Walter, Buboltz, Jenkins, Soper & Woller, 2004). “The concept of psychological reactance has particular application to paradoxical counseling, as the theory behind the use of paradoxical interventions predicts that some paradoxical techniques would be more applicable to reactant clients than compliant ones.” (Dowd, 2002).

Using the framework of reactance theory, it is possible to see the relative failure of attempts by health organizations and safer-sex programs

to advocate for condom use in effectively promoting safer sex, when they might well benefit from attempts that align with male gender role scripts and cultural values while de-pathologizing MSM relationships.

Pennebaker & Sanders (1976) efficiently and succinctly captured the essence of reactance theory in a simple experiment on a college campus. Two signs were posted at on separate college bathroom walls. One sign read “Do not write on these walls under any circumstances”. The other sign stated “Please don’t write on these walls”. After a two-week period, the more directive sign garnered significantly greater amounts of graffiti.

Resistance has been a constant characteristic of the struggle for LGBT rights and the reactance paradigm to stringent safer-sex campaigns has resulted in a “boomerang effect” (Crossley, 2004). Safer-sex promotion may be perceived by the individual as an authoritarian attempt to edit or censor their sexual expression, and if so, effectively acting as a promoter of what are considered unhealthy, unsafe or risky sexual behaviors. The act of choosing to engage in unprotected sex may be an attempt by the individual to push back against the dominant social values in a symbolic act of rebellion or transgression. These efforts may then instill or reinforce in the individual a sense of autonomy, self-determination or dissent, whether the individual is actually conscious of

these mechanisms. If the individual perceives health campaigns or perhaps even community and peer pressure as an attempt at suppression of their sexual choice or autonomy, this perceived pressure actually increases their motivation to engage in unprotected sexual acts. This may also reflect the barebacker's sense of disenfranchisement from numerous strata of the gay community and larger culture (Parsons & Bimbi, 2006). Decisions regarding behavioral social identity may act as the fulcrum upon which the individual expresses physiological stress responses, and the threat of social rejection, experience of shame and the weight of limited self-expression all have an impact on the development of the individual's identity (Cole, 2006).

However useful the theoretical concept of reactance theory is, looking only through this lens can pathologize whatever understanding we may have of MSM actively engaging in unprotected sex. Worse yet, the implied ethical imperative of regulating sexual expression may fetishize acts which, although dangerous, have become emotionally and physically stimulating for the individual (Martin, 2001). What it may lend to our understanding of the practice of barebacking however, is an individual's personal reactance level and how it interacts with other factors such as conformity to male role norms, that influence the choice to bareback.

Significant correlations in psychological reactance and the intent to engage in unprotected sex have been found among MSM (Braddy, 2004), but this data was gathered in a highly sexualized “circuit party” atmosphere where the use of disinhibiting recreational drugs is common and somewhat expected. Even so, this correlation would dovetail with Dowd’s characterization of reactance as a steady disparity variable in individuals that express along a normal distribution. In his view, “reactant individuals” have a positive self-image, but generally express as autonomous, dominant, generally intolerant and given to impulsivity (2002).

There is a lack of drive within the reactant individual to seek intimacy with or from others, as self-sufficiency and identity hold more priority (Dowd, 2002). As valuable as it may be to look at the level of reactance among those who choose to engage in unprotected sex, it may be critical to see “reactance” as part of a defensive system for the individual, much like the expression of Cluster B Personality Disorder tendencies that tend to emerge when otherwise “normal” individuals are distressed.

In our attempt to understand the phenomenon of barebacking within the framework of reactance it is irresponsible not to look at the larger social history and context of male culture when attempting to understand the choice to have unprotected sex. Despite the advances made

in anti-discrimination laws and rights in the last decade, there is a history of sexual minorities being marginalized, oppressed and pathologized throughout the history of this country and others. The struggling efforts of the Gay Liberation Movement through the 1960's pushed back against the labels of homosexuals as an illness, character disorder, neurosis and perversion. The explosion of sexual freedom and political expression that occurred during after the New York City "Stonewall Riots" in 1969 illustrates a broader example of reactance within the MSM community. Gay male identity, while previously forced to hide or skirt restrictive laws, could now express itself more freely through art, media and activism. This quickly evolving expression of sexual identity manifested in sexual freedom with gay men now claiming the right to sexual pleasure (Crossley, 2004).

### Internalized Homophobia

While a strict definition of the word is a "fear or dislike of men" (Oxford Dictionary, 1991), the Latin prefix "homo" became paralleled in the 1960's with "homosexual" so that the term became defined as a fear or dislike of homosexuals (Cronan, 2007). Ironically, a truly academic definition of the term would indicate a fear that the individual has of those like himself, lending weight to the argument that the root of homophobia arises from the fear of physical or emotional intimacy with a member of

the same sex (Cronan, 2007) or unconscious, denied same-sex desires in the heterosexually self-identified individual or unconscious, denied same-sex desires in the individual who exhibits the homophobic perceptions or behaviors (Adams, Wright & Lohr, 1996).

In the early 1970's, Weinberg coined the term "homophobia" and defined it as a persistent, irrational fear of same-sex orientation and the "dread" of close proximity to those identified as homosexuals (Farnsworth, 2002). Weinberg posited five triggers of homophobia that include religious teachings regarding the appropriate parameters of sexual behavior, a fear of those that live outside of anticipated social customs, the individual's fear of their own possible homoerotic impulses, the danger to traditional family values, and finally, the devaluation of relationships that do not provide vicarious immortality or preservation of identity through procreation (Weinberg, 1972).

The evolution of the term has continued over the past four decades as different theorists and researchers reflected the political and sociological zeitgeist in their definitions. Fyfe (1983) described homophobia in terms of a multidimensional construct with a solid foundation of inflexibility, repression, and political conservatism; a rejection of uncertainty and interpersonal difference that manifests in a broad array of negative attitudes and reaction towards homosexuals.

Morin and Garfinkle (1978) conceptualized homophobia as an alignment, whether conscious or unconscious, to hetero-normative standards that diminishes the value of same-sex relationships. Their definition expands to include the effects of negative memes, marginalizing labels, social discrimination, and epithets. Most importantly, Morin and Garfinkle proposed that homophobia progressed on a linear spectrum from a basic fear of homosexuals into a framework of perceptions, judgments, and behaviors towards homosexuals (Farnsworth, 2002, Morin & Garfinkle).

Following these foundational ideas, various researchers added to or honed their definition of homophobia over the proceeding decades as the concept of same-sex relationships continued to develop in the arena of Western culture, entertainment, and politics. Where Weinberg proposed a simplified phobic response to a perceptual antecedent (Farnsworth, 2002), there have been others who saw a standalone prejudice (Churchill, 1967), a reaction to perceived behavioral characteristics coined “homonegativism” (Hudson & Ricketts, 1980; Williamson, 2000), an adherence to hetero normative standards (Norris, 1982), and a fear experience that encompasses the entire population rather than just males (Cronan, 2007; Frost 1999). It can soundly be argued that the suffix “phobia” is not the most accurate descriptor in this term and may in fact detract from true operationilazation of the word. A true phobia must meet

several criteria wherein the individual experiences a fear that is constant, powerful and irrational, with a need to avoid the triggering antecedent (American Psychiatric Association, 2000; Reber & Reber, 2001).

