The Medical Condom: Contentions, Challenges and Opportunities for PrEP, HIV Prevention, Gay Sexuality and the Gay Male Body

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This dissertation titled
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Abstract

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The Medical Condom: Contentions, Challenges and Opportunities for PrEP, HIV Prevention, Gay Sexuality and the Gay Male Body

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This project studies the phenomena of PrEP, gay health, gay sexuality and HIV/AIDS within the context of the gay male body. To understand all of these phenomena, and how they are mapped on the gay male body, this project will take interviews from 20 Gay Men in addition to various resources to help gain an understanding of this new HIV prevention measure (i.e. PrEP). This dissertation will also discuss the various challenges and opportunities associated with PrEP as it is introduced to the gay community.
Dedication

To my Life Partner, Jeffrey A. Wickersham, Ph.D.

Thank you for all of the help and guidance during this journey.
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Table of Contents

Abstract .............................................................................................................................. iii
Dedication .......................................................................................................................... iv
Acknowledgments ............................................................................................................... v
List of Tables ..................................................................................................................... xi
List of Figures ................................................................................................................... xii
Chapter 1: Introduction ....................................................................................................... 1
  Introduction ..................................................................................................................... 3
  HIV Statistics .................................................................................................................. 4
  HIV Care & Treatment .................................................................................................. 10
  PrEP & HIV Prevention ............................................................................................... 16
  HIV, MSM/G, & Barebacking ....................................................................................... 18
  Conceptualizing PrEP .................................................................................................... 20
  Perception of PrEP ........................................................................................................ 27
  Criticism & barriers of PrEP ......................................................................................... 28
  Research Questions ....................................................................................................... 34
Chapter 2: Body Theory .................................................................................................... 39
  The Body, Gay Health, & Sexuality .............................................................................. 39
  Biopower: Disciplining Bodies ....................................................................................... 41
  The Gay Male Body ....................................................................................................... 49
  The Body & Corporeal Rhetoric ..................................................................................... 57
  Body Image, Mapping, & the Mobius Strip .................................................................... 60
  PrEP & the Meaning of HIV/AIDS .............................................................................. 65
  Conclusion ..................................................................................................................... 67
Chapter 3: Contextualizing the Gay Male Body ............................................................... 68
  Gay Health .................................................................................................................... 68
  Other indicators of gay health ....................................................................................... 74
  Navigating the Gay Male Body ....................................................................................... 76
  Talking about gay male bodies ....................................................................................... 79
  Sexuality & gay male bodies ......................................................................................... 80
  Gay Sexuality: Barebacking ......................................................................................... 85
<table>
<thead>
<tr>
<th>Chapter 6: Analysis Part II</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme #3: Interpretations of HIV</strong></td>
<td></td>
</tr>
<tr>
<td>Medical optimism.</td>
<td>211</td>
</tr>
<tr>
<td>Personal optimism.</td>
<td>214</td>
</tr>
<tr>
<td>Generational optimism.</td>
<td>217</td>
</tr>
<tr>
<td>Social &amp; personal pessimism.</td>
<td>222</td>
</tr>
<tr>
<td>Knowledge absence &amp; presence of HIV.</td>
<td>224</td>
</tr>
<tr>
<td>The language of HIV/AIDS.</td>
<td>228</td>
</tr>
<tr>
<td>Silence &amp; stigma.</td>
<td>230</td>
</tr>
<tr>
<td>HIV as object “it.”</td>
<td>235</td>
</tr>
<tr>
<td>Being gay = HIV.</td>
<td>238</td>
</tr>
<tr>
<td>The historical body.</td>
<td>244</td>
</tr>
<tr>
<td><strong>Theme #4: Interpretations of PrEP</strong></td>
<td></td>
</tr>
<tr>
<td>Language of PrEP.</td>
<td>246</td>
</tr>
<tr>
<td>Birth control references.</td>
<td>248</td>
</tr>
<tr>
<td>Doubt about PrEP.</td>
<td>253</td>
</tr>
<tr>
<td>Increased sexual risk.</td>
<td>259</td>
</tr>
<tr>
<td>Health &amp; medical interpretations of PrEP.</td>
<td>262</td>
</tr>
<tr>
<td>Negative criticism &amp; interpretations of PrEP.</td>
<td>271</td>
</tr>
</tbody>
</table>
## List of Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1: Summary of Themes &amp; Dimensions</td>
<td>306</td>
</tr>
<tr>
<td>Table B1: Probability of HIV Risk</td>
<td>393</td>
</tr>
<tr>
<td>Table D1: Colored Handkerchiefs &amp; Meanings</td>
<td>394</td>
</tr>
</tbody>
</table>
# List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1.</td>
<td>HIV infection rates in the U.S. by group.</td>
<td>7</td>
</tr>
<tr>
<td>Figure 2.</td>
<td>HIV infections rates in the U.S. by race and sexual orientation. CDC (2013c).</td>
<td>9</td>
</tr>
<tr>
<td>Figure 3.</td>
<td>Early findings of PARTNERS study.</td>
<td>12</td>
</tr>
<tr>
<td>Figure 4.</td>
<td>The HIV care continuum.</td>
<td>14</td>
</tr>
<tr>
<td>Figure 5.</td>
<td>The HIV care continuum by age. CDC (2012b).</td>
<td>16</td>
</tr>
<tr>
<td>Figure 6.</td>
<td>Relationship between PrEP efficacy and adherence.</td>
<td>23</td>
</tr>
<tr>
<td>Figure 7.</td>
<td>HIV prevention efficacy in relation to adherence.</td>
<td>24</td>
</tr>
<tr>
<td>Figure 8.</td>
<td>Illustration of the Mobius Strip.</td>
<td>65</td>
</tr>
<tr>
<td>Figure 9.</td>
<td>Percentage of HIV-positive MSM unaware of their status.</td>
<td>71</td>
</tr>
<tr>
<td>Figure 10.</td>
<td>U.S. states with laws that criminalize HIV.</td>
<td>84</td>
</tr>
<tr>
<td>Figure 11.</td>
<td>Image of Truvada pill.</td>
<td>246</td>
</tr>
<tr>
<td>Figure 12.</td>
<td>Image of #TruvadaWhore t-shirt.</td>
<td>277</td>
</tr>
<tr>
<td>Figure 13.</td>
<td>AHF anti-PrEP advertisement.</td>
<td>283</td>
</tr>
<tr>
<td>Figure 14.</td>
<td>Response to AHF’s anti-PrEP advertisement.</td>
<td>289</td>
</tr>
<tr>
<td>Figure 15.</td>
<td>AHF open letter to CDC advertisement.</td>
<td>313</td>
</tr>
<tr>
<td>Figure 16.</td>
<td>HIV/AIDS media coverage in media.</td>
<td>319</td>
</tr>
<tr>
<td>Figure 17.</td>
<td>Diagram showing level of contagion of various diseases.</td>
<td>320</td>
</tr>
<tr>
<td>Figure 18.</td>
<td>Double-helix HIV prevention &amp; care continuum.</td>
<td>329</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

All reflective inquiry starts from a problematic situation, and no such situation can be settled in its own terms. (Dewey, 1929, p. 189)

HIV/AIDS and I are approximately the same age – I grew up in the AIDS generation and was scared of sex. More hauntingly, I believe the disease forced me to stay in the closet. At the age of 13, I began to learn about my body and its sexual responses. I specifically remember looking at males my age in a way that I did not look at girls – I dared not ever share those thoughts or feelings with anyone. Being gay was detestable and I wanted no part in it (or did I?). When I was 14, the movie “Philadelphia” (Demme, 1993) starring Tom Hanks and Denzel Washington debuted in theaters. Tom Hanks’ character, Andrew Beckett, was a successful attorney who eventually lost his job because of the visible, physical evidence of an AIDS diagnosis. The film concludes tragically with him succumbing to the disease. The movie was deeply moving and sad even for a 14 year old such as myself.

After watching that movie, I vowed from that day on to never act or think about homosexual acts ever again – AIDS scared me. That of course never happened – the idea that I could possibly be gay plagued me and I thought my supposed “impure” and “immoral” thoughts were simply a phase that all boys my age go through at some time in their adolescent years. While slowly coming to terms with my sexuality (I didn’t fully come out until my junior year of college, and even then, only to a few people), the AIDS virus has always piqued my curiosity. It was not the biological aspect of the disease as much as the social aspect of why I found AIDS to be so intriguing. Perhaps I have always had a connection to the disease as a gay man? Even before my official “coming out”
phase? Regardless, it is a disease that fascinates me on many levels, especially the American phenomenon of the illness that has a heavy homosexual connotation. As a gay man, I live the disease even though I am HIV-negative. I live it when I open up gay lifestyle magazines. I live it every December 1st on World AIDS Day. I live it when I see and wear a red ribbon. I live it when I pay extra close attention to news reports about the virus. I live it when I read literature by gay authors talking about the disease from the perspective and context of the 1980s and 1990s. I live it when I purposely go out of my way to view the handmade AIDS quilts that come to campus representing the lives of those who unfairly died from the virus. I live it when my friends disclose their HIV-positive status. And now I live HIV/AIDS in this project.

There have been many great advances in prevention as well as in the treatment of HIV/AIDS. But 30-plus years into our awareness of the virus, there is still no cure or vaccination. New medical research has indicated HIV can be prevented, even through risky sexual behavior, by taking an effective, daily medication known as PrEP. This prevention measure arrives at a time that is extraordinarily complex when it comes to gay health, sexuality and HIV/AIDS.

Furthermore, as medical advances are made, Gay Men have become more comfortable and relaxed regarding safe sex practices. PrEP comes at a time when barebacking (i.e. not using condoms during anal sex) is not just a sexual practice but a behavior loaded with much meaning and significance for many Gay Men. Juxtaposing all of these phenomena (i.e. barebacking, PrEP, HIV/AIDS and gay health) is complex, yet I believe one cannot be discussed without the others.
When it comes to HIV/AIDS, barebacking, PrEP, gay health and Gay Men, it’s complicated – there is no other way to put it. At the center of these phenomena is the theoretical and philosophical notion of the body. Sexually active Gay Men, including myself, live interesting lives in which we constantly make negotiations in the complex maze of HIV/AIDS and in our sexual practices. This dissertation is intended to make sense out of these complex, interconnected phenomena. HIV/AIDS, barebacking, being gay, and PrEP all do not fit into a tight, organized chart. Instead, as I write about all of these phenomena, light will be shed onto the subjectivities, complexities, and, yes, even the contradictions that Gay Men try to navigate through the discourses of these entities and their meaning for our lives.

Introduction

The above personal narrative is my rationale for pursuing this topic. Specifically, the topic is of importance to me as a gay man as I have friends who are currently living HIV and friends who are engaging in sexual practices that are putting them at great risk of acquiring the virus. Some may think that HIV/AIDS research is old-hat scholarship that is no longer of importance, as HIV has become a manageable medical problem. Ironstone-Catterall (2006) conducted a book review on AIDS narratives and stated that “scholarship on the AIDS epidemic is often frowned upon. AIDS may no longer be a sexy topic of inquiry, but it does remain an important one” (p. 953). While the treatments are successful, there are still great issues when it comes to HIV within the gay community. This topic, while a personal one, is also an overall complicated project in which many inextricable phenomena are at play. More than 30 years have gone by since
the first cases of AIDS appeared in the gay community and in the United States and still today, HIV has created a lot of new problematic situations that, according to Dewey (1929) require “reflective inquiry” (p. 189). My goal in this project is to try to make sense of all these interconnected phenomena and how Gay Men navigate the landscape of sexual health. In particular, investigating their communication with partners and others, including medical personnel, will highlight the ways in which they relate to this complex landscape. The labels they give to the varying processes, and the values they attach to sexual practices will serve to illuminate the meanings (e.g., significance, import of actions and information related to AIDS and sexual life) they ascribe to gay life.

In this first chapter, there will be a thorough discussion of the latest HIV statistics. This discussion will provide a background of a large problem in the gay community. The next section will discuss the successful HIV treatments available to people who are HIV-positive. This discussion will also highlight the need for HIV testing and getting HIV-positive people into care. The third section will make an argument for how PrEP prevents HIV as well as criticism launched against this prevention measure. The chapter will conclude with the research questions that will guide this project.

**HIV Statistics**

According to the World Health Organization (WHO, 2014), as of 2013, there are approximately 35 million people around the world who are infected with HIV and more than 39 million people have died from the virus since its inception. Despite prevention campaigns to combat the disease, approximately 7000 new infections occur daily (Michael, 2010). Within the United States, according to the Center for Disease Control
and Prevention (CDC, 2013a), more than 1.1 million people are living with the virus “and
nearly one in six of those (16%) are unaware of their infections” (“National Overview,”
para. 1). While scientists and medical practitioners have only known about HIV/AIDS for
close to 30 years, it has affected millions of lives and continues to show signs of
increased infection rates throughout the world. Specifically, all ten major regions in the
world (e.g. East Asia, Sub-Saharan Africa, Western and Central Europe, etc.) have seen
increases in the number of HIV/AIDS cases from 2001 to 2009 (UNAIDS, 2010).

While yearly HIV rates in the U.S. have stayed stable over the last decade, the
CDC (2013a) notes that 50,000 people in the U.S. are “becoming newly infected with
HIV each year” (para. 3). To put that number in perspective, I work at a community
college that has an enrollment of approximately 25,000 students. The yearly HIV rate in
the U.S. would be two of my institutions. To put the number 50,000 into context:

The average baseball stadium holds about 50,000 people. That’s a lot of people.
It’s enough people to fill 125 jumbo jets. Or about 500 Ferris wheels. 50,000
people would fill a dance floor the size of an entire block in New York City. Or
stretch 47 miles when linked hand-in-hand. And if 50,000 people formed a human
pyramid it would soar 632 feet into the sky. 50,000. That’s a lot of people. It's
also the number of people in the U.S. who contracted HIV last year. And the year
before that. And every year since 2003. (Gilead Sciences, Inc., 2014)

This powerful public service announcement puts an overall visual on the epidemic in the
United States. Some may think that many more people are far more greatly affected by
heart disease, cancer, and other illnesses. While this is statistically true, this virus is
different from those diseases in that people pass HIV along to one another through sexual contact and/or intravenous drug use. Additionally, according to the CDC, in the U.S., “More than 15,000 people with AIDS still die each year.” (para. 4).

With this distinction in mind, it is important to note that, according to the CDC (2013c), “MSM¹ represent just 2% of the U.S. population, but account for 63% of all new HIV infections in the United States each year, as well as more than half of people living with HIV (52%)” (“Heavily Affected Populations,” para. 2). To put this in perspective and to see how this compares to other at-risk groups, figure 1² details all groups that are most affected by new HIV infections.

¹ MSM stands for Men who have Sex with Men – this what the CDC commonly uses in their reports of HIV and STD statistics.

² Throughout this document, you will see a number of visuals which will include figures of data, pictures, etc. The purpose of this this is to “crystalize” (Ellingson, 2009) the phenomena to be discussed for a reader who may not be familiar with gay culture. There will be a thorough discussion of crystallization in chapter four.
As noted in this figure, the MSM population is, more than any other group, at risk of acquiring HIV. This is not the case in many African countries, which has the highest rate of HIV/AIDS in the world, as infection rates are a result of heterosexual transmission and/or drug injections (Avert, 2010). Still, after all of the health campaigns that have encouraged condom use, especially directed towards MSM, there is still a steady rise of the virus in this population of the American public, specifically for other populations within the MSM population (i.e. those who identify as gay, bisexual, and/or transgendered).

While the numbers may not be familiar within our own American culture, the sense that HIV/AIDS is a potentially deadly disease remains ever-present. As many also now know, HIV/AIDS is not solely a disease that is associated with men who have sex with men (MSM). Less well known, however, is that MSM is not a label that references
only those who self-identify as “gay,” “homosexual” or “queer.” As the following statement makes clear, it is necessary, when considering the potential increase of HIV/AIDS within the general population, to think in terms of “MSM/G” (i.e. G = Gay Men—thereby distinguishing the activity and the corresponding “identity”—the two groups are not always the same:

In every country of the world there are men who have sex with men (MSM).
Some men who have sex with men label themselves as gay, others as bisexual, while a large number – particularly outside western countries – simply see themselves as heterosexual males who just happen to have sex with men. (Avert, 2011)

While MSM is the technical term used to assess and calculate HIV/AIDS statistics by the CDC and other organizations, this project will focus more direct attention on the term “Gay Men” as this will be the identifying factor and population involved in the methodological approach as well as the discussion of implications. However, given the fact that “Gay Men” is a subset of the larger, more diffuse MSM designation, I will use MSM/G in the following discussion as it will assist in recognizing the role “Gay Men” play in the larger picture.3

When it comes to race, African-Americans are at great risk of infection – more so than any other group by race and ethnicity. According to the CDC (2013c):

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3 As a convention, I will also capitalize “Gay Men” when referencing the community of acknowledged “queer,” “homosexual” men who have sex with men. This is consistent with the current use of MSM/G to designate the two groups. References to specifics, as in “a gay male” will retain lower case designation.
While blacks represent approximately 14% of the U.S. population, the latest CDC estimates show that they account for almost half of all new infections in the United States each year (44%) as well as almost half of all people living with HIV (44%). (“By Race/Ethnicity,” para. 1)

Furthermore, and even more disconcerting, is that “At some point in their lives, approximately one in 16 black men will be diagnosed with HIV, as will one in 32 black women” (para. 2). To understand that larger picture of how HIV affects different racial and gender groups, the CDC details these most-affected subpopulations in figure 2.

![Figure 2](image)

*Figure 2.* HIV infections rates in the U.S. by race and sexual orientation. CDC (2013c).
In addition to sexuality, race and gender, age is also a prevalent element that is cause for concern among public health officials. When looking at the sub group of MSM and age, The CDC (2013c) reported that:

The number of new infections among the youngest MSM (aged 13-24) increased 22%, from 7,200 infections in 2008 to 8,800 in 2010. Young black MSM continue to bear the heaviest burden, accounting for more than half (55%) of new infections among young MSM (4,800). In fact, young black MSM now account for more new infections than any other subgroup by race/ethnicity, age, and sex.

(“Populations at Higher Risk for HIV,” para. 3)

This is problematic on a number of levels due to sexual safety information that young people may or may not be receiving. Also, poverty is highly correlated to HIV prevalence. According to Denning and DiNenno (2014), those with yearly incomes less than $9,999 have a higher prevalence of HIV than any other income group. In that same report, HIV prevalence is just as high in poverty areas in the U.S. as entire countries such as Burundi, Ethiopia, Angola and Haiti. It is clear, from this evidence, that certain subpopulations are more affected by HIV than other groups living in the United States.

**HIV Care & Treatment**

While the HIV statistics look troubling, there are excellent medications that have been successfully treating the virus for close to two decades. While these should not be conflated as cures for HIV, the treatments keep the virus at bay (e.g., at “undetectable” levels) and from replicating in the body. Ray et al. (2010) and Bratstein et al. (2006) found in their research that the virus replication decreases with the use of antiretroviral
therapy (ARV). While this is great for the health of the person living with HIV, and prevents them from acquiring AIDS and dying from AIDS-related complications (ARC), it also protects their sexual partners. Cohen et al. (2011), in what has been termed the HPTN 052 study, found that early ARV therapy for the newly diagnosed HIV-positive person reduces rates of HIV through sexual contact. This is also known as “Treatment as Prevention” (TasP) because it is operating under the assumption that an HIV-positive person is taking his or her medications as prescribed, which is typically daily (sometimes multiple times per day), and then they are able to acquire an undetectable level of virus in the body; this is reached when the virus is less than 200 copies/ml detected in the body through an HIV blood test. As a result of this undetectable level, the risk of passing the virus on to another person is minimal or near zero.

Currently, there is a longitudinal study, reported by Cairns (2014a), taking place that is studying the risk of transmission of HIV to others through sexual contact (final results will not be out until 2017). What is called the PARTNER study (Rodger, 2014) did however report early findings from their research and found that those with a viral load of less than 200 copies/ml (i.e. undetectable status), regardless of sexual orientation, had a 1% chance to become HIV-positive from any anal sex act and 4% for anal sex with ejaculation (without condoms). With these minimal statistics, the principal investigator of the study, Rodger, stated, “Our best estimate is it’s zero” (Cairns, 2014a, para. 3). Compared to the HPTN 052 study, the PARTNER study has enrolled more gay couples. In their work thus far, they have not found a single transmission of HIV for those on

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4 There is a glossary in Appendix A of this document that lists all of the medical acronyms that will be used throughout this document.
ARVs and who are at an undetectable level. The following infographic (figure 3) summarizes the findings of their preliminary research.

**Figure 3.** Early findings of PARTNERS study. This report and brief description of the PARTNERS study shows the risk level of HIV transmission onto another individual when the HIV-positive person is on medications and at an undetectable level. Rodger (2014).

As a result of these excellent drug therapies and treatments, Samji et al. (2013) reported that, in adhering to ARV therapy, an HIV-positive person in the U.S. can live to
a life expectancy of 77 years of age. To put that into perspective, the life expectancy for all people living the U.S. is 78.7 and 76.3 for men and 81.1 for women (CDC, 2012a).

The TasP and undetectable models are promising for people living with HIV/AIDS (PLWHA) in helping them maintain an undetectable viral load and also protect their sexual partners from acquiring the virus. While these models are great, they are a bit idealistic because there are a number of underlying assumptions that need to take place. First, health practitioners need to make sure that PLWHAs get into care, stay in care, take their medication and have 100% treatment adherence. According to aids.gov (2014), they define this as “taking your HIV drugs when and how you are supposed to” (“Treatment Adherence,” para. 1). Unfortunately, the practices suggested by this model are not always followed around the world. According to a Kaiser Daily Global Health Policy Report (2010), while the number of HIV cases grew globally, so did the number of people taking ARVs. The bad news is there are still 10 million in need of ARV therapies.

In the U.S., the story is really no different in that while the treatments for HIV infections have been successful at keeping the virus suppressed within the body, many are not linked to care. What is often called the “HIV care continuum” or the “HIV treatment cascade,” this model “is used by Federal, state and local agencies to identify issues and opportunities related to improving the delivery of services to people living with HIV across the entire continuum of care” (AIDS.gov, 2013, “What is the HIV Care Continuum,” para. 1). Specifically, the model illustrates the five different groups of people and their link, or lack thereof, to care. This continuum is illustrated in figure 4.
Figure 4. The HIV care continuum. This graph illustrates the percentage of groups of people who are HIV-positive in various forms of care. AIDS.gov (2013).

According to this model, there are five different groups that are on various parts of the care continuum. The first group, those diagnosed HIV-positive are at 82%. One may think “why is that number not 100%?” According to AIDS.gov (2013), this is a unique group because:

The only way to know for sure that you are infected with the HIV virus is to get an HIV test. People who don't know they are infected are not accessing the care and treatment they need to stay healthy. They can also unknowingly pass the virus on to others. ("What is the HIV Care Continuum," para. 2).

According to this model, 12% of those who are infected with HIV do not know that they are infected and can potentially pass the virus on to other people. The remainder of the
model shows various states of care but the most telling group is the small minority of 25% of those who are HIV-positive are virally suppressed. AIDS.gov states that this category is one where:

By taking ART regularly, you can achieve viral suppression, meaning a very low level of HIV in your blood. You aren’t cured. There is still some HIV in your body. But lowering the amount of virus in your body with medicines can keep you healthy, help you live longer, and greatly reduce your chances of passing HIV on to others. (“What is the HIV Care Continuum,” para. 6).

Ideally, the goal is to get everyone who may test positive for HIV (assuming the person does not know that he or she has the virus) to first take a test, then into care, successfully keep and retain them in care, get them to take ART, and then to viral suppression. While this goal is lofty, there is quite the distance and gap between those who are HIV-positive and those who are at viral suppression. Unfortunately, three out of four (i.e. 75%) are not at viral suppression and it could be one of the major contributing factors for the new 50,000 HIV infections every year in the U.S. – mostly affecting MSM. The only thing that can solve this problem is an HIV vaccine and/or a cure. At best, what we currently have are prevention measures.

As noted earlier, HIV greatly affects younger MSM more than any other age group. When it comes to the HIV care continuum, the picture is even more disconcerting because while young people are greatly affected they are also less likely to be retained in

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5 Viral suppression, or what is typically called “undetectable,” has been a proven prevention strategy for those who are HIV-positive and who take a daily ARV regimen. Basically, their undetectable viral load makes it nearly impossible to pass the virus on to another person. This is also known as Treatment as Prevention (TasP). There will be further discussion of this idea later in this document.
care and be on the medications that get them to an undetectable viral load. The HIV care continuum, by age group is illustrated in figure 5. This figure tells a story, and perhaps gives an answer, as to why HIV is spreading rapidly among young MSM. The gap between those who are undiagnosed and those who are virally suppressed is the widest among the youngest age group.

**Figure 5.** The HIV care continuum by age. CDC (2012b).

**PrEP & HIV Prevention**

After more than three decades of the first diagnosed cases of AIDS, especially in Gay Men, it is extremely important to understand how Gay Men think about the disease within a 21st century context. While HIV is still on the increase among Gay Men, as a
result of unsafe sexual practices, there is a culture, and acceptance, of barebacking that has arisen within the gay community (Dean, 2009; Shernoff, 2006). In addition to all of the medical breakthroughs, such as the various drug treatments that have made HIV a more or less manageable disease, the latest medical evidence suggests that MSM/G can bareback without getting the disease by taking a daily regimen of HIV medications, also known as Pre-exposure prophylaxis (PrEP) (Grant et al., 2010). Specifically, this means preventing HIV before exposure as a form of protection.

With advances such as PrEP, it is important to understand how MSM/G interpret messages about this new medical phenomenon. While I present, as chapter three will detail, information about the current practice of barebacking, the addition of this new medical intervention has the potential to significantly alter the playing field. As it becomes better known and available, the challenge to health professionals will be one of crafting HIV/AIDS prevention messages that do more than “say no to sex without a condom.” Before that kind of campaign can be formed, we need to know, as suggested above, more about how Gay Men, as a subset of the larger, and more elusive group of men who may have sex with men, without necessarily claiming, or owning, the “gay” label, see this change. Specifically, this means gathering their perceptions, through the use of individual interviews, regarding how they interpret the meanings of PrEP within the context of the gay male body and what PrEP means to them in terms of barebacking and gay sexual health. Trying to gain an understanding of such perceptions is pertinent in how Gay Men understand, embrace, or shun the risk of contracting HIV/AIDS within this medical and health context or, conversely, how those already living with HIV/AIDS
perceive the practice. Designing a successful campaign that communicates the benefits and risks of a new drug, especially in the context of barebacking, or unprotected sex, requires, as noted above, an understanding of the gay community’s current sense of what this drug means for them—what impact it may or will have on their bodies as they engage in behavior that, up until now, faces a more direct probability of being “caught” in testing HIV-positive. In-depth interviews will be conducted to gather their perceptions and medical opinions of the new treatment in the prevention of HIV, especially for Gay Men. In more precise terms, the goal of this study, via an exploratory investigation of the messages concerning both barebacking and PrEP, and the corresponding attitudes among Gay Men who engage in the practice, is to understand how Gay Men, specifically, communicate with others in the process of ascribing meaning(s) to barebacking, HIV/AIDS, and gay sexuality and health within the context of PrEP.

**HIV, MSM/G, & Barebacking**

Although drug treatments for HIV/AIDS have prolonged life expectancy, and advancements in treatments continue to be made, this has made HIV/AIDS a disease more manageable than when it first became publically known in the 1980s. Some have thought that the advances of such treatments have created a culture of optimism in which HIV/AIDS is no longer viewed as a death sentence upon diagnosis. As noted earlier, while safe sex health campaigns are prolific in the gay community, the incidence of HIV in MSM/G has continued to rise, mostly because many men are not using condoms – specifically engaging in the sexual practice of barebacking. Dean (2009) describes the historical association of this term as “Queer culture, drawing an analogy from equestrian
pursuits and invoking a quintessentially North American cowboy image, has coined the term ‘barebacking’ to describe Gay Men’s deliberate abandonment of prophylaxis during sex” (p. 1). As will be noted in chapter three, the term barebacking is a part of gay culture, with websites dedicated to the sexual practice. These social networking sites allow for MSM/G to meet others who wish to practice barebacking as a sexual activity. In addition to these websites, the gay pornography industry has also created many films dedicated to the practicing of bareback sex which has become a specific and popular genre.

While bareback sex has become an increasing sexual practice among MSM/G, the term “barebacking” has not always had a consistent definition. For present purposes, the nature of the sexual activity without the use of a condom is the central feature across all of the definitions. What makes this complex are the conditions under which this activity is performed – that is, with a person whose HIV status is known or not, an accidental encounter or “slip-up” where passion rules protection, whether pre-meditated or happenstance, does not make barebacking an easy phenomenon to comprehend. A second feature that makes delineating what is and is not “barebacking” in a particular setting is the ever-changing nature of the term’s use. Thus, earlier studies of barebacking (when it first came on the scene as a term of preference), may not capture the complex ways in which the term is either used or understood by those currently employing it (or refusing to acknowledge the term’s applicability in a given setting). As data is collected for this project, analyzing the ways the term is used within the context of PrEP medications may

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6 A more thorough discussion of barebacking, including technical definitions, and various, deeper definitions, will be provided in chapter three.
provide a basis for creating more precise distinctions within the practice, or simply confirm the fluid nature of the term’s use within the gay community.

**Conceptualizing PrEP**

Preexposure prophylaxis (PrEP) is “the administration of antiretrovirals before HIV exposure to prevent infection” (Supervie, Garcia-Lerma, Heneine, & Blower, 2010, p. 12381). Antiretrovirals have been the current drug therapies used to treat HIV-positive patients for more than 15 years. Researchers have been experimenting with these treatments in HIV-negative men (Grant, et al., 2010) and in HIV-positive pregnant women in order to prevent transmission on to their newborn children (Smith et al., 2005).

In a landmark study in the *New England Journal of Medicine*, Grant (2010) and his colleagues found, in a double-blind, randomized controlled placebo trial, that in HIV-negative MSM, and transgender women (born male) who have sex with men, that taking a daily PrEP regimen of emtricitabine and tenofovir disoprixal fumarate (FTC-TDF, a drug known as “Truvada”)\(^7\) reduced their HIV risk by 44%. However, among those who were highly adherent to the prescribed drug regimen, their risk of acquired HIV transmission was reduced by 92%. This promising news comes at a time when researchers have been looking for preventative measures for HIV transmission other than condoms. The Grant et al. (2010) study comes at a time when, as noted earlier, HIV rates are still on the rise around the world and among MSM/G in the United States who are becoming infected without the use of condoms. While PrEP shows much promise and

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\(^7\) It is important to note the distinction between PrEP and Truvada. PrEP is the concept of preventing HIV before exposure while Truvada is the actual pill/medication prescribed as a form of PrEP. As of now, there are current studies going on to see if other available HIV medications can be used as PrEP.
efficacy, doctors and scientists are aware that more research needs to be conducted in order to monitor long-term use of PrEP treatments. PrEP offers so much potential in preventing HIV that *Time* magazine ranked the study number one as the top medical breakthroughs of 2010 (Park, 2010). Also, as a result of this medical breakthrough, President Obama called the research team to congratulate them on their work and findings (Glazek, 2013).

When I first started this project there was only one study to confirm these results. As one might expect, there have been multiple PrEP studies that have shown the drug’s tremendous efficacy in preventing HIV. After the Grant et al. (2010) study (also known as the iPrEx study), the Hendrix et al. (2011) study (also known as the FEM-PrEP study) was conducted. By enrolling all women in their research, Hendrix et al. found that efficacy of the drug was low because adherence to take the drug everyday was low (e.g., less than 50%). As a result of these poor results, the study was halted. In a study conducted by the research team of Thigpen et al. (2012), also known as the TDF2 study, enrolled sexually active female and male heterosexuals found that efficacy was 62.2%. Through these results, the low rate of efficacy was a result of those who seroconverted (i.e. moving from HIV-negative to an HIV-positive diagnosis) who had a lower amount of Truvada in their blood than those who remained negative during the study which resulted in them having higher levels of the drug in their blood. During that same time, the PARTNERS study was published (Baeten et al., 2012) in which male and female heterosexuals in a serodiscordant relationship (i.e. one person is HIV-positive and the other is HIV-negative) were enrolled from Kenya and Uganda. The results of this study
showed that those who received PrEP reduced their rate of HIV transmission by 75% and those with higher levels of Truvada in their blood showed 90% efficacy in preventing HIV. One year later, a study was published that studied PrEP with injecting drug users in Bangkok, also known as the Bangkok IDU study (Choopanya et al., 2013). Also, Celum et al. (2014) and his team found that Truvada, used as PrEP, can also provide for protection from Herpes Simplex Virus Type 2 (HSV-2). Their results showed efficacy rate of 49% overall but a higher rate of 74% for those who had detectable levels of the drug in their blood. There are currently PrEP trials going on in other parts of the world such as Canada (CBC, 2014) and England will soon be offering PrEP to their citizens through their National Health Service (Brown, 2014).

These results, while they seem to be all over the spectrum when it comes to efficacy, show a trend for those who take the drug consistently and daily as prescribed – also known as high levels of adherence. Jiang et al. (2014) conducted a meta-analysis on seven PrEP randomized controlled studies and found that “PrEP has protective effect against HIV infection in high risk populations” (p. 7). With efficacy and adherence being clearly linked, Grant and his team conducted another study in which they enrolled MSM and transgendered women who have sex with men (Grant et al., 2014). Their results found the more often the participants took the PrEP drug (the amount of the drug was detected in their bodies through a blood test), the less likelihood of HIV infection. In fact, in their study (also called the iPrEx OLE study) there were zero HIV infections per 100 people who took the drug a minimum of four times or more per week. In other words, the
more the participants took the drug, as prescribed, the risk of HIV infection dropped exponentially nearly to zero. Their results are illustrated in figure 6.

Figure 6. Relationship between PrEP efficacy and adherence. This graph illustrates a relationship between the risk of acquiring HIV and how often the participants took Truvada. Grant et al. (2014).

A recent study (Vaginal and Oral Interventions to Control the Epidemic; VOICE, Marrazzo, 2013) was conducted on the daily use of oral PrEP and vaginal microbicide gels that contained the drug. Again, due to low adherence, the results were not promising when it came to efficacy of both the oral drug and vaginal microbicide gel. Overall, the data from the PrEP studies clearly shows that the more that participants adhered to taking the medication at least four days a week or more greatly reduced their risk of acquiring
HIV. When compared to condoms, PrEP seems to offer better protection against HIV when the Grant et al. (2014) study is juxtaposed with condom usage from the EXPLORE study (Koblin, Chesney, & Coates, 2004). They found that, similar to PrEP, the greater the adherence, the less likely the risk of HIV transmission; however, PrEP showed greater efficacy in three different adherence levels. Results are illustrated below in figure 7. This information is telling in that PrEP, if taken at least four times a week, has better adherence than using a condom in four out of seven sexual encounters. The medical barrier of PrEP is better than the physical barrier of a condom.

![HIV Prevention Efficacy in relation to Adherence](image)

*Figure 7. HIV prevention efficacy in relation to adherence.*
This graph illustrates HIV prevention efficacy for both condoms and PrEP in relation to adherence. “findings of the iPrex, VAX004 and EXPLORE studies” (Leue, 2014, para. 17).
Due to the efficacy and promise that PrEP offers, especially to those who are at high risk, the Food and Drug Administration (FDA) approved Truvada to be used as PrEP (FDA, 2012). With any new drug, there are always concerns about safety and side effects. The CDC (2013c) conducted its own study of administering Truvada as PrEP to 400 HIV-negative MSM in San Francisco, Atlanta and Boston. In their report, the CDC notes:

The most common side effects of tenofovir among HIV-positive individuals have been nausea and loss of appetite. However, there have been reports of uncommon, but more serious health problems related to kidney function and reductions in bone mineral density. (“Encouraging First Results on Clinical Safety,” para. 2)

In their preliminary data on the side effects of Truvada used as PrEP, the CDC found “there was no increased risk in men taking a study pill compared to those not taking a study pill during their first nine months of study participation” (para. 6). In another study, Solomon et al. (2014) specifically focused on renal (i.e. kidney) function while taking Truvada as PrEP. They concluded that there were some mild decreases in creatinine clearance within the kidneys but those levels returned to normal once when they stopped taking Truvada. While these decreases were evident, researchers were not concerned with long-term damage to the kidneys by taking Truvada as PrEP.

Another concern for acquiring and using PrEP is the cost. It is estimated that the drug costs approximately $13,000 per year (San Francisco AIDS Foundation, 2014).

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8 High risk populations, as defined by the CDC, are illustrated in figure 1.

9 The drug in Truvada
While expensive, the cost of HIV-treatment, according to the CDC (2013d) is estimated to be approximately $23,000 annually and $379,668 for a lifetime (all in 2010 dollars). Clearly, there is a financial savings between using Truvada to prevent HIV compared to a lifetime of HIV treatment of ARVs. When it came to health insurance companies covering Truvada, the San Francisco AIDS Foundation (2014a) states:

To date, we have not heard any reports of health insurance companies denying requests to fill prescriptions for PrEP in the United States. Some health insurance companies have pre-authorization requirements to determine if you are eligible to have it covered under insurance. This doesn’t necessarily mean that your particular plan will cover it—we can’t guarantee that! However, reports indicate that most people have no trouble getting their private healthcare insurance to cover PrEP. (“Are you thinking about starting PrEP?” para. 9)

To test this idea, I called my benefit office (at my employer) and the administrator looked up the drug formulary to see if Truvada can be prescribed as PrEP and the answer was “yes” (Kaffaga, personal communication, October 15, 2014). PrEP is also being covered by Medicaid in some states such as New York (San Francisco AIDS Foundation, 2014) and by the Affordable Care Act (ACA) (Jacobs, 2014). Fortunately, many health insurance providers see the financial and health benefits of PrEP.

While PrEP has shown efficacy as a possible HIV prevention measure, post-exposure prophylaxis (nPEP or PEP), receiving ART treatments after high-risk sex, has been effective for more than a decade (Cardo, Culver, Ciesielski, et al., 1997). MSM/G who engage in high-risk sex, specifically men who engage in bareback sex or unprotected
anal intercourse (UAI), have been mostly prescribed these treatments to prevent the onset of HIV. The treatment of nPEP has been shown to be extensively administered in MSM/G who engage in high risk sex (Schechter, et al., 2004). Unfortunately, in New York City, a young man who believes he was exposed to HIV through a sexual encounter, went to the emergency room during a holiday weekend in 2013 to seek PEP and was told “there is no such thing” and was asked to leave (Osborne, 2013). This shows that healthcare practitioners may need to be better trained and informed on HIV and sexuality issues.

**Perception of PrEP.** In initial assessments of how Gay Men would respond to PrEP, 74% reported that they would intend on using PrEP treatments if it were made available to them (Mimiaga, Case, Johnson, Safren, & Mayer, 2009). Liu et al. (2008) reported that MSM/G who engage in high risk sexual behaviors that they would also use PrEP treatments. In a similar article by Golub, Kowalczyk, Weinberger, and Parsons (2010), they found, of 180 HIV-negative MSM in New York City, 70% of them would likely take PrEP if it showed 80% efficacy or better in preventing HIV. Hamel et al. (2014) found a different story in their research of a representative nation-wide sample. When asked what they know about PrEP, 55% of respondents said “nothing at all” and 25% stated “only a little” (p. 12).

While this research shows great promise in the administering of PrEP, the number of actual users and filled prescriptions of Truvada remain low. According to (2014a), “A survey of 1,175 infectious disease specialists in the United States and Canada published in December showed that 74 percent supported it, but only 9 percent had actually
prescribed it” (para. 22). Additionally, Hamel et al. (2014) found that only 10% of their respondents know someone, including themselves, who are taking PrEP. This shows there is room for improvement when it comes to the prescribing of Truvada as PrEP by doctors. Additionally, McNeil (2014a) stated that:

By analyzing pharmacy databases, Gilead has tried to track how many Truvada prescriptions are for the drug regimen, rather than AIDS treatment. As of last September, the company said, it knew of only 2,319 — of which 49 percent were for women. (para. 25)

The problem McNeil notes is that there is a gap in the kind of care that Gay Men are receiving – if they are receiving any at all. Specifically, many people, whether they are high risk or not, see physicians who are general practitioners, not ID doctors who specialize in HIV. This could be part of the problem as to why there is a low adoption rate of Truvada as PrEP.

**Criticism & barriers of PrEP.** While PrEP is a major medical breakthrough to prevent HIV, it is not becoming widely accepted among people in the gay or HIV-positive community. Many have questioned why should medical professionals provide drugs to healthy individuals? Lupton (2003) and Urla and Terry (1995) have both argued that the homosexual body is a contested site in which it is always at risk and is in constant need of repair. The larger question surrounding this medical breakthrough is why PrEP and why now?

Currently, there are eight ongoing or planned PrEP clinical trials according to Gostin & Kim (2011). But the experimentation and advancement of PrEP has received
criticism from many. One of the most practical arguments that is brought up is the often cited HPTN 052 study (Cohen et al., 2011) which lowers the viral load of HIV-positive people who are taking ARVs. Regan Hoffman (2011), editor-in-chief of POZ magazine (a magazine dedicated to those in the HIV-positive community), and one of the biggest critics of PrEP argues, “It must be acknowledged that treatment as prevention in people without HIV and treatment as prevention in people with HIV are very different things” (para. 7). But the problem with this model, as noted earlier, is the HIV continuum of care and the gaps between those who are positive and those who are at undetectable levels (only 25% of HIV-positive people are on ARVs and at undetectable levels).

In addition to this criticism, there are arguments about issues of access and privilege surrounding PrEP. Hoffman (2011) further argued that popularizing PrEP creates access issues between those who have money and access to healthcare and those who do not. While access to ARV therapies have risen in the past year, and there are more than six million people taking the drugs, there are still millions of HIV-positive people in need of treatment. The United Nations (2012) is committed to getting 15 million HIV-positive on ARV by 2015. Overall, of the approximate 33.3 million people worldwide living with HIV, there are only 6.6 million people who are taking the drugs – a very large gap between those who are and those who are not using drug assistance. In the U.S., thanks to health insurance companies and the ACA (i.e. Obamacare), PrEP is covered by most plans as a form of prevention.

Another criticism of PrEP treatments is directed at the company that makes the drug Truvada. According to POZ (Newsfeed, 2011) magazine, Gilead, the drug company
that manufactures of Truvada, raised the price of drug by 7.9 percent after the FDA approved the drug for PrEP treatment. Hoffman (2011) argues, “Make no mistake: PrEP is a profit-driven sex toy for rich Westerners, disguised as a harm-reduction and prevention tool for disenfranchised people at risk for HIV” (para. 24). Others have responded to Hoffman’s remarks, in a POZ blog, suggesting that pharmaceutical companies are purposefully doing research on treatments, such as PrEP and nPEP because those treatments require drugs which help the bottom line of these companies, while neglecting research on trying to find a cure or vaccine for HIV. There are no known reports that Gilead, or any other pharmaceutical company for that matter, is conducting research on Truvada or any other drugs to be used as PrEP. As noted earlier, it is more expensive to be on a lifetime of HIV medications than to use Truvada as PrEP. I would guess that pharmaceutical companies who wish to seek a profit are more likely to stay with creating life-long use of ARVs as opposed to a prevention tool that is less expensive. Additionally, Gilead has not advertised Truvada as PrEP (Glazek, 2013). In fact, Jim Rooney, Vice President of Medical Affairs at Gilead, stated in Glazek’s article that Gilead “does not view PrEP as a commercial opportunity” (para. 6).

Another argument brought up by critics is the practicality of administering PrEP treatments. First, patients need to go to their doctors and then, secondly, disclose their sexual orientation and discuss how they are sexually at risk. The New York City Department of Health and Mental Hygiene (2008a) reported that in a survey of 452 MSM/G in New York City, that 39 percent did not disclose their sexual orientation to their doctors. This number can arguably be much higher depending on various locations.
of the U.S. in which homosexuality, or MSM/G communities, is not as widely accepted as in metropolitan areas such as New York City. Furthermore, according to the same survey, 60 percent of Blacks, 48 percent of Hispanics, and 47 percent of Asians did not disclose their sexual orientation; in marked contrast, White counterparts’ non-disclosure rate was 19 percent. This raises a number of questions and problems for health practitioners who are aiming to prevent HIV transmission. With barebacking becoming more of an accepted practice among MSM/G, there again is a large gap between those who articulate their sexual practices and orientation to their doctors versus those who do not disclose. This makes PrEP very difficult to administer to MSM/G. And, once when patients make it to the doctor, disclose their sexual orientation, disclose risky sexual behavior, and have a doctor willing to provide them with PrEP treatments, will the medication then be taken regularly as prescribed? Evans (2011) argues that those who are HIV-positive struggle to take their prescribed ARVs on a regular basis:

At the end of the day, the most potent ARVs are worthless if people don’t take them, and keep on taking them regularly, and we know from several studies that up to 50 percent of people either fail to make it into care or to stay in care in the year following their HIV diagnosis. (para. 15)

From a practical standpoint, there is a lot of criticism suggesting that the administering of PrEP treatments might not be worth the time, effort, and minimal resources and instead efforts should be placed on getting people tested and on ARV therapies.

Furthermore, in addition to the gap that exists between those who disclose their sexual orientation to their primary care physicians and those who do not, another element
comes into play in regards to who has knowledge of prevention opportunities such as nPEP and/or PrEP and who does not. Mehta et al. (2011) found in their research that awareness of PEP, of MSM/G in New York City, correlated with a higher number of sexual partners and with their knowledge of PEP and PrEP treatments and to disclosure to a primary care provider. While this shows promise of preventing HIV in MSM/G with those who have a higher number of sexual partners, Mehta et al.’s research shows similar results of New York City Health and Mental Hygiene (2008b) research when it came to race. Specifically, Mehta et al. (2011) noted that White men were more likely to be aware of nPEP/PrEP than nonwhites (44 percent to 36 percent), only 39 percent with a college degree knew of these treatments, 36 percent of those in the study interacted with the healthcare system, and 49 percent whose primary provider knew of their MSM/G status. Again, PrEP treatments can ultimately come down to those who have access to healthcare and prevention strategies, and unfortunately race is sometimes a predictor of access to medical care.

The success and potential that PrEP offers can completely change the thought process in how safe sex is discussed and managed but it can also come at a cost. Many current HIV treatments are high in toxicity, which can put stress on vital organs in the body. Shortly after the PrEP study was published, criticism of PrEP treatments was raised almost immediately in the medical community. Gostin and Kim (2011) raised the ethical questions regarding the administering of the PrEP regimen, “Under what circumstances is it ethical to recommend that healthy individuals take medications with potential adverse effects and drug resistance?” (pp. 191-192). The ethical implication of prescribing toxic
medications to healthy people was also raised by Leydorf (2011). He argues “you have to question the rationale for taking something that can make you ill in order to prevent getting ill. It would be like doctors prescribing chemo for life instead of advising smokers to give up cigarettes” (p. 22). In addition to the ethical implications of the medication used in the PrEP study, there are many more policy questions as to whether or not health insurance should, or would, cover the cost of PrEP regimen. While scientific and medical results from the PrEP study show excellent results in preventing HIV among high risk sexual groups, PrEP enables, yet constrains, some of the many other issues associated with the administering of this treatment.

While some of the criticisms are warranted, and raise some valid concerns for administering PrEP, some are not as strong. For example, the above argument about giving chemo to people who are at high-risk of cancer is a false analogy fallacy. Cancer and HIV are two very different diseases. But one legitimate concern is how do health practitioners and public health campaigns get Gay Men, who are at risk of acquiring HIV, tested and informed accurately about PrEP? These criticisms launched against PrEP, no matter how valid or invalid, are pertinent issues because all it takes is an articulate, powerful campaign that aims to destroy the efficacy and credibility of PrEP. Secondly, the barriers to PrEP are very real and can create problems for the successful administering of the prevention measure to those who need it. These criticisms and barriers will be addressed within the in-depth interviews with participants.
Research Questions

The above review of the central phenomena that are involved (and more will be said in later chapters) provides a rationale for the examination of the way in which Gay Men name their association with HIV/AIDS, the sexual practice of barebacking in particular, and the potential use of a preventive medical intervention. The following will outline in brief form the central questions animating the study’s focus on Gay Men, as well as the developmental outline for the study. The preceding overview leads to the questions that will guide this entire project:

1) In their communicating about their experience with sexual behavior, what meanings do Gay Men subscribe to barebacking within the context of PrEP regimens?

2) In their communicating about their experience with sexual behavior, what meanings do Gay Men subscribe to HIV/AIDS within the context of PrEP?

3) What attitudes and values do Gay Men reflect in communicating about gay sexuality and health in their receptiveness toward PrEP treatments?

4) What does PrEP mean for the gay male body?

My rationale for pursuing these broad, and perhaps abstract, research questions is two-fold. First, PrEP is still new. As of now, we have excellent medical research laying out the efficacy and promise of PrEP in preventing HIV but we have few pieces of scholarship dedicated to the social aspects and implications of PrEP. Additionally, there have not been any, at least that I currently know of, qualitative projects dedicated to PrEP. Secondly, these broad research questions allow for flexibility in what I think will
account for multi-diverse, complex comments and perceptions from participants. Corbin and Strauss (2008) note that:

Qualitative studies are usually exploratory and more hypothesis generating rather than testing. Therefore, it is necessary to frame the research question(s) in a manner that provides the investigator with a sufficient flexibility and freedom to explore a topic in some depth. Also underlying the use of qualitative methods is the assumption that all of the concepts pertaining to a given phenomenon have not been identified, or aren’t fully developed, or are poorly understood and further exploration on a topic is necessary to increase understanding. While research questions in qualitative studies tend to be broad, they are not so broad as to give rise to unlimited possibilities. The purpose of the question is to lead the researcher into the data where the issues and problems important to the persons, organizations, groups, and communities under investigation can be explored. (p. 25)

These broad questions that I have proposed I believe are excellent questions as they allow for great flexibility for a new phenomenon (i.e. PrEP) to be explored against the complex phenomena of HIV, gay sexuality, gay health and the gay male body. As should be clear, the purpose of this chapter has been to orient the project in terms of the importance attached to PrEP in the context of gay sexual practices. The ‘meaning’ and ‘(re)thinking’ alluded to in the Research Questions will be highlighted through an analysis of what Gay Men are saying about their own experiences. From a rhetorical perspective, as outlined briefly below in a discussion of the study’s development, the language used in the
participant’s own narratives will play a crucial role in understanding and evaluating what PrEP signifies in contemporary gay life.

Moving beyond the preceding review of relevant literature, Chapter two will focus on the proposed theoretical frame to be employed in this study. The *gay male body* is the central focus of attention in framing the ensuing study of gay and perceptions of PrEP and its impact on the lived body. Chapter three will explore specific interdependent themes that function as a backdrop to the interviews. These themes are HIV/AIDS, barebacking as a sexual practice in the gay community, and PrEP. All of these phenomena cannot be discussed in isolation because they are all inextricably tied with one another. The intersections through which these ideas collide are complex. Chapter four will outline the methodological process and explanations for pursuing in-depth interviews.

As suggested above, the research questions will be revisited in the analysis of the interview commentaries provided by Gay Men. These questions, while overarching, and general, are loaded with many potential, complex answers. Additionally, as noted earlier, the central issue in this study will focus on how Gay Men perceive the introduction of PrEP in the context of their own preferred sexual practices, in particular, that of barebacking, HIV prevention and gay health. In particular, Chapters five and six will be an in-depth analysis of the interview data and narratives provided by the participants. Finally, chapter seven will discuss the significance of the findings in relation to what they mean for PrEP, gay health, gay sexuality and the gay male body.
Also, throughout this project, in addition to the theoretical research, you will see/hear my voice as I, a gay man, try to make sense of and navigate the issues of how my body intersects with HIV/AIDS, barebacking, and PrEP. My voice will at times parallel other voices and at other times appears contrary to voices raised in response to gay male bodies, and their lived experiences.

Contextualizing Health Communication

This project, while multi-disciplinary in nature, falls within the realm of health communication. The phenomena of HIV/AIDS, gay health, PrEP and gay sexuality are incorporated into this project from various forms of theoretical and popular culture literature. Nussbaum (1989) notes that:

Health communication cuts across all disciplines interested in human behavior. A good health communication scholar is not only aware of this fact but is constantly reading to incorporate all the existing literature into a sound knowledge base from which to generate his or her own research agenda. (p. 36)

With PrEP being such a new phenomenon, it is important to see how it fits into the socio-cultural milieu of the gay community both as a medical/health perspective and as a meaning-making force within the gay male body. Nussbaum also argues that HIV/AIDS is a relational issue as much as it is a biological issue within the understanding of health communication. PrEP, as well as the other phenomena that will be studied and discussed, are no different.

Additionally, the theoretical notions of the body and embodiment are an important piece to help understand these inter-connected phenomena. According to Babrow and
Mattson (2003), they outline “four characteristic tensions mark health communication as an especially significant form” (p. 40). One of those characteristic tensions is the “interplay of the body and communication” (p. 40). This project will reside specifically within that realm of health communication with the other inter-connected phenomena that will be discussed and studied. By discussing the theory of the body, this allows for the all of the phenomena to be studied in a way that challenges traditional binaries when it comes to sexuality and embraces fluidity within such complex phenomena. Parrott (2004) argues, “At present there is no communication theory to explain, for example, the process of naming, which is a meaning-making activity that compromises a core function of health communication” (p. 772). The phenomena laid out in this project do not necessarily fit into one singular theory which ultimately deal with how participants make sense out of, and create meaning around, and navigate these phenomena within the theoretical lens of the body.
Chapter 2: Body Theory

Sexuality is something that we ourselves create – it’s our own creation, and much more than the discovery of a secret side of our desire. We have to understand that with our desires, through our desires, go new forms of relationships, new forms of love new forms of creation. Sex is not a fatality [i.e. an inevitability]; it’s a new possibility for creative life. (Foucault, 1982, p. 163)

This chapter will focus on theoretically framing the study as one dealing with the Body – specifically using Elizabeth Grosz (1994) and the Body as a theoretical frame for the analysis. Other theorists will also be discussed and used to frame the theoretical discussion in the chapter. They will include but not be limited to: McKerrow (1998), Mary Douglass’s (1966) discussion of the body in *Purity & Danger*, and Foucault’s (1980) sense of “biopower.” The status of HIV/AIDS will be used to frame this discussion – it serves as the backdrop against which everything else possesses meaning/significance in terms of how barebacking and PrEP are addressed. As McKerrow (1993) has noted, “before the subject is the body” (p. 52). What this begins to suggest is the importance of understanding the body in relation to gay sexuality and health. The next section takes up this issue.

The Body, Gay Health, & Sexuality

The medical promise that PrEP offers to prevent HIV raises many ideas and questions in regards to Gay Men who wish to practice bareback sex. Specifically, condoms have always been the traditional form of protection against HIV and now the possibility of barebacking, accompanied by a daily PrEP regimen, can be presented as an
alternative form of safe sex. Because the innovation of PrEP offers many promising possibilities in terms of how HIV is prevented, it has the ability to both enable and constrain the way in which HIV prevention messages are both constructed and consumed. That is, people who are at high risk of acquiring HIV, especially Gay Men, are presented with a solution of HIV prevention that has the potential to change the entire terrain of sexual safety. The changes can be so dramatic that it can be examined through two overarching ideas in relation to Gay Men and HIV. First, the medical innovation of PrEP raises questions, and sheds light, on new ways of thinking about gay health and the new meanings of safe sex. Secondly, PrEP treatments also allow the possibility to re-conceptualize and re-think what HIV/AIDS means within the gay community and beyond. Both of these overarching ideas are also reflective of how the gay male body is medicalized, controlled, and managed. More specifically, PrEP is a major component added to the map of the gay male body.

The possibilities suggested by PrEP regimens offer many promises for sexual health in protecting the body from HIV but it also raises questions in regards to how the gay male body is often managed and regulated by medical culture. The gay male body is unique in that it is subject to disease and illness, especially from a sexual health context. Lupton (2003) notes that:

Over the past century and a half, the homosexual body has been subjected to intense medical scrutiny. As part of the quest to categorize, label and define human bodily functions and behaviours, medico-scientific discourses have constructed ‘the homosexual’ as a distinct human type. (p. 31)
With the advent of PrEP, the gay male body is, again, subject to medical scrutiny and examination by prescription drug companies as a phenomenon that needs to prevent a disease, HIV in this case, with the notion of corporeal armor.

**Biopower: Disciplining Bodies**

In the context of this investigation, Gay Men who bareback, or put their bodies in danger of HIV and STDs, violate the social norms of trying to maintain a healthy lifestyle that is encouraged and privileged by society and forms the normative structure from which the medical community approaches the issue. That is, many Gay Men are taking sexual risks that put them not only at risk of HIV but also of contracting other STIs that can easily be prevented by using a condom. Foucault (2000) noted this social norm as the “imperative of health” which he claimed is “at once the duty of each and the objective of all” (p. 94). The practice of barebacking, in transgressing the norm, raises many questions in a society that privileges a healthy lifestyle over risky sexual behavior. While same-sex relations and practices have been stigmatized by society, barebacking among Gay Men is further placed in spaces of stigmatization that exist both inside as well as outside of the self. Foucault states that “the whole machinery of power . . . was implanted in bodies” (p. 42). Power has specifically played a predominant role in regards to how sexuality is practiced, taught, and performed. Foucault notes:

> The power which thus took charge of sexuality set about contacting bodies, caressing them with its eyes, intensifying areas, electrifying surfaces, dramatizing troubled moments. It wrapped the sexual body in its embrace. (p. 44)
The sexual body has been regulated through elements of socially acceptable sexual practices and norms, and barebacking is no exception. Trying to understand such practices of some Gay Men further questions the notions of what is sexually and socially acceptable to do with one’s body and what is not. As a preventive tool, PrEP complicates the simplicity of “use a condom” as a response to the possibility of contracting HIV/AIDS and further impacts the management of Gay Men’s sexual practices. The question surrounding the advent of PrEP is whether or not it will be welcomed among Gay Men, as they are already showing increased rates of bareback sex.

Power, according to Foucault, does not exist in isolation – it finds its way into the body and plays a major role in how human bodies are managed and controlled. Foucault (1980) specifically argues:

What I want to show is how power relations can materially penetrate the body in depth, without depending even on the mediation of the subject’s own representations. If power takes hold on the body, this isn’t through its having first to be interiorized in people’s consciousness. There is a network or circuit of bio-power, or somato-power, which acts as the formative matrix of sexuality itself as the historical and cultural phenomenon within which we seem at once to recognise and lose ourselves. (p. 186)

As gay sexuality went through a liberation phase in the 1970s, and HIV/AIDS spread virtually unchecked throughout the 1980s, the hysteria to control the spread of the illness and to find a cure and HIV vaccine was the dominant discourse during that time. Since no vaccine or cure has been found, prevention and treatment of the disease is what has been
communicated and has forced many Gay Men to take control of their bodies through their sexual practices, in particular, practicing safe sex with a condom. Now that PrEP has the potential to take control of HIV prevention measures without the use of condoms, power is literally installed in the body in the form of medicine to protect against the virus, adding another social-historical element that may complicate while it eases the risk to the gay male body’s social existence. With PrEP, the gay male body is, in a sense, fitted with a script of protection against HIV. Neither condoms nor PrEP are failsafe measures, but the emergence of this new alternative changes the power dynamics within the gay community, as it also changes the power dynamics invoked in managing the gay body. The ‘safe-sex’ norm is also challenged with respect to the gay community’s reaction to this new regimen. PrEP, along with barebacking and HIV/AIDS, are powerful forces that add to the long history of the gay male body.

The script, specifically the per(script)ion of PrEP regimens, adds to the text of the gay male body as a valid form of HIV prevention. Cahill (2008) argues, “If, as Foucault claims, individual bodies are produced with certain identifiable characteristics that relate directly to power dynamics, then bodies are texts that we may read in order to discern the (sometimes implicit) claims of the dominant discourse” (p. 815). The text of the gay male body continues to be studied, medicalized, and managed through the influence of bio-power. That is, in order for Gay Men to protect themselves from the dangers of HIV they must further add to the text of their bodies through the scripts of PrEP regimens. And now that PrEP has become more of a reality, it brings with it new meanings, opportunities, and uncertainties for the gay male body. Lupton (2003) notes that “Like
the gendered body, the sexually active body is currently a primary site at which contesting discourses compete for meaning, particularly in the fields of medicine and public health” (p. 29). As Cahill (2008) argues, HIV/AIDS, barebacking, and PrEP are inscribed upon the bodies Gay Men.

PrEP focuses on sexuality in regards to how HIV can be prevented. Rubin (1999) argues that sexual behaviors are privileged within a hierarchy in society. The most privileged form of sexuality and practice is that of monogamous, married, heterosexual couples. Not very long ago, up until 1973, the Diagnostic and Statistical Manual (DSM) classified homosexuality as a psychiatric illness. The American Psychiatric Association removed the words and supposed “illness” of homosexuality from the DSM at its 1973 meeting in San Francisco (Chicago Public Media, 2002). While the psychiatric stigma of homosexuality started to change during this time, homosexuality as a lifestyle and sexual practice still today holds a high level of stigmatization. Rubin argues:

Most systems of sexual judgment – religious, psychological, feminist, or socialist – attempt to determine on which side of the line a particular act falls. Only sex acts on the good side of the line are accorded moral complexity. For instance, heterosexual encounters may be sublime or disgusting, free or forced, healing or destructive, romantic or mercenary. As long as it does not violate other rules, heterosexuality is acknowledged to exhibit the full range of human experience. In contrast, all sex acts on the bad side of the line are considered utterly repulsive and devoid of all emotional nuance. The further from the line a sex act is, the more it is depicted as a uniformly bad experience. (p. 152)
Rubin further argues that homosexuality has become more acceptable within the last few decades but has still not received the same respect as heterosexual practices by society. While Rubin does not speak directly to the sexual practice of barebacking, there can be an argument made that, within the hierarchy of homosexual practices, barebacking, even as its frequency increases, is not widely embraced among MSM/G, in general, or within the gay community. Larry Kramer, an AIDS activist since the early 1980s, is still making passionate pleas to the gay community about the health risks of barebacking (Kramer, 2005). This discourse is in direct competition with a gay pornography industry that’s producing bareback pornography at three times the rate of condom-only pornography (Sheon, 2011), not to mention the social networking websites dedicated to barebacking. Even though Gay Men are experiencing more equality and sexual freedom than previous decades, the practices of barebacking tend to fall on the other side of the wall of socially acceptable sexual practices. Now that PrEP has the potential of preventing HIV without the use of condoms, and allows for the potential practice of safe, bareback sex, the question is raised about what PrEP means for the gay male body, gay sexuality and health, and HIV/AIDS.

To take Rubin’s (1999) idea further, the efficacy of PrEP raises the question about the hierarchy of masculinity within the gay community. Gay Men who bottom (i.e. the receptors of anal sex) are the men who are expected to take the daily PrEP regimen in order to protect themselves from HIV while the men who top (i.e. anally penetrate bottoms) can potentially get a “pass” on not having to use condoms. The same parallel can be drawn for women who are often expected to protect themselves from the risk of a
pregnancy by taking regular regimens of birth control. Regardless of sexuality, the gay male, or the straight or bisexual male who penetrates his sexual partner is granted the privilege of placing the health risks and responsibilities onto the receptive partner. Will PrEP create the assumption and expectation for men who bottom through the act of barebacking that they are expected to take control of their own sexual health regardless of condom usage in the sexual encounter? PrEP has the potential of re-creating or strengthening a sense of male privilege within the gay community which, according to Shernoff (2006) already exists. He notes, “Some gay men who bareback seem to be acting out traditional male privilege without giving a thought to the impact of their behavior either on their sexual partners or on society at large” (p. 285). Gay Men who bottom, and take a daily PrEP regimen, have the potential to take control, own, and embrace their sexuality and bodies. But the other side of this argument is whether or not PrEP re-creates the potential of a gay sexual health hierarchy in that men who top are absolved from having to take the daily regimen while men who bottom are expected to protect themselves from the virus. This argument aligns with what Lupton (2003) has discussed in terms of the expectation of how people should protect and manage their bodies. She specifically notes, “At the turn of the twenty-first century, the concerns of public health have remained firmly fixed on controlling bodies, but have moved from containing infectious disease to exhorting people to take responsibility for maintaining personal bodily health” (p. 35).

Such a metaphor of a sexual hierarchy within the gay community is illustrative of what Foucault (1978) was discussing in regards to the relationship of power. That is, the
notion of *biopower* allows for an acceptance of homosexual behavior in this context but to put one’s body at risk of acquiring a disease violates the sexual norms established by most within the gay community and society. The ethical system of sex gets re-established within the gay community as safe sex is widely embraced and accepted while barebacking gets placed in a dark corner of the gay community. Dean (2009) argues that “power possesses a mobility that makes every subject the agent as well as the object of power: power is understood as a set of force relations (rather than as just a set of institutions) that we constantly make and remake as we move through the world” (p. 166). The power PrEP has in preventing HIV infection places the gay male body in a position of regulation and management but also allows for a sense of freedom and pleasure through the practice of bareback sex without having to worry about acquiring a lifelong, chronic illness. Specifically, the gay male body is mapped by the messiness of HIV and PrEP is the main artery and interstate that lets the gay male potentially avoid the disease while allowing for the practicing of bareback sex. PrEP is the compass on the map of the gay male body that provides guidance, direction, and navigation through the rough terrain of HIV/AIDS, barebacking and gay health. Power that is placed upon the gay male body, as previously stated, comes in various forms of biopower (i.e. HIV/AIDS and its prevention from the disease) as well as sociopower.

Douglas (1966) provides a similar argument in regards to sexual practices and their contentions with society. While she is writing about heterosexuality, I do not see such a distinction in regards to how her ideas are that much different for Gay Men. She notes:
There is a more interesting level at which pollution ideas relate to social life. I believe that some pollution ideas are used as analogies for expressing a general view of social order. For example, there are beliefs that each sex is a danger to the other through contact with sexual fluids. (p. 4)

For MSM/G, especially Gay Men, the “dirtiness” of male-on-male sex is filthy in the eyes of a morally conscious society, especially if there is a deliberate choice to not use condoms. These ideas clearly fall out of the social sexual order in a society that privileges consensual, married heterosexuality that makes a contribution to society through childbirth. Douglas goes on to write:

I suggest that many ideas about sexual dangers are better interpreted as symbols of the relation between parts of society, as mirroring designs of hierarchy or symmetry which apply in the larger social system. What goes for sexual pollution also goes for bodily pollution…. Sometimes bodily orifices seem to represent points of entry or exit to social units, or bodily perfection can symbolize an ideal theocracy. (p. 4)

Foucault’s (1980) notion of biopower and Rubin’s (1999) discussion of sexual hierarchy are complemented by Douglas’s perspective. The scare tactics, rhetoric and ostracizing of Gay Men and their consensual sexual practices clearly fall into these theoretical ideas. They fit because they are not just sexual practices but highly socialized, politicized and moralized acts. These ideas will be examined in more specific depth in chapter three and in the analysis chapters of this document.
The Gay Male Body

For Gay Men, HIV, barebacking, and PrEP are all exterior phenomena that exist outside of the body but can also be taken internally within the body; the body moves within these phenomena. The lurking danger of barebacking can lead to HIV transmission—it is always “out there.” The possibility of transmitting the disease can change the interiority of a body; on the other hand, PrEP is the corporeal armor that can be taken to protect that body from HIV. Given this knowledge, as a gay man, I identify strongly when Grosz (1994) states:

The body is my being-to-the-world and as such is the instrument by which all information and knowledge is received and meaning is generated. It is through the body that the world of objects appears to me; it is in virtue of having/being a body that there are objects for me. (p. 87)

As a gay man, the knowledge and meaning that comes with HIV, barebacking, and PrEP impact me more than it does my heterosexual friends. These phenomena, especially HIV, are ever-present during the sexual encounter and that is what makes the gay male body so unique as a field of study.

These phenomena – HIV, barebacking, and PrEP – are fluid entities that flow in and outside of the body. These phenomena, and more, are what create the body image and mapping as it is built into the gay male body. Grosz (1994) further argues that:

The body image established the distinctions by which the body is usually understood – the distinctions between its outside or skin, and its inside or inner organs; between and processes; between active and passive relations; and between
the positions of subject and that of object. The psychic investment in the body as a whole and in its various parts is as much a function of the subject’s relations with others as it is of the subject’s own sensations and libido. In this sense, the body image is the result of shared sociocultural conceptions of bodies in general and shared familial and interpersonal fantasy about particular bodies. (p. 84)

Communication and everyday talk among Gay Men focuses on bodies in unique ways that only Gay Men can really openly talk about. Whether it may be body appearance and looks, sexual practices, or whether one is “clean” (i.e. free of STDs), these are the conversations that are embedded socioculturally within a primarily gay community. The conversations are inscribed into, and onto, gay bodies.

Power is an important component that is inflicted on the body and this is what makes the body the center of the theoretical discussion in this project. But with the entrance of PrEP, barebacking, and HIV/AIDS, in concert with one another, the body is placed in a tricky position as it tries to navigate all of these phenomena. According to Grosz (1994), the “body is thus what is not mind, what is distinct from and other than the privileged term. It is what the mind must expel in order to retain ‘integrity’” (p. 3). And here lies the central, underlying frame for this project – the body as an area of study. PrEP, barebacking, HIV/AIDS and gay health are all phenomena that are intertwined with one another in which the body, specifically, the gay male body, is the central subject of investigation and inquiry. Many ask and wonder: “Why would anyone have unprotected anal intercourse with all that we know about HIV/AIDS today?” “Why would anyone want to take drugs to prevent an illness when they do not have the
disease?” These questions, that I often hear from others when discussing this project, are always asked in privileging the mind and rational judgment over the body’s desires. What Grosz rejects is society’s privilege of the mind over the body; it is no different when it comes to gay male bodies. Grosz further argues that “The body has been regarded as a source of interference in, and danger to, the operations of reason” (p. 5).

Grosz (1994) makes three central arguments for why the body is a site for scholarly investigation. First, she argues that “the body is primarily regarded as an object for the natural sciences, particularly for the life sciences, biology and medicine; and conversely, the body is amenable to the humanities and social sciences particularly psychology, philosophy, and ethnography” (p. 8). Grosz does not deny that the body is ignored by the humanities or social sciences but she states that body is researched as an object in those disciplines. She writes:

As an organism, the body is merely a more complex version of other kinds of organic ensembles . . . . The body’s sensations, activities, and processes become ‘lower-order’ natural or animal phenomena, part of an interconnected chain of organic forms. (p. 8)

The body is central to this project because the gay male body is not an object but is rather a living organism that is consumed by various phenomena that play into the identity and behaviors of what it means to “be gay.” Secondly, Grosz argues that another “line of investigation commonly regards the body in terms of metaphors that construe it as an instrument, a tool, or a machine at the disposal of consciousness, a vessel occupied by an animating, willful subjectivity” (p. 8). The body is viewed as a neutral entity that needs to
be controlled by ethical implications or “careful discipline and training” (p. 9). The criticisms launched onto the body, at this point, is the use of a drug (i.e. PrEP) that is being placed onto gay male bodies that serve as storage units in the protection against HIV/AIDS. Specifically, PrEP is being used as a tool of corporeal armor.

Grosz’s (1994) third point for the studying the body is also relevant and worth quoting in full:

[T]he body is commonly considered a signifying medium, a vehicle of expression, a mode of rendering public and communicable what is essentially private (ideas, thoughts, beliefs, feelings, affects). As such, is it a two-way conduit: one hand, it is a circuit for the transmission of information from outside the organism, conveyed through the sensory apparatus; on the other hand, it is a vehicle for the expression of an otherwise sealed and self-contained, incommunicable psyche. It is through the body that the subject can express his or her interiority, and it is through the body that he or she can receive, code, and translate the inputs of the ‘external’ world. Underlying this view too is a belief in the fundamental passivity and transparency of the body. Insofar as it is seen as a medium, a carrier or bearer of information that comes from elsewhere (either ‘deep’ in the subject’s incorporeal interior or from the ‘exterior’ world), the specificity and concreteness of the body must be neutralized, tamed, made to serve other purposes. (p. 9)

As will be detailed in chapter three, the gay male body is loaded with meaning and information in which feeling, sexual desire, impurity, and perversion are contained within the interior of the body when it comes to barebacking. Subsequently, the exteriority of
PrEP and HIV linger and attempt to break the threshold into the interiority of the body. Between the interiority and the exteriority in the body, there is a complicated negotiation by the body to deal with issues of barebacking, HIV, and PrEP and all of their meanings.

With these three positions as a general outline of the importance of the body as a research site, Grosz (1994) goes on to delineate six approaches to the study of the body as a theoretical idea. As suggested above, her first argument is to dispel the dichotomy that exists between mind and body: “First, it must avoid the impasse posed by dichotomous accounts of the person which divide the subject into the mutually exclusive categories of mind and body” (p. 21). People who hear about Gay Men who bareback, based upon my experience, always ask why would men want to engage in a risky sexual practice (i.e. barebacking) that can lead to a chronic illness such as HIV/AIDS. Many think that men are only serving their bodies with the notion of pleasure while neglecting smart, safe sexual practices. I argue that the mind/body dualism is not dualistic in most Gay Men. Specifically, Gay Men know the risks and still engage in such practices because many of them know that HIV/AIDS is a consequence but not one in which one suffers and dies after five years of diagnosis. On the other hand, there are Gay Men who separate the mind and body in a way that causes great conflicts within oneself. For example, the practice of bareback sex is embodied as erotic and pleasurable but most Gay Men know in their minds that this is a dangerous sexual behavior. This will be discussed in more depth in the next chapter.

Grosz’s (1994) second argument is that “corporeality must no longer be associated with one sex (or race), which then takes on the burden of the other’s
corporeality for it” (p. 22). The gay male body and its acts are not the equivalent of the straight male body or any other body for that matter. The gay male body does not need to pick up sport nor “gain control of their limped wrists”\textsuperscript{10} in order to follow the straight, heteronormative formulas of society. Furthermore, I would argue, based upon conversations I had with my gay and lesbian brothers and sisters of color that their body is “mapped” differently than the gay male white body. Race is differentiated in regards to sexuality, especially being lesbian or gay. Also, Grosz further argues that “One’s sex cannot be simply reduced to and contained by one’s primary and secondary sexual characteristics, because one’s sex makes a difference to every function, biological, social, cultural, if not in their operations then certainly in significance” (p. 22). And the significance of the gay male body, particularly through its own unique map, suggests a sociohistorical function that is different from the straight body. Advancing beyond her second claim that the body cannot be studied through one overarching lens, Grosz (1994) argues for a plural approach to models when studying the body. She argues:

Third, it must refuse singular models, models which are based on one type of body as the norm by which all others are judged. There is not one mode that is capable of representing the “human” in all its richness and variability. A plural, multiple field of possible body “types,” no one of which functions as the delegate or representative of the others, must be created, a ‘field’ of body types – young and old, black and white, male and female, animal and human, inanimate and

\textsuperscript{10} This is a comment that was constantly stated by one of my gay friend’s from his mother. Every drink and bite he took at the dinner table was an instructional workshop on not being stereotypically “feminine” or “gay.”
animate – which, in being recognized in their specificity cannot take on the coercive role of singular norm or ideals for all the others. (p. 22)

In a world of seven billion people, and counting, to reduce all humans, along with their narratives, into one body type or formulaic examination of the body is erroneous. Our narratives and experiences are not the same and the lives we live create multiple subjectivities and “mappings.” This argument by Grosz rejects the modernistic, objective approach toward studying the body and instead embraces the multiple subjectivities of a phenomenon that is lived uniquely by all of us.

Furthering her argument, Grosz (1994) argues not only against dualism but against essentialistic approaches of the how the body should be viewed and studied. She states “Fourth, while dualism must be avoided, so too, where possible (though this is not always the case – one is always implicated in essentialism even as one flees it), must biologistic or essentialist accounts of the body” (p. 23). HIV/AIDS, barebacking, and PrEP, all are bound up by biology in regards to HIV prevention and/or treatment. The biologistic approach to studying and understanding the body views the body from a deficit perspective as an object that needs to be fixed and maintained.

In Grosz’s (1994) fifth claim, she argues that the body is not simply an external mechanism as we live and see it on a daily basis. Instead, she argues that both exteriority and interiority are important dimensions for studying the body and its multiple functions. She states:

Fifth, whatever models are developed must demonstrate some sort of internal or constitutive articulation, or even disarticulation, between the biological and the
psychological, between the inside and the outside of the body, while avoiding a reductionism of mind to brain. (p. 23)

Barebacking is an external practice that can be viewed by and performed on Gay Men while the interiority of ejaculation and semen, as well as the internal protection that PrEP provides against HIV/AIDS, are phenomena that directly align with Grosz’s discussion of interior and exterior boundaries. Also, HIV/AIDS has a history that has moved from one of exteriority to interiority. Specifically, due to the advances in the treatments against the virus, HIV/AIDS is more manageable, especially in the management of external symptoms such as Kaposi’s Sarcoma or lipoatrophy which were associated with the disease from the 1980s and 1990s. Today, HIV/AIDS has moved more towards the interiority of gay male bodies because the exterior evidence of the disease is not as present thanks to medication. So the medical and biological notions of HIV/AIDS, while based within the interiority of the body, has social implications for how the exteriority of the HIV-positive body navigates the world socially in disclosing status and engaging in sexual relations.

Finally, Grosz (1994) summarizes her final theoretical claim by problematizing the binaries associated with the mind/body dualism as well as other constricting binaries. She argues:

Sixth, instead of participating in – i.e., adhering to one side or the other of – a binary pair, these pairs can be more readily problematized by regarding the body as the threshold or borderline concept that hovers perilously and undecidably at the pivotal point of binary pairs. (p. 23)
Specifically, she argues that the body cannot be summarized nor studied as any simple binary and that “The body is neither – while also being both – the private or the public, self or other, natural or cultural, psychical or social, instinctive or learned, genetically or environmentally determined” (p. 23). By rethinking and reconceptualizing the body out of binaries and rejecting essentialism and biologism, and studying the body as a site of sociohistorical associations, we can reject the notion that the body is an object or a “thing” but instead study and examine it from how events and various phenomena get invoked onto bodies. Grosz argues that “it is the body as cultural product that must be stressed.” (pp. 23-24). The gay male body is situated in a sociohistorical position in which HIV/AIDS, sexual practices (specifically barebacking), and PrEP are the phenomena that have mapped the gay male body in its current existence.

**The Body & Corporeal Rhetoric**

Similar to Grosz (1994), McKerrow (1998) also makes the case for the body and corporeality. He tries to step away from thinking of rhetoric as only privileging the mind. He argues that “in the processes of privileging a rational, male dominant voice, western rhetoric has in turn focused on the mind to the exclusion of the body” (p. 316). Secondly, McKerrow goes on to argue that “the mind/body split entails a second differentiating factor affecting rhetoric: that of man’s privileging reason to the exclusion of emotion as the hallmark of any rhetorical act” (p. 317). These arguments align with Grosz’s view of how popular culture should conceive of the body. In fact, McKerrow goes on to provide a definition by stating:
A “rhetoric of the body,” or more precisely, a *corporeal rhetoric* contains the features that are essential if we are to broaden the definition of rhetoric to include its practice in the lived experience of those outside what has been termed an administrative rhetoric. (p. 317)

The gay male body is a unique phenomenon from other bodies, as evidenced by what has already been discussed and will be written about in this project. The gay male body as a contested phenomenon, built with complex meanings and levels of significance, is an excellent and fruitful site for academic research and investigation. The rhetoric of the gay male body will be interrogated at these various levels (i.e. with regards to PrEP, HIV/AIDS, gay sexuality and gay health) to examine the multiple, complex and even contested meanings that gay men attribute to their sexual experiences.

In addition to theory of embodied rhetoric, are also the ideas of Kenneth Burke (1938). Through Burke’s lens of “equipment for living,” Gay Men can consume PrEP to prevent HIV in order to protect their bodies via what Foucault (2000) called the “imperative of health” (p. 94). As noted by Brummett (1984), equipment for living is exhibited “through types, components, or structures of literature, people confront their lived situations, celebrate their triumphs and encompass their tragedies” (p. 161). The messages that are sold and commoditized for Gay Men, including PrEP, are all elements of equipment for living for the gay male body. So as Gay Men try to navigate and understand the new technology of PrEP, coupled with HIV, gay sexuality and their bodies, Burke (1966) reminds us that:

11 There will be a thorough discussion on the various *equipment for living* within the gay community in chapter three.
Man is the symbol-using (symbol-making, symbol-misusing) animal, inventor of the negative (or moralized by the negative), separated from his natural condition by instruments of his own making, goaded by the spirit of hierarchy (or moved by the sense of order), and rotten with perfection. (p. 16)

Gay Men create and use many symbols that are not typically used outside of their community but those symbols, and the use of them, conflict with the hierarchy of the majority of society. These symbols, as well as their bodies fly in the face of morality and social order.

Furthermore, to expand on the elements that are “equipment for living” Burke (1968) notes that the body plays a central role as well:

Since the body is dogmatic, a generator of belief, society might well be benefited by the corrective or a disintegrating art, which converts each simplicity into a complexity, which ruins the possibility of ready hierarchies, which concerns itself with the problematical, the experimental, and thus by implication works corrosively upon those expansionistic certainties preparing the way for our social cataclysms. An art may be of value purely through preventing a society from becoming too assertive, too hopelessly, itself. (p. 105)

How society views the gay male body, and the meanings that are placed upon that phenomenon, are complex yet loaded with meaning. Additionally, the gay male body is placed in a heteronormative hierarchy in society that is often contested with the rules and norms of non-gay male bodies. In fact, the gay male body problematizes and complicates
heteronormativity. The continuation of those complex meanings for the gay male body will be discussed in the next chapter.

**Body Image, Mapping, & the Mobius Strip**

When it comes to body image, essentially our bodies speak. They speak to ourselves and to others. They speak to us from the inside and the outside. The sensory organs inside of us react to what we observe and we consume phenomena of the world on the outside that eventually moves to the inside. The desires, specifically sexual desires, that we react to play into our bodies. Grosz (1994) notes that:

Any part of the body is capable of sexualization, although which parts become eroticized is determined by the individual’s life history (and especially the history of its corporeality). There is a complete plasticity in the body’s compliance with sexual meanings…. Sexuality insinuates itself in the various biological and instinctual processes because there is, as it were, a space which it can occupy, an incompleteness at the level of instincts that it can harness for its own purposes. (p. 54)

This statement by Grosz speaks to the development of one’s “gayness” and the marking of homosexuality onto a body. It is not that being gay “clings” to a body, but a body responds to images, desires and sensations of other males.

The fascinations and curiosities I had with the male body, during my teenage years, began a process of inviting in and accepting desires. I could not articulate these desires at this young age but I knew they felt “good” and were enjoyable. They provided a meaning into my life that I could not quite understand at the time but they felt great and
were markers on my corporeal map beginning a long history of my own sexuality. Grosz (1994) further elaborates on this sexual significance on the body:

> Sexual drives result from the insertion of biological or bodily processes into networks of signification and meaning; through this immersion, they become bound up with and intimately connected to the structure of individual and collective fantasies and significations. The drive is a result of corporeal significances, the binding of bodily processes and activities to systems of meaning” (p. 55)

Looking back, although I was not quite mature enough to understand the sexual feelings I had towards males, my body reacted to those feelings before my mind could comprehend those desires. My mind told me that the meaning of “being gay” was detrimental towards my identity, especially within the carefully structured social hierarchy of high school. But I knew my body gave those feelings, desires, and fantasies meaning that my mind could not understand at the time. It was not until later in my life, college specifically, that I started to process the corporeal meaning of my sexuality into rational thought and acceptance. Now, today, I embrace all of my bodily desires when it comes to sex in which I have explored, experimented, elaborated, and even articulated those desires to, and with, others. The mind/body dualism in my own life was rejected until I started to thoroughly process an integrated, holistic perspective.

Also, the corporeal significances that Grosz (1994) discusses started the process of my sexual signification at a young age, before I could understand what it meant to be gay. Overall, the corporeal networks of signification and meaning result into a mapping
of my gay male body and others (because of conversations I have had with other Gay
Men about these desires and wants): “The body is quite literally rewritten, traced over, by
desire. Desire is based on a veritable cartography of the body (one’s own as well as that
of the other)” (p. 56).

But it is not only desires and sexual fantasies that develop and build into corporeal
significance within and onto a body; there are other markers along the way that further
construct the map of a gay body. In particular, the vast history of gay politics and
struggles are also mapped and marked on the body. The entire culture of Gay Men that
came before the particular gay body paves the way for bodily desire to be enacted within
the parameters of a societal attitude (both outside and within the gay community that
disciplines behavior. Grosz (1994) states that “This significatory, cultural dimension
implies that bodies, egos, subjectivities are not simply reflections of their cultural context
and associated values but are constituted as such by them, marking bodies in their very
‘biological’ configurations with sociosexual inscriptions” (p. 38). These inscriptions are
what creates the sociohistorical part of my body, and other gay male bodies, and how
they live in my day-to-day existence. While the process of my own body image and
mapping may be different from another gay man’s body, the comparisons and processes
are not much different (based on conversations with my gay male friends).

It is important to note that Grosz (1994) is not simply conceptualizing the body in
regards to an exterior surface, but also acknowledges interiority in that the body
incorporates more than simply the container of its cells, skin, and organs. She writes:
The body image is as much a function of the subject’s psychology and sociohistorical context as of anatomy. The limits or borders of the body image are not fixed by nature or confined to the anatomical ‘container,’ the skin. The body image is extremely fluid and dynamic; its borders, edges, and contours as ‘osmotic’ – they have the remarkable power of incorporating and expelling outside and inside in an ongoing interchange. (p. 79)

The external desires that are communicated on the outside of my body (i.e. sexual image of men and gay sexual acts) are consumed and then internalized as desire through sexual responses to those images. That is, what is available to me and my body on the outside can also be incorporated into the interior. Whether it be fetishizing semen or taking other gay males’ body parts to part of my body, sexual desire is both externally and internally woven throughout both parts of my body. Barebacking, PrEP, and HIV are all external phenomena that can also be drawn onto the inside of the body in both biological and social terms – both of which are loaded with meaning.