Homophobia as it is discussed in these writings does not meet the necessary pathological markers. A more apt depiction may be a moral aversion to homosexuals that exists in American culture that originates from a much broader foundation than originally envisioned by Weinberg (Farnsworth, 2000), an aversion that triggers fear within homo- and hetero-sexual individuals that they will be perceived as gay, or that in a sense they are not truly men (Kimmel, 2005). Even without the full impact of a truly clinical phobic fear response, what was a slow and steady gestation period during the 60's and 70's blossomed as an active construct during the 1980's as AIDS gave new meaning to "the dread of being in close quarters with homosexuals" (Cronan, 2007, Weinberg, 1972, Buchbinder, 1994).

Farnsworth (2002) asserts that the fundamental foundation for homophobia is slowly dissipating, collective preconceptions and social bias continue to exist in various forms such as the current United States Military's stance of "don't ask, don't tell", the correlations by evangelicals of natural, social and political disasters with mainstream acceptance of alternative sexuality (pg. 6), and most recently, the vast amounts of

funding poured into the defeat of Proposition 8 in California. While this may be true of the macrosystem, the impact of homophobia on the individual is still heavily influenced by age, race, ethnicity and cultural background. Comparing a twenty-something exposed to a steady diet of mainstream popular culture such as “Will and Grace”, “The L Word”, and “Queer as Folk” is likely to have had a normalizing effect will find a stark contrast to the fifty-something individual still living a closeted life due to their experiences during critical developmental periods. Though there is movement socially, politically and culturally, the individual’s experience of one’s self or social connections as other, defective, deviant or bad may be incorporated into negative core beliefs that exhibit in what is known as “internalized homophobia”. This has been linked to a number of affective and behavioral challenges such as depression, social isolation and social avoidance (Martell, C. R., Safren, S.A., Prince, S.E., Goldfried, M.R., 2004, Russel & Bohan, 2006) and as an emerging model has provided fertile ground for exploration in psychological research and has impacted a spectrum of psychological practices (Russel & Bohan, 2006).

Internalized homophobia seems an almost unavoidable outcome when individuals experience heterosexist norms that emphasize or present negative attitudes about homosexuality during their early development. Developmentally, individuals who experience same-sex attractions

generally lack parents who share their potentially stigmatized self-view, or parents who can serve as interpreters and guides through a hostile cultural environment (Huebner, Davis, Nemeroff & Aiken, 2002). This negative self-view can exist even within those that are able to identify with their gay culture (Williamson, 2000). Building on the earlier broad definitive points previously examined, internalized homophobia is more clearly understood as a framework of negative attitudes and behaviors focused on perceived homosexuality in others as well as those features in oneself, whether consciously or unconsciously recognized (Shidlo, 1994). It is a significant concept in understanding the breadth and impact of the individual's experience of same-sex attraction, as it is believed that all LGBT have familiarity with internalized homophobia to some extent (Sherry, 2007).

The individual's recognition that they are unlike their family members or social group instills a sense of being different that may lead to identification with negative societal views. This belief of otherness, particularly when negatively connoted, may occur prior to awareness of attraction to the same sex (Huebner, et. al., Farnsworth, 2000). When looking at other forms of societal and cultural subjugation in minority populations, researchers are no longer surprised at the impact on a distorted sense of self. Societal rejection of homosexuality is so endemic that Maylon (1982) posits that the impediment it poses to the normal

curve of identity development in individuals has become a normal marker experienced by many gay and lesbian individuals (Shidlo, 1994). This twist in development may manifest in any number of ways, such as the rejection by gay-identified individuals of those who exhibit gender non-conforming or effeminate behaviors that they may have themselves exhibited earlier in their development (Taywaditep, 2001). While a trajectory of identification with the gay community may lead to an unlearning and release of tightly held negative beliefs, varying degrees of internalized homophobia may affect individuals throughout their lifespan (Huebner, et. al.) reflecting the difficulties previously listed as well as challenges in meeting their need for intimacy (Williamson, 2000).

While higher levels of self-acceptance among gay men is related to greater levels of emotional control and lower levels of high-risk sexual behavior (Farnsworth, 2000), a growing body of information on internalized homophobia continues to reveal the negative impact on the individual's physical and psychological well-being (Martel et al., 2004; Williamson 2000). High levels of internalized homophobia correlate with higher levels of high- risk sexual behavior, greater frequency of compulsive sexual behavior, and lower safe-sex efficacy (Huebner, Davis, Nemeroff & Aiken, 2002, Sherry, 2007), higher global levels of anxiety and depression (Iguartua & Montoro, 2003), anxiety regarding sex (Dupras, 1994), higher

rates of shame (Allen & Oleson, 1999), higher rates of alcoholism and use of avoidant coping mechanisms (Allen, 2001, Farnsworth, 2000), low self-esteem, loneliness and distrust (Lima, Lopresto, Sherman & Sobelman, 1993, Shidlo, 1994), shorter duration and lower pleasure with relationships (Ross & Rosser, 1996), lower levels of self-concepts in relation to emotional stability and physical appearance as well as higher levels of guilt regarding sex (Rowen & Malcolm, 2002).

The development of a solid bareback identity may be in effect an attempt to reclaim aspects of identity stability that have been impacted by recognized or sublimated internalized homophobia. At the same time that the impact of internalized homophobia is illuminated, there is concern that the use of broad and varied definitions without careful consideration to conceptualization and operationalization may lead to “repathologization” of the homosexual or member of the MSM community even while it deserves and needs more research (Russell & Bohan, 2006; Williamson, 2000). Defining homophobia is not a simple task, and over the past four decades there has been a growing discussion in academic and research environments as to the most comprehensive yet definitive way to conceptualize the character and genesis of anti-gay and lesbian bias (Williamson, 2000).

Homophobia may be seen as an almost inevitable result of culturally driven emotional limitations placed on men during critical childhood development stages. This deficit in emotional bonding continues through the individual's development process, and regardless of sexual orientation, homophobia may negatively impact all strata of male-to-male relationships in the individual's capacity to express and experience intimacy, vulnerability and perspective (Cronan, 2007; Monroe, Baker & Roll, 1997), as well as play an inevitable role in the identity development of LGBT people (Maylon, 1982; Shidlo, 1994).

The theoretical and research literature in this area provides substantiation that gay men incorporate negative messages regarding non-heteronormative values that result in the internalization of homophobic beliefs. This process of incorporation may range from the broad and easily identifiable to the more subtle and insidious. Messages that impact the individual's view of accepted male role norms, their perception of their masculinity and subsequently, their ability to function fully in society as men in the ways that the culture requires. For some the awareness of the impact of these negative messages spur them to identify as part of a marginalized populations, push back against the perceived inter and intra-cultural oppression, thereby promoting psychic and emotional growth. For others, the impact of internalized homophobia may emerge in more

subtle ways, such as negative self-talk, lowered self-care, or impulsivity. The individual may then indulge excessively in the use of recreational substances to escape or counter the negativity that they feel about themselves.

As the previously noted, research clearly shows a direct connection of internalized homophobia with a variety of negative effects, suggesting that individuals with varying levels of internalized homophobia are more likely to engage in acts that ultimately may be self-destructive. Unprotected anal sex, whether insertive or receptive may be among these self-destructive acts during a time when the public is delivered mixed messages regarding the lethality of HIV infection, HIV superinfection and efficacy of HAART.

By cherry-picking through the existing identity development stage or phase models, one may find occasional alignment with facets of the identified barebacker: through an Eriksonian perspective, the identified barebacker is an example of an opportunity for reevaluation and modification of identity necessitated by life circumstance. In this case, the circumstances are being motivated by the study factors (masculine ideology, reactance, etc.) that lie outside the purview of Erikson's linear model, or the models espoused by Cass, Troiden and Coleman. Bareback identity has little to do with these identity development models,

particularly because there is so little quantifiable data regarding the varied ways that individuals evolve in regards to their sexual identity.

In the development of a “bareback identity”, masculine ideology, therapeutic reactance, sensation seeking and internalized homophobia all exist as facets of characterological expression that, when impinged upon, cause psychological distress to certain individuals. Rather than an explicit and active method of self-destruction, barebacking identity offers the individual a sense of internal solidarity that provides a sense of personal power and distinction. While this uniqueness may serve to reinforce the individual’s emotional and intellectual balance, it is based on an unrealistic perception of risk. An individual with a conscious or unconscious sense of entitlement regarding the expression of his sexuality may engage in a process of rationalization that occludes his awareness of the potential consequences of his sexual behavior.

### **CHAPTER III: STATEMENT OF THE PROBLEM**

#### Main Research Questions

This study examined the relationship between four areas of personality characteristics and the development of a “barebacker identity”. The data collection and analysis will examine whether and to what degree a relationship exists between MSM individuals’ measurements on scales of masculine ideology, sensation seeking, risk taking, reactance, internalized homophobia and their choice to engage exclusively in unprotected sex (a “bareback identity”) by utilizing empirically validated inventories of these five factors and demographic information. This study asserted that the formerly listed factors are intrinsic to the development of a bareback identity and discriminated between MSM who engage exclusively in protected sex (safe-sex identified) and those that express a secure barebacker identity.

#### Hypotheses

##### *Hypothesis 1*

Among MSM, individuals who identify as barebackers will have higher levels of reactance as measured by the Theoretical Reactance Scale (TRS).

*Hypothesis 2*

Among MSM, individuals who identify as barebackers will have higher levels of masculine ideology, as measured by the Conformity to Male Role Norms Inventory (CMRN).

*Hypothesis 3*

Among MSM, individuals who identify as barebackers will have higher levels of sensation seeking behaviors than those who choose to engage in protected sex.

*Hypothesis 4*

Among MSM, individuals who identify as barebackers will have higher levels of internalized homophobia than those who choose to engage in protected sex.

## **CHAPTER IV: METHODS**

The dependent variables in this study are the choices of MSM to engage exclusively in unprotected sex, or never engage in unprotected anal sex. Questions specific to exclusive bareback behaviors were placed in the demographic section of the survey.

T-scores of independent variables (masculine ideology, reactance, internalized homophobia, sensation seeking / risk taking, and bareback identity) were analyzed through the use of an analysis of variance through SPSS as the study looks at more than one dependent variable.

### **Recruitment of Participants**

Participants were recruited from two main sources: websites and email participation invitation. Internet sites that are specifically geared to MSM who are seeking to engage in casual sex were utilized through their splash pages as well as social networking sites. The study generated data from available email databases utilized for previous studies in this area, email listservs devoted to the LGBT community and a social networking site. Survey participants found through listservs were encouraged to forward the link to friends and colleagues who might care to participate, as well as a specific request to invite other individuals from all parts of the country in an effort to “snowball” the study to a more diverse population.

Several sites were chosen primarily because they offer access to other individuals who engage exclusively in unprotected sex. Sites such as barebackcity.org, manhunt.net and www.craigslist.com were contacted in order to narrow the participant list to those MSM who engage exclusively in bareback sex as well as individuals who sporadically or consistently choose to use condoms (see Appendix G). Barebackcity.org and manhunt.net chose not to participate in this data collection for this study.

Website members or visitors were invited to engage in an online survey via a hyperlink to a survey site hosted by surveymonkey.com. All participants were guaranteed anonymity with the exception of identifying information for email contact to facilitate delivery of an incentive prize. This researcher's initial intention was to engage a minimum of 400 participants, particularly those who incidentally or intentionally participate in unprotected or "bareback" sex. At the completion of the data collection process, 181 individuals had responded. Respondent sets that provided insufficient data for scoring were removed from the data, resulting in 169 usable responses ( $n = 169$ ). Participation in this study was encouraged by the offer of two \$50.00 credit card-type gift cards that allowed purchases at any retail store that accepts credit cards. The gift cards were awarded to two study participants through a lottery of all

participants who opt to provide an email address at the completion and acceptance of this research project.

### Description of Instrumentation

Demographic information was the first information requested from participants, including, but not limited to, age, geographic location, sexual orientation identification, racial identification, primary sexual position preference (anal active, anal receptive, or versatile / fluid), HIV status, if known, level of exposure to HIV / AIDS information from various sources. See Appendix B.

### Measures

Psychological reactance in survey participants was measured using the Theoretical Reactance Scale (TRS: Dowd, et.al 1991). The TRS is a 28-item index that is comprised of a total score (TRS:T) in addition to two subscale scores extrapolated from factor analysis. The subscales are labeled verbal (TRS:V) and behavioral (TRS:B) reactance. TRS items are composed of statements that are centered on verbal and behavioral oppositional behavior. Examples of items from the TRS include statements such as “If I am told what to do, I often do the opposite”, “I am relatively opinionated” and “I usually go along with the others’ advice”. The statements are rated on a 4-point Likert scale (1= strongly disagree to 4 = strongly agree). See Appendix C.

Masculine Ideology was measured for this study utilizing the Conformity to Male Role Norms Inventory, short form, (CMNI-22); (Mahalik, et al. 2000). The CMRNI is an index that assesses attempts of an individual to align with the standards of masculine ideology. The complete 94-item CMRNI is comprised of statements that measure of 11 diverse components of masculinity including Dominance: Emotional Control: Disdain for Homosexuals: Promiscuity: Power over Women; Pursuit of Status; Risk Taking; Self-Reliance; Violence: Winning and Work Primacy. The CMRNI-22 is comprised of 22 items that represent the highest loading statements from the complete CMRNI. Individuals taking the inventory indicate the degree to which they agree or disagree with statements by (e.g., “A man should never back down in the face of trouble”) that are rated on a 4- point Likert scale (1= strongly disagree, 4 = strongly agree). See Appendix D.

Internalized Homophobia was measured by using Multi Axial Gay Inventory-Men's Short Version (MAGI-MSV) developed by Dr. Ariel Shidlo in 2007. The inventory assesses an individual's internalized views on homosexuality, and is composed of 20 items (e.g. “I like it when people tell me I look straight”, “Some gay men are too effeminate” and “Gay persons' lives are not as fulfilling as heterosexual's lives”). The index is scored on a 4 point Likert scale (*strongly agree, mainly disagree, mainly*

*agree and strongly disagree*). The Likert-scores of each item are added and high scores signify high levels of internalized homophobia. The MAGI-MSV has an overall internal reliability coefficient (Cronbach's  $\alpha$ ) of .87, standardized item alpha of .90, a mean of 30.2, and median 28.0 with a standard deviation of 7.99. See Appendix E.