Grosz (1994) goes on to argue that the body image be viewed through the metaphor of the Mobius Strip. The Mobius Strip is a strip that is inverted at one point and connected to show that it has no beginning nor end, or inside or outside (see figure 8 for a visual depiction of Mobius Strip). When it comes to the body image and the Mobius Strip, Grosz notes that:

In physical notions of the body or body image, the body can be understood as the site of the intermingling of mind and culture; it can also be seen as the symptom and mode of expression and communication of a hidden interior or depth. (p. 116)
Again, it is the phenomena that Gay Men specifically interact with, as a result of our history and sexual practices, that places the body’s interiority and exteriority in a unique place the blurs the lines of these various phenomena and that gives them multiple meanings. The phenomena that are being addressed in this project all play into the gay male body’s interior and exterior as described by Grosz through the Mobius Strip. She notes:

> These interactions and linkages can be seen as surface effects, relations occurring on the surface of the skin and various body parts. They are not merely superficial, for they generate, they produce, all the effects of a psychical interior, an underlying depth, individuality, or consciousness, much as the Mobius strip creates both an inside and an outside. Tracing the outside of the strip leads one directly to its inside without any point leaving its surface. (pp. 116-117)

The interiority and exteriority of these phenomena – HIV, barebacking, and PrEP – place the body at the theoretical center of this project. They create a mapping of the gay male body both inside and out. An illustration of the Mobius Strip can be found in figure 8.
**PrEP & the Meaning of HIV/AIDS**

The scientific discovery of PrEP and the benefits it promises in preventing HIV is simply more than just a medical miracle. It calls into question the lifestyle that MSM/G wish to pursue in relation to sexual practices and sexuality. While HIV/AIDS biologically does not discriminate between humans, Gay Men have been the central focus of the disease not only in the United States but around the world. Treichler (1999) notes, “Whatever else it may be, AIDS is a story, or multiple stories, and read to a surprising extent from a text that does not exist: the body of the male homosexual” (p. 19). As the gay community, and all of society, begin to learn about PrEP and the potential it has in preventing HIV, many could view the treatment as an outlet for Gay Men to be more promiscuous and risky in their sexual practices.

Gay Men have constantly been scrutinized for their sexual practices and have therefore suffered repercussions at the expense of HIV/AIDS policy and straight political
leaders. For example, Uganda, which has a rising HIV problem mostly with heterosexuals, passed laws that allowed homosexuality to be punished by life imprisonment or death (UNAIDS, 2010). And it was found that three American evangelical Christian leaders “consulted” Uganda officials on the Anti-Homosexuality bill (Gettleman, 2010). Not to mention, here in the U.S., President Ronald Reagan’s administration was criticized for its absence of acting on HIV/AIDS in the early 1980s. Reagan did not mention the word “AIDS” until 1986 – more than five years after the disease was found to be living in the bodies of many Gay Men in the U.S. (Shilts, 1987). Black (1986) notes that:

Any account of AIDS was not just a medical story and not just a story about the gay community, but also a story about the straight community’s reaction to the disease. More than that: it’s a story about how the straight community has used and is using AIDS as a mask for its feelings about gayness. It is a story about the ramifications of a metaphor. (p. 30)

Again, HIV/AIDS is more than about medical treatments and cures or even its long associated history with homosexuality. Now that PrEP treatments show much more promise than any scientific trail on an HIV vaccine, the meanings and metaphors of HIV/AIDS may change in the eyes of Gay Men and how they view their sexuality. PrEP also has the ability to change, or further criticize and stigmatize, how the gay male body is perceived in light of sexual practices and the perceptions of HIV on the community. Lupton (2003) notes, “The metaphorical systems describing illness, disease and the body
are important linguistic choices which are revealing of deeper societal anxieties about the control and health of the body politic as well as that of the body corporeal” (p. 83).

**Conclusion**

The underlying theoretical assumptions of this project will aim to show how the gay male body is a rhetoric that is loaded with multiple, conflicting meanings. Moving forward, through participants’ interviews (which will be discussed in chapter five and six), other means of evidence such as popular culture artifacts (discussed in chapter three), and some personal reflections will aim to show the lived experiences of Gay Men that get inscribed onto, and into, the gay male body will become clearly evident to the reader. The gay male body, as a site of contested, complex, and often challenged meanings will not fit neatly into one overall implication but perhaps many – especially when talking about HIV, gay health, gay sexuality and PrEP. This chaotic and muddled journey continues in the following chapters.
Chapter 3: Contextualizing the Gay Male Body

Having outlined the rhetorical nature of the body in the preceding chapter, this chapter will “map” the gay male body in the context of a discussion of themes briefly noted at the end of chapter one. As outlined below, these comprise gay health, navigation and management of the gay male body, HIV and gay male bodies, gay sexuality – with a focus on the practice of bareback sex, and a resistance to condoms.

Gay Health

Men, not just Gay Men, do not have the best track record when it comes to subjecting themselves to seeking and maintaining medical care. According to the U.S. National Library of Medicine website (2014), “Compared to women, men are more likely to smoke and drink, make unhealthy or risky choices, and put off regular checkups and medical care” (“Men’s Health,” para. 1). As noted earlier, in chapter one, women live an average of five years longer than men (CDC, 2012). A potential reason for this could be the lack of healthcare that men seek out. According to Sandman, Simantov, and An (2000):

Many men are out of touch with the health care system and face barriers to care. One of four (24%) men did not see a physician in the year prior to the survey—three times the rate found for women (8%). Furthermore, 33 percent of men did not have a regular doctor to go to when they were sick or needed medical advice, compared with only 19 percent of women. (“Key Survey Findings,” para. 1)

It is clear from this evidence that men arguably do not take of their bodies and health as well as women. Lupton (2003) argues men focus on protecting their masculinity:
Men themselves tend to dismiss health needs as a means of constructing and performing dominant forms of masculinities. If to be ill and requiring of help and care are culturally represented as characteristically feminine, linked to vulnerability, weakness and loss of control over one’s body, then avoiding the imputation of illness is a way for many men to establish masculinities by demonstrating difference from women….These aspects of hegemonic masculinities have implications for the steps men may take to protect or otherwise neglect the health of their bodies and the ways in which they interact with health care providers. (p. 29)

The notion of being perceived as strong, healthy and not seeking out help and advice for one’s health is central in trying to understand how Gay Men will embrace, or perhaps not embrace, PrEP as an HIV prevention measure. While the above data illustrates how men overall navigate, and often neglect, healthy choices, for Gay Men, the picture is far worse.

Obviously, HIV greatly affects Gay Men far greater than any other population (as noted in chapter one). Correlated with that is the risk in which Gay Men place their bodies that make them susceptible to HIV and other STDs. As reported in the Morbidity and Mortality Weekly Report prepared by the CDC (2013):

Unprotected anal sex at least once in the past 12 month increased from 48% in 2005 to 57% in 2011. The percentage engaging in unprotected discordant\textsuperscript{12} anal sex

\textsuperscript{12} This means an HIV-negative person and an HIV-positive person engaging in consensual sex.
sex was 13% in 2008 and 2011. In 2011, 33% of HIV-positive but unaware MSM reported unprotected discordant anal sex. (p. 958)

These figures are alarming in that they show a dramatic increase in the amount of unprotected anal sex among MSM. There are many reasons as to why men engage in unprotected anal sex, and those reasons will be discussed later in this chapter.

Additionally, the most important part of knowing one’s HIV status is to get tested for the virus. In the same report by the CDC (2013e), they noted that:

Among MSM with negative or unknown HIV status, 67% had an HIV test in the past 12 months. Among those tested recently, the percentage HIV-positive but unaware of their infection was 4%, 5%, and 7% among those tested in the past ≤3, 4–6, and 7–12 months, respectively. Expanded efforts are needed to reduce HIV risk behaviors and to promote at least annual HIV testing among MSM. (p. 958)

Basically, those MSM who know their status as HIV-negative tend to get tested regularly while those who were found to be HIV-positive were tested less often. The CDC (2014a) does recommend that sexually active MSM should be tested every 3-6 months. To illustrate the need for more testing, and to build the argument for PrEP, figure 9 shows the frequency of testing among those tested positive for HIV in 2011. More data will be presented about the prevalence of unprotected anal sex among MSM later in this chapter.
Figure 9. Percentage of HIV-positive MSM unaware of their status. This graph illustrates the percentage of HIV-positive MSM who are unaware of their status who reported a negative or unknown HIV status, by time, since their last HIV test. From CDC (2011).

According to a report by Baggaley, White, and Boily (2010), they found that HIV transmission increases 18 times higher with anal sex than with vaginal intercourse. POZ (2014) magazine reports that for a receptive partner of anal intercourse, with ejaculation, that there is a one in 70 chance of acquiring HIV – the riskiest sex with the best odds of acquiring HIV. Appendix B shows all of the risks associated with acquiring HIV by both nonsexual and sexual acts and practices.

In addition to HIV and unprotected anal sex prevalence in the MSM/G community, the rate of other STIs also has increased. According to Patton, Su, Nelson, and Weinstock (2014):

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13 According to the Planned Parenthood (2014) website, they describe the difference between STD and STI as follows:
During 2005-2013, primary and secondary syphilis rates increased among men of all ages and races/ethnicities across all regions of the United States. Recent years have shown an accelerated increase in the number of cases, with the largest increases among MSM. (p. 402)

When it came to other STDs such as gonorrhea, the CDC (2014b) reported, “Overall, the proportion of isolates from MSM in selected STD clinics from GISP14 sentinel sites has increased steadily, from 4.6% in 1990 to 33.1% in 2012” (“Gonococcal Isolate Surveillance Project,” para. 1). Additionally, the CDC states that the overall STD rate has increased for MSM. They specifically note, from a public health perspective:

Compared to women and men who have sex with women only, MSM are at increased risk for STDs. Because STDs and the behaviors associated with acquiring them increase the likelihood of acquiring and transmitting HIV infection, STDs among MSM may be associated with an increase in HIV diagnoses. (“Public Health Impact,” para. 1)

Clearly, the sexual health of MSM/G is in question when it comes to sexual intimacy and practices. STDs can obviously be contracted through anal or oral intercourse but the risk increases with anal sex.

STD and STI are two terms that often mean the same thing — but the “D” stands for “disease,” while the “I” stands for “infection.” Medically, infections are only called diseases when they cause symptoms, and many STIs don’t have any symptoms. So that’s why you may hear people say STIs – it’s technically more accurate, and also reminds people that there are often no symptoms so it’s important to get tested. (“STD vs. STI,” para. 1)

14 GISP stands for “Gonococcal Isolate Surveillance Project”
The STD rates of MSM/G in the U.S. are not in isolation as similar patterns appeared in other parts of the world. For example, in the U.K., Cooper (2014) reported that:

Rates of gonorrhea, chlamydia and syphilis in gay men have soared in recent years, official figures show, while new HIV infections have also reached record highs….There were 36,000 STI diagnoses in men who have sex with men in England alone in 2012, including 8,500 new cases of chlamydia, 10,800 for gonorrhea and 2,100 cases of syphilis. Although improved testing and screening explains some of the rise, health experts agree that high risk behaviours have become much more common. (para. 2 & para. 9)

While PrEP does not necessarily prevent these other STDs, PrEP at least starts a conversation, and raises awareness, about overall prevention. Obviously, high STD and HIV rates among other MSM/G are evident in other parts of the world. These statistics are telling an interesting story in regards to how MSM/G, especially Gay Men, are exposing their bodies to these various risks.

These discrepancies in gay health present a great challenge for the administration of PrEP for Gay Men who are at risk of acquiring HIV. Unfortunately PrEP is only known to prevent HIV and not any other STDs. Luke Adams (2014), is a PrEP advocate who does clinical work around PrEP and HIV prevention. He stated the following about those who are interested in get on PrEP:

My patients were not low risk condom users to begin with. So PrEP is a godsend.
And I hear something like this every day: "It feels so good and hot and creamy
inside me, but I don't want to get HIV." Great. Did you get your Gardasil shots? Are you on Acyclovir and Truvada? Have you been vaccinated for Hep A and B and for meningococcus? Are you getting all your tests (including for HCV) every three months? Are you asking the statuses and viral loads of your partners? Have you stopped playing with coke/crack/speed/molly and binge amounts of alcohol? Do you ask your partners the last time they used? Are you willing to use a condom with someone anonymous? Because, if you're going to play hard, remember that it is not about good and evil, but it definitely is about risk and consequences. So be prepared to choose wisely from the new buffet of risk reduction options. That's what being a grownup is about. (Facebook Post, February 2, 2014)

Adams’ message is a powerful one because PrEP only curbs one of the major problems in gay public health – HIV. This message had me think about vaccination rates among Gay Men and while I could not locate a comprehensive study of vaccination rates among Gay Men, I found one study by Reiter and Brewer (2012) that reported, “Less than half of gay and bisexual men indicated they had received any doses of hepatitis B virus (HBV)” (para. 1).

**Other indicators of gay health.** Unfortunately, the bad news regarding the health of Gay Men gets worse. For example, the LGBTQ community reported higher rates of cigarette smoking than the rest of the population (CDC, 2014c). Specifically, they reported, “In 2009-2010, the prevalence of current cigarette smoking among LGBT individuals was 32.8%, compared with 19.5% among heterosexual/straight individuals”
Lesbian, Gay, Bisexual, and Transgender,” para. 2). The CDC notes that “This is in part due to the aggressive marketing of tobacco products to this community” (para. 1). In addition to cigarette smoking, is also the prevalence of alcohol consumption and substance abuse. According to Ostrow and Stall (2008), compared to the general population, LGBT people are more likely to use drugs and alcohol, abuse substances at a higher rate, are less likely to abstain from both drugs and alcohol, and are more likely to continue heavy drinking later on in life.

Also, when it comes to the health of Gay Men and managing their body weight, results from a study show some concerning results. According to a study conducted by Columbia University’s Mailman School of Public Health (2007) reported that:

More than 15 percent of gay or bisexual men had at some time suffered anorexia, bulimia or binge-eating disorder, or at least certain symptoms of those disorders – a problem known as a subclinical eating disorder, compared with less than five percent of heterosexual men. (para. 2)

According to the same study, 42% of men with eating disorders identify as gay or bisexual. This is another startling piece of evidence that shows the state of the gay male body when it comes to health.

Additionally, a recent study found that poverty and sexual orientation are highly correlated with one another (Lee Badgett, Durso, & Schneebaum, 2013). Specifically lesbian couples have a higher poverty rate than heterosexuals and male same-sex couples but the report also found that LGBT women and men have higher rates of poverty than their non-LGBT counterparts. Also, Gates (2014) reports that LGBT Americans reported
lower levels of financial, physical, social, community, and purpose well-being compared to their non-LGBT counterparts. Also, 40% of homeless youth identify as LGBT (Durso & Gates, 2012). Despite great advances and wins in the fight for marriage equality across the United States, there are a number of indicators, especially directed to the health of LGBT people, especially Gay Men, that show another picture. All of these various indicators of poor health and well-being can obviously be a barrier to getting care specifically designed for Gay Men and for understanding and acquiring PrEP for HIV prevention.

**Navigating the Gay Male Body**

How Gay Men navigate their own and other bodies within the community is a phenomenon that is ever-present. Bodies speak (Grosz, 1993). Specifically, bodies speak age, gender, and level of attractiveness, race and ethnicity, our body type, etc. For Gay Men, and their bodies, these phenomena are ever-present within the community. For example, Berry (2007) conducted an autoethnographic performance of embodiment in a gay bathhouse. He captures gay culture well, especially in performance of being a gay man in a bathhouse, by noting “Becoming more mindful of how Gay Men are self-implicated in the very hyperidealized standards of embodiment we engender puts us in touch with situated cultural practices and the joys and suffering endemic to these performances” (p. 278). Berry’s discussion of gay males was within the context of bathhouses where men go to have sexual encounters with other men. Berry is not alone in articulating the notion that gay culture embraces an idealized body.
The exploration of the physically idealized gay male body was studied and researched by Alvarez (2008). He took his research to the context of gay gyms and he argues that:

The body culture of the gay gym – identified by a focus on a built muscular body – is most present in the media, but it has come to affect gay life in many ways, from the way we identify and describe ourselves to the way we meet for sex, dating, or more serious relationships. (p. 2)

In his book, he lays out six major body types from his 200 survey responses and interviews – they include: the muscle boy, the older male, the poz jock, the athlete, the circuit boy, and the muscle bear. These distinct body types are evidence of the varietal ideal body types that are obtained at the gym to also match a particular identity for both themselves and others.

While trying to obtain the ideal, or a particular, body type is prevalent among Gay Men, deviating from that norm can be problematic for some Gay Men. Peitzman (2013) wrote a brief article in the popular press (i.e. BuzzFeed) about his experiences being an openly gay man who is overweight. He recalls the time when being bullied had nothing to do with his sexuality but everything to do with his body and weight. He wrote about a number of experiences of letdowns by dates discussing his weight and wrote:

But the stereotype of the gay obsession with body image and a six-pack is not unfounded. There is a widely held understanding that being gay means maintaining a certain standard of physical beauty, with very little room for deviation from the norm. (para. 9)
Based upon the experiences cited by Berry and Peitzman, I find them, from my own personal experiences and journey of navigating the gay community, all to be true. The ideal gay male body is one that is viewed not just as attractive (although in various forms) but also seen as aesthetically healthy.

In addition to the health and level of attractiveness with gay male bodies, is the perception of age and presence of HIV. Simply put, younger looking gay male bodies are more preferred than older aged bodies. Interviewed by POZ magazine, Dr. Perry Halkitis, an NYU researcher who studies HIV & MSM/G issues, noted that people make assumptions about the health of other Gay Men based upon age. He specifically stated that such assumptions from his participants typically fall along the thought process of:

He’s older and from the city, so he’s more likely to be positive and I won’t sleep with him. But a young guy from the Midwest who looks negative? Sure, let’s do everything! People are making decisions based on their assessment about the person, and it needs to be much more focused on the act. (Straube, 2014, para. 22 & 23)

The assumption of HIV status based upon age and sexual orientation is nothing new. Brouwer (2000) discussed a similar notion with the “trick exam” which “is used by some in an effort to discover – absent explicit verbal communication – if their sexual partner is HIV-positive” (pp. 101-102). Specifically, this is scanning and assessing a potential sexual partner’s HIV-status by feeling around the neck for swollen lymph nodes, looking for skin lesions, atrophy in the body, etc. (all symptoms of undiagnosed HIV and/or HIV that needs medical attention). These “scans” of the gay male body to assess HIV status
are prominent examples of how gay male bodies are evaluated by others – compounded by the fact of body image and level of attractiveness.

**Talking about gay male bodies.** There are additional elements that play a major role in how gay male bodies are assessed and communicated. One way is through race. Helligar (2014), who is Asian, is currently writing a memoir on race in the gay community. In a *Huffington Post* article, he wrote extensively about constantly encountering personal ads on mobile apps in which other Gay Men would write such things as “No Asians,” “No Blacks,” “White men only,” etc. Helligar’s account of these public wishes of certain gay racial bodies is not an anomaly – from my own personal experience, these messages are prolific across personal ads on social media sites and mobile apps geared towards Gay Men.

In addition to race speaking part of the gay male body, so does the perceived sound of one’s voice. Stereotypically, gay male voices sound and are performed in a more feminine manner especially in the media. Smyth, Jacobs, and Henry (2003) note that “In North America, having a gay voice can be stigmatized both within and outside the gay community(ies)” (p. 347). In their study, where they had participants guess sexual orientation based on hearing various male voices, they found participants were not accurate in guessing sexual orientation (i.e. gay or straight). Specifically, in their findings, they note:

For those gay men who have a gay-sounding voice, listeners are obviously detecting particular features of such a voice, and responding to them; for these
gay men, gaydar\textsuperscript{15} is quite accurate. However, there are many gay men who simply do not sound gay. Therefore, identifying the sexual orientation of men randomly chosen from the general population, by their voice alone, will not be very accurate. (p. 344)

This is interesting on a number of accounts. First, there are particular features that listeners will pay attention to that signal a gay sounding voice and that prompts the assumption of a gay sexual orientation. Also, voices that do not sound gay obviously throw people off if the speaker comes out about their homosexuality. I have personally dealt with this in that I have been told a number of times in my life that “I don’t sound gay” when people learn about my sexual orientation.

The voice is an element of the body that speaks to our identity and personality. For Gay Men, the voice, coupled with other elements of the body, are prominent in how Gay Men are perceived by others. The voice, along with an ideal body type discussed, by Berry (2007) and Alvarez (2008), are all landmarks along the map of the gay male body that are readable by others.

**Sexuality & gay male bodies.** When it comes to sexuality, Gay Men have constructed and used a comprehensive vocabulary when it comes to describing sexual interests and fetishes. As one example, already noted earlier but used here as it is a distinct use of terms, the most popular terms. For one, the most popular is whether a gay man sexually identifies as a “top” or a “bottom”; this language is nearly universal among in the lexicon of the gay community. A “top” is a person who wishes to penetrate his

\textsuperscript{15} This is known as the idea that people can detect or guess someone’s sexuality through observation.
partner during anal sex and a “bottom” wishes to be the receptive partner. Coupled with, but not necessarily all of the time, are various roles and body types that Gay Men wish to take on or seek during the sexual encounter. Scruff is a popular mobile social networking app in which Gay Men can meet others for sex. Through Scruff, they provide a comprehensive “Gay Slang Dictionary” with 23 different body identities and definitions in five different languages. These terms include “bear” which is defined as “A typically heavier, hairier (i.e. more body hair) and older gay man” (“Term: Bear”) and “twink” which is defined as “A typically younger, thinner, gay man with little or no body hair” (“Term: Twink”).

Even more specific, although not widely used in the gay community, is the use of handkerchiefs (also called the “Gay Hanky Code”). Reilly and Saethre (2013) define this code as:

A semiotic system used by men in North America to communicate their sexual interests to other men. A coloured bandana or handkerchief is placed in the back pants pocket. When located in the left pocket it indicates the wearer is the penetrator, sometimes referred to as active, more often referred to as top. A hankie in the right pocket indicates the person is the penetrated, sometimes referred to as passive, more often as bottom. The colour designates the specific sexual act. (emphasis in original, p. 69)

Examples of this hanky code can communicate a specific sexual act that the person wants or is looking for in someone else (e.g. grey, worn on left, is a bondage top and worn on

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16 To provide a greater, larger context of these various identities, all 23 terms and their definitions can be found in Appendix C of this document.
the right wants to be tied up). They can also communicate a role that a gay man wants to take on or wants from another (e.g. medium blue, worn on the left, takes on the role of a cop and the same color worn on the right wants to be the sub to the cop). They also communicate interest in body type, preferred race and ethnicity, the kind of clothing desired, as well as other various fetishes.\(^{17}\)

While the “Gay Hanky Code” is typically reserved for the leather community,\(^{18}\) these particular and miscellaneous sexual desires, identities, fetishes, and roles are very real in the gay community. These are not just commoditized sexual practices but are embodied realities that are built around an elaborate language system for Gay Men to communicate to one another.

In addition to being viewed as HIV-positive, being stigmatized by the legal system is another potential threat. According to Hernandez (2013), “At least 35 states have criminal laws that punish HIV-positive people for exposing others to the virus, even if they take precautions such as using a condom” (“State-by-State: HIV Laws,” para. 1).

All of the dark-shaded states in figure 10 show which states have HIV-specific criminal laws. As the map illustrates, the majority of states have one or more laws that criminalize selected sexual behaviors between/among Gay Men. The laws produce a disconcerting dilemma between not wanting to disclose due to health privacy and having to disclose in order to engage in consensual sex. Hernandez also reports that critics of these laws argue that “they thwart public health goals because they stigmatize the disease; undermine trust

\(^{17}\) A comprehensive list of more than 75 hankies, with definitions, can be found in Appendix D of this document to provide the reader with a greater context of this phenomenon.

\(^{18}\) According to the BDSMWiki website, this community is defined as: “The Leather Subculture typically includes both a style of dress and an affiliation with BDSM practice” (“Leather Community,” para. 1).
in health officials, who are sometimes enlisted to assist with criminal prosecutions; and fail to take into account the latest science surrounding HIV transmission” (para. 2). These laws place the HIV-positive body, most of whom are Gay Men, back into the closet when it comes to their status. These laws unfortunately have not kept up with the advances of HIV treatment (i.e. ARV). According to the Civil Rights Division of the U.S. Department of Justice (2014):

> While HIV-specific state criminal laws may be viewed as initially well-intentioned and necessary law enforcement tools, the vast majority do not reflect the current state of the science of HIV and, as a result, place unique and additional burdens on individuals living with HIV. (“Conclusion,” para. 1)

Unfortunately, these laws have done reprehensible damage to the lives of HIV-positive Gay Men. Nick Rhoades, who is HIV-positive, had consensual sex with Adam Plendl (Hernandez, 2013). Adam learned of Nick’s HIV status and charges were filed. Under Iowa state law, Nick was sentenced to the maximum of 25 years in prison but in 2008 had the sentence reduced to five years of supervised probation. Adam never contracted HIV and Nick is now a “‘Tier III’ sex offender for life. This designation groups Rhoades with the worst of the worst — ‘sexually motivated’ killers and kidnappers, child molesters, rapists and sex traffickers” (Section 5, para. 18). The criminalization of HIV-positive people, especially Gay Men, only adds another hazardous marker, similar to the scarlet letter, onto the map of the gay male body. These laws unfortunately pin Gay Men against other Gay Men and divide the community. It creates more stigmatization for those living the virus and pushes them further into the closet of isolation and fear.
Figure 10. U.S. states with laws that criminalize HIV. This map illustrates the U.S. states with laws that criminalize HIV (shaded states). Hernandez (2013).

Stigma against HIV is nothing new. In addition to the stigma laid against those who are HIV-positive by various state laws, there is a stigma with being HIV-positive in the gay community. According to Hamel et al. (2014), they reported that of the 431 gay and bisexual men they surveyed, “One in five had a relationship with someone HIV+, but twice as many have chosen not to pursue a relationship because of HIV” (p. 17). This shows an obvious lack of acceptance within the gay community even after all of the medical breakthroughs of treating and preventing HIV, especially with PrEP. According to Sandstrom (1994), “Within the interpersonal realm, the newly diagnosed ‘AIDS patient’ is resituated as a social object and placed in a marginal or liminal status. He is thereby separated from many of his prior social moorings” (p. 325). Although this was written more than 20 years ago, the liminal status of HIV is still highly stigmatized.
Another example of openly talking about gay male bodies is the stigma associated with being gay and juxtaposing it other diseases beyond HIV. Specifically, the ATLAH Missionary Church in Harlem, NY posted a sign with the message (all in capital letters), “All churches and members that support homos cursed be thou with cancer, HIV, syphilis, stroke, madness, itch then hell 1 Cor. 6:9” (Nichols, 2014, para. 1). These messages, especially in a predominant African-American community in New York City, show that not only is there a stigma against HIV but the entire sexualized gay male body with regards to physical and mental health.

This long, descriptive, although not entirely comprehensive, discussion of various elements and markers of the gay male body will not necessarily be studied in depth in the methodology and analysis of this project. The aim of this discussion is to contextualize how the gay male body navigates and inscribes, as well as embodies, various meanings. PrEP, as a new medical phenomenon for Gay Men who are at risk of HIV is not only added to the lexicon but becomes another element, land marker and space on the map of the gay male body. The following discussion further contextualizes the experience of gay sexuality, especially as it relates to barebacking, HIV, and PrEP – all phenomena that are central to this study.

**Gay Sexuality: Barebacking**

The following is a synthesis and thorough discussion of gay sexuality in regards to how Gay Men are navigating sexual practices and experiences, in particular, bareback sex – one of the central phenomena in this project. Additionally, it is meant to provide a primer to research question #1 (i.e. What meanings do Gay Men subscribe to barebacking
defining barebacking, barebacking as identity, why MSM/G bareback, the gay community and the history of barebacking, the prevalence of barebacking, barebacking and the internet, and bareback pornography.

**The gay community & history of barebacking.** Bareback sex in the gay community has a rich history that can be seen from two socio-historical perspectives – pre-AIDS and post-AIDS eras. These two time periods are laden with critical moments that impact the culture of gay sexuality. The pre-AIDS era stemmed from the Stonewall riots, in the summer of 1969, up until the discovery and spread of HIV/AIDS. The post-AIDS era was introduced in the mid-1990s when the medical community discovered protease inhibitors which could be used in treating HIV as a chronic illness. Both eras play a pivotal and important role into the practice of bareback sex within the gay community.

After the Stonewall riots in New York City, gay rights and the gay sexual revolution took off. Men were coming out of the closet to embrace their true identities and sexual exploration played a major role in the movement in the 1970s leading up to what would become the AIDS epidemic. Sexual exploration was more than finding a boyfriend, it always meant multiple partners, with whom condoms were rarely used. One interviewee in the documentary *Gay Sex in the 70s* (Lovett, 2005) recounted the time when he was visiting a gay bathhouse in New York City. He told the story of how having

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19 The Stonewall Riots took place at Stonewall Inn (bar) in the Greenwich neighborhood of New York City in the summer of 1969. The riots were the result of a confrontation between the gay patrons and NYPD. This symbolic fight escalated a movement for the gay community who was fed up with police harassment.
sex with a man with one leg did not matter to him but he vividly remembers the odd sexual experience he had with one particular guy who wanted to use a condom during their sexual encounter. Moore (2004) notes that “In the 1970s, Gay Men used sex as the raw material for a social experiment so extreme that I liken it to art.” (p. xxiv). Often times, bareback sex would take place in areas where many MSM/G would congregate such as the piers in New York City, bathhouses, parks, and gay bars and sex clubs to name a few. It was a time that ushered in what Holleran (1997) called the age of promiscuity. This pre-AIDS era lasted up until the mid-1980s, when everyone learned that unsafe sex put people, especially MSM/G, at risk of acquiring the disease.

During this time, many Gay Men were sexually exploring, while at the same time protesting and fighting for equality – both tend to be seen as separate behaviors while looking back at this history. But both behaviors are extremely tied to one another because sex, especially bareback sex, further created and tied the community of Gay Men together. Dean (2008) argues:

The communities of men formed around barebacking bond together like communities of soldiers during wartime. And it’s worth recalling that since the first decade of the AIDS epidemic killed off whole generations of gay men, those who survived resemble survivors of war. Barebacking may be, among other things, a way of connecting with the dead through the medium of a shared substance. Rather than necessarily disregarding and thus dishonoring those who have died from AIDS-related illnesses (as some critics charge), barebacking may represent an effort to maintain their vitality in the bodies of the living. By means
of a virus, some part of the deceased can be imagined as living on. Bareback subculture thus may be as much a culture of survival and imaginative reinvention as it is a culture of death (or of something called “the death drive”). (p. 90)

Sex, especially bareback sex, before and during the AIDS crisis in the 1980s brought many men out of the closet to explore their sexuality. When AIDS arrived in the community, many men changed their sexual habits and practices as they saw their friends and lovers die. This ushered in the post-AIDS era and created an era for safe sex practices; this quickly changed thanks to protease inhibitors.

As many Gay Men survived the AIDS epidemic in the 1980s and early 1990s, just as many men died from the virus that overtook their bodies. Those living with the virus during the 1990s were subsequently saved from dying due to the drugs (i.e. ARV) to help boost the immune system; this was a catalyst for behavior change among many and helped create a resurgence of the practice of barebacking. Adult film star Scott O’Hara famously stated in POZ magazine, “I’m tired of using condoms, and . . . I don’t feel the need to encourage negatives to stay negative” (Scarce, 1999, para. 2). In other words, as an adult performer, it is not Scott’s responsibility to send a message of safety or keep HIV-negative men within a negative status. As many Gay Men were living healthy, fulfilling lives with HIV, through the use of drug therapies, many other men (including HIV-negative and positive men) were relaxing their standards of sexual safety and neglecting to use condoms. In addition to relaxing sexual safety standards, Junge (2002) argues about this era:
In the middle of the 1990s yet another distinct cohort emerged: young gay men who had little or no personal experience with AIDS and associated disease risk with cohorts of older gay men rather than with a specific risky behavior in which any man might engage. (p. 191)

Combining men who did not live through, nor experience the AIDS crisis in the 80s and 90s, along with drugs that have kept many Gay Men healthy for years, barebacking has found a new place back in society, especially within the gay community and among MSM. Currently, there is a prevalence of the practice which suggests that bareback sex is nearly as popular now as it was in the pre-AIDS era.

**What is barebacking?** As noted in Chapter one, the meanings surrounding bareback sex are complex and multi-layered. The meanings are so complex that Dean (2008) argues that barebacking is “an erotic practice overlaid with a set of social and political meanings” (p. 80). There are both practical, technical definitions of what it means to bareback in addition to meanings that deal with a strong, personal identification with the sexual practice. This chapter will focus first on the definitional complexities associated with the use of barebacking as a descriptive term, and then on the widespread nature of barebacking across the internet and within the pornography industry.

**Technical definitions.** First, some scholars, and MSM/G,²⁰ have different technical definitions of what barebacking means as a sexual practice. Simply put, bareback sex is a sexual act in which condoms are not used during penetrative intercourse

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²⁰ To avoid confusion, I am once again using this expression as the more general term encompassing the entire community that may be involved in barebacking; where research more specifically focuses on Gay Men, that expression will be used.
with a sexual partner. Consistent with the earlier reference to a “cowboy image” of MSM/G engaging in deliberate potentially risky behavior (Dean, 2009), some researchers have referred to barebacking as any anal, penetrative sexual act without the use of a condom (Gauthier & Forsyth, 1999). While some researchers, and some, if not all of those who practice this sexual act, may define barebacking in such a manner, some question whether intentionality plays a role within this sexual practice. In particular, Shernoff (2006) argues that there needs to be a distinction between “unprotected” and “unsafe sex” in conceptualizing how barebacking is defined. He argues, “Unsafe sex refers to when an HIV-negative man has UAI (unprotected anal intercourse) with either a partner of unknown HIV status or with a partner he knows to be HIV-positive….Unprotected sex is anal intercourse without a condom between two HIV-negative men” (p. 17). While a distinction is made between these two terms, barebacking as a sexual practice is a little more difficult to define as it includes the practice of unsafe sex. For example, what about men who intentionally seek bareback sex versus accidental “slip ups” among men who consistently use condoms? Morin et al. (2003) notes, “Whereas the term originally was used to describe engaging in premeditated, consciously chosen unprotected anal sex, it has now been incorporated into colloquial discussions to describe the unintentional, unprotected ‘slip-ups’ that occur” (p. 357). According to Halkitis, Greene, and Mourgés (2005), in a sample among New York Gay Men, many meanings were provided by respondents in defining and conceptualizing bareback sex. Mansergh et al. (2002) aims at defining barebacking, regardless of HIV status, as “intentional anal sex without a condom with men who are not a primary partner (that is,
not someone the individual lives with or sees often and to whom the individual feels a special emotional commitment)” (p. 653). Some men also engage in the process of serosorting, which is when men are willing to engage in bareback sex but only with other men of their own HIV status (i.e. both men are either positive or negative in status) (Shernoff, 2006). In the negative case, the level of safety is in question; in the positive, it may be regarded as unprotected but no longer “unsafe.” This can be confusing and current literature shows some inconsistent and conflicting definitions which make it difficult in trying to pinpoint a precise technical definition of barebacking, as a sexual practice. Furthermore, other complications can be added to these definitions such as does bareback sex count if the ejaculation of semen take places inside another man or externally? So many different scenarios can take place which alter the technical definition of barebacking. When Gay Men were asked to conceptualize and to define their idea of barebacking it was found that:

Almost two-thirds of the men in our sample (64%) considered anyone engaging in any unprotected anal sex to be barebacking. Some men were slightly more specific (17%), requiring that the unprotected sex be intentional, rather than an accident or slip, to be counted as barebacking” (Huebner, Proescholdbeel, & Nemeroff, 2006, p. 73).

Overall, Shernoff (2006) notes that “The only definitive thing we can say about barebacking is this: it is not one behavior but a variety of behaviors that take place in many configurations among a wide range of men” (p. 283). As interview data is collected for this project, asking men to expand upon their technical definitions of barebacking
may provide a basis for creating more precise distinctions within the practice, or can simply confirm the ever-changing nature of the term’s use within the gay community.

**Barebacking as identity.** Although the technical definitions of the term barebacking may not have a universal meaning among MSM/G and researchers, the more elaborate meanings that deal specifically with barebacking as identification are much more complex. This creates a disconnect between many MSM/G and researchers when it comes to how men identify with the sexual practice of barebacking. Huebner, Proescholdbeel, & Nemeroff (2006) note, “academic discourse and existing empirical research on barebacking have utilized much more specific definitions that only a small percentage of gay and bisexual men actually endorsed” (p. 73). The definitions by many Gay Men are more elaborate and complex; Junge (2002) argues that “a label used by some queer men to describe themselves and their actions should be understood as an emergent, semantically unstable, and contested construction of sex and sexual identity” (p. 190). Additionally, Reisner et al. (2009) found that out of their 227 HIV-negative participants, 31% identified as a barebacker and they also found that this identity correlates with HIV sexual risk and alcohol abuse – not a surprising finding considering Gay Men report higher levels of alcohol abuse than the rest of the population (Ostrow and Stall, 2008). A more thorough discussion of this phenomenon (i.e. alcohol use and barebacking) will be discussed in the “Prevalence of barebacking today” section of this chapter.

Bareback sex, as an identity, has provided many Gay Men with an eroticization of the exchange of ejaculatory fluids with one another which goes far beyond a technical
definition of having anal sex without condoms. Mowlabocus (2007) notes, “The word ‘bareback’ has invested the previously taboo practice of unprotected anal sex between men with a ‘cool’ deviancy that has allowed some to legitimate and eroticize unsafe sexual contact” (p. 218). The practice of bareback sex by MSM/G has been eroticized and fetishized by the pornography industry and by social networks designed for MSM/G on the internet. Aside from the practice of barebacking, other sexual practices occur, such as felching (i.e. the oral removal of ejaculatory fluids from a partner’s anus); according to a study conducted by Klein (2011), semen is highly eroticized in about one in six men who have engaged in this practice. In other words, the men who reported this saw ejaculatory fluid as a highly sought fetish during sex. Thus, it is clear that semen and the exchange of ejaculatory fluids are eroticized among MSM/G in sexual practices that go beyond the practice of barebacking.

Also, barebacking is an identity that has emerged in a world where nearly all MSM/G, specifically in the U.S., know about the threat of HIV/AIDS and other STDs. One of the biggest debates surrounding what it means to bareback is the notion of intentionality – that is, why is it that many men deliberately forgo condoms in order to be sexually gratified, especially when they have knowledge of HIV/AIDS? Scarce (1999) sees barebacking as a practice that is not about the accidental, once-in-a-while forgetfulness of not using condoms but instead:

Represent a conscious, firm decision to forgo condoms and, despite the dangers, unapologetically revel in the pleasure of doing it raw. Some people use barebacking to describe all sex without condoms, but barebackers themselves
define it as both the premeditation and eroticization of unprotected anal sex. (para. 8)

Such a view of barebacking, as something deliberate and intentional, complicates the goals of health practitioners whose aim is to prevent HIV. One end of the bareback spectrum looks at the sexual act as an idea that happens accidentally and at another end it is a deliberate exercise that is meant to reclaim a sense of eroticism and corporeal connection with another man.

Another way barebacking is defined, through the use of identification, is through the context of sexuality, specifically, identifying as gay. Frost (1994) notes that:

For many gay men, sexual behavior is a statement of their sense of being gay, an affirmation of their right to be gay, an expression of love, a vehicle through which to achieve intimacy, and a repudiation of the felt prohibition by the greater society. For other gay men sex is a sport, a means of repairing from narcissistic injury. (p. 166)

The identification of being gay or having a connection with another adds deeper meanings of barebacking to its definitional spectrum. This meaning fulfills identification needs in relation to the practice. Some scholars have found, through surveying Gay Men, more specific meanings in relation to identification as to why they bareback. Halkitis, Parsons, and Wilson (2003) found, through surveying Gay Men, that barebacking for them increased intimacy between each other, it is more butch, or manly, thus affirming masculinity. Similarly, Carballo-Dieguez and Bauermeister (2004) noted that Gay Men disclosed that barebacking is a form of freedom and is a personal responsibility. These
reasons are examples that provide more specific and deeper levels of meaning, especially in terms of how Gay Men, in particular, identify with the practice of barebacking.

These deeper levels of meaning, in regards to barebacking, culminate in what Shernoff (2006) notes “is not one behavior but a variety of behaviors that take place in many configurations among a wide range of men” (p. 283). Furthermore, barebacking is more than flirting with acquiring HIV/AIDS. Mowlabocus (2007) notes that barebacking “must be understood as articulating themes far wider than simply those of disease” (p. 231). Conceptualizing barebacking as only one behavior and that a drug regimen, such as PrEP, can be a cure-all for stopping the spread of HIV may not have any impact on the practice of barebacking. I am not, here, arguing that PrEP has been created for the specific purpose of impacting barebacking as a social practice; rather, I want to stress the point that Vincke, Bolton, and DeVleeschouwer (2001) make: “considering that people are in search of meaning, sexual acts constitute an emotional and symbolic language. The meanings that gay men assign to specific sexual acts can make behavioral change difficult” (p. 57).

Another meaning Gay Men subscribe to barebacking is that the practice creates a deeper connection with another man. This is viewed as a major marker for a man in a committed relationship with another man. But does this sense of monogamous identification with one partner, whose HIV status is known, blur the meaning of barebacking within a social or academic context? Shernoff (2006) notes that:

Because of this lack of risk, those partners often do not label their sexual behavior as ‘barebacking’ with sexual behavior that introduces some risk of HIV infection
or reinfection, and that many men who are having UAI do not consider themselves barebackers” (p. 181)

Risk comes into play, which again complicates the notion of bareback sex because do both committed partners, in a monogamous relationship, know for sure that the other partner is not sexually active outside of their relationship? Or if the relationship is polyamorous, or practicing an open relationship, are both partners absolutely sure if bareback sex is not being practiced outside of their own relationship? Finally, hanging out at a gay bar or club can also help build gay identity and can be a space for great inclusion when it comes to meeting other Gay Men. A study by Flores, Mansergh, Marks, Guzman, and Colfax (2009) found that “Gay bar/club attendance was associated with an increase in reporting of HIV-discordant unprotected anal sex among African American and Latino MSM” (p. 99). They did find the same statistical significance for White MSM/G.

Overall, these various identities and the elaborate meanings subscribed to bareback sex can make the practice difficult to stop even through the use of PrEP treatments that are meant to curtail and prevent the increase of HIV in the MSM/G community. Due to the complex definitions and identities associated with barebacking, PrEP has the potential to offer a cure-all that can ultimately prevent HIV transmission while allowing barebacking as a sexual practice to take place among Gay Men.