Sensation Seeking was measured by utilizing the Zuckerman-Kuhlman Personality Questionnaire Sensation Seeking Scale. The SSS is a 19 item index that looks at levels of individuals' impulsive sensation seeking. The 19 items offer responses of "true" and "false" to statements designed to determine the level of the respondent's sensation seeking disposition (e.g. "I like to have new and exciting experiences and sensations even if they are a little frightening", "I usually think about what I am going to do before doing it", and "I often get so carried away by new and exiting things and ideas that I never think of possible complications"). See Appendix F.

The Barebacking Identity Scale – Study participants were asked to complete the Bareback Identity Scale, a single item mechanism consisting of a *yes / no* answer option to the statement "I consider myself a barebacker". The Bareback Identity Scale question will immediately follow questions that assess sexual practice history (See Appendix G).

### Ethical Assurances

This study adhered to the standards published by the American Psychological Association. A sample of the consent form for this study, which explains procedures, participation, rights, confidentiality, compensation, potential benefits, risks, and discomforts is included as Appendix A.

### Demographic Data

Demographic data collected for this study included, but was not limited to, age, sexual orientation, HIV status, relationship status, preferred sexual position, and number of sex partners in past year, as well as the frequency of times that unprotected anal sex was practiced. In this study, 181 individuals initially expressed interest in completing the survey, with 169 participants providing enough data required for the analysis of the hypotheses being presented. Response sets that did not include an answer to the Bareback Identity Scale (BBIS) or sufficient inventory answers to provide a T-score were eliminated. This discrimination then left 169 valid responses in the data set.

The mean age of the respondent sample was 44 years (S.D. 10.001) with a minimum age of 19 years and a maximum age of 69 years. Sexual orientation was examined with 92.9% (n= 157) of respondents self-identified as gay and 1.8 % (n= 3) identified as heterosexual (“straight”) or bisexual respectively. Additionally, 3.6% (n= 6) of the respondents identified their sexual orientation as “other”. In regards to HIV status, 77.5% (n=131) of respondents identified as HIV negative, 21. 3% (n=36) identified as HIV positive, and 1.2% (n=2) did not reveal their status.

Racial makeup of this particular study was definitely weighted, with 85.2% (n=144) of respondents identifying as Caucasian, 7.1% as

African-American (n=12), 3.6% as Latino (n=6), and 4.1% as Pacific Islander (n=7). In response to an item inquiring about the participants' relationship status and sexual activity within the framework of that relationship, 46.7% (n=79) replied that they were not in a relationship, 38.5% (n= 65) replied that they were in a monogamous, sexually exclusive relationship. Finally, of the valid participant responses, 14.8% (n= 25) of participants were engaged in a non-monogamous, (sexually non-exclusive relationships) with their primary partner.

In response to questions regarding their preferred sexual position, 27.8% (n=47) survey participants identified as anal-insertive/active ("top"), 20.1% (n=34) identified as anal-receptive ("bottom") and 46.2% (n=78) identified as having no preference ("versatile"). Five point nine percent of (n=10) participants indicated that none of the response options applied to their sexual activity. In response to a question that asked respondents to identify the number of partners with whom they had had anal intercourse (active/insertive or receptive), the following data emerged: 18.3% (n=31) had not engaged in anal intercourse of any kind during the previous year; 60.4% (n=102) had engaged with between one and five partners; 10.1% (n=17) had engaged with six to 10 partners; 5.3% (n=9) with between 11 to 15 partners; 1.8% (n=3) with 16 to 20 partners; and 4.1% (n=7) with 20 partners or more.

The amount of times that respondents engaged in unprotected anal intercourse, whether anal insertive or receptive, was also examined. Fifty point three percent (n=89) of respondents had unprotected anal sex with between one and five partners. As the number of sex partners increased, the times that respondents engaged in unprotected sex dropped dramatically: 4.1% (n=7) had unprotected anal sex with 6 to ten partners; 2.4% (n=4) with 11 to 15 partners; and 1.8% (n=3) with 20 or more partners.

### Data Related to the Research Questions

A one-way analysis of variance was conducted to evaluate the relationship between Bareback Identity and T-scores on each of the following inventories: Therapeutic Reactance, Conformity to Male Role Norms, and Sensation Seeking behaviors. Respondents' response on the Bareback Identity Scale served as the independent variable. Respondents' T-scores on the afore-mentioned inventories served as dependent variables. The resulting ANOVA scores examining the strength of relationship between Bareback Identity and the static characterological indexes were insignificant.

Research hypothesis number one posited that among MSM, individuals who identified as barebackers would have higher levels of therapeutic reactance as measured by the Therapeutic Reactance Scale (TRS). A significance level between groups of .154 was found, indicating no statistically relevant level of correlation between the observed variables:  $F(1, 164) = 2.05, p = n.s.$  (Table 1). Research hypothesis number two posited that among MSM, individuals who identified as barebackers would have higher levels of masculine ideology as measured by the Conformity to Male Role Norms Inventory (CMRN). A significance level between groups of .298 was found, indicating no statistically relevant level of correlation between the observed variables:  $F(1, 166) = 2.05, p=n.s.$  (Table 2).

Research hypothesis number three posited that among MSM, individuals who identified as barebackers would have higher levels of sensation seeking behaviors than those who choose to engage in protected sex. A significance level between groups of .108 was found, indicating no statistically relevant level of correlation between the observed variables:  $F(1, 158) = 2.61, p=n.s.$  (Table 3). Research hypothesis number four posited that among MSM, individuals who identified as barebackers would have higher levels of internalized homophobia than those who choose to engage in protected sex. A significance level between groups of .359 was found, indicating no statistically relevant level of correlation between the observed variables:  $F(1, 161) = .85, p=n.s.$  The level in this correlation was, however, substantially higher than the other three variables being observed in this study (Table 4). Additional post-hoc tests were applied to the study's core data, with no significant results being found.

#### Discussion of Study Results

This chapter illustrates the results of the study in four areas based on static characterological factors as measured by the TRS, CMRN, SSBI and MAGV. The first paragraph reviews a portion of the demographic data taken from the participants' sample. The following paragraphs report the study's findings in regards to the differences of mean scores for individuals who identified as barebackers or non-barebackers and T-scores of four

separate inventories as determined by independent samples t-tests. The exploration of four widely accepted masculine characteristics, did not, in this study, impact the adoption of a “barebacker identity” among MSM; none of the inventories utilized were able to predict group membership in either category of barebacker or non-barebacker.

As covered in the literature review, the perception of and individual’s loss of choice regarding the expression of his sexuality, his alignment with masculine ideology, and the desire for heightened sensory stimulation would seem likely candidates as factors in the adoption of a barebacker identity. These hypotheses, however, were not supported in this study. The results of scores on the four inventories utilized for this study with this limited sample do not indicate a direct correlation in spite of their potential relevance in the decision to engage or not engage in protected sex. In essence, my study found that there were no significant differences when comparing the populations of barebackers versus non-barebackers when using the TRS, CMRN, SSS, or MAGIV. In light of the LGBT models of identity development discussed in this study, perhaps the concept of “acceptance” applies across a wider domain to include sexual practices as well as sexual orientation.

### Study Limitations

Research comparing data collection methods indicate that online surveys are better than, or at least equal to traditional postal questionnaires (Mehta & Suvadas, 1995; Stanton, 1998; Thompson, Surface, Martin & Sanders, 2003), although errors due to non-response rate may lead to problematic analysis of study results. In this study, the data was self-reported and gathered through second and third party direction to an Internet survey site; therefore, self-selection bias may have been a factor, as in any community, online or not, there are individuals more or less likely to participate in a study about intimate details regarding their sexuality. Several study participants indicated their enthusiasm for the questionnaire and asserted their intention to forward it to numerous friends, however the final number of participants (181) indicated that this effect did not have as much influence as I would have expected.

A systematic bias may well have presented itself in regards to those who generally participate (or do not) in online surveys at all depending on the influence that daily computer use exerts in their lives. Additionally, though the possibility of double multiple responses from single individuals (potentially motivated by the prize incentive) was addressed by the recognition of Internet protocol addresses, there was no

guarantee of individuals responding authentically to the questionnaire items. A desire to “present well” may have also skewed the results of the inventories utilized as participants became more personally invested in the process of the survey. Unlike more complex assessment mechanisms such as the MMPI – III, none of the inventories used contained subscales to ascertain the veracity of participant responses.

Popular MSM websites with wide national exposure withdrew their willingness to support this study after initial commitment, which left data collection to less successful venues, such as social networking sites and “snowballing” (the encouragement of forwarding the survey link to friends and colleagues). As is demonstrated in the demographic data, the study does not represent an even geographical, racial or age-of-participant sample. Although the survey was kept to a length that required approximately 25 minutes of respondent participation, that length may have been prohibitive for some individuals. Internet access to the survey assumes a socio-economic status that allows for computer access, and as such, this study may not have reached a diverse sample in terms of race and education. These sampling issues, combined with the relatively small number of participants inhibited this study’s ability to generalize findings to the larger population.

As this study used the short form of four different inventories, it is possible that the mechanisms were not comprehensive enough to capture more subtle differences within the population of participants in the domains that they measured. The use of the complete forms, sometimes double or triple the length of the short form questionnaires could have generated more results. Additionally other instruments may be more successful in describing group differences within the research domains represented by the four utilized inventories.

#### Additional Findings and Implications for Future Research

An important observation that emerged from this study is that given the characterological domains and demographic data being examined, there were no significant differences between identified barebackers and non-barebackers. On a cursory level, this would imply a level of homogeneity within the population being studied, which is unlikely. The adoption of a bareback identity may then well be influenced by other static characterological factors that lie outside the scope of this study or may be possibly tied to other variables related to the demographic data of each individual.

While examining supplementary available data in the survey, several interesting phenomenon emerged; Individuals who responded to a demographic question regarding how long they had been HIV positive.

Using both Tukey HSD and Scheff regressions, a significant correlation emerged regarding Bareback Identity. In this study, the longer the individual had been diagnosed as HIV positive, the more likely they were to identify as barebackers. This is particularly interesting as it offers an alternate perspective to CDC studies that indicate less consistent condom use in the age category of 26 to 29. This phenomenon may be the result of a number of factors, such as “condom fatigue” or an inability/unwillingness by individuals to maintain over the long term what are considered necessary protocols for safe sex; the use of a condom. As discussed earlier, weighing the decision regarding the cost/ratio benefit for long term HIV positive individuals is not, in their perspective, irrational (Suarez and Miller, 2001) given the current arsenal of medications that allow for the management of HIV as a chronic condition.

When controlling for age in the study sample, several key points emerged regression analyses of the data: stronger alignment with masculine ideology was related to stronger psychological reactance while stronger alignment with masculine ideology was related to lower levels of internalized homophobia (and vice versa). Higher scores of psychological reactance was related to higher scores on sensation seeking, and when conducting a regression on all four inventories and bareback identity,

psychological reactance and sensation seeking emerged as having more impact than internalized homophobia or masculine ideology.

While there was no significance found in the status of the individual's relationship, identified barebackers who have been HIV positive for longer periods of time may well be engaging in strategies outlined earlier in this study such as strategic positioning or "negotiated safety" as indicated by Parsons and Bimbi (2005) that are not fully effective in preventing HIV infection. Research that focused specifically on these "strategic" barebackers may reveal educational interventions that are more successful.

Future studies utilizing these methods would benefit from a larger and more diverse sample of participants that addressed socio-economic, racial and cultural issues. The full inventories for each item, which would include more sensitive subscales might be further analyzed against bareback identity to ascertain whether these domains exert significant influence. Further discrimination within the subscales of the inventories may well parse out within group differences regarding beliefs vs. actual behavior, a specific not found in my study.

An alternative approach to research on bareback identity from this study would be to combine both qualitative and quantitative approaches in regard to these domains (masculine ideology, reactance,

sensation seeking and internalized homophobia). It is possible that more accurate and statistically significant results could emerge from the development of therapeutic alliance in face-to-face interviews. Such in-depth interviews combined with statistically sound assessment mechanisms may reveal key elements in individuals who identify as barebackers. As masculine ideology, sensation seeking and reactance have emerged as having impact, however small, further investigation into how these factors might be exploited in advertising campaigns for HIV testing and infection prevention.

In the current research arenas on bareback identity, reactance is an area that is virtually untouched. Future researchers in the area of bareback identity may well benefit from concentrating solely on this area to ascertain the impact of the perceived removal of choice regarding condom use or safer sex practices that individuals may experience. A deeper analysis of this area might reveal that this perception of choice is itself a complex issue that does not solely rest on condom use. Other researchers in this area are examining barebackers' perception of sex without condoms as being more intimate, but few have focused on what it means to the individual to have their choices regarding intimacy inhibited or removed in light of research is available regarding psychological reactance. Understanding the mechanics behind this perception could

prove to be a valuable tool for crafting effective motivational interventions to increase safer sex practices among MSM. Perhaps emphasizing the range of choices available in the arena of sexual behavior rather than emphasizing what is not available could prove to be more effective, as it was in the early days of AIDS and HIV awareness.

Advertisement campaigns walk a thin line in the battle against HIV infection. It is apparent that agencies are conducting research to find public health interventions that speak to a wide range of individuals, however they also have to deal with the backlash that occurs as a result of these attempts. In 2005, Aids Healthcare Foundation (AHF) began a billboard campaign entitled “AIDS – Not Fabulous”. It was an unconventional and ultimately controversial effort to educate the public regarding the reality of HIV infection. The photographs utilized showed men with extreme lypodystrophy (facial wasting due to long term medication usage) and diapers (to illustrate the gastric side-effects of most HIV medications). Protest from individuals and other agencies quickly ended this campaign, despite it’s attempt to accurately portray the consequences of HIV infection.