**Why MSM/G bareback.** Greatly tied to the identification of multiple meanings attached to barebacking by MSM/G are specific reasons as to why they engage in the sexual practice. The various reasons are as diverse in range as the many definitions used
to describe what it means to bareback. The various reasons as to why men bareback vary from the practical and simplistic to the more complex and elaborate.

Some of the more practical and simplistic ways of why barebacking happens among MSM/G deals with reasons that can be more easily explained. One of those reasons deals with the trust that a couple has with each other in a committed relationship. Gay couples may forgo condoms within their own relationship because they may have been tested and trust each other (Bartos, Middleton, & Smith, 1995). Huebner, Proescholdbeel, & Nemeroff (2006) reported similar findings in their research: “Men most frequently reported that they tried barebacking in the context of a relationship or an arrangement of negotiated safety (26%), or because of the increased physical sensation (21.9%)” (p. 73). Another reason has to do with the heat of the moment or the decision to not use a condom in that one instance (Gold & Rosenthal, 1998). Many believe also that bareback sex is simply more enjoyable, sexier, and fun compared to safe sex (Carballo-Dieguez & Bauermeister, 2004; Halkitis et al., 2003).

In addition to the reasons why MSM/G engage in barebacking, Roberts (2014) reported that “94% said they were more likely to have unprotected sex with a good looking guy” (para. 5) and that “8 out 10 young men in London have had unprotected sex with a stranger” (para. 2). Bauermeister, Carballo-Dieguez, Ventuneac, and Dolezal, (2009) found in their research that “HIV-positive men were more likely to associate gains with bareback sex as a way of coping with social vulnerabilities than HIV-negative men” (p. 165). Finally, another reason had to do with the combination of abusing drugs and barebacking (Halkitis et al., 2003; Halkitis & Parsons, 2002).
In addition to the practical and simplistic reasons as to why men bareback, there are often complex and elaborate reasons as to why MSM/G engage in this sexual practice. One complex reason for why men bareback has to do with the notion of forbidden fruit and the power that comes with obtaining a sense of pleasure that one cannot have because of what society, often a straight, male society, tells them not to do. Junge (2002) argues that “A similar incitement to discuss deviant sexual practices has, through religious, juridical, and medical discourse, facilitated interest in (and among some a desire for) anal sex” (p. 202). Foucault (1978) argued in a similar fashion with regards to the efforts of society centuries ago to prevent and control childhood masturbation. The deviance of such sexual activities, including barebacking, creates a culture of experimentation and the breaking of rules and norms, that a society, especially a Western, capitalistic one, tells them not to do.

Another reason why some MSM/G bareback has to do with them being out of touch with the AIDS crisis in the 1980s. That is, they did not face or deal with losing close friends and attending multiple funerals. Therefore, dying or suffering from AIDS is an out-of-mind, out-of-sight phenomenon within their sexual and social experience. McKusick, Horstman, & Coates (1985) found that Gay Men who were socially connected and were able to visually observe those living with the end stages of the virus changed their sexual habits by practicing safe sex or reducing the number of sexual partners. Blechner (2002) notes that:

Young gay men today may be lucky not to have lived through the terrible times of the early days of the AIDS epidemic, but consequently, many such people do not
share the great sense of relief that the previous generation felt at being able to stay alive by mere condom use. Some instead feel resentment and deprivation at the constraints of safer sex. (p. 29)

In addition to many MSM/G not having to deal with the virus socially, or first hand, many men are experiencing AIDS optimism in that they have a positive view of the virus because many people are living healthy lives with the HIV virus, thanks to daily treatments of ARV that have built up their immune systems. Overall, AIDS is no longer a death sentence today like it was in the 1980s and 90s.

A similar issue relates to the fetishizing of the sexual act (i.e. barebacking) and it being viewed as an “unclean” or unsafe act. Mowlabocus (2007) notes that “to many, bareback sex is a fetish that – like other fetishes – is thrilling because of its deviant status” (p. 220). And that fetish provides a deep connection with another person in which barebacking can be shared. Shernoff (2006) argues “There is something deeply erotic, profoundly connecting and, some feel, even sacred about one person giving his most private and special fluid, semen, to the other as a gift of love and a symbolic joining of two souls” (p. 80). This might provide more evidence as to why men engaging in the practice may not be able to articulate the deep connection that is formed on the basis of participating in the act of barebacking.

Whatever reasons or meanings that men subscribe to the performance of barebacking, it is a practice that has often gained a tone of acceptance within the community of MSM/G who practice the act. Morin et al. (2003) notes, “The normalization of the term ‘barebacking,’ combined with media attention and community-
level discussion about it, have contributed to the perception that the behavior is widespread in the community, creating a [new] social pressure to conform” (p. 357). Part of the normalization of accepting barebacking as a sexual practice can be attributed to condom or safe-sex fatigue (Halkitis, Parsons, & Wilson, 2003). In another study by Golub, Starks, Payton, and Parsons (2012), they found that “Beliefs that condoms reduce intimacy were strongly associated with beliefs that condoms reduce pleasure; however, in the multivariate model, only intimacy emerged as a significant predictor of percentage of sex acts that were unprotected” (p. 630).

The reasons for not using condoms vary across men who engage in bareback sex. As has been suggested, the reasons or meanings men attribute as to why they bareback are complex. Elovich (1999) argues that:

Talking about our sexual experiences helps us to become conscious of them, as unerotic as that may be. Stories in the media about barebacking and bug-chasing sensationalize our sex while most of us still can’t talk honestly about why getting fucked is such a powerful experience that we might want to do it without a condom. (para. 30)

Finally, due to the complexities of what it means to bareback, or the reasons why MSM/G engage in the behavior, it raises the question whether PrEP can be used as a singular solution to a very complex phenomenon.
**The prevalence of barebacking today.** As suggested above, barebacking was prevalent in the pre-AIDS era; it came to a near abrupt stop during the 80s and 90s, and then slowly picked up again with the advent of ARVs in the mid-1990s. Today, barebacking has gained more acceptance among men in the MSM/G community. Specifically, bareback sex is prevalent within gay culture today on many different levels. Not only has research suggested a rise in the practice, the internet, specifically social networking sites, and pornography have all become a breeding ground for more acceptance of bareback behavior. Since the 1990s, evidence suggests the phenomenon of barebacking has been happening in some metropolitan areas. Ekstrand, Stall, Paul, Osmond, and Coates (1999) reported that UAI increased from 37% to 50% in just a three-year period in the mid-1990s among their San Francisco research participants. Also, in a survey conducted by the New York City Department of Health and Mental Health (2003), 55% of the MSM/G who were surveyed said that they did not use a condom the last time they had sex. Similarly, more than 14,000 men were surveyed in Great Britain and 56% reported being penetrated anally by their partner without a condom while 58% reported having penetrated a partner without a condom (Hickson, Weatherburn, Reid, Jessup, & Hammond, 2007). Similar findings are documented by other researchers. Mehta et al. (2011) reported that 62.8% of MSM/G in their study reported unsafe sex in the past 90 days and 7% reported sex with a known HIV-positive partner. Dr. Frieden, former Health Commissioner of New York City reported that “Of most concern, among men who have sex with men who had 5 or more partners in the past year, 36% did not use condoms consistently. This is a core group which is at high-risk for getting – and spreading – HIV”
The increase in bareback sex is not an isolated phenomenon in the U.S.; UAI among younger Gay Men in UK has also increased (Dodds, Nardone, Mercey, & Johnson, 2000).

Although research suggests an increase in the practice of bareback sex, it does not happen in isolation as a unique behavior – it often flourishes under the influence of drugs and/or alcohol. It has been suggested by many that Gay Men in general take more risks than those who do not identify as gay. The New York City Department of Health and Mental Hygiene (2008c) reported that nearly 25% of MSM/G in NYC engaged in binge drinking compared to 15% city-wide. They also reported that “Alcohol, however, may be more responsible for HIV transmission than drugs because is much more commonly used” (p. 1). They also reported that a strong correlation exists between heavy drinking and an increase of sexual partners – 40% of MSM engaged in binge drinking reported having 5 or more sex partners in the past year. More specifically, 48% of MSM/G with 20 plus partners in the past year were under the influence of alcohol last time they had sex. What sticks out the most from this report is that 35% of those who were drinking did not use a condom while having receptive anal intercourse. While evidence suggests that MSM/G are barebacking while under the influence of alcohol, recreational drug use also suggests a similar correlation (Bellis, Cook, Clark, Syed, & Hoskins, 2002; Clutterbuck, McMillan, Lewis, & McIntyre, 2001; Mattison, Ross, Wolfson, & Franklin, 2002; Ross, et al., 2001).

Gay Men, barebacking, & the internet. While evidence suggests a dramatic increase of barebacking among MSM/G, one of the biggest factors driving bareback sex
today is the internet. While the pre-AIDS era, forced men to meet publically to engage in sexual encounters, MSM/G, especially those who prefer to remain discreet, look to online venues to explore their sexual desires without the danger of being seen publically. Shernoff (2006) notes in his book that online forums have dramatically changed how men pursue their sexual interests:

There was a time when men would wear hankies of various colors to signify what sexual behavior they were looking for. Now, the search engine has replaced the hanky, and men are able to more easily find men who share their sexual interests. (p. 145)

While it is difficult to estimate the amount of men who use the internet to meet other men for sex, Liau, Millett, and Marks (2006) reported that 40% of MSM/G have met sexual partners online. Many MSM/G use the web to find other men to share in similar sexual interests with one another without having to spend more time and money going to a gay bar or sex club. Also, it allows them to manage their anonymity and discretion if they do not want others to learn of their sexual orientation (including bisexuality) or sexual interests. Kim, Kent, & McFarland (2001) found that Gay Men were more likely to use the web than heterosexual women and men in searching for sexual partners. Additionally, Hillier and Harrison (2007) found in their study of young (ages 14-21) Australian LGBT people use the internet for six predominant reasons. They include the practicing of: sexual identity, same-sex friendships, disclosure, same-sex intimacy and homosexuality, and learning about their respective communities. Finally, Dowsett, Williams, Ventuneac, Carballo-Dieguez (2008) looked at six popular bareback internet sites and found “The
more sophisticated the site (i.e. more resources, more complex design) the more
specificity is asked of users in profiling themselves; it is a refined act of ongoing self-
definition” (p. 131). There is clear evidence to show the internet provides a safe space for
Gay Men to meet other men without the fear of rejection or stigmatization that is present
in face-to-face situations.

In addition to the web providing a space for MSM/G to explore the practice of
barebacking, there are other avenues, including a movement to purposely deny any form
of sexual safety. This latter avenue is explored through a few websites in which the
discourse surrounding barebacking is highly embraced, with some perceiving it to be
more extreme than others. One website, Barebackjack.com (2014), embraces the sexual
practice but does not totally eschew sexual safety. Also, this site acts as a social
networking site in which men can find other like-minded men to pursue the pleasures of
bareback sex – it acts much like Facebook in which profiles and videos are created to
fulfill bareback desires. They state on the front of their site:

While health information may not be your first reason for visiting this site, it is
the underlying motivation of Barebackjack.com. We believe that men can enjoy
hot, unprotected sex best if they are informed about the risks involved and what
they can do to minimize those risks to themselves and others. We're the only
bareback site on the internet that refuses to sweep HIV under the carpet. We offer
this information to you free... you don't have to be a member to access any of the
health information we provide. (“Preview,” para 1 & 2)
As a user navigates through the site, it is obvious that HIV is not a phenomenon that is to be taken lightly even though the sexual practice of barebacking is embraced. Their goal, while it is difficult to determine if it is successful or unsuccessful, does make users aware of the health risks associated with bareback sex even though they simply mention HIV as a potential danger.

Some may believe that a site such as Barebackjack.com pushes the envelope in which a space is created for men who want to pursue bareback desires. A more direct and blunt form of discourse on the internet, in relation to barebacking, comes from Bareback.com (2014) which acts quite similarly to Barebackjack.com as a form of social networking. What is fascinating is that they make reference to a community in which barebacking is basically a culture and an accepted performance of the sexual body. Furthermore, they discuss rules of making contributions in their community section of the site. It reads:

Welcome to the bareback.com community home page. Prepare to take your first step out of the condom closet. This is your own personal hot link to our dirty bulletin boards and sweaty chat rooms. Get ready to have your ass pounded! Like any community, we have standards. . . . Chats and posts of a sexually explicit nature are not only tolerated – they are encouraged. We want you to get down and dirty. Don’t be a bone killer. Tell us your dirtiest secrets and we will tell you ours. Being mean or lecturing any members of the community is not allowed. Health class was in high school – we have grown up! Rubbers are for women and
children on a rainy day – not for a little piggy’s bedroom! Cum inside our bulletin boards and chat rooms and get ready for a nasty ride! (“Community,” paras. 1-5)

The website not only provides a space for men to explore bareback inhibitions but the behavior is highly encouraged in addition to the discourse about the practice. The creators are encouraging bareback behavior without mention of HIV/AIDS and are denouncing any form of safe sex. Discourse such as this can make medical treatments in preventing HIV, such as PrEP, more difficult to implement. Mowlabocus (2007) argues that online spaces, especially for barebacking, allow for such discourse to be vocal and embraced:

The erotic economy of barebacking is intimately linked with the condom code, though condoms are consciously eschewed by those who participate in bareback sex, and while many barebackers cite corporeal connection as a primary motivation behind barebacking, it is within the disembodied spaces created by networked communication systems that the subculture associated with this sexual practice has been most vocal. (p. 221)

The online environment creates a space for men to be very vocal and specific about the sexual practice they wish to pursue. The discourse provided by sites such as bareback.com and barebackjack.com, make any kind of health prevention difficult for health practitioners, especially for PrEP. But PrEP is in a unique position in that PrEP is an invisible form of sexual safety and protection (i.e., it is taken in pill form, hence can be taken in privacy without anyone observing the person) while condoms are a very visible form of sexual protection in which a sexual partner(s) can see whether or not
another guy is wearing a condom. PrEP has the unique ability to curtail the backlash by some in the community to wear condoms all while still keeping MSM/G safe from HIV.

No matter how extreme the discourse, the web provides an important space for a niche community, such as men who seek out bareback sex, to meet, fantasize, and collaborate. Although the community is small on these sites (there were only approximately 1000 men online at bareback.com at the time of this research – 200 members and 800 visitors), the discourse is embraced by those who wish to be a part of the community. In a report of internet relay chat (IRC) (i.e. synchronous one-to-one internet chat) and embodiment, Doorn, Wyatt, and Zoonen (2010) argue:

The internet, or in this case IRC, is indeed not an autonomous “thing,” but is made up of people who bring their everyday experiences to a realm where their actions together constitute a shared, temporal reality. It is important to keep in mind, then, that this “reality” consists of discourses that originate from an embodied understanding of how our world works and who/what/how we can be to make our lives as livable as possible. (p. 371)

For MSM/G, the internet, mobile apps and social networking sites to meet others for sexual experiences become real, embodied spaces for participants to explore, fantasize and eventually seek out others who share in the same desires. In addition to the safe space of the internet, which allows for privacy of MSM/G to seek out bareback sex, the pornography industry is another avenue for MSM/G who wish to view, consume, and fantasize about bareback sex.
Gay Men & bareback pornography. The prevalence of barebacking is not only evidenced in online social networking but it is prolific within the gay pornography industry. Hardy (2008) notes that the “American porn industry alone has been conservatively estimated as worth something in the region of $10 billion per year, with an annual output of 10,000 to 11,000 films, compared to Hollywood’s 400” (p. 60). Gay pornography makes up approximately one-third to one-half of the money made in the entire pornography industry (Thomas, 2000). While it is unclear how much bareback pornography is on the market, it is estimated that bareback pornography is produced at approximately three times the rate as pornography that uses condoms (Sheon, 2011).

Gay pornography for MSM/G was created for men as a form of sexual expression and experimentation (Escoffier, 2009; Burger, 1995). Burger specifically notes that “Gay pornography seemed to me to be a warehouse of our cultural heritage and memory, as well as an important site for the production and modification of this heritage and memory” (p. x). Whether it is condom-only or bareback pornography, the art form has played an important role within gay culture and it, like the practice of barebacking has a similar, rich history.

Burger (1995) has discussed the period of Pre-AIDS Awareness, in which pre-condom pornography reigned up until around 1987; this is very interesting in terms of the rhetoric of “pre-condom” versus using the term and discourse of “bareback.” In 1988, safe-sex was not being practiced widely in the gay pornography industry, according to Burger, and the nation as a whole was slow to react to the AIDS virus (Shilts, 1987). It is amazing to see how quickly the industry retreated back to what is now termed “bareback”
pornography. While the gay porn industry did not take the lead in exercising safe-sex practices, it quickly has taken the lead in creating bareback only films. It is interesting to see old films that are advertised in the Pre-AIDS Awareness area as “pre-condom” as the phrase denotes ignorance of HIV/AIDS by performers, directors, and producers in creating the films. Now, the same exact behavior (i.e. unprotected anal intercourse [UAI]) is called “barebacking,” which insinuates a deliberative behavior to not wear a condom during anal intercourse. This is similar to how barebacking earned its name; as an analog to a rider who decides not to use a saddle while on a horse. It is fascinating that the non-condom use behavior has not changed, from the Pre-AIDS Awareness period, though it is being referenced with different a name having been institutionalized for the same sexual practices.

This history has nearly the exact parallel to the practice of barebacking in the gay community. Similarly, the pre-AIDS era embraced the sexual exploration of MSM/G having unsafe sex (not marketed as barebacking then) and now in the post-AIDS era, the industry has ushered in a prolific production of films dedicated to barebacking. Not only is it being created at an astounding rate compared to condom pornography (Sheon, 2011), it is also being heavily consumed by many men. In an unpublished internet survey of 821 men who have sex with men, who have a high risk of HIV transmission, “77.2 percent reported viewing bareback pornography in the last 90 days” (Silvera et al, 2009, p. 1732). With what seems like a rise in bareback gay pornography, and a concomitant rise in its consumption, this sexual behavior is making its way into the public memory and culture of gay life. Burger (1995) notes that “pornography, as a visual means of representation,
usually elicits a physical response (orgasm) from the viewer, and therefore has the potential to educate the viewer about his body’s sexual possibilities” (p. 22). Silvera et al.’s preliminary research is suggesting that the barebacking phenomenon is definitely taking place within the gay community and its consumption could most likely lead to a behavioral response in Gay Men in trying to recreate what they have observed from a pornographic film. It is evident that the rise of bareback films, and rise in consumption, has created a new wave of gay pornography that has become a major part of gay history, lifestyle, and culture.21

In fact, many think that it is an acceptable form of art and embrace the production of this pornographic genre. In a poll conducted by *POZ* (2011) magazine, a monthly publication for those living with HIV, *POZ* readers were asked if the use of condoms should be regulated in the pornography industry and nearly half (47%) said “no.” While research suggests that barebacking is on the rise and has become more acceptable among MSM/G, this poll seems to suggest that people who are familiar with this kind of pornography seem to be equally divided on the issue; their attitude suggests an equal difference of opinion when it comes to practicing safe sex.

It is not quite clear or understood how pornography influences or effects viewers but some suggest a connection. Paul and Shim (2008) report from their study that

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21 One of the most popular and well-known production companies producing bareback pornography is Paul Morris’ *Treasure Island Media* company. His production company produces bareback-only MSM/G pornography. One actor, named Dawson, a performer for Treasure Island Media has established himself as a supreme star boasting titles such as *Dawson’s 20 Load Weekend* (2008) and *Dawson’s 50 Load Weekend (Parts I & II)* (2009). Dawson, as a premiere award-winning performer, is very well-known throughout the gay community even though he and Paul Morris have brought on a lot of controversy regarding the bareback content within their films, especially within the gay community and pornography industry.
“Overall, results show that high levels of pornography consumption appear to be associated with experiencing greater difficulty in maintaining one’s personal and social life and an increase in the number of unsafe sexual behaviors” (p. 197). At best, we have correlations of the two phenomena, of barebacking pornography and sexual behavior and it is difficult to prove cause and effect between these two practices. Haynes (2010) notes, “There’s little data on the effect of pornography on its audience’s individual practices, but many health practitioners believe that media play a larger role in encouraging high-risk behavior” (“Spreading the Love?” para. 1).

Similarly, in an interview with Pulse magazine, comedian Bill Maher was asked about the effects of political ads on the American public. He humorously and sarcastically responded by saying:

Yeah, and Americans are so good at ignoring ads. If they were good at ignoring ads, would anyone ever drink Budweiser? Have you ever heard anyone say, “Yeah, Budweiser, that’s the best beer I’ve ever had?” No, they drink it because it’s advertised the most. (Heffernan, 2014, para. 6)

Although Maher is a comedian that makes people laugh, his humorous social commentary about media effects does not sound different between the creation of bareback only pornography and sexual behavior. As noted by Sheon (2011) and all of the studies showing the dramatic increase of condomless or bareback sex among MSM, there is a direct correlation between the two phenomena that make me personally think that Maher is correct in his assessment, although crass, on the effects of certain media in society.
Resistance to Condoms & Criticism of Public Health Campaigns

Another reason why bareback sex has increased is due to the failed health prevention campaigns that promote safe-sex. Many may ponder and question the fact that more than 30 years into the HIV/AIDS pandemic; why, with all of the information that is available to the public, especially to Gay Men, are people still taking sexual risks, especially when it comes to barebacking? With an array of health information available to the general public and health practitioners, one would certainly question why there continues to be an increase in HIV/AIDS and the voluntary participation of bareback sex among MSM/G. Crossley’s (2001a, 2001b, 2001c, 2001d) research raises critical questions of public health campaigns that aim to focus on such safe-sex messages. She argues:

The vast majority of health promotion and education interventions tend to espouse information and education as the foundation of behavior change. Such assumptions produce an image of the individual that is overly rational and fails to takes sufficient account of the complex interrelations between psychology, health issues and the sociocultural and moral environment in which people live.

(Crossley, 2004, p. 226)

With all of the complex technical and identity meanings attributed to barebacking, Crossley argues that safe-sex prevention campaigns ultimately do not consider the complexities around certain sexual behaviors. Crossley also notes that such prevention campaigns sometimes achieve the opposite effect. Mowlabocus (2007) also argues that “The rise in barebacking cannot and – should not – be separated from the history of
HIV/AIDS in the West and it is not unreasonable to state that barebacking is in fact a byproduct of earlier HIV prevention campaigns” (p. 231).

The effects that prevention campaigns do not want to achieve ultimately aim at risk or the phenomenon that can be a result from practicing bareback sex. Junge (2002) argues:

Safer-sex ideology thus influences but does not determine popular gay notions of risk. Nonetheless, it seems clear that public health constructions of risk do substantially (if unconsciously) inform the sexual fantasies of barebackers, lending clarity to which behaviors are to be considered dangerous and therefore potentially erotic. (p. 208)

A specific criticism of failed prevention efforts is a result of how “public-health initiatives tend to ‘talk-at’ people rather than engage with them – a failure, in a sense, of the ethics of proximity inherent in these efforts” (Haig, 2006, p. 871). If prevention efforts do not work as a some research believe they should, specifically through the use of wearing a condom, then how will PrEP prevention efforts be communicated and ultimately embraced by MSM/G? Crossley (2004) argues that “gay sex is without human meaning, thereby overdetermining gay men as sexual beings and undermining the complexity of sexual behaviour. Such meanings must be understood if health promotion is to have any impact on such behaviours” (p. 226). Again, Crossely stresses the complexities of barebacking and that various meanings exist for why MSM/G engage in the behavior.
In addition to the failed public health campaigns aimed to curb risky sexual practices, such as barebacking, the model of Western medicine is also brought up as a critique. It could be suggested that PrEP is another answer from the medical community to manage the bodies of Gay Men whose behavior is perceived as deviant. Urla & Terry (1995) argue that “The modern bodies we imagine today are in many ways the legacies of techniques of measurement, visualization, and classification that grow out of the powerful domains of scientific empiricism and medical treatment” (p. 6). PrEP has the potential to be a major medical breakthrough in which HIV can be prevented in many MSM/G who bareback. Or, PrEP could become just another failed medical prevention that exists but will be eschewed by MSM/G and Gay Men.

Aaron Laxton, (2014), a blogger about LGBT and HIV issues, summarizes the campaign for condoms only by stating:

The “condom-only” message is falling on deaf ears and if we are serious about addressing those who are at greatest risk of becoming infected with HIV then we must embrace new technologies such as PrEP. We must consider PrEP even if there are those in the community who rail against anything other than condoms.

(para. 8)

Again, his argument shows that PrEP can fill these voids between the time, money and energy spent on creating condom-only campaigns and the prolific practice of bareback sex among MSM/G. As of now, there are only a few campaigns to support PrEP that also include stories from the media.
Resistance & Criticism towards Barebacking

As might be expected given that the sexual act of barebacking is prevalent within the gay community, and among MSM, the practice has its critics. Larry Kramer co-founded the *Gay Men’s Health Crisis (GMHC)* – an organization that advocated for AIDS awareness and cared for Gay Men living with AIDS in the early 1980s. Kramer has always been vocal in persuading Gay Men to stop the unhealthy sexual behaviors even before HIV/AIDS had a name. He wrote in his famous novel, *Faggots*, “why do faggots have to fuck so fucking much?” (Kramer, 1978, p. 335). His language, quite blunt and vulgar, even continued on as he advocated into the early years of the AIDS epidemic taking place in New York City. He famously wrote in his 1983 *New York Native* article, “1,112 and Counting,” that Gay Men “need to quit fucking each other to death”(para. 24) Kramer has lost support of people in the gay community during this time because of his vocal opinions and criticisms of New York City and Federal politicians’ apathy towards AIDS. He still continues today, vocally advocating against the dramatic increase of barebacking by MSM/G and in the pornography industry (Kramer, 2005).

Conclusion

This long discussion of “mapping” the gay male body is certainly not complete but attempts to provide a thorough context of gay male bodies without regards to PrEP. When looking alone at the various markers and signals of the gay male body, one may see a number of challenges or road blocks that can inhibit the successful administering of PrEP to those who are at risk. These barriers were investigated in the in-depth interviews
and are thoroughly discussed in analysis chapters of this document. The next chapter will outline the methodology for the project.
Chapter 4: Method

Also, at my intellectual core perhaps is the sense that – however naïve you think this – the world of social phenomena is bafflingly complex. Complexity has fascinated and puzzled me much of my life. How to unravel some of that complexity, to order it, not to be dismayed or defeated by it? How not to avoid the complexity nor distort interpretation of it by oversimplifying it out of existence? This is of course, an old problem: Abstraction (theory) inevitably simplifies, yet to comprehend deeply, to order, some degree of abstraction is necessary. How to keep a balance between distortion and conceptualization? (Strauss, 1993, p. 12)

As noted by Strauss (1993), complexity is a by-product of social phenomena and this project is no different. Trying to understand how gay health, gay sexuality, and HIV relate to the gay male body within the context of PrEP will not be an orderly presented argument. But the goal is to use the narratives of willing participants to reveal their perspective on how they understand and navigate all of these phenomena. The purpose of this chapter is to layout the methodological process for this project. Specifically, the discussion will focus on how the study was conducted, including the rationale for pursuing interviews, recruitment of participants, interview protocol, an explanation of how the interview data was analyzed, and how the method of crystallization was used in this project.
Why Interviewing?

My motivation for choosing to conduct interviews is both philosophical and practical, especially for this project. There have been a number of theorists and readings that have spoken to, and refined, my epistemological and methodological understanding of qualitative research. To say that I have taken classes in interpretive, qualitative methods, especially in interviewing, is not the argument I wish to put forward for my motivation in pursuing this elaborate, often complex methodological approach. While I do not believe there is one best methodological approach to understanding human phenomena, I find that interviewing fits my personality, my methodological philosophy, and the overall context of this project.

First, I believe that interviews allow for deep reflection, exploration, and explanation of human phenomena. Kvale and Brinkmann (2009) note that “The qualitative research interview attempts to understand the world from the subjects’ points of view, to unfold the meaning of their experiences, to uncover their lived world prior to scientific explanations” (p. 1). The complex meanings that MSM and Gay Men ascribe to barebacking are vast and complex and by honing in on those complex meanings, including those about HIV/AIDS, gay sexuality and health, and the gay male body within the context of PrEP regimens, provides data that is responsive to the research questions that frame this study.

Due to the nature and content of this project, especially regarding barebacking, it can make for interview subjects perhaps not wishing to share some aspects of their lives, especially those that are sexual. Since the research questions of this project ask for deep
reflections of barebacking and gay sexuality, it is imperative that I, the interviewer and overseer of this project, am noncritical, nonjudgmental, and fully give my mind and body to their answers, narratives, and lived experiences. Fortunately, for me, being an openly gay male, I arguably have more insight and experience into the gay lifestyle both sexually and nonsexually. This provides me with a slight advantage over those researchers who may be pursuing a similar project but do not identify as gay. Kvale and Brinkmann (2009) argue that:

The knowledge produced by such research depends on the social relationship of the interview and interviewee, which rests on the interviewer’s ability to create a stage where the subject is free and safe to talk of private events recorded for later public use. (p. 16)

This reflection offered by the authors suggest that rapport, established with a foundation of trust, is the key aspect in allowing for a safe space where participants can disclose what is often a private experience (i.e. the sexual act of barebacking). The fact that I am also gay also means that I must be wary of letting my own experiences color my perception or interpretation of interview data. These are twin issues that will be reflected on in the final chapter.

When it comes to the philosophical foundations for why I am choosing to interview MSM and Gay Men, it will provide me with a deeper understanding of the phenomena that I wish to examine. According to Rorty (1979) “We see knowledge as a matter of conversation and of social practice, rather than as an attempt to mirror nature” (p. 171). As the future conversations/interviews unfold with my participants, there will be
more light shed into the various issues that are reflected in my research questions. Also, the interview process allows for the interviewer and interviewee to explore the vast maze of the lived human experience. I draw some of my methodological philosophy from Merleau-Ponty (1962) who privileges the immediate, first-hand, primary account of the lived human experience:

All my knowledge of the world, even my scientific knowledge, is gained from my own particular point of view, or from some experience of the world without which the symbols of science would be meaningless. The whole universe of science is built upon the world as directly experienced, and if we want to subject science itself to rigorous scrutiny and arrive at a precise assessment of its meaning and scope, we must begin by re-awakening the basic experiences of the world of which science is the second order expression. (p. viii)

Lived experience is both rich and complex; interviewing allows for both interviewer and interviewee to tap into the specific narratives and experiences of MSM and Gay Men.

Furthermore, the interviewing process allows for the presence of doxa and episteme to exist in unison with each other. Doxa, which is representative of the opinions, narratives, and the experiences of the participants, which can vary greatly from one another, “can also be employed as conversational ways of producing episteme, knowledge that has been justified discursively in a conversation” (Kvale & Brinkmann, 2009, p. 37). This philosophical notion of personal experience transferred to, and justified as, knowledge is important in this project as MSM and Gay Men discuss and elaborate on
their narratives. As will be noted later, the themes that emerge provide responses to the
study’s research questions.

Finally, my last reason or philosophical notion for interviewing comes from
Alfred Kinsey’s (1948) work, *Sexual Behavior in the Human Male*. Kinsey and his
research team were monumental in breaking down barriers and taboos related to sexual
practice. While this project will not take on the same magnitude as his (he and his team
had approximately 6,000 men participate in hour-long, individual interviews), the culture
of MSM and Gay Men engaging in bareback sex has its own taboos. Kinsey and his team
stressed that rapport with participants is key, especially when talking about sensitive and
taboo topics such as sexual acts. They note about interviewing:

The interview has become an opportunity for him to develop his own thinking, to
express to himself his disappointments and hopes, to bring into the open things
that he previously had been afraid to admit to himself, to work out solutions to his
difficulties. He quickly comes to realize that a full and complete confession will
serve his own interests. (p. 42)

Although sexual practices today, especially homosexuality and sodomy, are not legislated
like they were during the time when Kinsey conducted his research, discussing issues
such as barebacking, whether at the surface or deep level can be difficult for participants.
As Kinsey and colleagues argue, allowing MSM and Gay Men to elaborate on these
various experiences and contexts can serve their own interests. Within the gay
community, it is that case that while many may have engaged in the practice, few have
discussed barebacking in-depth. Doing so within the context of this project allows the
participant to understand, think, reflect, and discuss barebacking, gay sexuality and health, the body, and HIV/AIDS within the medical framework of PrEP.

**Participant Recruitment**

I concentrated my recruitment of Gay Men in and around the greater New York City area. My reason for doing so was two-fold. First, I live in the greater New York City area; hence this is a convenience sample. Second, there is data noting that barebacking, sexual risk taking, and HIV infections are on the rise in New York City. A report released by the New York City Department of Health and Mental Hygiene (2007), in addition to the nationwide data published by the CDC cited in chapter one of this document, noted there was a 33 percent increase in HIV cases among men under the age of 30. Also, according to a CDC (2008) report, HIV is spreading at three times the national average in NYC and MSM accounted for 50 percent of new infections. These statistics, including the statistics stated in Chapter Two about MSM in NYC taking sexual risks, are important as social awareness had been raised in regards to MSM. In other words, although HIV treatments have dramatically improved since the 1980s, the rate of HIV is still on the rise among MSM. According to, a New York City government report (2008) stated that “New Yorkers with same-sex partners are three times as likely as those with opposite-sex partners to report more than one partner in the past year.” All of this data suggests that many MSM and Gay Men in the NYC area are potential resources regarding the phenomena proposed in this study. While the data published by the CDC, and other agencies, uses “MSM,” I focused on recruiting and interviewing Gay Men – not MSM. My rationale for interviewing only Gay Men is because, as a gay man, I have found that
most men within this community talk candidly and openly about sexual behavior and practices. Second, if I were to attempt to recruit someone who was just simply MSM, that person may feel uncomfortable in discussing sexuality, especially if he is not out to friends and family. This would make recruitment difficult and provide different narratives than those who identify as a gay man would offer.

Another reason for recruiting and interviewing Gay Men in the New York City area has to do with research published by Mehta et al. (2011) in which the researchers assessed the level of awareness of PrEP and nPEP among MSM in the NYC area. Overall, their research found that awareness of both treatments is low. In addition to the low awareness, they also found that those who were aware of these medical treatments were greatly linked to patients who had a primary provider and disclosed their MSM status. Thus, the gay population in the NYC area contains participants who are more likely to be aware of PrEP regimens than those who are not.

Recruiting Gay Men in the New York City area and gathering their perceptions and narratives in regards to barebacking and the other phenomena I am investigating, within a PrEP context, provides insight about the positive and negative aspects of this prevention treatment. In recruiting participants for this study, I used my extensive social network of Gay friends and contacts in New York City. In addition to my contacts, I also used the snowballing technique to recruit participants based upon referrals. Snowballing has been used for projects to study what society would consider taboo or deviant phenomena. Almeida and Silva (2003) implemented such a technique in recruiting participants for their study of people who used ecstasy in Sao Paulo. Snowballing worked
well in this study because once when a few people were interviewed and felt comfortable, they reached out to their friends and encouraged them to be interviewed without fear of repercussions. While this study is not examining ecstasy or any drug usage, the subject of barebacking is a private act and often taboo among many people, including some members of the gay community. Also, snowballing is a helpful methodological technique for this project because those friends that I interview first will hopefully then contact their friends and can help ensure that trust and confidentiality will be exercised during the interview. As will be noted in the analysis chapters, I was successful in obtaining 20 interviews/participants.

Interview Data Collection

PrEP’s role within the gay community has the potential to change the discourse of safe sex, gay sexuality, and the meaning of HIV/AIDS. In-depth interviews enable the researcher to understand how the gay male body is situated, and seen, in relation to all of these phenomena. In particular, I focused on the language used by the participants in describing their perspective on the complex interlocking features of safe sex, gay sexuality, barebacking, HIV/AIDS, and the potential participants saw in the use or non-use of a PrEP regimen. With respect to the latter, I was able to account for changes in the way barebacking is viewed as well as to examine how PrEP and barebacking provide meanings for the gay body, gay sexuality, gay health, and HIV/AIDS. Much can be learned through interviews about a sexual culture that is often stigmatized by a society that privileges heteronormative sexual relationships. Rubin (1999) argues that “We have learned to cherish different cultures as unique expressions of human inventiveness rather
than as the inferior or disgusting habits of savages. We need a similarly anthropological understanding of different sexual cultures” (p. 154). Lindlof and Taylor (2002) note that “Interviews also enable researchers to elicit the language forms used by social actors in natural settings” (p. 174). Encouraging participants to discuss, and reflect critically on the potential for PrEP regimens, and what that means in regards to their own bodies and sexual practices, provides in-depth insight into the role this new regimen may have in preventing HIV/AIDS.

**Interview Protocol**

As a result of working with human subjects, I obtained approval from Ohio University’s Internal Review Board (IRB). On June 13, 2013, they approved this research study with an expiration date of June 12, 2014. The IRB approval letter and consent form can be found in Appendix E. In order to follow IRB regulations, participants were asked to read, sign and date a release form which is in the IRB application.²²

Participant eligibility was determined on the basis of five criterion— they must identify as gay, be at least 18 years of age, must be HIV-negative, must have practiced bareback sex at least once within the last six months, and must have a basic knowledge of PrEP. My rationale for establishing such criteria has to do with the various phenomena I am studying and the research questions I am asking in this project. The criteria, with one exception, were provided to participants on the release form they signed in agreeing to the interview. One criterion – engaging in bareback sexual activity within the past six

²² In the IRB application, you will find that PrEP is up to 90% effective in preventing HIV. Clearly that is different from the 99% efficacy discussed in chapter one. The reason for this discrepancy is not in error but has to do with when the IRB application was first drafted compared to the medical literature that was out about PrEP at the time.
months – was introduced verbally prior to proceeding with the interview. My rationale for not placing this item on the release form is because the participant’s signature will be attached to such criteria and if the release forms were ever found by another person then others would know about that person’s sexual practices. Additionally, in relation to the final criterion – having a basic understanding of PrEP – participants were given a CDC (2012c) PrEP Fact Sheet (see Appendix F).

**Interview Collection**

My initial step was sending out an inquiry to those in my social network who might be interested in participating. Once they indicated an interest, and indicated they met the criteria I sent them as part of the inquiry, I then sent an email with the CDC (2012) PrEP Fact Sheet for them to read over. I also asked them set up a time and place (of their choosing) to conduct the interview.

When I arrived at the interview location, I showed the participant the IRB letter approving this research (Appendix E). I also provided them with the release form approved by IRB. Each participant was given time to read it over and asked if there were any questions. Before starting the actual interview, I reiterated the right to terminate the interview at any time as well as not answer any question(s) that the interviewee was not comfortable answering. In order to establish early rapport in the interview process I informed the participants that I too am a sexually active, open/out gay man. Also, I encouraged the participants to be as authentic and realistic as possible. My intent was that the participants would be themselves, especially when it comes to talking about their own sexual behaviors and experiences. From my experience, oftentimes when people talk
about these experiences, they elect to use words such as “fucking” as opposed to “intercourse.” My rationale for indicating it was perfectly fine to express themselves as they normally would was two-fold. First, I believed this authenticity would provide for more rich, realistic data. Secondly, it helped establish rapport between me and the participant. Lindlof and Taylor (2002) argue that:

Researchers should try to put themselves in the role of the participants and prepare to respond to the sorts of issues that concern the participants about the study, the interview, and what kind of professional – and person – the researcher is. (p. 189)

By communicating these statements to the participants prior to the interview, it enabled them to feel like an equal in the interview process.

In order to protect privacy, participants were tasked with assuming a pseudonym so others would not be able to distinguish them from the interview data and narratives. Also, participants were asked to not mention anyone’s name during the interview so as to protect the identity and privacy of others. I encouraged participants to use general pronouns of “he/him” or “I once met a guy who…” so they have a clear understanding of how to protect people’s privacy. All interviews were recorded on a digital recording device and were then uploaded to my personal, password protected laptop. When all of the interviews were collected, I sent the digital files, with the pseudonyms of all participants, to a professional transcription service that produced hard-copy transcripts of all the interviews. To ensure that the transcripts were produced accurately, I listened to each interview as I read each transcript – no errors were found in any of the transcripts. I
also emailed each transcript to all of the participants to check for clarity and accuracy. None of the participants found any errors and thought the transcripts reflected what they disclosed during the interview.

When an interview is taking place, it is more than simply asking questions and waiting for answers from the participants. In fact, this exercise requires high levels of immediacy and interactivity as an interviewer. The digital recorder does not capture everything in the interview. Lindlof and Taylor (2002) note that:

The researcher thinks through the conversation as it unfolds, and silently asks:

What am I learning now? What else should I learn? What can I do to help the participants to express themselves? The researcher theorizes about the possible meanings in what the person said or what the person might have meant. (p. 193)

This form of active, present listening shows the participant that what they are disclosing matters to me, the interviewer, and to the project as a whole. Their “participation” is more than simply their time and disclosures. Instead, their participation is highly valued due to the rich narratives they wish to share. They allow me into their lived experiences and entrusted me with their personal narratives. As result of this, I am more than obliged to do more than simply listen; instead, I needed to be present, aware, reflexive and responsive to what they chose to disclose to me.

In order to capture these moments, I wrote some field notes as the interview was conducted. Corbin and Strauss (2008) note that “Whenever observations of events are made, the observations are filtered through the eyes of the researcher who can’t help but start thinking about classifying the information” (p. 123). Additionally, Corbin and
Strauss encourage the qualitative researcher to write memos which are distinctly different from field notes. They define memos as “lengthier and more in-depth thoughts about an event, usually written in conceptual form after leaving the field” (p. 124). When I concluded the interview I wrote at least one paragraph of every interview with regards to my experience and perception of what took place. Being actively present in the interview, taking field notes and writing a brief memo after every interview started the initial process of analysis.

When it comes to the questions that I asked participants, I used both nondirective and directive questions. According to Lindlof and Taylor (2002), “Nondirective questions are the preferred way to help people talk freely about themselves and their scene” (p. 202). These are excellent questions to ask, especially when it comes to the phenomena that I will be researching. Knowing that all of my participants came from different backgrounds and lived experiences, nondirective questions allowed them to disclose as they see fit for that particular question. For example, in asking the question – “When it comes to getting an HIV test, what emotions and other things are experienced?” I received a number of different stories, range of emotions and experiences for this particular answer. From those answers, I probed for clarification and a better understanding of their perspective. Directive questions ask the participant to focus on a specific idea or scenario. On such example would be: “Would you consider taking a PrEP regimen?” Lindlof and Taylor describe this as an emergent idea which is “asking participants for their thoughts about the idea” as another “technique that builds structure into the question” (p. 203). The last set of questions, which deal with the sexual
experiences of barebacking, were saved for last in order to build up to that point in the interview. Lindlof and Taylor argue that these sensitive questions “of personal or political nature are best left for later in the interview” (p. 203). The question protocol is in Appendix G.

When the interview concluded, I provided the participants with a list of free, confidential HIV testing sites located throughout the five boroughs of New York City and Long Island. That comprehensive list is located in Appendix H. My rationale for providing them with this list was to encourage them to get tested and as they have admitted, by agreeing to be in the interview, that they have practiced bareback sex at least once in the past six months. This also ensured their health, and safety in relation to following IRB regulations.

**Interview Analysis**

In addition to checking transcription accuracy, listening again to the interviews while reading the transcript allowed me to re-live the interview. When this process was complete, began the analysis of all the interview data within the transcripts, my field notes and memos. Specifically, I analyzed all of the interview data through a grounded theory approach. Lindlof and Taylor (2002) note:

Two features of grounded theory (or the *constant-comparative method*, as it is also known) are important: (1) Theory is grounded in the relationships between data and the categories into which they are coded; and (2) codes and categories are mutable until late in the project, because the researcher is still in the field and
data from new experiences continue to alter the scope and terms of his or her analytic framework. (p. 218)

Specifically, I took individual narratives that were present in the interview data, and compared those against others. Also, “As the researcher moves along with analysis, each incident in the data is compared with other incidents for similarities and differences” Corbin & Strauss, 2008, p. 73). As I went through the transcripts, I tracked pertinent data that fit within concepts and themes by using a code book. This process of grouping is also called creating themes or concepts from the data. Corbin and Strauss further stress that:

Incidents that are found to be conceptually similar to previously coded incidents are given the same conceptual label and put under the same code. Each new incident that is coded under a code adds to the general properties and dimensions of that code, elaborating it and bringing in variation. (p. 195)

These various codes that emerged from the data fit into concepts or themes that were written about extensively in the analysis chapter of this document (i.e. chapters five and six). In writing about the concepts and themes,23 I wrote about all of the examples that fit into those themes which Corbin and Strauss call dimensions. Specifically, they note that “the researcher can break a substance into various components in order to identify their properties and dimensions” (p. 46).

Based on the analysis, I developed three to five themes/concepts from the interview data. When I reached this point, what Corbin and Strauss (2008) call conceptual saturation (e.g., having “acquired sufficient data to describe each

23 Corbin and Strauss (2008) use those terms interchangeably.
category/theme fully in terms of its properties and dimensions, and until I have accounted for variation, and most of all until I can put together a coherent explanatory story” [p. 197]). The task of taking 20 in-depth interviews, getting them transcribed, checking for inaccuracies, deriving themes with comprehensive dimensions and creating a story to tell with both my own perspective as well as the participants was not an easy task – it is complex and needed careful organization and commitment. Corbin & Strauss also note that “Researchers are translators of other persons’ words and actions. Researchers are the go-betweens for the participants and the audiences that they want to research” (p. 49). Specifically, “Grounded theory entails developing increasingly abstract ideas about research participants’ meanings, action, and worlds and seeking specific data to fill out, refine, and check the emerging conceptual categories” (Charmaz, 2005, p. 508). Using a constant-comparative method enabled me to explore the various interpretations that MSM have in relation to what PrEP means to the gay male body, gay sexuality and health, and HIV/AIDS. Also, since PrEP is a relatively new medical phenomenon, trying to gain an understanding of what it means in the context of the gay male body, gay sexuality and health (including barebacking), and HIV/AIDS is pertinent for how MSM and Gay Men subscribe meanings to all of these phenomena.

**Participant Overview**

Over the course of ten months, I collected 20 in-depth interviews of self-identified Gay Men aged 20-63. None of the interviews were terminated and the participants answered all of the questions that were asked. The interviews lasted from 30 to 90 minutes with the average interview lasting an hour in length – this accounted for a total of
386 pages of transcription. All of the participants met the minimal criteria to participate in the interview and all of them signed the release form. When all of the interview data was collected and then transcribed, transcripts were returned to all participants to check for clarification and context – none of the participants asked to make changes. The master code list, which matched the name of the participants to their pseudonyms, was destroyed after the participants looked over their transcript and returned it to me. One participant, Damon, refused to take on a pseudonym as he wants to get his message out about his views and perceptions of PrEP.24 I located all of the participants by contacting friends and many of them referred me to others who may be interested in participating. I contacted one participant, a complete stranger to me, via Facebook after he appeared in an article in the New York Times about his experiences in taking PrEP – that person was Damon.

Similar Research Studies

There have been similar studies conducted using this methodological approach. For example, Ridge (2004) interviewed 24 men to try to understand the various meanings associated with bareback sex. To understand the interview data, he used grounded theory and found five distinct themes from the narratives and disclosures of the participants. Similar studies have also been conducted by Cooke-Jackson, Orbe, Ricks, and Crosby (2013). They interviewed high-risk African-American to understand the meaning associated with their condom usage. Through their research, they developed three major

24 I had personal communication with Dr. Benjamin Bates, a member of the IRB at Ohio University, about this issue. He said it was okay to use Damon’s original name, as insisted, and note that this was a journalistic interview.
themes. Theme analysis was also used in a similar study about an HIV diagnosis and stigma (Poindexter, 2004).

When it comes to communication scholarship and the studying of phenomena such as sexual behavior, and how it relates to HIV prevention, the discipline has trailed behind other fields of study. Comella & Sender (2013) argue that:

Communication studies has, somewhat curiously, lagged behind its social science siblings when it comes to creating institutional spaces that recognize the importance of sexuality research as a specialized area of study marked, for example, by divisions and interest groups in professional associations, peer-reviewed journals, and dedicated graduate programs. This delay is especially surprising given that the discipline offers a theoretically robust framework for examining the production and circulation of sexual meanings, practices, values, discourses, norms across myriad material and symbolic contexts. (pp. 2560-2561)

While this project is personal, the phenomena that are being studied come at a time when the field of communication can use more research in the field of sexuality and communication. The analysis of the interview data and the participants’ narratives will have a focus on meaning and what kind of meanings they are subscribing to PrEP, HIV, and gay health and sexuality. It is suspected that the interview data provided by participants will be multi-layered with diverse discourses and meanings within the context of health communication.
Conclusion: Using Crystallization

In addition to the methodology of interviewing, crystallization will also be present as a co-methodology throughout this project. Crystallization, as defined by Ellingson (2009):

Combines multiple forms of analysis and multiple genres of representation into a coherent text or series of related texts, building a rich and openly partial account of the phenomenon that problematizes its own construction, highlights researchers’ vulnerabilities and positionality, makes claims about socially constructed meanings, and reveals the indeterminacy of knowledge claims even as it makes them. (p. 4)

This project has been supplemented with my own voice and lived experience as a gay man. Additionally, this project is layered with many different perspectives with regards to HIV, PrEP, gay sexuality and gay health (see chapters one-three). Specifically, this is offered to provide the background for the analysis of the data retrieved from the interviews. This is what Ellingson (2009) calls integrated crystallization which “involves producing a written and/or visual text consisting of multiple genres that reflect (straddle) multiple points on qualitative continuum” (p. 97). The complex, multi-faceted, multi-dimension, and multi-layered phenomena that are being examined in this project, particularly in the preceding chapters, cannot be understood in simple isolation without questioning other elements that are not exactly external to each individual piece of phenomena. For example, I believe one cannot have a conversation about PrEP without having a comprehensive understanding about HIV, especially in the gay community.
Also, one cannot have a full understanding of HIV in the gay community without a thorough discussion of gay sexuality and behaviors such as barebacking. These phenomena are all intertwined within gay experience, and are implicated in considerations of gay health. One could say that the gay male body is the “container” and that gay health, HIV/AIDS, gay sexuality, and PrEP are the phenomena contained within that overall context. In actuality, any configuration of these phenomena can be contained by any one phenomenon. Overall, these ideas are difficult to separate and that is why a deep understanding of each phenomena is imperative for understanding just any one individually. This is the reason I also supplement the academic research articles and interview data with visuals, items from popular culture and my own personal perspective. This is why I embrace Ellingson’s perspective of crystallization for a project of this nature because it is meant to bring together a complex, messy and often chaotic puzzle that many are trying to navigate and understand. She captures this process beautifully by stating, “crystallized qualitative projects produce both aesthetic and functional products that benefit a range of stakeholders and reflect the voices of both researchers and participants” (p. 99). The journey of studying and discussing these complex phenomena continues into the next chapter.
Chapter 5: Analysis Part I

This chapter will briefly discuss the background of the participants and will outline the first two themes of the interview analysis. The participants came from various backgrounds with regards to education, age, relationship status and their experiences of knowing others with HIV. Nineteen of the 20 participants were White/Caucasian and one was Hispanic/Latino. This is one shortcoming in the participant pool as new HIV infections are greatest among MSM of color. I did contact an African-American who was interested in participating but our schedules unfortunately could not align. All of the participants had some level of college education with four of them having obtained a Bachelor’s degree, six earned a Master’s degree and three with Ph.Ds. Most of the participants, 14, identified their relationship status as single and six stated they are partnered – five of which reporting they are in open relationships. One participant, Harold, identified as being in a serodiscordant relationship (i.e. his partner is HIV-positive). Only two people were on a PrEP regimen – Brandon and Damon. Harold and Harley both disclosed to me, months after their interviews, that they are currently taking PrEP regimens. Harley originally said that he would not take PrEP in his interview but he currently is, as his partner recently learned that he is HIV-positive.

When it came to sexual contacts, participants disclosed that they barebacked with anywhere between one or 1,000 Gay Men. The results were all over the place. One person reported approximately 1,000 partners in his lifetime and four reported 100s of bareback partners. Five disclosed that they barebacked with only one person. Six participants reported having non-HIV STDs at some point during their life that were
eventually treated. When asked if the participants knew anyone who was HIV-positive, only two reported that they did not know anyone. All of the other 18 participants reported knowing anywhere from one to 15 different people within their social circle who is HIV-positive. Four participants disclosed that they have known at least three people in their social circle who died of AIDS. Larry, who worked as a Chaplain in a hospital in New York City, witnessed hundreds of deaths as a result of AIDS.

One friend of mine, who wanted to be interviewed, kept delaying the interview as a result of his busy schedule; he eventually disclosed to me that he would not be able to participate because he is HIV-positive. Two participants disclosed to me, months after their respective interviews, that they are HIV-positive and they did not know of their status and diagnosis at the time of the interview. As an interviewer, I asked them if they are receiving care and treatment and, thankfully, they are doing well. These cases show the need for PrEP awareness in the gay community.

After I read through the transcripts multiple times, I noticed four predominant themes that emerged through analysis of the interview data. They include a presence of the body among participants, medical and health communication, various interpretations of HIV and various interpretations of PrEP. These themes, thoroughly discussed in this and the next chapter, have many dimensions that are built into, and crystalize, the four themes. The first, and most evident and prevalent, theme throughout all of the narratives of the participants was the thorough discussion of the body in a number of dimensions. Specifically, the dimensions that will be discussed within this theme include HIV testing,
barestock sex and the body and other medical conditions that have been marked on the bodies of the participants.

**Theme #1: The Body**

**HIV testing & the body.** The first dimension of the body theme that was evident had to do with participants discussing the stress and anxiety associated with getting tested for HIV. Nearly all of the participants discussed numerous “scares” they had with sexual partners which subsequently lead them to getting tested. The act of getting an HIV test is an embodied activity. As a gay man who has also put himself into risky situations, I can relate to the stress, anxiety, judgment, and stigma I felt as well as the judgment I perceived coming from healthcare practitioners. Larry’s experience is similar to most of the other participants – he disclosed:

> I had doctors check me out like that and so I was always worried. I was very paranoid about the whole thing. I wasn’t finally tested until I got into trouble and I was sent to be tested. Yeah, so—which I was negative, obviously. For me, as a gay man, it was a very paranoid type of era, the ’80s. (2014, February 2, Interview)

This dimension of the body theme was evident in that participants discussed the action of getting tested as well as the emotions associated with getting tested. Many tend to think that emotions are isolated in the mind but they are embodied experiences that the mind and body both react to as a result of the situations and circumstances of life. Floyd (2011) notes that emotions “are the body’s multidimensional response to any event” (p. 246)
Nearly all of the participants reported heavy levels of stress and anxiety when getting tested for HIV.

While some participants have thought of the hypothetical instances of how they could have possibly acquired HIV leading them to the clinic or a doctor’s office for a test, some have actually had closer calls with an HIV diagnosis. The following narrative, provided by Brandon, prior to going on PrEP, details his very close call of acquiring HIV.

I decided to include it here in its entirety to provide a full context:

I got called from Nassau County because that’s what was my real address. This guy knew me as living in Nassau. I was living at the time in Suffolk. I got the call when I was living with a friend and her son, who was five at the time. Of course, they’re very vague, too. They don’t tell you anything but you need to come in for testing. As vague as they were, it was almost worse because they couldn’t tell you, “Everything’s fine, even though you’re living in a house with a child.” They wouldn’t tell you any information. The nerve-racking part of that was just not knowing anything about it, and they wouldn’t give you any information. That was the most worrisome part about it because was a child in danger? Was the adult in danger? They don’t give you enough information at all. I ended up going into the Suffolk County Health—Board of Health instead. . . . That day, cuz they wanted you to come in immediately type of deal, the sooner the better. I went to Suffolk County instead of Nassau County cuz they’re all connected. I took a rapid test, and then I took a full-blown blood test. The rapid came back negative, of course,
within the 20 minutes, which is the most nerve-racking time ever. (2014, February 6, Interview)

This scare was more visual in his mind as a result of getting a phone call. The complicated thing about HIV is that those who may unknowingly have it may not exhibit any signs or symptoms of infection. All of this time Brandon may have felt fine, may have been exhibiting signs of great health in his body, but that phone call changed everything. He could have easily thought that his body was one that was different – marked by his past experiences.

In addition to the various emotions associated with getting an HIV test, many participants noted the visualization of having a positive test or those that have sat in the same chairs and received news of a positive test result. Paul disclosed:

I think that especially when I was younger, and of course, when HIV really was considered a death sentence for many people. I probably had a lot more fear and anxiety, and of course, being young and romantic. Imagine lots of bleak futures and gothic situations and so forth. As I’ve been more mature though, and of course, I mean I do try to be highly aware of my behavior and what is risky and so forth. The truth is I know I don’t do much that would be terribly risky. (2013, June 26, Interview)

Matt also noted similar emotions and experiences during his first and only test, “Panic. Anxiety. Like, ‘What’s gonna happen if I do? How come I was such an idiot, not protecting myself?’” Jack similarly noted that when it comes to an HIV test “I link it with
so many people that don’t have a good outcome and I see even the testing place as just a not welcoming place.”

One participant, Mark, reported that he was used to getting tested during his regular check-ups but had multiple doctors as one left the practice and another retired; these changes resulted in having to ask every new doctor for a blood test for HIV and STDs. He felt as if he had to “come out” every time there was a new doctor. Similarly, participants also noted and felt a sense of judgment from doctors and clinical staff in asking for a test. While no one ever witnessed or reported outward judgment, they felt it from those in the clinic. Ashton detected judgment and stated:

I feel like they always say like, ‘This isn’t because you’re gay or this isn’t because of this, but we’re gonna test you for HIV and we’re gonna do your blood work and you have to sign off on this paper. You don’t have to get tested, but off the record, I think you should. (2013, August 19, Interview)

Jack also reported similar experiences when going in for a test. He noted:

I always feel like when I’m gettin’ an HIV test or any STD test, I give them the paperwork of what I need to do or it’s in their computer or whatever, and I feel like, ugh, here I am bein’ fuckin’ judged. Like, “What kinda weekend did you have?” You know what I mean? (2013, October 15, Interview)

It is as if the participants and their behaviors are under the microscope as well their blood. The moment when they walk into a clinic for an HIV test their bodies are evaluated, judged and stereotyped. Paul summarizes this best by stating:
That has a lot to do also with society testing, labs, so forth. Is there a stigma about getting tested? Is there a stigma about being HIV positive? That’s the thing that we still battle. We’ve known this for decades, right? We’ve been battling this since the ACT UP years. We’ve known this, right? (2013, August 19, Interview)

Ganguly and Tasoff (2014) presented a paper studying whether or not college students wanted to learn test results of the HSV-1 (the herpes virus that causes cold sores) and HSV-2 (the more severe herpes virus appearing on the genitals) viruses. The experiment they created was for the students to pay $10 if they decided they did not want to have their blood tested. For the HSV-1 test, 5% declined to have their blood tested, and for the HSV-2 test, students were three times more likely to avoid the test. This is telling behavior by participants that could possibly suggest that ignorance among Gay Men when it comes to getting an HIV test could be a potential barrier to learning about their status and towards getting on PrEP for those who are most at risk.

**PrEP & HIV testing.** For the two participants I interviewed who were taking PrEP, their experiences of getting tested were completely different from the participants who were not taking PrEP. Brandon made a specific reference to PrEP as a form of corporeal armor in protecting him from HIV. He specifically stated, “There it gives me a medical condom I guess for the body without having to worry about it.” This disclosure and perspective, in regards to taking PrEP, provides participants with full body protection against HIV but also lessens or eliminates the bodily reaction of anxiety and stress.

Damon discussed his experience of being on PrEP as a pure stress release. When going for a test, now that he is on PrEP, he disclosed “Now it’s a cake walk. It’s like, ‘Yes,
please, take my blood. I know I’m negative. I know I’m negative, so feel free. Take it any way you want’” (2014, January 16, Interview). While I only gathered interviews from two participants on PrEP, what Brandon and Damon disclosed is consistent with experiences that I have seen of those on the PrEP Facebook page.  

While PrEP is in its infancy, it seems as if it can provide many Gay Men with the needed stress release of having to not incessantly worry about the fear of whether or not “I have it.” As a gay man who has been tested for the virus, I know the fear, shame, guilt, self and public judgment and the multitude of other emotions that my body experiences at the clinic. PrEP, taken daily, has the ability to ease the minds and worries of Gay Men, as well as others, much like a regimen of birth control provides for women.

**OraQuick & HIV testing.** Within this dimension was the theme regarding the technology of HIV testing. Nearly all of the older participants (i.e. 42 and older) could discuss, at length, the amount of time associated with getting tested. When the HIV test first came out it was a miracle piece of technology in helping to detect HIV antibodies in the body. But with any new form of technology comes a downside. Christian noted: “I would eventually start getting tested when I was in my undergrad. That’s back when it took two to three weeks for the results, and it was horrid.” Charlie also noted:

I thought I had been exposed - and I can’t remember exactly why, a couple of times. It may—it was a gut feeling or whatever. The first time I went for an HIV test it was when you had to wait, like I forget how long it was, like twelve days or

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25 This is a private, closed Facebook group. Unfortunately, my original IRB application did ask for permission to use data from this forum.
two weeks or something like that. . . . It was walking like on egg shells the whole two weeks. (2013 December 10, Interview)

In addition to Charlie’s experience, nearly all of the participants 42 and older reported the sense of dread over the two week period. Louis similarly stated, “We did the blood test at that point, and it was a very scary two weeks” (2013, October 17, Interview).

Compared to the participants 42 and older, the less than 30 year old participants obviously do not recall such a waiting period. In fact, many within this group never reported about their experiences of having to wait for an HIV test result. Melchior disclosed his multiple use of purchasing and using the *OraQuick* test from his local pharmacy. According to the *OraQuick* (2014) website, it is an over-the-counter, FDA approved, one-time use oral swap that tests for HIV-1 and HIV-2 antibodies and promises results in 20 minutes – all in the comforts of your home. Melchior appreciated the fact that an intimate and anonymous activity, such as getting an HIV test was an option, because it took him out of the clinical setting and meant not having to disclose his sexual orientation to a physician or nurse. *OraQuick* also promises near 100 percent accuracy in providing results. According to their website: 99.9% of people (4,902 out of 4,903) correctly reported a negative test result. The lab and OraQuick® In-Home HIV Test found the same result. This means that 1 out of 4,903 people not infected with HIV reported a positive test result even though that person was really not infected with HIV. This is called a “false positive.” (“Test Performance,” para. 2)
While *OraQuick* provides the confidentiality and accuracy that many Gay Men want, Jack reported his doubts over the test because the lack of professional setting a traditional HIV test provides.

Zander had a unique experience with the OraQuick test compared to all of the other participants. He reported “I’ve had people offer me to come over and take an OraQuick test.” He always found those hookups to be a turn off and he never pursued them. Similar to Jack, he questioned the scientific legitimacy and accuracy of OraQuick compared to a traditional, blood HIV test. Zander’s experience is not out of the ordinary.

Reading about Zander’s experience with potential hookups asking him to take an OraQuick test, got me thinking about any person who agrees to take such a test in front of a hookup, who may not be a medical professional, will have revealed private, socially stigmatized medical information, especially if it is a positive test result. The hookup may possibly not only abandon their sexual partner but may tell others without the other’s consent.

Carballo-Dieguez, Frasca, Balan, Ibitoye, and Dolezal (2012) conducted a study in which they gave *OraQuick* tests to HIV-negative, sexually active gay and bisexual men. They asked them to administer the tests to potential hookups when they came over to their residences. Of the 101 partners the participants tested, 10 showed a positive result and for six of those men it was the first time they learned about their status. 23 partners refused testing and “seven led to verbally aggressive situations” (p. 1757). This is proof that things may not go well during a sexual encounter when people are asked to take a test. While it gets people talking about HIV status, sexual safety and the willingness to
get tested, I see a great concern with another person knowing of a person’s positive status and the potential breach of privacy and disclosure of that person’s status to others.

Another problem with *OraQuick* is that it only tests for HIV antibodies; these typically do not show up for months after the initial infection (Morgan, 2013).

The entire experience and association of getting an HIV test is more than a medical exercise. Grosz (1994) states that “In short, bodies, individualities, are historical, social, cultural weavings of biology” (p. 12). While the test itself is a biological phenomenon in the medical field, for many Gay Men, including the participants of this study, it is much more than that. The drawing of blood is a narrative, specifically a sexual narrative of the hookups, the risk, the dangers, that Gay Men place themselves in with every sexual experience because it is the blood or saliva that tells the ultimate verdict – negative or positive. And then the emotions of the stress, anxiety, judgment, and fear of waiting for the result is a compounded embodied experience of having to get the bodily fluid(s) studied, examined, and interrogated. Grosz further argues that “The specificity of bodies must be understood in its historical rather than simply its biological concreteness” (p. 19). That is, the experience for the gay man getting an HIV test is embedded with all of the reminders of being gay, and the sexual risks that come with that identity. The medical professionals can also certainly jump to those conclusions when a single man walks into the clinic full of anxiety and ready for a test. And speaking from my own experience, the gay male body acquiring an HIV test is wrapped up in a personal sexual history as well as the cultural, social, and stereotypical judgments and stigma that
accompany that history when he walks into the clinic or publically purchases the take OraQuick home test.

**Bareback sex & the body.** A second dimension pertaining to the body was how participants discussed barebacking and the positioning of the body within that sexual practice. The barebacking dimension was evident in multiple forms which included the freedom and pleasure of barebacking, the natural feeling barebacking provided to the participants, the positioning of bodies while barebacking, selection of bodies in barebacking, the deep bond and emotional connection barebacking brings, the flirtation with danger and risk of barebacking, how not using condoms plays into barebacking and the body, and finally how bareback pornography & embodiment are greatly tied to one another. Each of these ideas are outlined below.

**Barebacking experiences.** The first, and most obvious dimension of this theme was the in-depth discussion many participants engaged in with respect to how bareback sex felt within their body. That feeling is one of pure pleasure and erotic ecstasy. Christian provides the following candid, in-depth account on barebacking:

> I fuckin’, I love the thought of bareback. I love the rawness of it, the wetness of it, in a way. I love big dick and smaller ass, smaller hole. That turns me on a lot. I’m very turned on by it. *[Pause]* Big fan of the real raunchy, the raunchy move of someone getting fucked and taking a break and suckin’ the guy’s dick…. Like a guy fucking and cumming in a guy’s asshole and pushing it in. That’s really nice…. Yeah, I like that. It’s hot. I think it’s cuz it’s—it’s interesting to think about how that—is it because that it’s so risky? I don’t know. It’s so interesting
that I can get off to it now, and do most often, where back in the day, I wonder if I would have seen that—we didn’t have the internet then. (2013, November 21, Interview)

Christian’s description of barebacking is no different than the other participants and why they enjoy barebacking – it provides a sense of freedom, great pleasure and release.

In addition to the pleasure of practicing bareback sex is the sense of escape that many participants discussed. Paul notes:

The times that it’s happened, alright, especially where I’ve been the top and I know that I’m negative, there is a certain pleasure in it. There’s just the actual sensation itself. There is probably also frankly something a bit about escaping the burden that I’ve lived under all my life of the threat of AIDS and the need to practice safe sex, to use a condom, right, to escape from that. I mean maybe it’s almost the porn I was talking about before to imagine, to fantasize the world. (2013, June 26, Interview)

Paul’s story captures a time in the AIDS crisis in which Gay Men were careful to not place their bodies at risk of acquiring what was then a deadly disease. Living through those times, and seeing the advancements in HIV treatment as well increased life expectancies, Paul’s experience of barebacking is one of release; the messages and images of Gay Men dying in hospitals across the country became more distant.

**Barebacking & natural feeling.** Paralleling the pleasure dimension of barebacking is the shared sense of a “natural feeling” the Gay Men experienced with their own bodies. This dimension, within the body theme, was prevalent throughout most of
the interviews. The “natural feeling” phenomenon is the idea of sex, specifically gay sex, being a natural exercise without the use of condoms. Damon, a user of PrEP, makes an argument as to why gay sex should be natural:

I mean every single one of us came out of bareback sex, unless you came from a Petrie dish, your mother and father did it bareback, however your mother and father are. We're talking about the most natural form of sexual expression there is. We're talking about putting a barrier to that kind of intimacy. That has worked semi-well with the men of my generation and older who saw the devastation of AIDS and were affected by that up to a period of time. (2014, January 16, Interview)

Damon’s case for bareback sex is evidence of gay male bodies being no different than heterosexual bodies especially when it comes to sex and desire. Also, it is interesting that Damon simplifies barebacking as an overarching term for both Gay Men and heterosexuals, especially in the context of the sexual act that takes place in order to reproduce. Luke elaborates on why he likes to forgo condoms and practice bareback sex:

The feel is obviously different. There's not some latex in between your skin and his, so it feels different. When someone has a condom on, you can tell there's a condom on because there's a piece of latex there. I also think it's more arousing. I know that there are some men who lose their erections—their hard-ons—when they have a condom on, and I certainly don't want that to happen. (2013, September 13, Interview)
It was evidently clear that the participants thought that condoms created an unnatural barrier between them and their partner. Without the condoms, many of the participants discussed how they could feel their partner and his body and enjoy the experience and sexual encounter. PG also provided a similar perspective:

“It's just intense. It feels right. Just the idea of somebody else's load in you, it's—
that's all. [Laughter] …. No barriers….Nothing. A condom is a—I don't say “no.”
I never say no, but—Yeah. I just want to get more dick. A condom's on it, it's on it….Oh, yeah. Let's go. Keep going, right? Hurry up cuz the guy outside the door wants to come in. [Laughter] (2014, September 14, Interview)

Discussing the body more specifically, when it comes to forgoing condoms, specifically is the sensation and the touch of human bodies together. Matt states:

“I like feeling the—I like feeling skin, not a piece of plastic or whatever…. I
dunno. That's what I like about it. I like it cuz you're actually touching the person.
You're not just feeling the condom, I guess…. It's just so much better. You're just feeling the—I dunno. Yeah, just feeling the person. Feeling the person. If the person is uncut, you're gonna feel the person more. You're not gonna feel that person if you have a condom on. (2013, August 27, Interview)

Coupled with the sense of human touch and experience of being with another man, is the presence of pure freedom with a partner. Matt describes such as an experience of barebacking, “There's something about the mystique of—not could you contract it, but the, 'I'm not wearing a condom, and I'm just gonna throw you across the bed,’ or whatever.” Matt’s experience discusses the heat of the moment and the actions that

151
follow – the sense and connection with another gay, consensual body. Dean (2008) summarizes these narratives by the participants so well by stating, “Barebacking is not as much a sexual act as it is an embodied act especially in the heteronormative sense” (p. 86).

**Barebacking & body positioning.** Some participants discussed this notion of “body positioning” which is the idea in which sexual role and positioning they play while engaging in bareback sex. Specifically, some participants discussed how they carefully participate in bareback sex as a top or bottom and the emotions that come with that specific sexual role. Paul notes:

> I guess let me make a distinction. When I barebacked as a top, I feel that thrill. ….

> As a bottom, I don’t. It actually fills me with a certain kind of—dread is too heavy a word. I don’t actually find it pleasant. It doesn’t excite me. (2013, June 26, Interview)

Some other participants who described themselves as “tops” reported similar experiences – there is a sense of thrill while engaging in bareback sex. Many who bottom reported the flirtation with risk and a sense of guilt after engaging in the act of being the bottom. From these narratives and disclosures, is seems the way participants positioned their bodies in sexual encounters depended on types of emotions they experienced after the sexual encounter.

**Selection of bodies.** Within the practice of barebacking there seems to be a concept that was discussed among participants concerning the particular selection of bodies. Charlie disclosed his preference:
I hate the guy—I don’t like guys who are effeminate in bed. One guy came over, and he started wailing. He started saying, “Fuck my, pussy!” I was like—I just went soft immediately. I’m like, “No, dude, this isn’t gonna work out.” (2013, December 10, Interview)

Charlie’s preference for more “masculine” bottoms debunks the stereotype of men who prefer to bottom as being feminine. Ridge (2004) noted from his research:

The narratives suggest that sex, including anal penetration, does not have fixed meanings based on dichotomies such as active/passive. On the contrary, the accounts of informants have confirmed that sex is a repository for a range of meanings, where meanings tend to be contextualized, fluid, emotionally based, multiple, layered and constructed through sexual practice. (p.274)

While there are certainly Gay Men in the community who may prefer to take on a feminine role in the sexual encounter, this is obviously not an absolute. Charlie’s narrative, in addition to many men in the community, show a sense of sex, whether it be bareback or not, to be fluid and subjective. Ridge (2004) further argues, “While receptive anal sex was considered a feminizing act by some, the meanings of anal sex were negotiated in practice, and receptive anal sex could take on masculine meanings” (p. 266).

Charlie’s preference for a certain body type is not an anomaly among members of the gay community. In fact, there are co-communities built around body types within the overall gay community. Specifically, those communities and body types are linked to various niche websites, mobile apps, conventions/conferences, bars and clubs. A nearly
comprehensive list of co-communities and body types are listed in Appendix C of this document. In addition to body types are the clothing, accessories and/or undergarments that are coupled with that co-community. The mobile app Scruff, for example, appeals and markets to Gay Men who wish to pursue men with moderate to prolific body and facial hair.

Also attached to body type and selection of body preference with another sexual or romantic partner is the connection of age, which is typically evidenced on the body. Charlie further disclosed the following narrative with his preference for older men when he was younger:

I didn’t go as frequently as I would’ve liked. Certainly, the clubs and the people in the city were more sophisticated than the people out here. I had an attraction to older men because I didn’t wanna talk to somebody else about Madonna. . . . First of all, they would talk to me like I was an adult, and they could fuck like mad. They taught—they were so good, and they taught me everything. (2013, December 10, Interview)

What Gay Men prefer or select in terms of body type is not only limited to the look, feel, texture, race and/or ethnicity or size of the body. Age is another component that is evident in the community and where various co-communities have formed – such communities include daddies and daddy chasers (these body types and co-communities are listed in Appendix J). For many, these distinct co-communities are discerned in the perception of how young or old, fat or thin, healthy or unhealthy a person appears to be.
Emotional bond & connection. In addition to the sense of closeness of not only physical and erotic sensations of bodily contact the participant’s narratives expressed a deep bond and emotional connection with their partners. Melchior describes his preference for barebacking during sex and the emotional sensation and experience that are tied to that activity:

I feel like it's—for me, it feels like there's more of a connection just because there's not that barrier, but typically, most of the time, I only do it with partners, so it's more of a closeness, a bonding-type thing. (2013, August 6, Interview)

A relational bond and connection that a person has with another human being produces feeling and various emotions – all of which are bodily responses and it is obviously no different with a sexual encounter. Harold, who is in a serodiscordant [one is HIV positive; the other is not] relationship with his partner, states a similar desire to forgo condoms in order to have the intimate experience with his partner:

Like I said, you sort of wanna feel your partner after a while, not just what the outline of it, they are, sort of. Instead of—we wanna actually feel, as opposed to going through the act of it, kind of. It’s much different thing to have the condom on and the condom off, like on an emotional level as opposed to just the physical, just fucking, whatever, getting it over with, and with that random person. (2013, September 4, Interview)

For some participants, especially Harold, the close bond with a romantic or sexual partner is important and the decision not to use condoms is an avenue toward achieving that deep level and feeling of intimacy in the bareback sexual encounter.
Flirtation with danger & risk. While the embodiment of barebacking was evident in the narratives of nearly all participants, by enjoying the sensation, having bodily contact without a barrier and the emotional bond with partner(s), many participants understood a sense of flirting with the risk and danger of acquiring STDs – especially HIV. Zander captures this phenomenon the best:

I think that it changes people’s perspective and makes them want to have bareback sex. I think that the reason why it’s become so prolific is because I think people want to have bareback sex. I think that part of the reason why bareback sex is so enticing is because of the danger of it. I don’t wanna say it’s the thrill, but it’s just—it feels—it really—truthfully, I think it feels better, but there’s a connection whenever you’re—there’s just a physical connection there that you’re having that is like—I don’t know how to put it into words. It’s like a level of trust that you’re putting in that person. It’s just like—I don’t know. There’s something about it. It’s just really—it’s just really good. (2013, July 5, Interview)

Zander’s perspective, as well as what other participants revealed, there is a controversial dichotomy that is present – many Gay Men know that bareback sex is dangerous from a personal health standpoint and yet is extremely pleasurable, erotic and fun.

This dichotomy is also illustrated by Damon. He shared a similar experience and level of anxiety of acquiring HIV or another STD before he went on PrEP:

Some people say that there's HIV in pre-cum and that's a risk factor. Other people are like, “It's really not that much of a risk factor.” Nevertheless, I knew I was playing with fire. Even though these guys are pulling out, or I'm making sure
they're pulling out before they cum, how far are we gonna go with this before
there is that? Moreover, my excitement that I didn't want them to pull out, but
horrification, it's like, “Oh my God, I don't want these people to pull out, but they
have to pull out.” Going back and forth with that was really scary. (2014, January
16, Interview)

Through the narratives disclosed by Zander and Damon, the rules of practicing safe sex
are constantly with them when they are engaging in sexual activity but the practice of
safe sex with condoms is typically not present. Paul seems to clarify the conflicting
dichotomy through the following disclosure:

I think different people deal with it differently, and different people think not just
about the particular stigma of HIV or AIDS, but also just about health in general,
the way we think about our bodies and our health. Different people just have
different ways of thinking about that or expressing it…. I mean not even dealing
with HIV, but any just sexually transmitted disease that it’s not somehow some
verdict or judgment or anything quite so terrible. I know it’s a medical fact when
people engage, when bodies engage, there’s always a chance of transmission of
infection. This is part of what it means to be alive and engaging with other people,
and that as long as you’re aware and conscious about these issues and good about
your healthcare and responsible to other people, that this is all frankly just part of
being a mature adult. This is how you handle things. (2013, June 26, Interview)

Paul’s rationalization to solve this dichotomy seems to suggest that we make certain
decisions with our bodies (sometimes irrational and dangerous) but our bodies speak to
the desire and eroticism that tempts us to what we prefer – to what feels good. Rofes (1998) summarizes the risk that Gay Men flirt with when engaging in unprotected sex by stating, “Gay men have always been driven to risk and transgressive acts” (p. 245).

**Condoms, barebacking & the body.** Participants also discussed the bodily sensation, or the lack thereof, they experience when using condoms in sexual encounters. Charlie forgoes the use of condoms for the following reasons, “I can’t cum (when wearing condoms). Only once in my life did I, and that was quite a session…. I don’t like them. There’s a—I love the feeling of dominance I have. It really gets me off.” As noted earlier by Charlie, the act of two masculine-acting men, both engaging in an act of sexual dominance, presents an experience where both men can have an uninhibited sexual encounter without the rules and barriers of safe sex in order to feel the body of his respective partner. Ridge (2004) captures this experience by stating the following, “This was clearly evident in the descriptions of the smell of sweat, ‘rough’ sex play, wrestling and muscles grinding. There was a real sense of sharing in and celebrating masculine subjectivity through embodiment” (p. 265).

Harold also experienced the same problems with using condoms during sex with his partner:

We’ve been together two-and-a-half years, and we were always very safe. I tend to have trouble feeling anything with a condom on if I’m topping. It’s always been uncomfortable for me, more so, if I’m bottoming with the condom on. Just being—not having felt my partner of two-and-a-half years, like it’s sorta—you just wanna have that moment and really connect. (2013, September 4, Interview)
Beyond the unpleasant bodily sensation associated with using condoms, Harold also wants to have the bodily connection with his partner that he has not been having as a result of being in a serodiscordant relationship.

**Bareback pornography & embodiment.** Pornography was also discussed thoroughly in all of the interviews and all of the participants disclosed that they have consumed and watched bareback pornography. What was interesting is how pornography was discussed as a form of embodiment. Charlie discussed how he likes to couple bareback sex with pornography, “to this day, I like to—even when I’m having sex, I like to watch, fuck—pornos goin’ on at the same time.” It is as if his watching and consumption of bareback sex while in the same act of sexual behavior are reflections of one another – as if it is a form of bodily reenactment. When it comes to consuming bareback pornography, Melchior provided the following rationale:

> I think partly because of the lessening stigma of someone with HIV or the lessening stigma of being able to pass it on. I think it's one—I wouldn't say a fetish, but it's a turn-on for people to see porn that they're not using protection.

(2013, August 6, Interview)

Another form of bodily reenactment was discussed by Thomas C. when he was dating a woman. When asked about the connection of bareback pornography and behavior he disclosed the following:

> I definitely think it’s increased behavior only because for instance, I got into this discussion with an old girlfriend of mine, who out of nowhere wanted me to cum over her face. She wanted it because she had seen it in a porno, and now I know
that that’s something that she’s majorly into and what not. (2014, October 10, Interview)

While this is a disclosure about pornography from a straight perspective, this revelation brings up an old debate about whether or not pornography leads to behaviors performed by those participating in the films. In fact, this debate extends well into media effects and advertising. How much do we know of what causes us to behave in particular ways? At best, all we have are correlations when understanding these two phenomena. In an article by Stein, Silvera, Hagerty, & Marmor (2012), they found that of the 851 participants in non-monogamous relationships 77.2% viewed UAI (i.e. unprotected anal intercourse) pornography and, of those viewing this type of pornography, 42.6% of which were the insertive (i.e. top) participant and 38.9% engaged in receptive (i.e. bottom) unprotected, bareback sex with another partner. These actions were all performed three months prior to the research being conducted. This research of course does not suggest causality but it certainly shows a correlation and it reflects the research discussed in chapter three of this document with regards to bareback pornography.

Pornography will be discussed at more length in the medical and sexual communication theme of this chapter but it is important to note that what Gay Men see and consume from a bodily perspective tends to be a reflection of bodily desires, fantasies, and sometimes our behaviors. Paul summarizes such phenomena by stating:

I guess part of how I think about it is that pornography exists in this weird space between the real and the fantasy. Right. I could see why people would wanna watch pornography that does not remind them about disease and the specter of
death frankly. Is that still part of what a condom can represent for people like it reminds them? Okay. That’s safe sex. Why do you need safe sex? You need safe sex cuz there’s a disease. What does disease do? Why are we afraid of it? The almost of fantasy of wanting to imagine a world without the need for safe sex, right, where barebacking is just normal and fine and poses no risk, but of course, that is a fantasy. (2013, June 26, Interview)

The dilemma suggested here by Paul is one where our bodies can roam freely and experience the pleasure of sex and sensation while at the same fearing our bodies flirting with disease and contamination. Pornography, especially bareback pornography, places our bodies between a battle of what we desire and fantasize (and sometimes may practice) and what we fear in our bodies.

Another participant went as far to discuss how he likes to watch bareback pornography and mimic the bodily movements and behaviors of the performers. Luke states:

Yes, I do watch pornography, and I do pay special attention, a lot of times, to the bottoms, and like to watch—What are they doing? Where's that foot when they're trying to ride here or this or that?—and then emulate them—[laughter]—and extend. (2013, September 9, Interview)

Luke’s special attention to bodily placement in pornography and his mimicking of what the performers are doing is evidence to suggest that pornography shows a sense of embodiment among those who consume the pornography. Burke (2003) seems to capture the disclosures by Luke, Paul and Charlie by writing:
Whatever the possible range of incidental readjustments, DUPLICATION is so basic to the relation between motion and symbolicity, nothing of the moment seems quite complete unless we have rounded things out by translation into symbols of some sort, either scientific or aesthetic, practical or ritualistic. Sex is not complete without love lyrics, porn, and tracts on sexology. The nonsymbolic of springtime are completed in the symbolic action of a spring song. (p. 154)

This idea, suggested by Burke, as well as the participants, makes an argument for pornography serving as a symbolic script within the sexual activities of Gay Men, especially bareback pornography. While it can be viewed as a fantasy by some, it seems to be a symbolic reproduction of what is consumed by Gay Men, whether they are watching it alone or with other men.

Opposite of this perspective, is what some participants consider to be the embodiment of the fantasy of bareback pornography. Ashton discusses how he separates the consumption of bareback pornography from the fantasy of the experience:

You’re sitting here with your ass open letting them in your body. It was hot, I wanted it. I always watch porn that’s bareback. I don’t know why. I just generally—I don’t know why…. There’s like a whole more like animalistic side to it I think. If one guy’s getting fucked by three or four guys and they’re all dumping a load in them, it’s hot. It’s animalistic. They all want it. Like, look at this hot, sexy thing, let me fuck this…. If I could jerk off watching two other guys fuck bareback and I don’t have to get blood work tomorrow. (2013, August 19, Interview)
Like many Gay Men, Ashton’s perspective can separate the consumption of bareback pornography from the actual participation in the sexual activity. Despite this disclosure, Ashton, as well other participants still have engaged in bareback sex with other men.

Regardless of whether Gay Men use bareback only pornography as fantasy or a supplement to their sexual activities, consuming it displays a form of embodiment not only for the performers but for the sexual reactions and/or mimicking of the viewers. Whether it is the natural feeling, the connection and/or the flirtation of risk when practicing bareback sex, it is a powerful embodied activity for nearly all of the participants even when they consumed pornography dealing with the activity of barebacking. To an outsider, many, including some within the gay community, in addition to all MSM who practice bareback sex, may look at or hear about this activity of desire in the gay community, and ask why are men putting themselves into such danger when they should be educated enough to understand the dangers that barebacking brings. Douglas (1966) provides some insight into possibly navigating such a predicament:

I suggest that many ideas about sexual dangers are better interpreted as symbols of the relations between parts of society, as mirroring designs of hierarchy or symmetry which apply in the larger social system. What goes for sex pollution also goes for bodily pollution. The two sexes can serve as a model for the collaboration and distinctiveness of social units. So also can the process of ingestion portray political absorption. Sometimes bodily orifices seem to represent points of entry or exit to social units, or bodily perfection can symbolize an ideal theocracy. (p. 4)
Bareback sex in the gay community is not a simple phenomenon to understand – it is loaded with multiple meanings and frameworks in the minds and bodies of Gay Men.