In the fall of 2009, AHF took a different approach with a citywide billboard campaign that showed a photo of the nude back of an unidentifiable male with the words “Stay Negative” tattooed on his

shoulder. Although this emphasizes the importance of maintaining one's HIV negative status, it could also be seen as divisive: a marginalization of HIV positive individuals. Following this campaign, a radically different approach was taken through another dense citywide billboard showing Blair Underwood, an attractive, masculine male celebrity of color, accompanied by the new slogan "Man Up". Although the "Man Up" campaign was not intrinsically aimed at the MSM community, it directs viewers towards AHF's services of free HIV testing, as well as emphasizing personal responsibility in sexual behavior by using a gender-based directive. The campaign coincided with a substantial increase in HIV tests in the Los Angeles area although AHF does not have research indicating if the two were related (AHF, 2009). As of September 2009, AHF's current billboard campaign shows a black and white photograph two embracing male torsos: One of the models holds in his hand a bright green four-leaf clover. The tagline of the billboard states "Don't count on luck, get tested". These latter two attempts by AHF appear to focus on appealing to the concepts of a conjunction of responsibility and masculinity as well as addressing the issue of impulsivity.

### Summary and Conclusion

The practice of engaging in unprotected sex continues to grow at a startling rate among MSM in the United States, despite years of effort

made by public agencies to educate and inform the public. This is particularly alarming as the current economic challenges in the United States are directly affecting funding related to treatment and research as well as metropolitan low-cost, or free testing centers. While advances in treatment for HIV have emerged over the past decade that have vastly improved the life-expectancy and life-quality of individuals infected with HIV, an effective and unified front of prophylactic public education holds the potential to have as much impact on the public by reducing the number of new infections.

This small study of barebacking identity illustrates the importance of understanding what is obviously a complex phenomenon with far-reaching implications for public health on a national and international level. While this study found no significant levels within the stated hypotheses, other data emerged that reflects a relationship between characterological factors that appear integral to the adoption or development of a bareback identity. Efforts to understand these male-centric mechanisms involved in the adoption of a bareback identity may well hold the key for interventions that can successfully reduce or eliminate the rising numbers of annual HIV infections in MSM.

## TABLES

Table 1.

Bareback Identity Scale (BBIS) and Standard Deviations for Therapeutic  
Reactance Scores (TRS)

Groups	N	TRS Mean	TRS SD	F	Sig.
Bareback Identified	53	66.73	5.45	2.05	.154
Non- Bareback Identified	113	66.38	5.75	2.05	

Table 2.

Bareback Identity Scale (BBIS) and Standard Deviations for Conformity to Male

Role Norms Inventory Scores (CMRN)

Groups	N	CMRN Mean	CMRN SD	F	Sig.
Bareback Identified	53	24.65	5.49	1.09	.298
Non- Bareback Identified	113	23.71	5.42	1.09	

Table 3.  
 Bareback Identity Scale (BBIS) and Standard Deviations for Zuckerman –  
 Kuhlman Sensation Seeking Scale (SSS)

Groups	N	SSS Mean	SSS SD	F	Sig.
Bareback Identified	51	9.66	4.17	2.61	.154
Non- Bareback Identified	109	8.55	3.97	2.61	

Table 4.  
 Bareback Identity Scale (BBIS) and Standard Deviations for Multi-Axial Gay  
 Inventory (MAGI)

Groups	N	MAGI Mean	MAGI SD	F	Sig.
Bareback Identified	53	70.65	1.00	.848	.359
Non- Bareback Identified	110	71.66	.681	.848	

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## APPENDIX A

### INFORMATION SHEET FOR NON-MEDICAL RESEARCH

This study has been reviewed and approved by the Antioch University Santa Barbara Review Board and the Psychology Department Human Subjects Committee.

You are being asked to participate in a research study conducted by Scott C. Musgrove, MA, from the Psychology Department at Antioch University Santa Barbara. You were selected as a possible participant in this study because you elected to open this webpage. Your participation is voluntary. You must be aged 18 or older to participate.

Proceeding with this questionnaire by clicking the “next” button at the bottom of this page confirms your agreement to participate in this study.

#### PROCEDURES

You will be asked to answer a series of questions about your attitudes, beliefs and practices in a number of areas regarding sex. The entire survey can be completed in approximately 45 minutes. No identifying information will be collected from you except email addresses of participants who are interested in being considered for a drawing. Two winners of the drawing will receive a \$250.00 credit-card type gift card for use at any retail establishment that accepts credit cards.

#### POTENTIAL RISKS AND DISCOMFORTS

There are no anticipated risks to your participation; you may experience some discomfort at completing the questionnaire or you may be inconvenienced from taking time out of your day to complete the questionnaire.

#### POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

You may potentially benefit from participation in this study by being considered for a prize drawing. We believe that your participation can be very beneficial for society.

#### PAYMENT/COMPENSATION FOR PARTICIPATION

You will not receive any payment for your participation in this research study. Two participants will be selected from a lottery drawing those that elect to provide email contact information in a drawing. The prize will be a \$250.00 gift certificate to a nationwide chain of electronics retailers.

### CONFIDENTIALITY

The survey is completely anonymous. There will be no information obtained in connection with this study that can be identified with you or your email address. Only the author of this study will have access to the data associated with this study. The data will be stored in the investigator's office in a locked file cabinet and password protected computer. The data will be stored for three years after the study has been completed and then destroyed. When the results of the research are published or discussed in conferences, there will be no information that will be included that may reveal your identity since no identifiers are being collected from you.

### PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time, however, to be considered for the gift certificate drawing, all questions in study must be answered. The investigator may withdraw you from the analysis of this research if circumstances arise which warrant doing so. If you have any questions or concerns about the research, please feel free to contact Scott C. Musgrove, M.A. at [smusgrove@antiochsb.edu](mailto:smusgrove@antiochsb.edu).

### RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights, or remedies because of your participation in this research study. If you have any questions regarding your rights as a research subject, contact the Antioch University Santa Barbara IRB, 801 Garden Street, Santa Barbara, CA. 93101, attention Michele Harway, Ph.d. [mharway@antiochsb.edu](mailto:mharway@antiochsb.edu).

Thank you for participating in our study!

## APPENDIX B

## DEMOGRAPHIC QUESTIONNAIRE

1. Year of Birth
2. Age at which first same-sex sexual experience occurred.
3. How old were you were you experienced your first same-sex experience?
4. Do you identify as
  - Gay
  - Straight
  - Bisexual
  - Other
5. HIV status (if known)
  - HIV Positive
  - HIV Negative
  - Prefer Not To Say
  - Unknown
6. Length of time HIV Positive, if applicable.
  - Not Applicable
  - 1-5 years
  - 6-10 years
  - 11-15 years
  - 16-20 years
  - 21+ years
7. Racial Background
  - Caucasian
  - African American
  - Latino
  - Pacific Islander
  - Mixed Race
  - Prefer Not To Say

8. Currently in relationship?
  - No
  - Yes, Monogamous
  - Yes, Non-monogamous (“open relationship”)
  
9. Length of current relationship.
  - Not Applicable
  - 1-5 years
  - 6-10 years
  - 11-15 years
  - 16-20 years
  - 21+ years
  
10. What choice below best describes the age of your preferred sexual partners?
  - Within 1-5 years of your age
  - Within 6-10 years of your age
  - Within 11-15 years of your age
  - Within 16-20 years of your age
  - Within 21+ years of your age
  
11. Please think of a typical month during the last six months (i.e., not on vacation or unusually busy). How often did you have sexual intercourse (that is, entry of the penis into the anus) with a male partner?
  - None
  - 1-3 times within that month
  - 1 time a week
  - 2 or 3 times a week
  - 4 times a week
  