Medical conditions & the body. Another dimension that was evident throughout the narratives in the interviews, is that the participants discussed in depth about coming into close contact with HIV and other STDs. Nearly all of the 20 participants discussed in depth their close contact and near misses they had with HIV. Some discussed at length how they felt their body reacting from what could have been contact with HIV. Damon describes in detail about his bodily reactions and experiences:

Well the hardest one for me was the very first time 'cause my first sexual experience when I was 18 was as a top and that was without a condom. Again, I didn't know anything about—and nobody really knew the difference then between—risk factors between top and bottom. I just knew this was a really, really hot guy and it was my first sexual experience. He wanted me to fuck him without a condom, which I did. I'd had no reason to think he was positive and I somewhat kept up with him, but you know, no reason to think he was positive. Nevertheless, the horror and the fright—and it was only one time, but the horror and the fright of that one time kept me paralyzed with fear for the next year-and-a-half. This was in 1990, '91. I would check my arms, my legs constantly to see if I had KS lesions, any new spot—so any new freckle, any mark was--- panic. I'd be in yoga and I'd see a mark and I'd be panicked like, “Oh my God, I'm gonna die….” I'd get a sore throat or I'd get a cough or I'd have a night sweat. I'm like, “Oh my God, this is it, I have AIDS. I'm dying.” The fear finally got so bad
after a year-and-a-half that I was just like, “I have to find out because not
knowing now is worse than if I did know. At least if I know I'm gonna die, then I
know I'm gonna die.” That's what AIDS meant then. Then, if it turns out I'm not
positive then it's like, “Okay, I can just fucking let go of this.” (2014, January 16,
Interview)

Damon’s reaction to potentially acquiring HIV and constantly checking his body for the
evidence of the disease was a constant behavior in his life (until he started taking PrEP).
His reaction to little changes in his body is no different than other participants. Paul
shared a similar experience:

Right. If you’re not feeling well like you have a sore throat that won’t go away,
that the mind instantly goes to, “Oh, my gosh. Could it be HIV?” You know
something like that. I’ve definitely experienced that not always rationally. (2013,
June 26, Interview)

As a gay man, I can also relate to the experiences described by Damon and Paul. Every
swollen lymph node, cough, sore throat, fever, weakness, etc. always raised the inevitable
question in relation to the health of my own body. Those experiences, like those of the
participants, would always lead me to the clinic for an HIV test.

Theses narratives are evidence of how the bodies of Gay Men speak to them – no
matter how irrational it may seem from within or from others. The process of these bodily
reactions is linked back to that specific behavior(s) and/or that one (or multiple)
encounter(s). Some HIV scares are sometimes beyond the bodily surface but are rather
real and frightening. Brandon shared such an alarming experience:
The time that I have ever had a worry, years ago, probably back in 2005, I was called by the Board of Health saying that someone that I was in contact with had become positive, that I had to come in for testing. I guess that’s the one time where it goes to your mind of like, “Do I have it,” or, “Is there a time that it came through,” because I didn’t know the person. Not until maybe about a year-and-a-half ago I found out who that person was….We’re talking about maybe eight years or seven years not knowing who it was. Then you change your mindset of who you’re playing with or who you’ve played with beforehand, because you don’t know if it was them and they are just not saying anything or whatever their situation may be. No matter if you’re safe or not, it’s still that 20 minutes of nerve-racking. They don’t tell you any information about it, but they will tell you that, “Someone in your past sexual experiences became positive. They were able to tell us what your age was or around your birthday, where you lived, enough description about you for us to find you, or if he had your number to find you.”

(2014, February 6, Interview)

Brandon’s experience, while he did not notice changes to his body and attribute it to HIV, his circumstance and scare became very real to his body and what possibly “could have been.” Luke’s experience is not different from Brandon’s and the other participants as he too had an experience where he became very sick and he thought the inevitable:

I think I was more scared then, probably also because, again, of the uncertainty surrounding the whole thing, but I do remember a time distinctively when I lived in Fort Lauderdale. It was after I lived in Key West. I had left that job bartending,
I moved back to Fort Lauderdale, cuz I had lived in Fort Lauderdale, then moved down to Key West for a years and bartended there, and then I moved back to Fort Lauderdale. That's when I opened the restaurant. I opened the restaurant with two other people. It was a gay restaurant. There was a time—there was a period where I one day—I was sort of seeing somebody, probably the one great love of my life, but he was not completely giving back everything I needed—He was living with me. One night he didn't come home, and I was so sick that night. I couldn't sleep, and I was sick. I was sick. I couldn't sleep. I was so sick—I thought I was gonna die—that I actually got up and called a cab and had this cab take me to the hospital to the emergency room. That was extremely scary for me—that whole incident, especially because I knew he was fucking around all over the place. I didn't really think I was gonna die that night, but—Yeah, I thought this could be it. (2013, September 9, Interview)

Again, as evidenced by Luke, circumstances, as well as bodily reactions and processes, lead participants and many Gay Men to think that it all adds up to an HIV-positive diagnosis. Similar to Brandon’s experience, Thomas C. also experienced a scare in which a girl from his sexual past disclosed that she had contracted herpes. As a result, he was tested and found that he was negative. These close encounters between the participants and their bodies reflect that their bodies are also “on monitor” or surveillance for HIV and STDs – whether symptoms show or people from the past call to disclose their status.

In addition to bodily reactions that could have resulted in HIV, participants also discussed other bodily encounters that they experienced in the form of STDs. The other
health problems and STDs included syphilis, hepatitis B, gonorrhea, scabies, and crabs. Additionally participants reported an anal fissure and colon cancer. While these are not necessarily STDs, they could have resulted from an STD. Margolies and Goeren (2009) reported that “Among men who have sex with men (MSM), and especially HIV-positive MSM, the incidence of anal cancer is significantly more prevalent and increasing annually” (p. 1). Anal fissures, while not directly related to STDs need to be treated carefully as they are an opening/tear in the anus which could raise the risk of acquiring HIV and/or other STDs. According to the Cleveland Clinic website, anal fissures can also be caused by anal sex. While colon cancer and anal fissures are not STDs per se, they are directly related to gay sex and health.

While the above discussion focuses on one’s own body, one participant, Christian, described the observation of the bodies of others and his reaction to what he interpreted from reading those bodies:

To me, to have sex with another man meant that it was very possible, if not likely, that I was gonna die. That carried over. It affected a lot of the ways in which I was or was not comfortable. More specifically, it probably made it to be very uncomfortable. For instance, if I was hooking up with a guy who I didn’t know, or if I did know, for that matter, who was thin, and if I could feel his hip bones, to me, that told me that he was ill. Right? Skip five years later, or six years later when I was in my first long term relationship, which was about two and a half years. I also remember being—so this would have been in 1996-ish, or ’07, maybe in ’08. I remember with my first long term relationship, the guy was
Mexican. He has what I have come to understand is common birthmarks for Mexican men. To me, I thought his birthmark was an AIDS sore and it was a significant disconnect for me, and it caused arguments. I’m about to fuck him and I would see it, and I think there was a while where I believed him, but I didn’t know if he knew it, if he knew his status. I just was in doubt. (2013, November 21, Interview)

Christian’s worry over acquiring HIV from observing the body of another gay man is not something that is out of the ordinary. For one, humans read and observe other each other’s bodies when it comes to describing, loving, fearing, and wanting another person’s body. This of course does not exist in isolation – it comes from a context or an understanding as we try to assess desirable from undesirable bodies. Christian elaborated on this experience:

I think that’s from coming out when I did and what we knew and didn’t know.
My coming out on the family side was very positive, but just personally with—it was a different time then. I still do not believe I’ve watched Philadelphia all the way through. Because, for me, it was contextualized in that time, even though the parts I’ve seen have been incredible….Yeah, I didn’t wanna see myself in that.

Sick. (2013, November 21, Interview)

I too can relate this as I watched Philadelphia (Demme, 1993) growing up watching how HIV can devastate and destroy a body. To me, it showed how one wears HIV on their body. Observing other accounts of people with HIV can make one, especially a gay man, constantly see HIV in other Gay Men. Brouwer (2000) discussed the idea of observing
bodies and attributing HIV to other Gay Men through trick exams and nonverbal vernacular. Specifically, what Gay Men see and touch on other Gay Men can cause them to think that their sexual partner is HIV-positive.

The notion of looking healthy by examining the bodies of other Gay Men for HIV status was questioned by Louis. He challenged the idea about looking healthy through bodies:

I do think that young men in particular will see that and they’ll think that it’s okay. If they really thought about it, they’d realize, “Well, I am taking a risk here.” The biggest fallacy, I think, that people fall under is that, “Well, he looks healthy.” What does that mean? You don’t know what that means. What does it actually—he looks healthy. Okay, yeah, but he could have HIV. He could have whatever. I’m not saying that there’s a stereotype or that you can tell someone who has HIV; but you should treat everybody that way, really, as far as I’m concerned, to be safe. (2013, October 17, Interview)

Whether Gay Men misread or read other gay male bodies correctly or incorrectly, participants have described how they look at bodies and assess health. It is as if the gay male body is a map filled with a history that is interpreted by others. Crossley (2004) articulates this idea by stating, “health-related behaviours are inextricably connected to the social and economic structure of society insofar as contradictions between ‘production’ and ‘consumption’ are inscribed on our individual bodies, and more generally, on the ‘social body’ of which we form a part” (p. 240). The ideal, healthy body
is the ultimate aim in society even though many people place their bodies at risk, especially in terms of HIV and STDs.

**The meaningful body.** This theme, I believe provides a lot of insight on the gay male body but it only shows a small glimpse within the phenomena of gay sexuality and health. Grosz (1994) states that:

No person lives his or her own body merely as a functional instrument or a means to an end. Its value is never simply or solely functional, for it has a (libidinal) value in itself. The subject is capable of suicide, of anorexia (which may in some cases amount to the same thing), because the body is *meaningful*, has significance. (p. 32)

Barebacking, HIV testing, and other gay health issues are more than just biological or sexual phenomena that are placed on the body. Instead, from the narratives of the participants, these phenomena are loaded with deep, yet conflicting and competing meanings. Specifically, all of the participants knew the risks associated with barebacking yet still practiced it and provided in-depth and complex meanings for why they embody the sexual practice.

Their practice fits within into Grosz’s (1994) first argument for a study of the body where she argues that scholars should get away from the dichotomous idea of mind versus body. An outsider reading this dissertation may resort to the logic that prevails the mind with regards to why would Gay Men want to engage in risky, unsafe sex. Left out of this thinking and logic is how the body is central in navigating and making sense of
complex meanings that cannot be articulated from logic alone. The distinct and exclusive
categories of mind and body still are pervasive in how scholars approach problems.

As Grosz (1994) has noted, “In short, bodies, individualities, are historical, social
cultural weavings of biology” (p. 12). The risk of barebacking and its potential risks and
dangers (i.e. HIV), coupled with advancements in HIV treatment (which resulted in
various forms of HIV optimism), has come full circle since the beginning of the
HIV/AIDS crisis. The gay male body carries the long history of HIV within every sexual
encounter even if PrEP is used because it is intended to prevent the virus. Without PrEP,
HIV is also carried within the gay male body as a risk because barebacking can result in a
positive diagnosis. Regardless, HIV is always present within the gay male body because
it is built into the culture and history of gay sexuality.

Summary.

The bodies we witness through performance
Are here, in search of homes through asylum,
A safe place to piss-shit, and trans torments
Begone. To walk and suffer in silence
On stage, on trail, in voice and deed, to speak
With rage and calm: The words can eat afresh
And act anew. The body’s guts will leak
In public places, become putrid flesh
Yet thrive, again, and demand some control
Over private acts and public view. Choice.
How do we assert the strength to extol

A performance of virtue, bliss, vice, voice?

Engage. Touch yourself. Feel skin. We exist.

Bodies know. Bodies feel. Bodies resist.

(Corey, 2013, p. 285)

This journey of the gay male body, while incomplete, through the eyes of participants, sheds light onto some of the numerous issues associated specifically to the gay male bodies as noted in chapter three. How the gay male participants in this first theme perceived their bodies in relation to barebacking, HIV testing and through various medical conditions show that the gay male body is one marked with unique experiences, challenges and complexities that are not necessarily associated with other bodies. The above poem by Corey (2013) artistically conceptualizes the performance of complex bodies and how we navigate and experience the world through our bodies. Finally, Zander seems to capture all of the above complex dimensions within this theme of embodiment in the following narrative:

Yeah. I think that—I mean, it feels good. I mean, it really does. I mean, when you’re not—when you’re using a condom, I mean, it’s exactly what—it feels exactly—unless you get—you need some expensive, good lube to make it feel like— anywhere near what it’s like to be barebacking….Then you’re fine. I don’t know. It’s just like the skin-on-skin contact. The heat. The human contact. It’s just for me, and then it’s also that emotional knowledge that you and this person are having this connection. It’s a physical connection that you can’t really
experience in any other way. It just is—it turns you on. It turns you on. It feels
good. Turns you on. Even the danger of it is a little bit sexually arousing. It’s
like—You’re breaking the rules. It’s like people who are skydiving. You’re living
on the edge. It’s like a little bit of an adrenaline rush. It’s not like jumping out of
an airplane because I’m sure that’s—I’ve never done it. I’m sure that’s—that’s a
crazy adrenaline rush. It’s just you’re breaking the rules. You’re living on the
edge a little bit. You’re doing something you shouldn’t do, and you’re putting
yourself at risk. You know that it’s wrong, but in the moment, it’s just either the
lust. [Laughter] I mean, it happened. Yeah. I mean, I know when I first moved to
the city, I went crazy hooking up with a lot of people. You move to the city, and
it’s fabulous, and there’s—it’s bright and shiny, and there’s so many things to
play with. It’s fun to go out and get drunk and be gay and fabulous.
Then you meet someone. You go home. You’re either drunk, and you have
unprotected sex. Sometimes it’s like unprotected sex where you start having sex,
and you’re like, “Put on a condom.” Then, you’re like, “Okay. It was not really
unprotected sex,” but it’s still unprotected sex. I’m not sure, but it’s something
that I’ve become more and more conscious of after living here for a while. Once
the glamor of the city wears off, you’re like, “Oh, what am I doing to my body?”
Especially, mainly being the receptive partner in these types of sexual
relationships, you are more at risk of contracting something from someone who is
fucking you than you are of—you could fuck an HIV-positive guy. You could top
him. You’re way less at risk of contracting something than if you are a bottom
and someone is fucking you because you could have an anal fissure. You could have a little, tiny cut. Things are—you could have anything. Just like a little bit of semen gets in there. You never know. It could—it’s just a rough world. (2013, July 5, Interview)

Based on Zander’s apt summation of central dimensions of the body theme, it can be concluded that the gay male body remains a contested site of complexity, disruption and conflict. Navigating such issues is not easy and the next theme, which is surrounded by medical and sexual communication, is an extension of this theme’s complexities and intricacies of the gay male body.

**Theme #2: Medical & Sexual Communication & Knowledge**

The second prominent theme evident in the interviews was a presence of medical and sexual communication and knowledge. Obviously, the entire interview centered around a dialogue of sex and medicine (i.e. HIV prevention and PrEP) but participants disclosed many specific elements of medical and sexual communication in a variety of contexts. There are four prominent dimensions within this theme that will be discussed – they include: the participants’ knowledge and perception of their formal sex education, their informal sex education, their sexual health communication with doctors, and their communication with other Gay Men about HIV.

**Formal sex education.** The first dimension within this theme of medical and sexual communication has to deal with the extensive discussion I had with participants regarding their sexual education. Perhaps one of the reasons for a lack of understanding, when it comes to knowledge about HIV prevention and understanding the current status
of HIV in our culture, is a result of sex education that many of the participants discussed in their interviews. They offered diverse perspectives and experiences regarding their sexual education at a young age, specifically in high school. Philipe shared his experience with sex education:

I don't really know. I would assume that it probably came up in that fake sex ed that we had in fifth grade cuz they do like, "Here's how the sex stuff works, and then here are all of the diseases that you can get if you're having sex," and all that type of stuff. I'm sure that they talked about HIV/AIDS and some point. I don't know though the first time that I really started thinking about it. (2013, November 23, Interview)

In addition to Philipe’s experience, Zander shared a similar experience but he remembers educators specifically talking negatively about sex. He disclosed:

I mean, they tell you about it in the seventh grade in Health Education. They tell you it exists. I think that—I mean, I think you’re aware of it. Then, you know, they have these—in your Health class, they have these scare tactics like, “Oh. You have sex. You’re gonna get AIDS. You have sex. You’re gonna get—you’re gonna get pregnant. You have sex. You’re gonna get chlamydia or gonorrhea….” I think that—I don’t think that they purposely tried to do scare tactics, but they were very open with saying like, “If you have sex, this could happen.” I think that as a young, impressionable person, that you automatically associate like, “Oh, my God. If I have sex”—you really get paranoid. Human beings are a paranoid existence. It’s like we are all hypochondriacs thinking there’s something wrong
with us, and as a seven-year-old—rather, as a seventh grader, a 15-year-old kid, you’re like, “Oh, yeah. That’s gonna happen to me.” You’re 14 years old. “Oh, my God. I don’t want”—they describe in detail what happens. It’s just like, “Uh.” (2013, July 5, Interview)

When I pressed Zander if the sex education experience he received was negative overall, he said it absolutely was a negative experience. These negative conversations about sex at a young age can potentially give young people distorted views of sexual health, especially when it comes to protecting themselves from STDs and HIV.

Mark’s encounter with his sexual education is similar to other participants but his experience was an optional one. Mark discussed his experience in the following narrative:

From what I remember, I think they did have a health class, but it was an elective. It wasn't something that was mandatory, which is kind of interesting because you have the arts and—I love the arts, but I think also health should be something that should be mandatory just because—I remember in high school, everyone's, like, "Oh"—the rumors and whatever—"this person is hooking up with this person" kind of thing. I think it's something that shouldn't just be an elective. Even though it was an elective, I didn't hear about it. Classes that I took that were electives, I would take because I had friends that were taking those classes, and I would hear about those. I would hear good things about those classes, but I never really heard anything about a health class, so I never really took any health classes during high school, which is sad. (2013, August 14, Interview)
In Mark’s case, and the experience of his high school peers, only a limited number of adolescents received proper sexual education if they wanted it. While the participants were all above the age of 20 when these interviews took place, there is current research to suggest whatever sexual education young people are receiving, if they are receiving it, is poor overall. According to the CDC (2014d), of those surveyed, 46.8% of high school students had sexual intercourse, 34% had sexual intercourse during the previous three months and of these, 40.9% did not use a condom last time they had sex, and 15% had already experienced sex with four or more people during their young life. In addition to these statistics, the CDC reported the following:

An estimated 8,300 young people aged 13–24 years in the 40 states reporting to CDC had HIV infection in 2009; Nearly half of the 19 million new STDs each year are among young people aged 15–24 years; More than 400,000 teen girls aged 15–19 years gave birth in 2009. (paras. 8-11)

Alarmingly, these statistics do not stop here. It was also reported that 25 percent of the new 50,000 yearly HIV infections are youth aged 13-24 (CDC, 2012d). In that same report, among the 83% of males in this category, 87% are a result of MSM. Furthermore, in 1997, 92% of youth were taught about HIV infection but that number dropped to 84% in 2011 (CDC, 2012e). These current statistics reflect a need for better, comprehensive sex education in our public schools. There is clear evidence that more and more young people are being affected by STDs and HIV and show a high need for better education.
For some participants, their education about HIV, and sex at a young age, is more personal. Harold shared a story about how there was a teacher in his school district that had AIDS and a made-for-television film was produced about his life:

Yeah. Yeah, it was in school, but then also, a teacher at the school—I think one of the teachers had a twin brother. They were both gay, and the other one died of it— when they were in the school. It was kinda like a big thing, and that was brought up a lot, cuz they were very loved teachers and people in the community.

(2013, September 4, Interview)

When I pressed Harold for details, he was not able to recall all of the ideas but I did find that the film was titled My Brother’s Keeper (1995) and starred John Lithgow who played both twin brothers. Thomas J. Bradley was the brother who had AIDS. Mr. Bradley, a teacher in the Bayport-Blue Point School District on Long Island, was the district’s union president and was Teacher of the Year in 1986 (Ketchum, 1990). He kept his diagnosis a secret for years before finally disclosing it to others. Surprisingly, considering the times, the community and school rallied around Mr. Bradley, especially when he was denied insurance coverage for a needed bone marrow transplant. Thousands of people in the community helped to raise money for his cause. Unfortunately, he never saw the film about his heroic fight as he passed away in 1991 (Ketchum, 1995). According to Ketchum (1995), the film, “It is not a story about AIDS. It is a story about love.”

This personal connection to HIV/AIDS is an incredible narrative to encounter at a young age. This obviously helped to shape Harold’s idea of how to perceive HIV. More important, was the leadership and community engagement embracing Mr. Bradley that
helped to de-stigmatize a virus that alienated people at the time. In addition to Harold’s early experiences with HIV/AIDS, being in a serodiscordant relationship has also given him a different point of view of HIV that many of the young participants could not articulate. He noted about being in such a relationship:

Right, yeah. It was kinda like, “All right. We’re in this now, so let’s just”—and there was a few articles that we’ve come across recently that were saying sort of like, if the one person is poz and healthy and on their meds and undetectable, you are pretty safe to say that—there’s gotta be many other things going on to get you infected from that situation, sort of. If one person is really takin’ the—making an effort and on meds and stuff, you should be all right if—It’s part of our nature, is—he is a teacher, and I’m a librarian, so research and finding out things, and like—yeah. (2013 September 4, Interview)

Harold’s unique experiences, compared to the other participants, has helped him to manage and navigate all of the uncertainties involved with being in a serodiscordant relationship and to remain HIV-negative. Perhaps other participants would have different views of HIV if they knew more Gay Men who were HIV-positive, dated them, had sexual encounters with them, and/or talked about the virus with them.

Informal sexual education. The second dimension within this theme was how pornography played a role in providing knowledge about sex among Gay Men. Burger (1995) argues that “Gay pornography seemed to me to be a warehouse of our cultural heritage and memory, as well as an important site for the production and modification of this heritage and memory” (p. x). This dimension is different from how pornography was
discussed in the first theme; that theme was about bareback pornography, while this
dimension focuses on pornography as informal education.

In addition to the formal education, and lack thereof, many of the participants
discussed pornography as a form of sexual education. When I asked participants if they
believe bareback-only pornography contributes to or increases bareback behavior within
the gay community, their responses varied from absolute certainty to doubt. Matt
disclosed the following:

If people are watching porn, and they're exposed to more so of a certain type of
porn, that's gonna be stuck in their head, and they're gonna wanna do that and
recreate that in their life when they're having sex with someone else, more so than
the porn that they're not seeing—the other style of porn maybe, whatever it be.
(2013, August 27, Interview)

Matt’s conviction about Gay Men consuming bareback pornography suggests that a
direct relationship exists between watching such films and the sexual behavior of Gay
Men. Like Matt, Brandon believed the same phenomenon, “Well, I think that it sends the
messages that it’s okay, and if these guys can do it, then anyone can do it” (2014,
February 6, Interview). While Matt and Brandon both believe that the consumption of
bareback pornography contributes to that form of sexual behavior, Matt believes it does
not entirely contribute to an increase in sexual behavior. He stated, “I don't think 100
percent, but I think it does reflect a portion” (2013, August 27, Interview)
Zander, who tends to agree with the previous participants on bareback pornography, provided the following explanation as to how bareback pornography contributes to bareback sex:

I think that it changes people’s perspective and makes them want to have bareback sex. I think that the reason why it’s become so prolific is because I think people want to have bareback sex. I think that part of the reason why bareback sex is so enticing is because of the danger of it. I don’t wanna say it’s the thrill, but it’s just—it feels—it really—truthfully, I think it feels better, but there’s a connection whenever you’re—there’s just a physical connection there that you’re having that is like—I don’t know how to put it into words. It’s like a level of trust that you’re putting in that person. It’s just like—I don’t know. There’s something about it. It’s just really—it’s just really good. [Laughter] I mean, but the thing is it’s like that’s the importance of having the willpower to not do that or to want to be in a long-term relationship, a long-term monogamous relationship to keep yourself safe and to keep others safe. I think that with pornography, some people, yes, I think are probably taking that as, especially young men, young Gay Men who watch pornography. I mean, this is where young people learn what sex is, through pornography. For people my generation, I think that the reason why there is this porn is because there is generations and generations that have been taught that bareback sex is no, no, no. You always want what you’re told not to have. This is their fantasy escape. They may not actually be practicing bareback sex. They may be using this as their outlet for that. I mean, for me personally, I like
watching bareback porn. I prefer it over porn with condoms. I don’t practice bareback sex on a regular basis. I mean, like I said, it’s happened in slip ups, but I don’t practice it because I’m conscious enough of my body that I don’t wanna put myself at risk for that. I don’t want the anxiety of every week being like, then you have to get tested a lot, and then you gotta pay to get tested a lot. Thank God we have OraQuick now. (2013, July 5, Interview)

Zander’s long explanation, along with the disclosure of the other participants, is very telling in regards to how they perceive other Gay Men viewing bareback pornography; however, not one of the participants reported that their own consumption of bareback pornography contributed to their practice of bareback sex. This is an interesting phenomenon in that they all reported watching bareback pornography, practiced bareback sex but did not believe the two were connected to one another in their own sexual activity. Overall, it is a difficult argument to make. At best, there may be a slight correlation between these two phenomena but it is still unknown whether one leads to another.

Regardless of whether or not there is a connection between viewing bareback pornography and practicing bareback sex, it is possible to argue that bareback pornography, as well as other forms of pornography, acts as a form of education in regards to sexual practices and habits. As noted in the previous theme of the body, it was stated by many participants that watching the bareback sexual acts of men in pornography was a turn-on and some went as far to say that they tried to reenact those practices.
While some believed that bareback pornography contributed to the increase of bareback sex, other participants were not so sure. Luke does not believe that consuming bareback pornography necessarily contributes to an increase in behavior. He states:

No. I don't even think it's that. I just think that when you're engaging in sexual activity, you do what you're gonna do. I don't think watching—I don't believe that the media of any sort was ever that way where they just—it's not like some hypodermic needle infecting us, and we all become Stepford children and do whatever they tell us to do….I don't really believe that anyway. I think, yeah, for some people, it might be, "Wow. That looks pretty fun, pretty good. I wanna try that." There might be some change-over because of it, but I don't really think it is—no, I don't really think it has that big of an effect. (2013, September 9, Interview)

PG argued along the same lines, “Everybody makes up their own decisions of what they want to do. In the end, you make your—you decide what you want to do.” While some participants did see a direct connection between these two phenomena, others did not.

While it is unclear, and may never be determined, as to whether bareback pornography leads to an increase in the behavior of bareback sex, the amount of time devoted to watching, consuming and embodying bareback pornography does fulfill a curiosity especially for those who wish to inquire about the practice. Burger (1995) writes:

Gay male porn merely reasserts that which gay men already know. But it always helps to know someone else is thinking and feeling the same things. In this regard,
gay porn works in two ways. It reflects gay sexual practices, and, at the same time, constructs new erotic trends….That is to say, pornography, as a visual means of representation, usually elicits a physical response (orgasm) from the viewer, and therefore has the potential to educate the viewer about his body’s sexual possibilities. (p. 22)

Whether it is gay bareback pornography or any sexual curiosity among people, there is a sense of education that pornography provides, whether it is for the novice virgin or someone with many years of sexual experience.

While I did not probe or interrogate why participants’ watch porn, how much of it or what genre they prefer, I was curious as to their consumption of bareback pornography as it relates to the experience of bareback sex and HIV risk and prevention. The ideas I elaborated on within the context of sexual education in a formal secondary school setting and through pornography provides interesting evidence as to why Gay Men are not embracing HIV prevention measures such as condoms and new, innovative prevention measures such as PrEP. Furthermore, the limited, vast and diverse examples of sexual education provided by participants sheds light on why PrEP can be a difficult prevention measure for Gay Men to embrace.

Within this theme so far, even coupled with poor, or the lack of good, quality sexual education, HIV is still the winner today. With 50,000 new infections each year, with no evidence of slowing down, this recipe allows HIV to win and creates a demand for more visibility and awareness. Harley noted in his interview that “Maybe they have to have another march and build another afghan—It’s just not a pressing issue anymore. I
don’t see it on the forefront of anywhere. It’s not in the forefront of any men’s mind anymore.” He went on to argue that the AIDS Quilt provided that sense of visibility that Gay Men today need to see and experience.

When trying to understand all of the narratives from the participants, when it comes to their understanding and education of sex, it seems as if participants learned about sex, STDs and HIV prevention from more informal settings (i.e. not in a school setting). Whether it was pornography or personally knowing someone who is HIV-positive or actively seeking information for oneself, participants seem to gain more information from the outside of a formal setting of a classroom. My personal experiences are not much different. This could ultimately be detrimental to the advocacy of PrEP especially since, as I will discuss later, there is so much conflicting information about this prevention measure.

**Sexual health communication with doctors.** Another dimension within this theme is the interaction and communication that participants had with their doctors and health care providers. Participants such as Paul and Philipe disclosed that they always talk to their doctors about their sexuality, getting tested, risk of HIV and STD transmission, and overall prevention, excluding PrEP. One item that was interesting about this dimension is the gender and sexuality of the physician that some participants discussed. Zander’s doctor is a gay male which has allowed him to openly communicate about his sexual practices as well concerns related to getting tested. Zander disclosed:

> Yeah. He’s very accepting. He’s a great doctor. He’s gay himself. He gets it. I don’t tell him all about my sexual escapades. I give him enough information that
he can take care of me. I tell him, “Oh, I think I need to get tested.” He’s like, “Oh, have you been having sexual intercourse? Have you been having sex?” I’m like, “Yes.” “How many partners?” I’m like, “More than”— “Enough.” (2013, July 5, Interview)

By having a physician who is gay, this allows Zander to openly discuss his sexuality and sexual practices without judgment and criticism. Louis’s experience was quite similar but with a physician who was female. He noted:

It was funny because I had changed insurances so I went with a new doctor, a female doctor. She was actually one of the first doctors that sat down and talked to me and asked me questions about my lifestyle. Yeah. Honestly, I don’t remember the date, but I would have to say maybe around 1990, something like that. I explained to her that I’m a gay man and have sex, am active. Then she recommended that in addition to being tested for hepatitis that I be tested for HIV. We did the blood test at that point, and it was a very scary two weeks. (2013, October 17, Interview)

Louis’s recalled this experience from the 1990s when many healthcare providers were trying to navigate through HIV prevention and testing, but the candid, open conversation about his sexuality allowed his doctor to ask important questions in regards to health that aligned with his experiences as a gay man. Harley has experienced similar, positive episodes when getting tested for HIV. He regularly visits Planned Parenthood where the staff is familiar with HIV and STD testing, especially for Gay Men. Harley reported that
in addition to receiving testing and counselling for HIV, he was also encouraged to be tested for other STDs (i.e. gonorrhea, chlamydia, etc.).

While some participants have had positive experiences communicating their sexuality, sexual practices and experiences with doctors, other participants struggled with disclosures of such personal information. Melchior discussed his reason(s) for not discussing his sexuality and practices with his doctor:

It's weird to go to talk to someone and be, like, "I think I was exposed to HIV through anal sex or something." Just as sex in the hetero community is a very taboo subject, I feel like talking about sex in a health-type setting in the gay community is a very taboo subject. (2013, August 6, Interview)

While other participants may not have felt the same way, Melchior’s disclosure shows evidence that talking about sexuality and sexual experiences to a doctor can be difficult and therefore is not disclosed. As noted earlier in this chapter, Melchior also prefers to use the take-home OraQuick test so that he does not have to undergo testing in a medical setting. Jack’s experience provides one reason for a ‘home test’ choice:

At my doctor's they have a sheet of paper and it's laminated, so basically with a dry erase marker, you mark off what you want. It's basically a menu of—chlamydia, gonorrhea. Did I get my Hep A shot yet? All these. Then sometimes it's not all the way wiped off, so you see what other people wrote before you. You hand it to them and they look at both sides and it's just—terrifying. (2013, October 15, Interview)
Instead of having a conversation with the doctor or nurse about his sexual practices and/or symptoms, Jack has to fill out a form that lists multiple STDs which can be intimidating because it shows what the body can be subject to when one engages in risky sexual behaviors. Basically, it makes his risks a reality when it comes time to enter into the medical encounter.

Mark provides another example in talking about the anxiety that is experienced when he has to come out to a doctor about his sexuality. What compounds his anxiety is the turn-over and change in physicians. He recalls his experiences in the following narrative:

I think it's just—for whatever reason, I feel, I guess, some anxiety just asking the doctor, "Can I have a blood test?" It's really weird about this. I went to the same place, but we've been having different doctors. One retired. The other one—I guess he left the practice. There's a new doctor now. It's the same practice. The same people are working there, but it's just a different doctor. I guess a different head doctor person that owns the practice. (2013, August 14, Interview)

Mark is unique in that he is not “out” to his family and some friends so disclosing his sexuality and sexual practices to a new doctor, who is a complete stranger, brings anxiety and apprehension to a space where medical information needs to be disclosed in order that appropriate prevention and counseling can be delivered.

I have to state at this point that I have used disclosure of sexuality and sexual experiences as two separate phenomena even though they are interdependent. As a gay man, I remember the first time I saw a doctor under my own health insurance. The doctor
asked if I was married and then directly jumped to ask me, “Are you gay?” While I did not expect the question, and was caught off guard, I was relieved when he asked the question that I would have otherwise not disclosed. I disclosed to him that I am indeed gay and he then asked about condom usage but then left the conversation and never offered advice or a plan for prevention. While that was the most in-depth conversation I ever had with a doctor (at that point in my life) with regards to my sexuality, I did not realize at the time that much more should have been discussed in relation to sexual practices, prevention, risk, and counseling when it comes to the various risks and precautions that I need to think about as a sexually active gay man. It seems as if for most participants the same disconnect exists between making the leap from disclosure of sexual orientation to sexual practices and this creates a problem for the conversation to take place about HIV prevention beyond condoms, including discussion of new drugs, such as PrEP. This was evidenced by Matt when I asked if he would consider talking to his doctor about PrEP and he stated, “Probably, but I don't know. I don't think it would probably come to my mind.” It is important to note that Matt had an HIV scare prior to participating in his interview.

Beyond the conversations about HIV and STDs, some participants had a discussion with their doctors regarding PrEP. Harold, who is in a serodiscordant relationship with his partner, asked his doctor if he should take PrEP as a preventative measure because his boyfriend is HIV-positive. Thinking that his doctor would put him on the medication, he received a different answer:
He seems a bit hesitant to put me on it, just cuz he’s—we are pretty safe when we have sex, and he doesn’t necessarily want me to be on a medication that I don’t need to be on; just to put me on a pill for the rest of my life everyday as a preventive—I dunno. He’s still torn, just cuz it’s so new and there’s not that many studies. He still sorta doesn’t wanna put me on it yet, I don’t think. (2013, September 4, Interview)

This philosophy to not put Harold on medication when he is perfectly healthy was a common approach when PrEP was first introduced to the public. Since the interview with Harold, he did disclose to me that was on PrEP after he and his doctor had another conversation about HIV prevention.

Damon’s experience with PrEP was a little different. Damon, who clearly showed a high level of knowledge when it came to HIV transmission and prevention, read a lot about PrEP prior to seeing his doctor. He talked extensively about his experience when it came to how he brought up the issue of PrEP to his doctor:

If I have a positive partner and I'm on PrEP and he's on antiretrovirals, the opportunities to transmit HIV are pretty much nil. There is more statistical likelihood that I will get shot right now in the United States than actually get HIV based on PrEP use and his antiretrovirals. With that in mind, I started thinking about how do I talk about this with my doctor? Fortunately, I love my doctor and I'm usually very open with him. I wasn't that open with him about sex. Yeah, I'm healthy and I don't really see him that often. I made an appointment to see him.
and I brought him the information I had been given at this GMHC\textsuperscript{26} conference from—one of the researchers was actually at this conference and was giving out data. (2014, January 16, Interview)

Furthermore, Damon found that he not only had to educate his doctor about PrEP but had to educate him about his own sexual experiences and his wishes to want to pursue condomless sex.\textsuperscript{27} After disclosing his wishes to get on a PrEP regimen and then his sexual experiences, Damon had to further educate his doctor about getting regularly tested for other STDs. He elaborated:

PrEP offers no protection against other STDs. Again, this is why someone needs to see their doctor. In my case, I had to educate—my doctor's an AIDS specialist, but he was taking my urine to make sure I had no STDs. Right. I had to say, but I primarily receive as a bottom, so I want you to check my butt, too. If I'm—have gonorrhea, it's not necessarily going to show up in my urine because I don't top that much. It's more likely if I were to receive gonorrhea you would see it in my ass, so I need you to take samples of my ass. (2014, January 16, Interview)

This is a conversation that most people probably do not wish to have with their doctors. What is really puzzling is that his doctor is an AIDS specialist and Damon had to encourage him to conduct such tests. Damon is clearly an anomaly when it comes to the kind of interactions and communication that he has with his doctor compared to other participants.

\textsuperscript{26} Gay Men’s Health Crisis

\textsuperscript{27} Damon preferred to use the term “condomless sex” as opposed to “bareback sex.”
As a result of being on PrEP and thoroughly discussing intimate details of his sexual experiences and desires with his doctor, Damon disclosed that he is at a level of sexual responsibility that many sexually active Gay Men are not. He notes:

I had to do a little educating with my doctor about that. Nevertheless, I am so much less—let me put it like this, if I'm getting tested every four months for all these STDs, but before PrEP I only saw my doctor once every two years, I feel so much more responsible about it now. People could argue either side of that. I would say that people who are using PrEP, following the CDC guidelines, are being more responsible about STD prevention than people who are not, who may only see their doctor once or twice a year or once every two years. (2014, January 16, Interview)

Damon’s initiative to take charge of his health in both a clinical setting and in public is something that many men, gay and straight, do not do on a regular basis. There is a need in the gay community for other men to adopt a similar way of thinking – those who are willing to take initiative in health and in HIV and STD prevention. At the same time, Hayoun (2014) reported that “the medical community is largely ill equipped to help gay men make informed decisions about their sexual health” (“A meaningful dialogue,” para. 1). Also reported in that same article, Dr. Kathy Brown, who is an HIV program Medical Director in Seattle, stated that Gay Men “feel they have more control over their risk and in some cases may take less risks, because they no longer have this fatalistic thought that ‘it doesn’t matter what I do, I’m going to get infected sooner or later’” (para. 11).
For some, those seeking to get on PrEP by non-infectious disease doctors are running into problems, including stigma and prejudice. Ryan (2014) reported on the following case:

Lisa, a 34-year-old living in a major East Coast city who is looking to get pregnant with her HIV-positive boyfriend, first asked her gynecologist about PrEP. “As soon as I told her my partner was positive, the look that woman gave me was of such disgust,” Lisa recalls. “She talked to me like I was an irresponsible person, and the scum of the earth.” (Section 7, para. 10 & 11)

This is evidence of the ignorance and lack of knowledge surrounding PrEP in the medical community – not to mention the stigma and judgment associated with inquiring about an effective HIV prevention measure.

At least in New York, there are productive efforts to deal with these issues. In New York City, Demetre Daskalakis has been hired as the Assistant Health Commissioner of the Bureau of HIV/AIDS Prevention and Control. According to a *New York Times* article, which introduced him to the City, Hartocollis (2014) writes that Daskalakis is:

A wiry AIDS doctor and gay health activist, spent late nights and early mornings in the city’s sex clubs and bathhouses. There, he would strip off his leather jacket, and in his muscle T-shirt, talk the men around him into lettings him inject them with meningitis vaccines. (para. 1)

Daskalakis is not only openly gay but he proudly embraces his sexuality as he has a picture of himself in drag on his Facebook page. A person such as Daskalakis is so
important in the fight against HIV and STDs in the gay community because he brings forth high levels of credibility as a gay man who understand the culture and knows about the social complexities associated with the gay male body – he is also an advocate of PrEP. Additionally, New York State Governor Andrew Cuomo (2014) “announced a three-point plan to ‘bend the curve’ and decrease new HIV infections to the point where the number of people living with HIV in New York State is reduced for the first time” (para. 1). One of his points is to provide access and raise awareness about PrEP. These efforts show a positive move toward raising positive awareness of PrEP and HIV prevention.

This approach to health care, for Damon, the patients of Dr. Brown, and any other gay man who is able to have open conversations about HIV and STD prevention and risk, sexual experiences, and overall general health, is idealistic. It makes sense on many levels of public health and health economics but it is far from the reality of what is happening with Gay Men. Based upon the disclosures of what participants stated in the interview, it is clearly evident that there is some hesitancy and anxiety about disclosing sexual orientation, sexual experiences and desires, which promotes an honest discussion about HIV and STD prevention and transmission in a clinical setting. In Hamel et al. (2014) survey of gay and bisexual men, they found that nearly half have not discussed or disclosed their sexual orientation with a doctor and only 35% would feel “very comfortable” discussing it with their doctor. Additionally, they found that access to care is an issue to discuss HIV with a doctor. They specifically noted that “31 percent either say they don’t have a regular place to go for medical care or that don’t have a regular
physician” (p. 24). As a result of this evidence, they are less likely to have conversations centered around sexual health, especially when it comes to HIV, and getting tested.

Additionally, the conversations need to be two-way and not entirely left up to the patient but should also be encouraged by the physician. Hamel et al. (2014) reported from their survey results that 54% of their participants disclosed that their doctor’s never recommend an HIV test and that only 12% discuss HIV every time with their physicians. In the African-American community, where HIV has had a large impact, Wong et al. (2013) found that testing rates by black primary care physicians were low. Based on their research, they suggest:

That more education and training is needed to improve the communication of sexual histories during clinical encounters so that both sides are more comfortable discussing topics such as HIV testing and sexual practices in order to diagnose patients with HIV sooner and place them into care. (p. 8)

While these are not easy conversations to have between Gay Men and their healthcare providers, they need to take place to not only raise awareness about PrEP but for HIV and STD prevention and overall gay health. Since I started this project (approximately in fall of 2010) a lot has changed. Just recently, the CDC (2014e) put together a comprehensive 67-page document for healthcare providers on how to understand and prescribe PrEP appropriately.

**Communication with sexual partners.** Another dimension within this theme is how participants navigated the discussion of HIV, STDs and sexual practices with other Gay Men. In all, participants who are not taking PrEP, disclosed that they do not talk to
their sexual partners about HIV, STDs or condom usage. Matt stated that the conversation that takes place prior to meeting a partner online is a difficult one to have:

Yeah. I do, but—I dunno. It's a weird conversation cuz they don't wanna talk about not getting AIDS, and you don't wanna talk about it. If someone knows somebody, they don't wanna be, like, "Oh, I know that person that has AIDS"—you know what I mean?—cuz then you could get it from them so that you wouldn't wanna have sex with them….I think more people just wanna talk about sex. They don't wanna talk about getting AIDS, or having AIDS, or someone contracting AIDS from you if you have it. They just wanna talk about sex cuz that's what they're online for. They're not online to see if you have AIDS. They're online to have sex with you. (2013, August 27, Interview)

Many of these websites and mobile apps (i.e. Adam4Adam, Manhunt, Scruf, Grindr, etc.) are marketed as “hookup” sites that are ultimately used to make money and to get Gay Men to use them and connect with other Gay Men for dates and/or sex. PG’s experience is no different when I asked him if he talks to his partners about barebacking and/or HIV status he said “Hell no… Just do it.” The primary goal overall is to engage in and complete the sex act without thought or conversation dedicated to HIV/STD status and prevention.

All of the participants seem to have a clear understanding of HIV transmission, risk and prevention but disclosed that they did not have such conversations about these phenomena with their sexual partners. While knowledge in these areas was high, having these conversations was nearly absent from the disclosures of the participants. Zander
described this phenomenon well when discussing how he talks to his friends (in nonsexual situations) about HIV and barebacking. When asked if he talks to partners about HIV he answered:

No. Maybe talking to my friends about how it’s hot or talking about it in terms of saying, talking about a friend who’s in a relationship who was talking, thinking about having bareback sex but me talking to them about like, “You’re aware. You’re being careful.” Because I think that’s important to communicate about this kind of thing, about HIV, and I think that there is a lack of communication about it. I don’t think there’s a lack of knowledge. I think that people really do know. I think that people might act like they don’t really know what’s going on, but I think that there’s more so a lack of communication. It’s an uncomfortable conversation to have, but it’s a really important conversation to have. To ask someone that you’re randomly hooking up with, “What’s your status?” It’s such an easy question, but it can be so uncomfortable, and part of you is like, “I don’t really wanna know because I don’t wanna have to not hook up with you. I don’t wanna have to turn you down because then you’re the shitty person who’s not gonna have sex with an HIV-positive person who is undetectable.” You know what I mean? (2013, July 5, Interview)

Zander’s disclosure is interesting in that Gay Men, outside of a sexual context, talk about HIV and sexual practices such as barebacking in social situations and may give lectures and share advice with one another but in the heat of the moment the conversations are not taking place. Luke, who was in his 20s during the height of the AIDS epidemic in the
U.S., talked about how much has changed in relation to having conversations about HIV/AIDS during sexual encounters:

See, it doesn't scare me, really. It really doesn't scare me, and it's not something—to be honest, I won't even necessarily bring it up when I meet a potential sex partner. It used to be—10 years ago, 15 years ago, it was a very common practice, even for me, that when you met a potential sex partner, you discussed it. You asked each other their status, but it also didn't mean if you were positive and they were negative, or you were negative and they were positive, that you didn't have sex. Most of the time, you still did. You just took the proper precautions. Right? Today that has evolved to—I don't even care about the conversation anymore. Like I said, if they are positive and they're on meds, then fine. If they're not and they transmit, then deal with it. It's to the point now where that conversation to me is oftentimes an interaction killer, so I don't think it's necessary anymore. (2013, September 9, Interview)

Luke is approximately 30 years older than Zander but both are currently sexually active and have found that, currently, conversations about HIV and STD status are not taking place. Approximately 20-30 years ago, these conversations were at the forefront of the sexual encounter. What is interesting about these disclosures is not only whether or not Gay Men are having conversations about HIV status, but it is also whether or not a gay man knows 100 percent that he is HIV-negative, or STD-free, and whether he is telling the truth. Trust is an entirely different issue that will be discussed later in this chapter.
While these participants stated that they did not have conversations with sexual partners about HIV and STD status, some disclosed that they did have such conversations but the discussion and the actions did not line up with one another in a preferable order. Thomas C. stated this about a current experience he had with another man. He stated, “my most recent hook up is I had sex with this guy, and then afterwards he went, ‘You’re clean. Right?’” (2014, October 10, Interview). The placement of the conversation after the act is obviously too late. Again, there is a sense of knowledge and understanding of HIV and STD transmission and prevention, despite some of the bad sexual education disclosed by participants in this theme analysis, but it does not line up or parallel the act of sex itself. Harley discussed how, in his experience, condom usage and safe sex are not necessarily brought up in conversation but are advertised or stated on the profiles of Gay Men looking for sex online or through the mobile phone. He stated the following:

Anyone that says, “I’m only in safe only.” That’s crap. Because they’re in there and you’re on there. Let’s use Grindr as an example. They go, “What are you into? I’m safe only and I’m into oral.” You’re like, “Mm. All right.” If I’m horny enough I’ll be, “Okay. Come on over or I’ll go to you.” Whatever. Ninety-nine percent of the time they’re full of shit. Before you know it, they’re grabbin’ your cock and wanting you to put it inside them. You’re like, “What about that safe only stuff.” Then they’re like, “Come inside me. Come inside me.” I’m like, “Well that completely defeats—you’re only into oral you told me.” A lot of people lie about that. Rarely do I find someone that actually only does that, uses condoms. (2014, April 5, Interview)
Passion, desire, “the heat of the moment,” are all competing phenomena when it comes to discussing HIV and STD status, prevention and risk. There is obviously a large gap between knowledge, conversation and practice.

Beyond the lack of conversation, or the sexual practices not lining up with the conversations taking place, participants elaborated on why the conversation about prevention (i.e. condoms) are not discussed when engaging in a sexual encounter. Zander spoke extensively about this issue:

I mean, emotionally, for me, it’s more of a lapse in judgment first probably because sexually, it’s very stimulating, and then, after it’s already happening, it’s well, it’s already happening, and it’s a really hot moment between you and someone else. Then it just keeps going. There have been times where I’ve been hooking up with someone, and they start to try and have bareback sex with me. Stick it in once or twice, and I’m like, “Okay. You need to put a condom on.” There have been times where they’re sticking it in a couple of times, and I’m like, “Oh, my gosh. We should really use a condom” or like, “Uh,” and then they keep doing it, and just then you’re having bareback sex. (2013, July 5, Interview)

The sexual act for many participants almost always took on a life of its own. While some may believe that having a conversation beforehand would raise awareness and prevention, it does not guarantee the actual act would take place. Harley discussed how the flow can be interrupted:

I think it’s the spontaneity of it. Honestly, the way I view having sex with someone is that, I mean, rarely do I like it planned. I mean you’re comin’ over.
We’re just gonna have sex. You walk in. I mean you fall down on your knees and then you start or whatever. That is fun sometimes. For me, the reality is I like the spontaneity of you invite the person over. You’re sittin’ around having a beer, having a chat on the couch watchin’ TV for 10 or 15 minutes…. I think that whole—the condom piece or whatever I think that just gets in the way of the spontaneity of—I mean there has been recently some that I had more than one encounter with that used a condom. Three times we had the encounter. I just found it annoying. It got to the point where he’s like, “You have to get the condom. You have to get the condom.” I had to get up, get out of bed, go around to where I have them in the other room, take ‘em out. Open the fuckin’ package, put it on, get back in bed. Before you know it, it’s three minutes later. You have to restart everything again for a few minutes. I guess—it interrupts the flow.

(2014, April 5, Interview)

The conversation that may or may not take place before the sexual act is very different from what actually takes place in the sex act. There is no formula for sex – it is a fluid, flexible and sometimes a complex phenomenon that Gay Men navigate differently. Again, this could be a space for health and sex educators to discuss sexual spontaneity and how to manage and navigate this multifaceted phenomenon. Matt, who is aware of these problems in the gay community notes:

It's still a problem, but a lot of—I don't know. When you go to sites like Adam4Adam or whatever, you'll often see a lot of people—they'll just write "no strings," whatever. Then when you talk to them, a lot of times they talk about just
going at it and not really—no protection—or they don't talk about their status. Sometimes it doesn't seem like it's relevant, but it is. When you're thinking, "Oh, when was I last tested?" and you're thinking about "If I do hook up with this person?" There is that window and getting tested, and—it's just—it's a problem, but sometimes it doesn't seem like a problem at the time until you're waiting for those results. Right now, I think it's still a problem, but a lot of people just don't really see it as such. (2013, August 27, Interview)

Louis echoed Matt’s perspective but he sees it through a different lens – mostly due to his age and experience with HIV. He expressed concern for today’s Gay Men and their participation in sex with other men:

I’ve actually observed, in some of the socializing I do, where people have had unprotected sex spontaneously sometimes, without even, I guess, having a conversation about “Are you negative? Are you positive?” That scares me a little bit. It’s not just the HIV, there’s other things that are going on, but certainly with HIV. (2013, October 17, Interview)

This is a far cry from when Louis was younger and more sexually active in the 1980s and 1990s. His experience is also evidenced by the work he does working with newly diagnosed HIV-positive Gay Men. Overall, the conversations are not taking place among Gay Men about HIV and STD status and prevention.

To supplement these narratives and disclosures from participants, is what appeared in the research of Hamel et al. (2014). They found in their survey of gay and bisexual men that only 20% “often” talked to their casual partners about HIV, 12% with
long-term sexual partners and only 6% with friends. This shows, that more than 30 years
after the inception of the virus, conversations around HIV are not easy to engage. Also, in
that survey, only 37% always ask a potential partner’s HIV status.

Brandon, who takes a daily PrEP regimen, discussed how he navigates the
complexities of being on PrEP and communicating that to his sexual partners. He
specifically stated, “Anyone who has ever asked me I will tell them, cuz I think that every
gay man should be on it.” Brandon seeks a lot of his sexual partners through mobile apps
such as Grindr. When I asked him if the advertises his PrEP regimen on the app, he
disclosed:

I do, because I think that it’s a pretty good assurance to tell people that you are on
something that is very solid. Everyone can say that they’re negative as of
whatever date, but that doesn’t really mean anything if they don’t do anything
about it or they’re not proactive about it. It could change. It could not be negative.
It could have been a false negative, whatever it was, when they did take the test.

(2014, February 6, Interview)

Brandon is making reference to a popular feature on nearly all of the websites and mobile
phone apps that Gay Men can use a form of search criteria and that is HIV status. For
example, when a user creates a profile for any of these services, he can scroll and select
an option for HIV status that is positive, negative, or “ask me.” Sometimes users will
write their HIV status in the ad and status of their profile. Brandon’s perspective is that
listing and stating that he is on PrEP to potential men he may be hooking up with is
evidence of more proof that he is 100 percent negative and is a better indicator of status than simply stating or selecting an HIV status.

When Gay Men engage in sexual activity with others, the manner in which they communicate with one another varies according to research. Like some participants stated, some prefer to remain silent during the sexual encounter – at least when it comes to talking about HIV. As noted by Brouwer (2000), the “trick examination” is a nonverbal tactic to feel around in a partner’s body for swollen lymph nodes or other pieces of evidence of HIV on or within the body. Language and speaking is not always embraced. He notes that with these nonverbal tactics:

Obviously, this latter recommendation recognizes the HIV risk management can be practiced even in situations where adequate verbal communication does not or will not take place. Some gay men practice either or both of these risk management strategies – verbal disclosure coupled with verbal negotiation of sexual behavior, or silence coupled with “universal precaution.” Other gay men, however, choose neither. Instead, during a sexual encounter with someone whose serostatus is unknown, these men employ nonverbal “vernacular” tactics of HIV discovery in order to make decisions about sexual behavior. (p. 98)

Similarly, Elwood, Greene and Carter’s (2003) study of Gay Men in bathhouses found that silence is a norm when it comes to sex with other men. This created a culture of anonymous sex wherein condoms were not discussed or part of the sexual equation. Adam Zebroski (2013), a gay man who is an advocate and user of PrEP, works at a sex club for his evening job and as an HIV test counselor and recruiter during the day. As an
advocate and user of PrEP, he wrote “The guys I test tell me they feel more comfortable talking to a peer like me about PrEP, HIV risk, sex, etc.” (para. 2). Also, Kosenko (2010), found in her research with transgendered individuals that “one dilemma identified by participants involved a lack of language with which to talk about transgender bodies and sexuality” (p. 139).

This research, coupled with the disclosures of participants and what others have written in mainstream media outlets, shows a pattern that it is not always easy to talk about sex or HIV/STD prevention or status. Supplemented with this research, are the narratives and disclosures to suggest that talking to a gay doctor or friend, who understand gay culture and the gay male body, is helpful in having conversations about these issues. But it seems that when a sexual encounter is about to take place, at least according to some of the narratives provided by interview participants, the conversation is not taking place.

**The discursive body.** Additionally, the way participants talked about HIV testing and how it is associated with the history of their own personal gay sexuality and encounters is important to consider. For Gay Men who did not use PrEP, the fears were raised due to the bareback encounters that they had with other Gay Men. Their sexual history became a fear for them and their bodies and then with a sense of relief. No matter what phenomena we interact with, our bodies interact with those phenomena and that provide deep, complex meanings to us. As Grosz (1993) notes, “Bodies *speak* without necessarily talking, because they coded with and as signs. They *speak* social codes” (p. 199) and the gay male body is no different. With the narratives and disclosures provided
by participants, they were not necessarily speaking about their sexual behaviors and simply recalling how they felt about getting an HIV test. Instead, they were communicating about their bodies and how their bodies speak to them.

Grosz (1994) spends a great deal of time discussing bodies as inscriptive surfaces. Specifically, bodies are written upon. From the disclosures and narratives of the participants, with regards to formal and informal sexual education within this theme, this is evidence that all forms of sexual education are thoroughly inscribed within and on the body. Grosz states, “The body and its privileged zones of sensation, reception, and projection are coded by objects, categories, affiliations, lineages, which engender and make real the subject’s social, sexual, familial, marital, or economic position or identity within a social hierarchy” (p. 141). What participants learned about sex were powerful messages that stuck with them well into adulthood. Whether it was in an informal, structured classroom or through pornography or friends, these messages became internalized and embodied. As was discussed in the first theme of this analysis, participants discussed in detail about the elaborate messages and meanings they took away from bareback pornography and embodied such practices and desires. Pornography and formalized sex education are highly coded objects and messages that are observed and absorbed by the body. In a sense, these phenomena act as corporeal knowledge.

As stated earlier in this project, Cahill (2008) argues, “If, as Foucault claims, individual bodies are produced with certain identifiable characteristics that relate directly to power dynamics, then bodies are texts that we may read in order to discern the (sometimes implicit) claims of the dominant discourse” (p. 815). The dominant
discourses, for many of the participants, are the various forms of sexual knowledge they procured from informal and formal education modalities. These discourses, from what the participants disclosed, shaped their worldview of how they viewed sex specifically safe versus unsafe sex and the presence or absence of formalized sexual education. These discourses are profoundly more than instruction or commentary on gay sexuality but are inscribed upon the body. According to Grosz (1994):

> Just as there is a zone of sensitivity concerning the body’s opening and surfaces, so too there is a zone outside the body, occupying its surrounding space, which is incorporated into the body. Intrusion into this bodily space is considered as much a violation as penetration of the body itself. The size and form of this surrounding space of safety is individually, sexually, racially, and culturally variable. (p. 79)

The discourses of pornography, various forms of sexual education, and the conversations that are had with doctors and sexual partners are all written upon the body – they act as forms of corporeal knowledge not only carried in mind but also within the body. These bodies of knowledge are embodied and are arguably carried through one’s life – they help to define sexuality for many of these participants.

**Summary.** The formal and informal sexual education of participants and the health and sexual communication that takes place between doctors and sexual partners has created a theme rich with opportunities. For one, there is a clear need among society to embrace a plan to create and deliver comprehensive sex education at a young age. Included in that sex education, should be ways for people to learn how to talk to their sexual partners about HIV/STD prevention and status. This of course, has always been a
challenge in American society. Additionally, Gay Men need to be encouraged to talk to
their doctors about their sexuality and sexual practices. Similarly, doctors need to ask
about sexuality and sexual practices of their patients. The next chapter will detail the last
two themes – interpretations of HIV and PrEP.
Chapter 6: Analysis Part II

Theme #3: Interpretations of HIV

PLAGUE! We are in the middle of a fucking PLAGUE! And you behave like this! PLAGUE! 40 million infected people is a fucking PLAGUE! We are in the worse shape we have ever, ever, ever, ever been in! – Larry Kramer (Cogan & France, 2012)\(^28\)

Larry Kramer, one of the founders of Gay Men’s Health Crisis (GMHC) and ACT UP (AIDS Coalition to Unleash Power), attended an ACT UP meeting in 1991 –10 years after the first reports of AIDS appeared in the media. His interpretation of HIV/AIDS at the time ensued when a heated argument broke out at an ACT UP meeting. Kramer sat silent and listened to the argument with his head down. He looked up, and screamed the above quotation. The room went silent because this interpretation of HIV/AIDS at the time was a reality for those suffering from the virus, especially those in the gay community. He went on to say:

All of those pills we are shoveling down our throats? Forget it! ACT UP has been taken over by a lunatic fringe, that can’t get together, no one agrees with anything, all we can do is field a couple hundred people at a demonstration – that’s not going to make anybody pay attention, not until we get millions out there. We can’t do that. … And I say to you in year 10 that same thing I said to you in 1981 when there were 41 cases – until we get our acts together, all of us, we are as good as dead. (Cogan & France, 2012)

\(^{28}\) I highly recommend viewing this scene on YouTube. The written quotation does not capture Kramer’s passion within this historical context. It can be found at https://www.youtube.com/watch?v=KN9fjecqxLM
While HIV has taken on a different narrative today, this was the interpretation and understanding of HIV/AIDS at the time. Today, the interpretation is a bit different but Kramer’s words still powerfully resonate with me about the pressing need to talk about HIV with one another, especially in the gay community.

The third theme of analysis for this project will focus on interpretations of HIV among the participants. This multi-dimensional theme, while different from the interpretations of Larry Kramer, still parallels deeply rooted meanings about HIV within the gay community even though those meanings and interpretations have changed. The dimensions that are outlined and will be discussed in depth include medical optimism, personal optimism, generational optimism, social and personal pessimism, the language of HIV/AIDS, knowledge absence & presence of HIV, silence and stigma, HIV as object/“it,” and finally, equating gay sexuality to HIV.

Medical optimism. The first dimension within this theme was a prevalence of a medical optimism and how the participants thoroughly discussed their views on the disease in terms of today. Specifically, there were ideas that were disclosed regarding the optimism of potentially having HIV today as well as great stigma associated with the disease. First, there was a wide acceptance of HIV optimism among the participants. That is, HIV is a manageable disease that can be treated in a healthy manner. The most prominent of these perspectives was the HIV optimism expressed through a medical perspective. Philipe notes in his interview that he has:

The impression that it's not as serious of an illness as it may have been in the past because—my understanding is that treatment for HIV/AIDS has—we've made a
lot of progress with that. I feel like it's something that, whereas before, it was a
death sentence, now, people are living perfectly happy, healthy lives with it. It's
like, do what you can to not get it, but it's also not gonna kill you necessarily if
you do. (2013, November 23, Interview)

Philipe, who is 26 years old, notes a sense of optimism with HIV treatment if someone
were to seroconvert. He also comes from a generation where HIV/AIDS is perceived as
under control with proper care and treatment. PG’s view was similar, “You can live with
it, but you just—you got to take your medicine, and it's manageable.” The Reisner et al.
(2008) study found that “self-identified barebackers had higher levels of HIV treatment
optimism than MSM who did not identify as barebackers” (p. 259). Contrasting this
knowledge and these perspectives of HIV to Charlie’s, who is 51, is night and day. While
there is a sense of HIV optimism among many participants, some, like Charlie, expressed
optimism yet a sense of worry regarding today’s younger generation and their knowledge
and views of HIV. He disclosed:

The other thing is since treatments came in, people are like, “Okay, if I get it, no
big deal.” They don’t really understand what no big deal means. I have read some
reports about the increase in the gay community of HIV spreading, especially
among young people. I remember when everybody was uber safe sex. Then, that
seems to all have waned. It worries me. It’s worrisome. (2013, December 10,
Interview)
Charlie, because he lived through the advent of HIV/AIDS in the 1980s and 1990s, had a great view and understanding of HIV in terms of 2013. His lens of looking at the disease today is still sparked by what could possibly happen and erupt in the gay community.

Damon offers a different perspective as his experience as an HIV/AIDS educator provided him with an optimistic outlook of HIV. He noted the following in our conversation:

Okay, well let me preface by saying I've been working in education, prevention, and treatment for 21 years now. I have never seen a better time to be living with HIV and AIDS nor a better time to be loving people with HIV and AIDS. We have never had more success medically and more hope scientifically, as far as the quality and the quantity of life for people living with HIV. To see that now at this point in history and to be participating in that right now is the—really exciting, so different from when I started in 1991 working in the field and just pretty much the inevitability of clients, friends, loved ones would be dead. That was pretty much the inevitability then. To see how far we've come of living with a chronic, yet treatable condition versus a devastating death sentence is—I'm grateful for that every single day. (2014, January 16, Interview)

The most important element and disclosure of Damon’s interview was the love and respect he communicated for those who are HIV-positive. While many participants talked about HIV optimism from an individual viewpoint (i.e. if they acquire the virus they can manage and live with it), Damon understands it as a stigma that should not exist
especially in a gay community where sometimes vanity and the ideal of the young, healthy body dominate gay media and culture (as was noted in chapter three).

Matt remembers going in for his first HIV test and thinking the inevitable thought of life-ending moments but over time has become more educated about HIV and managing the virus. He discloses:

That's what I thought when I was first—I didn't know anything about it. I was, like, “Oh, my god, I had this scare, and I went to go get tested. Oh, my god. I'm gonna die if I get it. Oh, my god. My life's gonna end,” but I don't think that's true anymore. (2013, August 27, Interview)

Sometimes personal experience of thinking how life can be if “something” can happen that could be life-altering and becoming educated on that issue can force an individual to learn that the worst that can possibly happen will not be an automatic moment.

**Personal optimism.** When it came to viewing HIV optimism from another perspective, one participant, Harold, saw HIV from a personal perspective due to his serodiscordant relationship with his current boyfriend. Overall, his view of HIV has evolved over time as a result of his relationship:

Well, I guess, at the time of me coming out, I sort of met my partner kind of into that, and he was positive, so it was kind of coming into being gay and positive was sorta—this was sort of at the same time. It was kind of a lot at first. At first we didn’t connect, I think because he was dealing with things, and I was dealing with things, and we weren’t quite at the same point, at that time. Then time went by, and then we reconnected, and it worked, cuz I was able to process that. I
think, in actuality, what someone who is positive’s life is much different than what I thought it was, cuz I really had no clue about the disease or anything. I knew what they teach you in school, that it’s—you know, it’s, use condoms; a lotta people died in the ‘80s; and that’s kinda where we’re at; or just what was represented on TV or something. It was a very limited—I had a very limited education on it. (2013, September 4, Interview)

Harold’s narrative is unique among all of the participants due to his relationship with his partner. While many participants know of other Gay Men in the community who are HIV-positive, it did not come up in the interview that they have personal conversations about their respective boyfriend’s diagnosis and how they manage and treat the virus. Zander disclosed the following in relation to his friends who are living with an HIV diagnosis:

Well, I definitely know three or four, and I’m sure I know more than that. It’s not like—I don’t know. I don’t ask. There are some people who I think probably are, but I don’t—it doesn’t matter to me. They’re just friends of mine, or they’re my friends who are in the community. I have several friends who are actually young and have contracted it. (2013, July 5, Interview)

Despite HIV being present in the lives of some participants, there seems to be little conversation taking place about HIV treatment, management and prevention with these friends in the gay community. In other words, there is a clear understanding of how the virus is transmitted but having discussions about HIV in both sexual and non-sexual encounters seem to be nearly absent in the lives of participants from what they disclosed.
Other participants also have friends who are HIV-positive but do not have the conversations with them about the virus. Within this perspective of personal HIV-optimism, is the complete opposite that came up in one of the interviews from Jack. He disclosed:

I have a friend who is also on one of those apps and we always talk about who we're chatting with and who we're talking to. He'll show me a guy and he'll be like, “Oh, but he's HIV positive.” He's like, “That's not very poz-friendly of me to just write him off if he's positive.” (2013, October 15, Interview)

His perspective is one that rejects associating, at least sexually, with someone who is HIV-positive; this is evidence that HIV is still highly stigmatized by some in the gay community. Overall, it seems like the basics of HIV is understood at the intrapersonal level but conversations are not taking place within any context at the interpersonal level.

These three different and conflicting accounts disclosed by Harold, Zander and Jack call into question the rift in the gay community of having open conversations about HIV prevention and/or treatment. Even Harold admitted that the initial experience with his partner was not easy and he was trying to understand but he thankfully, through time, learned and became more understanding. Unfortunately, this project was not purposefully oriented toward eliciting the narratives of HIV-positive Gay Men to hear their perspective about dating and people’s reactions to dating; however, an article by an HIV-positive young man, Nicholas Napoli (2014), living in Texas, suggests the following about being rejected outright at a dinner date with another man:
The fact is that there is never a right time to tell someone. Everyone is different; some guys like to be told upfront and others like to get to know you before they ask about your status. I, for one, now prefer to wait a week or so before I tell them. So I looked him in the eyes – I’m sure he could see it in my face – and I told him the truth. This was one of those worst-case scenarios. He shut down on me and asked me to leave. I tried to explain some of the facts, but he didn’t want to hear any of it. So I grabbed my things and I left. The fact that he couldn’t handle my status isn’t what hurt. It was that he didn’t bother to be educated about HIV and then make an informed decision. I can understand if someone says that they would rather not date someone with HIV once they know the facts. Trust me, even with modern medicine and a new world of knowledge, dating someone with HIV can seem scary. But fear happens on both sides of the coin and education is the only way to get rid of it. (para. 5)

This sense of intolerance shows that yes, there is HIV optimism from a medical and scientific perspective, but when it comes to personally interacting, dating or becoming physical with another HIV-positive man that optimism is nonexistent and instead fear, misunderstanding and distress set in and therefore creates a stigmatized arena for many HIV-positive persons.

**Generational optimism.** In addition to the medical and personal perspectives of HIV optimism, there was another element that was disclosed in what seems to be HIV optimism from a generational outlook. The following narratives provided by the participants offer an interesting view in regards to generational differences when
articulating HIV optimism. Zander provides a perspective from the younger generation and his friends:

I think that it’s a growing problem in young gay people because they didn’t experience the AIDS crisis, because they have this—they’re growing up with this sense of invincibility. They’re growing up with this sense of this is something that affected people, or they may not even be educated to know that it’s still not curable. (2013, July 5, Interview)

Zander alluded to this earlier about young people not having a conversation with one another, at least from his experiences, about HIV prevention and treatment. This narrative could possibly suggest that, because HIV does not appear to be discussed as much today as it was in the 1980s and 1990s, the conversation is simply not taking place among many in the gay community. Charlie, who is much older than Zander, offers a similar, yet different perspective:

I’m not really in the know. My students—they’re very fluid. They’re gay one minute. They’re not the next. It’s not a big deal. It was a big fuckin’ deal when we were kids. It was a lot—it was very stressful. For them, it’s like, “What are you talkin’ about?” I wonder about them. They’re more blasé about it on the one hand. Does that engender recklessness or risk taking that they don’t even—they don’t think at all about the issue. For example, for years now, the student activities is bringing in parts of the quilt, the AIDS quilt. Remember when it was laid out in D.C.? Everybody in the world was weeping. It was horrible. It was beautiful, but it was horrible. I don’t think our students know when they come to the Student
Charlie’s perspective of growing up in the 80s and 90s shows a community revolving around a singular, loud message in regards to HIV/AIDS awareness. Perhaps the lack of communication, presence, health campaigns, dialogue and conversations about HIV today creates the sense of optimism in how Gay Men perceive the virus today? PG, a participant, who bottoms during his bareback sexual encounters, stated:

I really don't think of it. It's like cancer, right? I don't think of it on a day-to-day basis except when you hear something on the news, maybe some sort of headline of the week or year, but nothing that consumes my day. It's like other illness. I don't talk about that. (2014, September 14, Interview)

From my perspective, these disclosures call for a need for Gay Men to have an open, healthy discussion of HIV prevention and treatment. While these narratives do not capture the entirety of what is taking place in the gay community, what was disclosed can certainly be a barrier to getting accurate information about HIV prevention strategies such as PrEP. That is, the HIV optimism, coupled with HIV stigma, in the community could potentially be a barrier to implementing PrEP as a viable way to prevent HIV. Paul provides an excellent narrative in regards to the growth of HIV optimism from the 1980s to today:

I certainly think there was a perceptible shift around 1996 when protease inhibitors come out and really change the way that people think about like a death sentence and that sort of thing. I think in general because I’m mostly in an urban
white community, relatively affluent, that sort of thing that there’s a different perspective about how devastating HIV can be. As long as you have health coverage, it’s manageable. I think that’s the way I hear most people talk about it. It’s a manageable condition. My own sense is that that’s not completely accurate, that there’s still long-term effects that we’re still finding out about in this generation. Sometimes, I think people are maybe a little bit too – I don’t know what the right word is like not as serious about it as they could be. A lot of that may have to do also with my own perspective having lived through the ‘80s when it was a really terrifying crisis. For a new generation, maybe they don’t have that same sense. I would say overall that people are still aware about HIV and AIDS, but there’s not that sense of crisis anymore. (2013, June 26, Interview)

While there are many different perspectives offered by the participants, they are all different from one another in terms of philosophy and personal experience. While some had a clear understanding of HIV treatment today, some seem to lack knowledge. Perhaps this can be a result of poor education and weak, nonexistent communication campaigns about the virus. Then again, these conflicting perspectives could be a result of HIV-negative Gay Men not seeking out the information because they do not have the virus or perhaps feel they are not a high level of risk.

Some participants viewed HIV as a huge problem in gay community. Brandon described his perception of what is happening in the gay community with HIV:

I think that we’re going back to almost the epidemic of where it started because the revolutionary—Everyone feels like there’s a new revolution of, “We can
bareback again because we—because AIDS is no longer a death sentence.” I think that—then people are becoming positive because they aren’t playing safe, but they don’t even care because they can take some meds. It’s a pill a day, and they’re good to go.…It’s a huge problem. It’s almost a pandemic at this point because it just keeps growing and growing. The numbers I think were under control for so many years that people are afraid of it, and then now no one’s afraid of what it is again. Because I think the strains have changed, doctors are having a harder time trying to figure out what cocktail will work for somebody to be undetectable for lengths of time. Because from things that I’ve read or gone through is that if two positive people are having sex, and they negate—they almost negate their own meds that they won’t become undetectable. Then they have to change their meds again to do so. (2014, February 6, Interview)

Larry offers a contrasting position about HIV in the gay community:

I’ve often said that the gay community, after the ’80s and the beginning of the ’90s really got its act together and responded extremely well to AIDS prevention. I think that has borne out in that, if I’m not mistaken, the statistics are that in the gay community, they are not as terrible, the new HIV cases, that it’s more in the heterosexual community which has not gotten its act together. Matter of fact, it has only become more risky in their behavior. (2014, February 4, Interview)

These two opposing viewpoints of HIV in the gay community are starkly different. There seems to not be a distinct understanding of what it means to be positive and how to
manage a diagnosis while another participant is saying that HIV is more of a problem in the heterosexual community.

**Social & personal pessimism.** While HIV optimism was portrayed from a medical perspective, HIV pessimism was disclosed from a social and individual perspective in the form of stigma. Thomas C. offers a counter to the optimism that currently exists as he notes:

> Yeah. I mean, I always hear about these medical advances, and I almost feel like there’s a belief among the gay community that, “Well, I don’t have to worry about getting AIDS anymore because there’s going to be a cure or there already is a cure” and stuff like that, so – I don’t have to be as safe. I don’t necessarily believe that. (2014, October 10, Interview)

Despite his view that HIV is highly treatable, Thomas C. is still highly cautious about the future of HIV/AIDS treatments. Contrasting this knowledge and these perspectives of HIV to Charlie’s, who is 51, is night and day. While there is a sense of HIV optimism among many participants, some, like Charlie, expressed optimism yet a sense of worry of today’s younger generation and their knowledge and views of HIV as he articulated earlier in this theme. Because he lived through the advent of HIV/AIDS in the 1980s and 1990s, he had a great view and understanding of HIV in terms of 2013. His lens of looking at the disease today is still sparked by what could possibly happen and erupt in the gay community.

This conflicting account is also disclosed by Jack who offers a similar perspective:
I think it's seen as not as big of a deal anymore. I think it's seen as more of a manageable disease. I think it's an afterthought that people have. I think it's a blessing and a curse when they say that it's very hard to get because people take that for granted sometimes. I think not many people—I mean, a generalized statement. I tend to have a negative outlook on things so I see people as not caring as much. Maybe they do care as much and they just estimate their risk as low and they do care, but I see it as people who just don't see it as that big of a deal anymore…. I think it is a problem. I think while it is manageable and it is a—you can live a full life with it, I think it's not easy and I think it's expensive. It's not something you, obviously, want to have. No one wants to have that. I think it is a problem just because any disease is a problem regardless of what it is. (2013, October 15, Interview)

This sense of awareness of HIV is coupled with the stigma of having the virus and shows that while optimism may be a perspective held by some in the community, there is HIV pessimism in form of stigma toward others. Finally, as one last example of HIV pessimism, Matt discussed at length his perception and interpretation of HIV:

I hate it, obviously. I do not have it. Recently, I had a scare, and I went and I thought—I don't know why I thought I had it, but I did, and I just went crazy. Then I went to go get tested, and I was fine. I think if you're safe, and you're doing certain things for yourself to protect yourself, you'll be fine, but other than that, yeah, don't worry about it. (2013, August 27, Interview)
The meaning associated with HIV for Matt created a sense of deep anxiety until he elected to get tested. I personally took him to do this due to his anxiety and uncertainty of being tested for the first time. Thankfully, his anxiety was put to rest due to a negative test result.

**Knowledge absence & presence of HIV.** There seems to be a dichotomy among participants when it comes to general knowledge of HIV. Some are comfortable in their level of knowledge, while others admit almost complete ignorance especially in how HIV is treated and managed. This is highly problematic in that all participants identified as gay and have had bareback sexual experiences. Ashton out right admitted this halfway through his interview, “I’m so uneducated with HIV and AIDS, it’s awful.” Tyler disclosed a similar sentiment. He argues that with as much knowledge that is available regarding HIV prevention, he states that, “I feel it’s definitely something where the information’s out there. People can grasp it. A lot of people, especially younger people, don’t really take part in it.” There seems to be this sense that Gay Men are aware of HIV at its most basic level (i.e. transmission), and learn this at a young age, but do not pursue more information about the virus specifically with regards to treatment and reiteration and re-education of how it is transmitted.

From these disclosures, it appears that not all of the participants had the same education when it comes to HIV prevention and treatment. One participant in particular, Luke, has expressed a sense of doubt in regards to HIV. His lengthy narrative provides a little explanation:
Certainly, it's not the way that it used to be. It's become a chronic, manageable illness as opposed to a necessary death sentence the way it was when it first arrived and when I first became aware of it. I've had mixed emotions about it over time. There have been times when I thought it wasn't even real. I read a book called “What If Everything You Ever Wanted to Know about HIV and AIDS Was False?” It actually was a great book that gave me a lot of doubts about it as a virus—HIV as a virus, because it doesn't act like any other virus known to humankind. It also documented many people who were doing no medications and doing better than people who were doing medications. I've seen so many people do medications and seen their systems get shot up and ruined over it. I've had mixed emotions about it. Today I think it's something that—I think it plays more of a role probably than it should in gay men's sex lives in some ways. In other words, I think probably every gay man has had sex with someone who's positive—or most of 'em. Anyone who's someway getting around. Yeah. Those who have monogamous partners and that's it, then, no, maybe, but anybody who's had sex with multiple people or had sex regularly I think has probably been with someone who's positive. Yet if they say, "I'm negative" to you, then you're all for it, and you'll go and have sex with 'em, but if they said they were positive, they get rejected. That I find really to be just a negative thing. That's why I say I don't think it should play as big a role because I think today, first of all, those who are positive or who are on treatments probably can't transmit anyway. If everybody just has safe sex, then what's the difference if somebody's positive or negative?
Somebody who could say they'll have sex with somebody who's negative and they'll use a condom, but they won't have sex with somebody who's positive and use a condom, and I don't understand that. I think the stigma has been reduced somewhat about it but that it's still there and still even more of an issue among the gay population than it is among straight people. (2013, September 9, Interview)


We typically dismiss HIV/AIDS denialists as a small group of rogue journalists and unstable troublemakers. Sadly, people who work on HIV/AIDS often fail to realize that denialism is a significant problem because denialists dissuade those affected by AIDS from seeking help. People lured to denialism are invisible to AIDS service and treatment providers. Denialism – like stigma, sexism, and homophobia – undermines the fight against AIDS. At the very least, denialism diverts attention and resources from the global AIDS disaster. At its worst, it disinforms affected populations about the importance of prevention, the necessity of HIV-testing, and the availability of life-prolonging treatments. At its core, denialism is destructive because it undermines trust in science, medicine, and public health. (p. 1)

While I will not call Luke an “AIDS denialist,” his suggestion of questioning science and medicine speaks to a larger issue in the management and prevention of HIV/AIDS today, especially when it comes to new prevention measures such as PrEP. Furthermore, it makes PrEP even more difficult to implement and accept because PrEP is a medication
that needs to be taken daily in order to be successful in preventing HIV. Questioning science and preventing diseases is nothing new, especially with the movement of parents not giving their children vaccines. Alcindor (2014) interviewed Dr. Paul Offit who is the Chief of Infectious Diseases at Children’s Hospital in Philadelphia. He noted states such as “Idaho, Illinois, Michigan, Oregon and Vermont — where more than 4.5% of kindergartners last year were unvaccinated for non-medical reasons — as examples of potential hot spots. Such states' rates are four times the national average and illustrate a trend among select groups” (para. 9). This is evidence how denial of science and medicine can ultimately be harmful to humans and their health.

Additionally, denialism is nothing new within the realm of HIV/AIDS. For example, there is a lot of speculation as to whether Michel Foucault, whose ideas have been coincidentally used in this project, denied the existence of AIDS in the early 1980s. O’Farrell (2002) wrote:

Neither were doctors in a position in the early 1980s to offer much useful advice on the subject of HIV/AIDS or on safe sex. It is certainly true that gay men, including Foucault, expressed initial disbelief in the existence of a disease that specifically targeted gay men, seeing this as yet another poly by the medical establishment to exercise social control. (para. 4)

Part of the reason for denialism is the language that originally surrounded AIDS at the time which was known as GRID (Gay Related Immune Deficiency) – more will be discussed on this in the next dimension. But for Foucault, and many, denial was arguably
high with so much uncertainty surrounding a new virus that mostly affected the gay community.

Overall, the knowledge and experiences of HIV, shared by the participants, have the potential to shape their worldview when it comes to sexual practices and STD and HIV prevention and treatment. From what was provided by participants, there is more that still needs to be communicated to Gay Men in regards HIV prevention as well as prevention and management.

The language of HIV/AIDS. Some of the participants, those 42+ years, remember the actual original names used to describe HIV/AIDS in the 1980s. They spoke at length about these names and remember the time and place when it came to naming the virus. Charlie fondly remembers when he got a job and when he first saw a name for the virus:

Well, I was in college. I actually was working at a gay bar as a bouncer, which was funny as hell because I was tall and skinny and I didn’t know how to fight, but I was bouncing. Actually, one of the owners wanted to be in my pants, that’s why I got a job there, plus I hung out there all the time. I remember the local gay newspaper, which I can’t remember what it was called. There was a magazine called *Parlay*. Then, there was a newspaper that was very old and publishing since the ‘50’s I think. The first mention I read about it was the gay cancer. The medical name for it at that time was HTLV-III. They had identified something. I was flipping out a little bit, but I was confused. While that was happening, the first person I know who got HIV, we just didn’t, people didn’t even say you got
HIV, you said you got AIDS, was a student I was going to school with and he was he was a little bit older, and he was very flamboyant. He was great fun. His name was Robert29 I used to go out to the clubs with him. We’d have such a blast because I was so naïve, and he was so skilled. (2013, December 10, Interview)

In addition to the naming of the virus as “HTLV-III,” Charlie had a face, a personal friend to place to the virus. It was no longer a “thing” but it had a human, embodied form now within his friend. The technical name of the virus in the early years was no longer scientific to him but was a reality. Additionally, I think it is interesting how “HIV” was not in the lexicon of the gay community, and others suffering from the virus, but it was “AIDS” – this probably had to do with the few treatment options available during that time.

In addition to Charlie’s narrative about the naming of AIDS being called “HTLV-III,” Luke too remembers a time with the naming of the virus. He notes:

In the early ’80s, probably around ’83, ’84, I remember hearing about some gay disease. We didn't really know what it was. It wasn't called AIDS, or HIV hadn't been isolated yet, but it was GRID or "the gay cancer." We didn't really know what it was. Then it was GRID, and then it was—moved on. Didn't really hear much about it and didn't really know much about it, just that there was something out there that was striking the gay community. Again, that probably led to— because of that uncertainly—led to the fear. Then I remember hearing about Ryan White pretty early on, cuz that was in the ’80s, too, and Elton John, of course,

29 This is a pseudonym for this person.
taking up the friendship with him. That gave it a face, finally, and it wasn't a gay face. It was a straight little boy. Then I remember it burgeoning more and hearing more and more about it, seeing more news stories, etcetera, about it. Ryan White was really the big turning point, I think, for me, of hearing things about it and paying more attention to it. (2013, September 9, Interview)

“GRID” stood for “Gay Related Immune Deficiency” (Shilts, 1987) and this stemmed from the first, and often cited, *New York Times* article from July 3, 1981 titled, “Rare Cancer Seen in 41 Homosexuals.” In that article, the initial cases of what we know now to be AIDS, states:

> The sudden appearance of the cancer, called Kaopsi’s Sarcoma, has promoted a medical investigation that experts say could have as much scientific as public health importance because of what it may teach about determining the causes of more common types of cancer. (Altman, 1981, p. A20)

From gay cancer, to GRID, to HTLV-III, the naming of the virus provides some who are older in age with a historical perspective that many of the other participants could not articulate.

**Silence & stigma.** Similar to remembering the early names for HIV/AIDS, was how some participants discussed how the virus was talked about in the early years of it being in the public eye. Larry, who was a former priest and chaplain in a hospital and cemetery remembers the early days of AIDS vividly and recalls how people would never say “AIDS” or mention it when in the presence of a sick or dying patient. He recalled:
Yeah, over a hundred cases. Because then, in the nine—where was I? I guess the late ’80s it had to be—yeah, the late ’80s I was chaplain at a cemetery. There, I was up against many, many AIDS patients being buried. At that time, undertakers would not identify it as being AIDS. You’d generally go for the [pause]—what do you call it?—the disease, that opportunistic disease, and they would call it that. So, he died of pneumonia. All of a sudden, we were getting 19, 20, 25 year olds dying of pneumonia, and you knew perfectly well that it was AIDS. Cuz that’s what many of the AIDS patients died from, ultimately, was that certain pneumonia that was resistant to all bacteria. Yeah, yeah. I met a—I was in touch with a lot of that where the undertaker wouldn’t even dare say that it was AIDS. They didn’t do that because if the reputation got out that they were burying AIDS patients - other families would be afraid to use that, because—— they thought the—not the infection, but to get it was so easy. I mean, they were scared to death. That’s why they kept it a secret. For a long time they kept it a secret. (2014, February 4, Interview)

Not mentioning AIDS verbally was cause for concern not only for patients, their rights, and their families, but for a business in this situation. Due to the great concern, compounded by homophobia and stigmatization, “AIDS” was not always overtly discussed; silence contributed to the spread of the virus.