12. How often did you have unprotected anal intercourse during this time?
  - Never
  - Occasionally
  - Less than half the time
  - Most of the time

13. What is your preferred sexual position?
- Top (anal active)
  - Bottom (anal receptive)
  - Versatile (no preference)
  - Not applicable
14. With how many different partners have you had anal intercourse within the past year?
- 0 partners
  - 1 - 5 partners
  - 6 - 10 partners
  - 11 – 15 partners
  - 16 -20 partners
  - 20+ partners
15. With how many different partners have you had unprotected anal intercourse within the past year?
- 0 partners
  - 1 - 5 partners
  - 6 - 10 partners
  - 11 – 15 partners
  - 16 -20 partners
  - 20+ partners
16. With how many different partners have you had anal intercourse on one and only one occasion in the past year (i.e., a “one night stand”)?
- 0 partners
  - 1 - 5 partners
  - 6 - 10 partners
  - 11 – 15 partners
  - 16 -20 partners
  - 20+ partners
17. Do you use drugs for recreational purposes?
- No
  - Rarely (once a year)
  - Occasionally (once a month)
  - Often (once a week)
  - Very Often (2 times a week +)
18. Do you feel drugs influenced your decision to have unprotected anal intercourse?

- Never
- Occasionally
- Less than half the time
- Most of the time
- Always
- Not Applicable

19. How many alcoholic drinks do you have in a typical week? (1 beer or a measured shot of spirit = 1 drink)

- Not Applicable (you are a non-drinker)
- 1-2 drinks per week
- 3-4 drinks per week
- 5 – 6 drinks per week
- 7+ drinks per week

20. Do you feel alcohol influenced your decision to have unprotected anal intercourse?

- Never
- Occasionally
- Less than half the time
- Most of the time
- Always
- No sexual or unprotected activity with a partner

21. What is your zip code?

## APPENDIX C

**THEORETICAL REACTANCE SCALE**

Next to each statement please choose the response that corresponds to the degree to which you agree or disagree with each statement.

Strongly Disagree

Disagree

Agree

Strongly Agree

1. If I receive a lukewarm dish at a restaurant, I make an attempt to let that be known
2. I resent authority figures who try to tell me what to do.
3. I find that I often have to question authority
4. I enjoy seeing someone else do something that neither of us is supposed to do.
5. I have a strong desire to maintain my personal freedom
6. I enjoy playing “devil’s advocate” whenever I can
7. In discussions, I am easily persuaded by others
8. Nothing turns me on as much as a good argument
9. It would be better to have more freedom to do what I want on a job
10. If I am told what to do, I often do the opposite.
11. I am sometimes afraid to disagree with others.
12. It really bothers me when police officers tell people what to do
13. It does not upset me to change my plans because someone in the group wants to do something else.
14. I don’t mind other people telling me what to do.
15. I enjoy debates with other people.
16. If someone asks a favor of me, I will think twice about what this person is really after.
17. I am not very tolerant of others’ attempts to persuade me.
18. I often follow the suggestions of others.
19. I am relatively opinionated.
20. It is important to me to be in a powerful position relative to others.
21. I am very open to solutions to my problems from others.
22. I enjoy “showing up” people who think they are right.
23. I consider myself more competitive than cooperative.
24. I don’t mind doing something for someone even when I don’t know why I’m doing it.

25. I usually go along with others' advice.
26. I feel it is better to stand up for what I believe than to be silent
27. I am very stubborn and set in my ways.
28. It is very important for me to get along well with the people I work with.

## APPENDIX D

**CONFORMITY TO MALE ROLE NORMS INVENTORY SHORT  
FORM (CMNI- 22)**

Thinking about your own actions, feelings and beliefs, please indicate how much you personally agree or disagree with each statement by circling SD for "Strongly Disagree", D for "Disagree", A for "Agree", or SA for "Strongly agree" to the right of the statement. There are no correct or wrong answers to the items. You should give the responses that most accurately describe your personal actions, feelings and beliefs. It is best if you respond with your first impression when answering.

Strongly Disagree  
Disagree  
Agree  
Strongly Agree

1. My work is the most important part of my life
2. I make sure people do as I say
3. In general, I do not like risky situations
4. It would be awful if someone thought I was gay
5. I love it when men are in charge of women
6. I like to talk about my feelings
7. I would feel good if I had many sexual partners
8. It is important to me that people think I am heterosexual
9. I believe that violence is never justified
10. I tend to share my feelings
11. I should be in charge
12. I would hate to be important
13. Sometimes violent action is necessary
14. I don't like giving all my attention to work
15. More often than not, losing does not bother me
16. If I could, I would frequently change sexual partners
17. I never do things to be an important person
18. I never ask for help
19. I enjoy taking risks
20. Men and women should respect each other as equals
21. Winning isn't everything, it's the only thing
22. It bothers me when I have to ask for help

## APPENDIX E

### MAG-MSV

The MAG – MSV inventory, developed to measure individuals' levels of internalized homophobia, is copyrighted. The following contains directions for the individual taking the inventory, and a sample of five inventory items.

The following is a list of statements that people use to describe their feelings about gay issues. Try to be as honest as you can.

Please circle the appropriate answer for each statement

SA = Strongly Agree

MA = Mainly Agree

SD = Strong Disagree

MD = Mainly Disagree

Try to answer every statement even if you are not sure of your choice.

1. I like it when people tell me I look straight (heterosexual).
2. Some homosexual women and men flaunt their homosexuality too much.
3. Some gay men are too effeminate.
4. Homosexuality is a hellish life.
5. Whenever I think a lot about being gay, I feel depressed.
6. It almost seems like AIDS is a punishment for being gay.
7. I accept but don't celebrate my homosexuality.
8. I feel ashamed after I've had sex with another man.
9. Most gay men end up lonely and isolated.

## APPENDIX F

**ZUCKERMAN-KUHLMAN PERSONALITY  
QUESTIONNAIRE/SENSATION SEEKING SCALE**

This test helps to determine the level of sensation seeking disposition. There are no right or wrong answers, as everyone is an individual. Just respond to the statement and choose either true or false. If you do not like either choice, mark the choice you dislike the least.

1. I like to have new and exciting experiences and sensations even if they are a little frightening.
2. I like doing things just for the thrill of it.
3. I sometimes do “crazy” things just for fun.
4. I sometimes like to do things that are a little frightening.
5. I enjoy getting into new situations where you can’t predict how things will turn out.
6. I’ll try anything once.
7. I prefer friends who are excitingly unpredictable.
8. I like “wild” uninhibited parties.
9. I would like the kind of life where one is on the move and traveling a lot, with lots of change and excitement.
10. I am an impulsive person.
11. I like to explore a strange city or section of town by myself, even if it means getting lost.
12. I would like to take off on a trip with no preplanned or definite routes or timetables.
13. Before I begin a complicated job, I make careful plans.
14. I very seldom spend much time on the details of planning ahead.
15. I tend to begin a new job without much advance planning on how I will do it.
16. I usually think about what I am going to do before doing it.
17. I often do things on impulse.
18. I often get so carried away by new and exciting things and ideas that I never think of possible complications.
19. I tend to change interests frequently.

## APPENDIX G

### **THE BAREBACK IDENTITY SCALE**

Barebacking describes the choice to primarily and intentionally engage in unprotected (condomless) sex. Using this definition, please answer the following question:

I am a barebacker.

- True
- False

## APPENDIX H

**INTIMACY ATTITUDE SCALE SHORT FORM, REVISED**

The following items reflect feelings and attitudes that people have toward others and relationships with others. Specifically the items are concerned with attitudes of closeness, intimacy, and trust.

If you strongly disagree with an item, fill in the space with a letter A. Mark the space with the letter B if you mildly disagree with an item. That is, mark the letter B if you think the item is generally more untrue than true according to your beliefs. Fill in the space with the letter C if you feel the item is about equally true as untrue. Fill in the space with the letter D if you mildly agree with the item. That is, mark with the letter D if you feel the item is more true than untrue. If you strongly agree with an item, fill in the space with a letter E.

- A. Strongly disagree
- B. Mildly disagree
- C. Agree and disagree equally
- D. Mildly agree
- E. Strongly agree

1. I like to share my feelings with others.
2. I like to feel close to other people.
3. I like to listen to other people talk about their feelings.
4. I am concerned with rejection in my expression of feelings to others.
5. I'm concerned with being dominated in a close relationship with another.
6. I'm often anxious about my own acceptance in a close relationship.
7. I'm concerned that I trust other people too much.
8. Expression of emotion makes me feel close to another person.
9. I do not want to express my feelings that would hurt another person.
10. I am overly critical of people in a close relationship.
11. I want to feel close to people to whom I am attracted.
12. I tend to reveal my deepest feelings to other people.
13. I'm afraid to talk about my sexual feelings with a person to whom I'm very interested.
14. I want to be close to a person who is attracted to me.

15. I would not become too close because it involves conflict.
16. I seek out close relationships with people to whom I am attracted.
17. When other people become close they tend not to listen to each other.
18. Intimate relationships bring me great satisfaction.
19. I search for close intimate relationships.
20. It is important to me to form close relationships.
21. I do not need to share my feelings and thoughts with others.
22. When I become very close to another I am likely to see things that are hard for me to accept.
23. I tend to accept most things about people with whom I share a close relationship.
24. I defend my personal space so others do not come too close.
25. I tend to distrust people who are concerned with closeness and intimacy.
26. I have concerns about losing my individuality in close relationships.
27. I have concerns about giving up control if I enter into a really intimate relationship.
28. Being honest and open with another person makes me feel closer to that person.
29. If I were another person I would be interested in getting to know me.
30. I only become close to people with whom I share common interests.
31. Revealing secrets about my sex life makes me feel close to others.
32. Generally, I can feel just as close to a woman as I can to a man.
33. When another person is physically attracted to me I usually want to become more intimate.
34. I have difficulty being intimate with more than one person.
35. Being open and intimate with another person usually makes me feel good.
36. I usually can see another person's point of view.
37. I want to be sure that I am in good control of myself before I attempt to become intimate with another person.
38. I resist intimacy.
39. Stories of interpersonal relationships tend to affect me.
40. Undressing with members of a group increases my feelings of intimacy.
41. I try to trust and be close to others.
42. I think that people who want to become intimate have hidden reasons for wanting closeness.
43. When I become intimate with another person the possibility of my being manipulated is increased.

44. I am generally a secretive person.
45. I feel that sex and intimacy are the same and one cannot exist without the other.
46. I can only be intimate in a physical sexual relationship.
47. The demands placed on me by those with whom I have intimate relationships often inhibit my own need satisfaction.
48. I would compromise to maintain an intimate relationship.
49. When I am physically attracted to another I usually want to become intimate with the person.
50. I understand and accept that intimacy leads to bad feelings as well as good feelings.

## APPENDIX I

## FORM B

**THIS FORM IS TO BE COMPLETED BEFORE RESEARCH  
BEGINS****Insuring Informed Consent of Participants in Research:  
Questions to be answered by AUSB Researchers**

The following questions are included in the research proposal.

1. Are your proposed participants capable of giving informed consent? Are the persons in your research population in a free-choice situation? Are they constrained by age or other factors that limit their capacity to choose? For example, are they adults or students who might be beholden to the institution in which they are enrolled, or prisoners, or children, or mentally or emotionally disabled? How will they be recruited? Does the inducement to participate significantly reduce their ability to choose freely or not to participate?

The participants in my study will be giving informed consent. The participants are in a free-choice situation, that is, they will be invited to take part in this study as they investigate websites devoted to casual sex connections between men. No participant is constrained by age unless they are under 18 years of age. While this study does not directly target mentally or emotionally disabled individuals, it is possible that those who do have access to these websites might elect to take part in the survey.

2. How are your participants to be involved in the study?

Participants will be asked to answer a series of questions that include demographics, sexual preferences, and health history. Additionally, participants will be asked to answer questions on a number of scales that indicate personal attitudes and beliefs.

3. What are the potential risks – physical, psychological, social, legal, or other? If you feel your participants will experience “no known risks” of any kind, indicate why you believe this to be so. If your methods do create potential risks, say why other methods you have considered were rejected in favor of the method chosen.

There are no physical risks involved, although some of the questions regarding sexual practices may cause mild anxiety in the participants. Given the context and nature of the websites through which the participants have been directed to this study, it is unlikely that they are unfamiliar with many of the questions being asked.

4. What procedures, including procedures to safeguard confidentiality, are you using to protect against or minimize potential risks, and how will you assess the effectiveness of those procedures?

Participants are assured of complete confidentiality in this study. Participants are not required to provide identifying or contact information unless they wish to participate in a drawing for a gift certificate. Participants will be informed that the author of the study will be the only individual with access to their contact information, and this data will be stored in a secure and locked or password protected manner. The data will be stored for three years after the study has been completed and then destroyed. Participants' contact information will not be connected with their demographic or scale response information. The data will be stored for three years after the study has been completed and then destroyed. When the results of the research are published or discussed in conferences, there will be no information that will be included that may reveal participants' identity. Internet Protocol addresses will be logged by the survey host site in order to prevent individuals from taking the survey more than once.

5. Have you obtained (or will you obtain) consent from your participants in writing? (Attach a copy of the form.)

Informed consent will be provided as participants are directed to the survey site used for this study. Participants are informed regarding all of the previously covered material and it is explained that clicking the "Next" button in order to begin the survey acknowledges their consent to take part in the study.

6. What are the benefits to society, and to your participants that will accrue from your investigation?

Understanding the impetus involved in the choice of MSM to engage in unprotected sex may provide valuable information for the creation and use of successful pro-social messages. These messages, when used adroitly by clinicians, health care providers and HIV services organizations, may have

an impact on unsafe sexual practices that are directly related to the spread of HIV.

7. Do you judge that the benefits justify the risks in your proposed research? Indicate why.

The potential benefits in this study outweigh the minimal potential for risk. The possibility of instigating mild anxiety in study participants is likely to be much less impactful than the day-to-day challenges involved in living with HIV.

Both the student and his / her Dissertation Chair must sign this form and submit it before any research begins. Signatures indicate that, after considering the questions above, both students and faculty persons believe that the conditions necessary for informed consent have been satisfied.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_  
Scott C. Musgrove, M.A.  
Student

Date: \_\_\_\_\_ Signed: \_\_\_\_\_  
Barbara Lipinski, Ph.D., J.D.  
Chair