While Larry’s perspective is from a different generation, another participant who is much younger in age recalls a time when he learned one of his favorite television stars died of AIDS. Jack describes the following story:
When I was in 4th grade, I remember the guy from—I don't remember his name, which is probably bad—the guy who played Mr. Brady from The Brady Bunch. Yeah, he died and I remember this. It's funny that I don't remember a lotta things when I was younger, but clear as day I remember this girl in my class in 4th grade saying that he died. I said, “Oh, how'd he die?” cuz I loved The Brady Bunch. I used to watch it with my mom and everything and every night on Nick at Nite or whatever. I was like, “Oh, how'd he die?” She said, “AIDS.” I was like, “I don't know what that is.” She didn't really explain to me what it was, but she basically said, “Don't tell your mom I told you it was AIDS. Don't say it was AIDS.” (2013, October 15, Interview)

While Jack’s perspective is many years behind Larry’s experience with AIDS, there is a similarity here in not wanting to talk about the virus. This creates a sense of silence around the virus, prevention, and subsequently treatment.

Mary Fisher, a white, heterosexual mother living with HIV, delivered an address titled, “The Whisper of AIDS” at the 1992 Republican National Convention about her experience with the virus and how the nation needs to “lift the shroud of silence of AIDS.” Her call, a brave one, was to tell the nation that when a society keeps a virus, such as HIV/AIDS in silence, we all suffer regardless of sexuality, gender, race or age. Her brilliant message unfortunately is still not realized. Based on the interview data that was gathered from participants, and discussed earlier in the theme of sexual and medical communication, Gay Men are not having conversations about HIV/AIDS with their doctors and their sexual partners. Fisher also noted in her address that “Because, unlike
other diseases, this one travels….But HIV is different and we have helped it along. We have killed each other-with our ignorance, our prejudice, and our silence” (Fisher, 1992). This statement, although a little different than today because not as many are dying of AIDS, still resonates today as Gay Men try to navigate through the complex web of HIV treatment and prevention. Fisher concludes her address with a powerful message, “To all within the sound of my voice, I appeal: Learn with me the lessons of history and of grace, so my children will not be afraid to say the word ‘AIDS’ when I am gone. Then their children, and yours, may not need to whisper it at all” (Fisher, 1992).

Fisher’s speech was a clear, needed message to all American during that time. For example, many celebrities provided alternative illnesses and disease to their ailing health and would dare not mention AIDS. To put this in a socio-historical context, Shilts (1987) states:

Attention to the epidemic waned only slightly in 1986. There were other celebrity AIDS patients now, but for all the media cachet, the disease remained fundamentally embarrassing. When Broadway’s star choreographer-director Michael Bennett fell ill, he maintained he was suffering from heart problems. A spokesman for Perry Ellis insisted the famed clothing designer was dying of sleeping sickness. Lawyer Roy Cohn insisted he had liver cancer, even while he used his political connections to get an experimental AIDS treatment protocol at the National Institutes of Health Hospital. When Liberace was on his deathbed, a spokesman maintained the pianist was suffering the ill effects of a watermelon diet. As these well-known gay men lied to protect their posthumous public
images, it was the first professional athlete to contract AIDS, former Washington Redskins star Jerry Smith, who calmly stepped forward and told the truth. (pp. 585-586)

The evidence during this time, even though it was five years before Fisher delivered her address, shows how many tiptoed around HIV/AIDS. Today, while the medical treatment and awareness has increased, still shows signs of silence around the issue, especially with Gay Men not talking about these issues with their medical practitioners and sexual partners (see chapter five).

Furthermore, the silence surrounding AIDS during that time was much more magnified during Ronald Reagan’s administration. Shilts (1987) notes that in November of 1984, “When claiming victory on election night, President Reagan told a cheering crowd, ‘America’s best days lie ahead.’ It was during the month of Reagan’s reelection that the nation’s AIDS caseload surpassed 7,000” (p. 495). Unfortunately, it was not until May 31, 1987 that Reagan finally mentioned the term “AIDS” in a public speech. It was a speech that “was little talk of education and a lot of talk about testing” (p. 595) and finding out who has the virus. Boofey (1987) wrote that in the speech, “Mr. Reagan was greeted with some booing and hissing when he expressed his support for routine testing, mandatory testing of immigrants, and prenuptial testing” (para. 21). Many, such as Larry Kramer thought the message on AIDS was misguided. Shilts (1987) noted that the word “gay” was never even mentioned. He wrote, “There was something so utterly dishonest about discussing almost every aspect of the AIDS epidemic in this address and not mentioning the fact that it was homosexuals who had been killed and homosexuals who
had, in fact, done so much of the work in fighting the epidemic for all of those years that Reagan had ignored it” (p. 596).

The notion of HIV being used as a form of silence is nothing new. It does however build an interpretation into how Gay Men think, act and navigate through HIV prevention and treatment more than 27 years after Reagan’s initial silence. Not wanting to talk about it with sexual partners and/or medical practitioners creates a barrier to HIV prevention such as PrEP and ultimately treatment. Additionally, the silence of HIV, at any level, helps to create more stigmatization related to the virus and those who may or do have it. The group ACT UP created the symbol and slogan “Silence = Death.” While not nearly as many Gay Men are dying from AIDS today, their message is still a powerful one in that continued silence about HIV, at the interpersonal and mass communication levels, still contributes to the spread of the virus. The socio-historical contexts of silence surrounding HIV/AIDS over the last 30 years is a complex phenomenon but it does create a level of stigmatization which builds an interpretation, and various levels of meanings, in how Gay Men treat the virus.

**HIV as object/“it.”** Another dimension that appeared in the interview was how HIV was treated and discussed as an object. This did not appear to me automatically in the interviews nor in the first reading of the transcripts. It was when I was re-reading a transcript that this notion of HIV as object appeared. Specifically, HIV was referred to as “it” often in language used throughout the participants’ interviews. Let me clear that “it” was not simply used as a reference to a noun, in this case HIV, it seemed to be used a
sense of object that silences the issues associated with HIV. Brandon provides that best
illustration of this idea:

Me personally, I have worried about having it. I have not worried about having it—being infected knowing it. The time that I have ever had a worry, years ago, probably back in 2005, I was called by the Board of Health saying that someone that I was in contact with had become positive, that I had to come in for testing. I guess that’s the one time where it goes to your mind of like, “Do I have it,” or, “Is there a time that it came through,” because I didn’t know the person. Not until maybe about a year-and-a-half ago I found out who that person was. (2014, February 6, Interview)

This narrative provided by Brandon is an illustration that many participants shared – the use of the word “it” to refer to HIV. As a result of this language substitution, this made HIV seem like an object or a thing that people “get,” “prevent,” and/or “treat.” It is as if HIV is a thing that no one wants but could acquire or “get.” If a gay man does seroconvert then he will use one of the objects/things that is advertised in a gay publication (i.e. an HIV medication). Matt also talked about HIV in the same light:

Yes. I found out that—I had sex with someone. This was two-and-a-half years ago. Then I found out that they had HIV recently, and I got scared. That's what started my scare. After I found out that they had it, I was panicking because I didn't know when they got it, or how they got it, or if I had contracted it from them. Then I went to get tested, and I was fine. (2013, August 27, Interview)
By encasing HIV in the language of “it,” and supplementing the virus with the behavior of risky sexual behavior (i.e. bareback sex), HIV is placed in a space that is far from reality for many Gay Men. Most Gay Men, including the ones that were interviewed, know that HIV is a risk in their sexual practices but many talk about HIV as something that is not close to them in terms of the virus being a reality. In all of the transcripts that I read and coded, the word “it” was used 124 times on average in any given interview but 20 percent of those references, on average, were used to discuss HIV – more than in any other context.

Additionally, such language and references to HIV could possibly be one of the reasons why HIV is difficult to talk about in sexual encounters (see chapter four) because it is a phenomenon that is in a separate space. Furthermore, bareback sex is an embodied activity filled with sensuality and Gay Men perhaps do not want to ruin the moment with things such as condoms or with a discussion about an object such as HIV.

In addition to the references and naming of HIV as “it,” two participants discussed how they heard jokes about AIDS when it first became labelled and named in the 1980s. Larry stated:

There was a joke, and maybe you’ve heard it. There was a joke at that time that when—not about AIDS, but about being gay, that the worst part of being gay is trying—no, worst part of getting AIDS—it was about AIDS—was trying to convince your parents you were Haitian. (2014, February 4, Interview)

Clearly, this joke makes a mockery of AIDS in a racist manner and treats it again as an object in that the meaning of AIDS is contained in a joke – it is a “thing” that gets shared
and laughed about with a catchy one-liner. Paul also remembered a joke from his high school days:

Definitely in the ‘80s. I mean it wasn’t maybe talked about so much in school as a subject, but of course, kids talked about it. Also, kids told really horrible homophobic jokes. One of the jokes I remember, and this would have been in early high school like mid-‘80s or something. Kids saying, “What does gay stand for?” The answer is, “Got AIDS yet.” That was a joke in the ‘80s. (2013, June 26, Interview)

While AIDS was not overtly discussed, according to Paul, it was discussed and encased into a joke which suggest that is how young, straight teenagers in 80s talked about AIDS.

Jokes and humor provide a lot of levity to scary situations but in this case, when a population such as Gay Men that are greatly affected by AIDS, it allows for a shielded expression on the issue that can be shared among one another in the public in a way that does not make others uncomfortable. Jokes carry powerful meanings and these are no different. It is easier to tell a joke referencing HIV/AIDS than to talk about the difficult issues of prevention, treatment, death and sexuality. These jokes suggest that AIDS is not of importance nor serious enough to discuss with one another, or a way of making fun of those who might be vulnerable, especially during the 1980s.

**Being gay = HIV.** Another dimension that was discussed by participants in the interviews was how being a gay man, and coming out, was its juxtaposition to having or getting HIV/AIDS. Luke stated that “I think gay men need to worry about it more than straight people.” His remark is to suggest that Gay Men are more at risk due to their
greater participation in having sex with one another, particularly unsafe sex. Larry recalls a similar idea in regards to gay being associated with AIDS, “In the ’80s, when everybody, you seemed like you knew. Well, they practically said, in the beginning of this, that all gay men were gonna get AIDS” (2014, February 4, Interview). Philipe, who is of a different generation and age than Luke and Larry, stated something similar, “I haven't seen the statistics lately, but I feel like the gay male population is still disproportionately affected by HIV/AIDS, so I would say yes, but it's also not just our problem” (2013, November 23, Interview).

While Luke and Larry are both from a different generation than some of the younger participants in this project, Tyler, who came out within the past few years, recalls great acceptance among his family and friends but also remembers the warnings about being careful in the gay community when it comes to preventing and contracting HIV and STDs. Tyler disclosed:

I mean when I came out that was the first thing that everybody jumped on. Well, you have to make sure that you’re protected. That was – their main concern. It wasn’t even the fact like, “Oh. Sure.” It was more like, “All right. Well, that’s fine. Whatever makes you happy but just make sure that you are safe.” Yeah. That was definitely a concern, which I thought was strange. It was definitely something where I was like, “Why now? Why is that so relevant now? It should’ve been relevant period.” Yeah. That was definitely a concern that first time I did come out. (2014, April 21, Interview)
To me, this disclosure is interesting on so many levels. While, yes, Gay Men are statistically at greater risk than their heterosexual peers and friends at contracting HIV and other STDs, Gay Men seem to be the population that are talked to more about these issues than their straight counterparts. Philiipe shared a similar narrative when he discussed how when he came out the conversation would not have been the same if he were straight. Philiipe disclosed:

Really, if I think about it, it probably became more salient of an issue after I came out because there was this perception, I think, that I had at the time that it was an illness that really only affected gay men. As soon as I came out, then it was like, this is something that I might actually to deal with, whereas before, when I identified as straight, I'm like, not a problem. (2013, November 23, Interview)

Personally, for me, I specifically remember from my own coming out process that, similar to Tyler, family and friends were accepting of my sexuality but warned me about “protecting myself” and being cautious. I came out in my early 20s and clearly knew about sex, how it worked, etc. but not one person, friend nor family member, ever discussed sexual safety and precautions when everyone in my social circle assumed I was straight.

Prior to Ashton coming out, he carried a powerful message nearly all of his young life about being gay. He recalls:

Before I came out, my mother had an uncle who died of AIDS. Yeah, so that was the first I ever knew of it, so I was very afraid to come out. Cuz I always thought that that was the end result of being gay was—Yeah, so she had two uncles. She
had one that died from AIDS, and another one that they found overdosed in drag in his apartment. So it was like heavy, heavy shit. I automatically as a young boy, even up to 18 years old always thought like this is gonna be the outcome of a gay lifestyle, so that is when I first wrapped my head around HIV and AIDS. (2013, August 19, Interview)

From Ashton’s narrative, he clearly struggled with the notion of being gay and associating the lifestyle and sexuality with AIDS. Again, similar to Ashton’s experience, I felt the same way growing up, especially that first time I saw the film Philadelphia (Demme, 1993). Watching Tom Hanks’ character suffer through the physical ravages and consequences of AIDS I remember vividly swearing to myself that I will never attempt or live the life of a gay man, no matter what my mind and hormones were telling my young teenage body.

Thomas C. grew up in a similar experience although he did not know or experience someone in his life who was diagnosed or who suffered from AIDS. His equating “being gay” to AIDS was based up on what everyone else talked about in school. He recalls:

Hearing things in elementary school. I think it just trickled down like, “Oh, that’s a bad thing. AIDS.” Then, in high school, you have kids calling each other “faggot” and stuff like that. It would almost become an insult. It just got mixed into that whole insults of “faggot” and words like that. I only associated AIDS with gay people. (2014, October 10, Interview)
Not only did this take place at school but it was in his elementary years that he was exposed to this thought process initially and then to have it develop into homophobic insults and slurs. This falls directly in line with the notion of reducing HIV down to an object and then applying the association, erroneously, to just Gay Men. This was the common perception among adults as well in the early years when the virus was becoming more public through the media.

Josh Thomas (2014), an Australian actor who stars in a semi-autobiographical sitcom titled, Please Like Me, talked to Terry Gross on her show Fresh Air about coming out to his parents. He recalled, in the interview, when he told his father about his sexuality via text message:

And then he just spoke to me about AIDS for, like, a really long time. And it's sort of in the show, where he, like, says, like, homosexuals are 30 times more likely to get - he said AIDS, but he meant HIV, but that's fine. And I was just, like, I just don't think this is, like, a true fact. And also I'm across it. Like, I'm across condoms. Like, it's not, like - it's actually not much different, you know, now that I'm gay. Still got to wear a condom. I mean, babies are terrifying. You know, like, I know about this. That's all he wanted to talk about - was HIV.

Josh’s disclosure is not different than some of the coming out stories of the participants. Again, as Josh states, where was the conversation about condoms and sexual safety when his parents and others operated under the assumption that he was straight? In fact, where was the conversation with all of the above participants, including myself, when our parents, friends and acquaintances assumed we were straight? I would also like to add
that coming out is a personal process and journey that never ends. A gay, lesbian, bisexual and/or transgendered person does not do this process once but does it many times, in multiple ways, through the life span of that individual. Every new job, new cocktail party, new potential friend, etc. provides a new opportunity to come out to others. The reactions can obviously vary as well as the potential for recommendations about sexual safety, especially HIV among Gay Men. The bottom line is that sexual safety should always be discussed among all individuals.

As noted in chapter one, statistically, Gay Men are at greater risk of HIV acquisition but linking the virus to Gay Men is a far greater phenomenon that still seems to envelop the gay community. Ashton has also noted that Gay Men do bear some responsibility for HIV being juxtaposed to being gay. He notes, “I think it’s more relevant because of the amount of anal sex that’s practiced, so I think that from that is where we take on a brunt of the blame for that.” Additionally, every gay publication I pick up, every advertisement within these gay publications, including online media and other websites, always has a focus on HIV whether it is an advertisement for an HIV medication or some other discussion on the virus. Publications and other online media that are geared towards heterosexuals, where sex appeal is obviously used in advertisement and magazine covers, HIV is almost never discussed or mentioned. More than 30 years later, after all that we know about the virus, Gay Men are still strongly affiliated with HIV in the public’s consciousness. While it is clear that HIV is not just a “gay disease,” there is still a focus and assumption of equating HIV to being gay by the
general public. This assumption and interpretation of HIV by Gay Men and others further builds stigma around HIV and homosexuality.

While none of the participants in the interviews carried interpretations of HIV like Larry Kramer did in 1991, the narratives and meanings shared by the participants were rich, multi-dimensional and complex. For a virus that is close to 35 years old, the interpretations and meaning of the virus seem to have a long, storied history. Many years from now, long after this dissertation collects its share of dust on the shelf, another set of interpretations will surface and be embraced by Gay Men. No one knows how HIV will be viewed in the future but it may be interpreted and encased in powerful meanings of a vaccine or a cure.

The historical body. This theme offered a lot of great insight into the competing meanings of how HIV was perceived by participants. On one hand, there are various levels of optimism but there are still heavy negative connotations associated with the virus. Built into this idea is the stigmatization associated with HIV/AIDS by participants after 30 years of the virus’s existence. Grosz (1994) states that “The body is not outside of history, for it is produced through and in history” (p. 148). It was clear from the various interpretations of HIV provided by the participants was that many of these complex meanings showed a sense of history from inception of the virus up until the present with the success of HIV treatment. It was clear that Gay Men in this study carried the vast history of HIV/AIDS within their bodies and the many meanings associated with its history.
These meanings did not simply “arrive” within a context of causality or making a connection between gay male bodies and HIV. Grosz (1994) states:

The relation between the subject and objects is thus not causal but based on sense or meaning. The relations of mutual definition governing the body and the world of objects are “form-giving” insofar as the body actively differentiates and categorizes the world into groupings of sensuous experience, patterns of organization and meaning. (p. 87)

The complex meanings and interpretations of HIV provided by the participants are elaborated by participants and shows that no singular or subscribed meaning-making is adopted by all Gay Men. These meanings are co-constructed and embodied with a sense of fluidity of what HIV means within and among the gay male body. Hawhee (2009) states that “Bodies and language, then, irreducibly distinct and yet parallel and complementary, mediated by sensation and attitude – at times undermining, at others duplicating each other, but often, if not always, in effect moving together”(p. 166).

Language and embodiment are not separate but are co-creators, and generators of meaning, of each other. For the Gay Men in this study, this is no different.

**Theme #4: Interpretations of PrEP**

One little blue pill. That’s all it is. (Brandon, 2014, February 6, Interview)
As simplistic as this statement reads, and as non-threatening as this pill looks, many of the interpretations provided by participants were quite different. Yes, one little blue pill packs so much hope and promise in scientifically and medically preventing HIV, yet it comes with many social implications, expressed by participants as well as other influential people in the media. The interpretations about PrEP, expressed by the participants, will show that there is more to PrEP than just a “little blue pill” – instead, it is a complex phenomenon that many Gay Men are still trying to understand and navigate. This theme will be outlined in seven dimensions which includes language of PrEP, birth control references to PrEP, increased sexual risks, doubt about PrEP, health and medical interpretations of PrEP, negative criticism and interpretations of PrEP, and positive embracement of PrEP.

**Language of PrEP.** When interviewing participants about PrEP, it was interesting to note how some of them discussed the language around PrEP both advertently and inadvertently. Five participants inadvertently called PrEP “prepare” or
“preparation” when discussing the prevention measure. While PrEP does not mean or stand for “prepare” or “preparation” in its scientific or medical definition, it does suggest a sense of “preparation” as in “preparing” the body to build a defense from HIV infection. The PrEP community, mostly made up of Gay Men taking the regimen, are taking the acronym of PrEP to build messages about preparation in preventing HIV. Recently a panel of experts delivered a presentation titled, “PrEParing for the End of HIV?” (Whitman-Walker Health, 2014). Another marketing campaign was put together by the National Minority AIDS Council (2014) where they are advertising “PrEPARE for Everyday Life” equating PrEP for at risk communities to birth control for women. They also use the social media hashtag “#PREPAREFORLIFE.” Many people, and even some organizations, are taking advantage of the distinct name of PrEP to create an overall message of “preparedness” with regards to HIV prevention. Even one participant, Christian, commented about PrEP, “I love the name, by the way. It’s kinda cute.”

In addition to participants referencing PrEP to “preparation” and “preparedness,” was another instance of a participant inadvertently creating a name for PrEP which subsequently became part of the title of this project – PrEP as “a medical condom.” Brandon, a user of PrEP, stated in his interview about the regimen, “The other thing about it is that I don’t think anyone is giving head with condoms on. There it gives me a medical condom I guess for the body without having to worry about it.” In addition to the clever name and languaging labelling of PrEP, is the situation that PrEP provides to him when he, or others who are taking a PrEP regimen, are engaging in oral sex. While it is extremely low risk (near zero chance) to acquire HIV through oral sex (Page-Shafer et
al., 2002 & CDC, 2014), Brandon suggests that many Gay Men are not wearing condoms when engaging in oral sex. Oglesby (2004) reported from a national survey, “The majority – 84 percent – of the survey respondents said they take necessary steps to prevent catching an STD, but 82 percent of the sexually active participants said they never use barrier protection when having oral sex” (para. 1). While this research is more than 10 years old, condom usage overall, for sexual encounters, is low as reported in chapter two. Brandon believes that PrEP is a medical condom that one does not wear while engaging in various sexual behaviors – it is in a sense an invisible condom. From Brandon’s tone, and demeanor in the interview, I perceived him as saying “medical condom” in an indirect way as a metaphor for PrEP – a powerful metaphor that helps others to easily understand the medical and scientific implications of this new HIV prevention measure that many are still trying to understand.

The creative play with the letters of “PrEP” have already gained steam by some organizations and there seems to be potential for future uses of the term. Any time there is a new technology, a language is created to discuss and use that innovation that is translatable to a society. PrEP, and its potential, has the ability to be used through creative marketing and media campaigns that can potentially reach a lot of people who are known to be at risk of acquiring HIV.

**Birth control references.** Throughout some of the interviews, there was a comparison of PrEP to birth control. Participants mentioned this comparison within their disclosures and narratives. When I asked Matt questions with regards to his perception of PrEP he stated the following:
I think that's a really good advantage that we have now. You could just take it once a day, and as long as you take it every single day, you're at a much less rate to get it. I think that's a really good thing. Yes, cuz now people will think, "Oh, I'm just taking the pill. I don't have to wear a condom." Well, actually, you can still get it if you don't wear a condom. Condom—it's just an additive level of protection. You shouldn't be taking another level off. You know what I'm saying? Cuz then that is another level of risk that you're not—now you're adding risk, but in your mind you're, like, "Oh, I'm fine." No. You should be doing everything to protect yourself cuz once you get it, you can't get rid of it. It's not gonna go away. You can't take all of the blood out of your body. You can't. It's impossible. You'd die. There's no way to get rid of it. It's impossible. (2013, August 27, Interview)

Matt’s perspective made reference to taking “the pill” as if PrEP is a known daily pill regimen. This is something I did not probe as I did not notice it until the transcription was complete, but it seems as if Matt said “the pill” inadvertently because he never stated it again in his interview. This is important because PrEP, in a medically comparative way, acts as “the pill” does for birth control. Mark’s disclosure and comparison seems to be receptive to PrEP as an HIV prevention measure, but he still expressed concerns about the possibility of transmission.

One participant, Damon, overtly talked about PrEP’s direct relationship to birth control. Damon, a user of PrEP since 2011, stated the following:

This shit really works and I—but for me, I would still wanna be on PrEP, even if I had a monogamous partner who was positive and zero viral load. I would still
personally prefer to have the—it's like—one of the powerful things about the birth control pill for women is that it was the first time a woman got to have control of her reproductive rights. It was always dependent on the man before. The pill really gave her the opportunity to be autonomous sexually. (2014, January 16, Interview)

Damon argues that if birth control gave women the right to be sexually autonomous then why not Gay Men? Damon also shared an interesting conversation he had with his parents about his decision to use PrEP:

I said to my mom and dad, “If I was a woman and I was on birth control pills, would you support me on that? Would you agree that that might be a rational, wise, responsible decision?” They're like, “Yeah, sure.” I said, “If there was a vaccine for HIV, if I could be vaccinated from HIV, would you agree that that would be smart for me to do that?” They're like, “Sure.” I was like, “Okay, well I'm not a woman and it's unlikely we're gonna have a vaccine any time in the next decade or two, but here's something I can do instead. Here's another way that I can be 99 percent protected from HIV.” It made sense to them on that level. (2014, January 16, Interview)

What is interesting about Damon deciding to tell his parents about him using PrEP was that it seemed to be another “coming out” to his parents. With that second coming out, they may have developed ideas about Damon’s sexual life as a gay man in New York City. It is important to note that Damon is 42 years old and he does not necessarily need to tell his parents, as an adult grown child, about his sexual choices and forms of HIV
prevention, but he felt obliged because Damon has been featured in a number of newspaper articles in addition to other mainstream media outlets. It is safe to say that Damon has become the unofficial spokesperson for PrEP.

Damon continued with the metaphor of birth control in his defense and description of PrEP throughout the interview. While he used this metaphor to talk to his parents and friends about PrEP, which he found to be successful, he also believes it can help people, especially Gay Men, communicate with their doctors about sexuality, sexual practices and prevention. He specifically argues:

I encourage people to say the same thing if their doctors are a little ambivalent and on the fence. Would you give me birth control pills if I was a woman? Would you encourage me to have harm reduction? Birth control also does not eliminate harm. Birth control can have side effects. Birth control can lead to other STDs. It is harm reduction similar to PrEP. If a doctor will prescribe birth control to a woman, would they prescribe PrEP to a gay man? Would they prescribe Viagra to a straight guy and then not prescribe PrEP to a gay guy? Hmm, interesting disparity there. (2014, January 16, Interview)

Damon’s argument, I believe, is spot on especially in the realm of arguing and advocating for individual sexual and reproductive rights. In another interview with Zander, he also expressed concern about a gay bottom protecting himself from a potentially infected top. He too compares the idea of PrEP to the rights that many have, and still, obtained:

That is also another thing where it’s like that comes down, even I think, to problems of our society as a whole, and it’s like feminism ‘cause it’s like the
woman’s the receptacle partner. The man’s a receptacle partner. You know what I mean? It’s like a top who wants to fuck you and doesn’t give a shit if he gives you HIV. (2013, July 5, Interview)

While Zander is one participant not willing to take PrEP, he does however see the value in how a gay man who prefers to bottom may want to protect himself.

The comparisons articulated by participants between PrEP and birth control, gay sexual rights and women’s reproductive and sexual rights are not too far off from one another. Both populations have experienced, and still continue to experience, stigma and discrimination in many facets of society. Lupton (2007) argues in regards to women’s reproductive rights:

Contraception and abortion are focal points of societal ambivalence about the feminine role, the right of women to take control over their bodies and their reproductive destinies, and the subsequent impact upon potential emancipation. Controversies over the provision of contraception and safe methods of contraception to women have revolved around notions of the ideal of motherhood for all women and the desire of the medical profession to maintain control over women’s reproduction. (p. 149)

Similarly, PrEP allows Gay Men, as well as other communities of people, to take control over their bodies in both a social, sexual and medical setting. Lupton goes on in her writing to note other controversies surrounding contraception as it evolved. While Gay Men are unable to bear children, the same debate, along with its context, is not very
different from the struggles that many women face. These controversies of PrEP will be
discussed in the next dimension of this theme.

**Doubt about PrEP.** Overall, there seems to be a sense of doubt about PrEP as an
effective medical, preventative tool against HIV. One doubt was captured by the fact the
PrEP is simply too new in eyes of some participants. Harold disclosed, from his
communication with friends that:

Yeah, and that’s what I’ve noticed from people. People are basically saying and
suggesting, like, “Yeah, it’s great. It looks great on paper. It does all these
amazing things. However, we need more research.” That’s what I’m really
finding from people. (2013, September 4, Interview)

At the time of the interview, Harold discussed going on PrEP because his partner is HIV-
positive and his doctor stated he really did not need to go on the regimen. Since the
interview, Harold has been taking PrEP. While in this disclosure, he talks about what his
friends are saying, there is doubt that is expressed by his gay friends within his social
network. Harold’s recommendation, from his friends, calls for more research, but Paul
expressed similar doubt about PrEP being new even though he acknowledges the sexual
opportunities and pleasures that it can bring. He stated:

I think you’re right that the role that something like PrEP can play in terms of
what barebacking means, how it functions, and the real risk involved in it,
whether it’s people’s individual lives or whether it’s the performance of a
pornography. Yeah. I agree. I think that can be a major factor. I haven’t
necessarily thought through all of that cuz to me, it’s still a relatively new phenomenon. (2013, June 26, Interview)

This dichotomy described by Paul is one that I personally as a gay man understand. At one end, PrEP seems like a license to play with uninhibited desire and eroticism yet, at the other end, it is still so new to the public with many unanswered questions. This sense of doubt is compounded by the competing messages about PrEP which will be discussed later in this theme.

Another sense of doubt is that condoms should not be entirely rejected from the sexual experience if someone is using PrEP. Zander disclosed what he has so far learned from PrEP:

I work in the media, and whenever they first came out with PrEP—I guess maybe when they were first proposing it to the public, I think that I’ve only heard of it as used for most at-risk people for gay men for HIV prevention. For example, if you’re in a relationship with an HIV-positive man, like one HIV-negative man and one HIV-positive man, the HIV-negative man can take this, and it increases—it’s like in addition to using condoms is what I’ve mostly read it as. Recently, I guess, they’ve come out with saying it can almost replace a condom, but I think that’s still the general practices that you should use both if you’re really at risk. I have never heard of it being used or recommended for people who are just sleeping around. I guess, where is that line drawn? I’m not sure. (2013, July 5, Interview)
What I think is most revealing from Zander’s disclosure is the notion of “most at-risk” which is translated as “high risk” by many medical professionals and organizations. According to the CDC (2013c), they state that MSM are considered to be the population at higher risk of HIV transmission. What is interesting about Zander’s statement, coupled with what the CDC states, is the notion that sexually active Gay Men are at high risk and should strongly consider being on PrEP. But as simplistic at this seems, it is more complicated than that due to the newness of PrEP.

Charlie, who lived through, and experienced, the AIDS crisis in the 1980s and 1990s, sees great value in PrEP and is happy to see it being made available to Gay Men but his doubt is expressed by the message getting out to Gay Men who need it the most. Charlie suggested:

Well, it seems like a really good idea, but one of the things I thought is a lot of times really good ideas don’t get out there. For example, HIV testing you heard about it all the time, on the radio, on this and that for a long period of time, and now you don’t, not so much. That would be—I think it’s a super idea, but to get people to incorporate in a meaningful way in their lives, I think it’s gonna be a struggle. It’s like when they finally figured out that the human papillomavirus causes cervical cancer. It’s comes—it’s basically an STD. Many, many people didn’t wanna get their daughters inoculated because my daughters don’t have sex, right? (2013, December 10, Interview)

Charlie’s opinion about getting the message out to those who need PrEP is one that should not be dismissed.
Louis, who is from the same generation as Charlie, has doubts about PrEP due to taking a medication to prevent a virus or illness. Also, he is worried about the era of the 1970s resurfacing in modern times:

My thoughts are that it’s a good thing if it really works the way it’s intended to work. I have a lot of concerns about taking a medication to prevent HIV or any kind of infection, for that matter, ahead of time because one of the medications might affect your kidneys. That concerns me, number one. Number two, I worry about the fact that it almost becomes like a morning-after pill for some people with that concept that “I can still do this but take the medication” although, obviously, you have to take it ahead of time. I’m worried about that mindset. I’m worried about the cost. In today’s environment, insurance companies, are they gonna pay for so-called preventative medicine and not wait till you get infected, then cover it. Those are three things that concern me about it. On the other hand, I think that if a person is active sexually and not just with one partner. We’re talking here multiple partners, fooling around, which again I’m not condemning. More power to you, basically, if you’re gonna do it, but I would hope that you’d be safe. I wonder if being on that regimen is gonna make people careless, is gonna make people believe that they’re protected so that then they can be careless. From what I understand, it is a supportive type of medication. In other words, you still should use a condom. God forbid the condom breaks, now you hopefully will have some protection. That’s my concern. More than anything else, it’s my concern that it makes people callous about “I have this medication, I’m taking this
medication; so now, if something happens or rather an accident happens, I’ll be okay.” Hopefully, that would be the case, but I wonder how that’s gonna affect people’s intent to have sex. It’s a safety net that if it works the way it’s supposed to, it’s beautiful; but I’m wondering if people are gonna take that as an excuse to then have the 1970s all over again. (2013, October 17, Interview)

Louis is worried about the resurrection of unsafe sexual practices by Gay Men, but earlier in his interview he disclosed about recently observing young Gay Men on Fire Island engaging in anal sex where they were not using condoms. Some may argue that the 1970s has reemerged with regards to sexual practices among Gay Men. The question is, are Gay Men, or most of them, acting in a careless manner? Some of what Louis mentioned will be discussed in the medical interpretations of PrEP dimension within this theme.

Finally, doubt was also expressed similarly to what Louis discussed as Gay Men taking PrEP and becoming potentially careless. As result of such carelessness, Thomas C. believes that it could lead to and create more infections. He disclosed:

After reading up on it, I think the first thought that came across my mind was that it could lead to a lot more infections ‘cause people think that it’s like the end all, be all. It’s guaranteed to work and be safe, and if you’re with someone in a relationship or just with a hook up and they say, “I’m on PrEP,” you might abandon all defenses against HIV or any STDs. You really don’t know if they’re telling the truth or if they’re taking it regularly and all that stuff. (2014, October 10, Interview)
Although there is doubt in Thomas C’s mind about the prevention measure, his doubt was also expressed by those saying they are taking it and entrusting others to take it daily which Louis also expressed. Mark’s doubt was also expressed similar in that other precautions need to be taken:

You still have to take precautions, and you can't just rely on one thing, especially since it's not something that's a sure thing for now. I think you still have to be cautious about who you have sex with. There's still that chance. Even if you know the person, there's that chance that's— there’s still a chance. (2013, August 14, Interview)

Mark’s interpretation of HIV still being transmittable was cause for concern and Melchior’s doubt about PrEP was no different:

I think it's still—in my mind, it's still important just because there's other—although HIV is one of the more—not detrimental, but one of the more prominent STIs that you could get; the other ones are more treatable—but I feel like in my mind it would make people feel less inclined to use protection because they feel, "Oh, well, I can just go get this PrEP thing." I think for people that—I dunno. (2013, August 6, Interview)

Overall, the doubt among the participants had to do with other STDs and STIs still being transmitted while being on PrEP, which is obviously true, in addition to concerns about whether or not Gay Men would take it consistently, doubt about the positive messages of PrEP being communicated to a larger audience, doubt of who should or should not take PrEP, and any other doubt associated with the medication. Doubt is a powerful
phenomenon that nearly all humans deal with at some point in life. Father Brendan Flynn, the character played by Philip Seymour Hoffman in the movie Doubt (Rudin & Shanley, 2008), stated, “Doubt can be a bond as powerful and sustaining as certainty. When you are lost, you are not alone.”

**Increased sexual risk.** The fourth dimension within this theme that often appeared in the interview data are the various health and medical interpretations that participants shared in regards to PrEP. There are a few elements that will be discussed – the first of which is the notion about participants worrying about others protecting themselves less from HIV and other STDs. Specifically, participants expressed concerns about younger generations protecting themselves from HIV and other STDs. Melchior stated:

> I think that it could lessen—especially with all the antiviral drugs and everything that are out there, it's lessened the impact of getting a positive test result. I feel like PrEP—even though I feel like it's a good thing, I feel like it could lead to more future generations being more lackadaisical about protecting themselves. (2013, August 6, Interview)

Melchior notes that successful HIV treatments make life easier for those may become infected but then seems to provide an antithesis to PrEP by noting that it will create a culture of relaxed safe sexual practices. Similar to Melchior, Larry also suggests that PrEP could open the floodgates to welcome unsafe sexual practices. He specifically states:
I have mixed feelings about it. I’m really happy that such a thing exists, but what I would be fearful of, and maybe it’s unfounded, is that risky behavior would become the norm again. That may be the case for a while, but nature has a way of raising its head again, and something else popping up that could—Whereas, the Gay Men’s Health organization really pushed condoms, condoms, condoms, and the gay community picked it up and really went with it. I’m fearful that condoms will go away again. (2014, February 4, Interview)

When these interviews were collected, PrEP was brand new, and yes it is still a new phenomenon as this analysis is being written so there are rightfully some concerns about how PrEP could potentially change or cause a shift in safe sex practices. Looking back to chapter two of this document, as well as chapter four, there is a plenty of research and evidence to suggest that unsafe sexual practices in the gay community, or barebacking, is an embraced norm by many sexually active Gay Men. The condoms, unfortunately seem to have disappeared on both the pornography level as well as the interpersonal level.

Luke had a similar reaction and expressed doubt about PrEP:

I’ve read a little bit about it and have heard that it's seeming to be a pretty good thing. I question it, personally, and think that the methodology is completely skewed and flawed in several ways. I think if there is something, that's great. I think that that's a wonderful thing. My fear is that it will also make people think, "Oh, I can just take these pills and then do whatever I want." All of a sudden, standards will become lax, and people will be throwin' their legs up for anybody that walks past. (2013, September 9, Interview)
Jack also believes that PrEP provides less protection and that it would therefore create a culture of unsafe sexual behavior. He noted:

Oh. No. I think you should—well, I mean, I still think you, if you want to be as careful as you can, I still think you should use a condom. I don't think this would prevent anything. I worry that this would give people even more of a free pass to just go out and do whatever and not expect any consequences from that or affect other people in that way. (2013, October 15, Interview)

There are a few items to take away from these perspectives of the participants. One, is that PrEP is not the end all, be all as far as protecting individuals from other STDs. Secondly, condoms were recommended in addition to taking PrEP in the studies published on this medication. But deep down inside, with the competing message from the pornography industry, one that is creating a large amount of barebacking-only pornography, the bareback practices of the participants, and the increase of bareback sex, do men in the gay community really believe that PrEP will cause a culture of unsafe sexual practices? Based on my personal experience, and the results of the interviews, we may already be there.

These speculations about future sexual practices and promiscuity are nothing new. Women had to deal with the same competing narratives when birth control was first introduced in the medical arena. Doctors were noted as saying that birth control would cause “galloping cancer, sterility and nymphomania in women; mental decay, amnesia and cardiac palpitations in men; in both sexes the practice was likely to produce mania leading to suicide” (Walsh, 1980, p. 184). The notion of nymphomania creeping into the
lives of women, as a result of birth control, almost creates this vision of women being out of control sexually as a result of contraception – at least at the time when birth control was first introduced. For Gay Men, it is not that different in that people, both in and out of the gay community, are claiming that PrEP is going lead to more promiscuity and unsafe sexual practices – two realities that are evident from the research discussed in chapter two as well as the narratives disclosed by participants. In this instance, unlike the earlier fear of what contraceptive devices would create, it may come to pass that the sexual culture does become more promiscuous and less safe.

**Health & medical interpretations of PrEP.** Another dimension within this theme are the various health and medical interpretations of PrEP that participants expressed. Within this theme, participants provided various interpretations and speculations about the science and medical efficacy of PrEP. For example, Luke questions the actual science in regards to the research conducted by the PrEP studies. He states:

> Studies are saying that—I forget the percentage—80 percent or something that were staying negative, but they were saying that they were supplying them with counseling. They were encouraging safe sex. They were doing this little kit of safety, when really the only thing there was the pills. Everything else is there available to everybody anyway. You can't imply causality that the pills are doing something when maybe it's because I'm on the pills, I'm more conscious and just engaging in more safe sex. I'm not doing anything unsafe. I've changed my risky behaviors because of the awareness of it. That's great if that's causing that
awareness, but you still can't imply causality that the pills are doing it. I think that the reporting of those reports are overstated. Even the ones that then were negative and have become positive—they were suggesting that they weren't taking their pills as much as, that there wasn't as much of the medicine in their blood. I don't know. I just had some issues with the way things were reported about it and that it's not exactly true. (2013, September 9, Interview)

While Luke’s concerns are valid, it is important to note that multiple studies have found that PrEP, taken at least four days per week can prevent HIV by up to 99 percent (see chapter two). With any new drug or technology of this nature, these questions will certainly arise and with time will hopefully dissipate with more research and education.

For others, the question of science was raised but in another form. Zander mentioned how he would need a more sure-proof way of preventing HIV instead of through a pill such as Truvada. He notes:

I’m not gonna take a pill so that I can get fucked bareback sex. Yeah. Bareback sex is great, but I know my body. I don’t need to take a—find a cure. I know this is working towards a cure, but no. This isn’t like, “Oh. Now we have something that can manage it and keep you safe from it.” No. Find a vaccine. Find a vaccine, and then I’ll feel safe. (2013, July 5, Interview)

Medically, Zander needs more than PrEP to be safeguarded from HIV – he expects a cure or a vaccine. There the doubt in the science of PrEP and its efficacy is still an issue for some Gay Men and perhaps among the MSM population as well.
Another element within this health and medical interpretations dimension, that participants expressed concern about, was idea of a new strain of HIV being formed as a result of Gay Men using PrEP and then having unprotected sex. Jack noted:

I think I read this somewhere. I don't know if it was just some weird person saying this, but this preventive—and correct me if this wouldn't happen—but making an even more resistant strain of HIV from this. Do I think that it would hurt to try it? No. Do I think we should be giving it to every gay man in the world? No. I think people at highest risk should be on it, but I don't know. Cuz that in itself is enough of a question. Would you create something worse from preventing this? (2013, October 15, Interview)

Jack was not alone in his scientific and medical concerns surrounding PrEP. Paul, who is nearly double the age of Jack, stated something similar:

What I recognize is a change for the community at large. That’s for the better. Yeah. I hope so. I mean do I have questions about this as well? I do. Say, for example, I know some people talk about, “Well, okay. If there’s constant cycles of reinfection, can you create new strains of HIV?” Is there a danger that people on PrEP feel like, “Okay, I can bareback?” Are there then different exposures that can happen repeatedly that actually then things mutate and change? (2013, June 26, Interview)

Both of these participants question whether or not new strains can evolve from use of PrEP coupled with unsafe sex. These concerns, while valid, have yet to be proven. As of the writing of this dissertation, there has been no study or evidence to indicate that using
PrEP can create a superinfection or a resistant strain of HIV. Liegler et al. (2014) noted recently, in their study, that “Detection of PrEP-selected DR [i.e. Drug Resistance] mutations was infrequent” (p. 1224). Of the small number of people who did develop DR they noted, “Minor variant DR mutations were rare, and when detected, were measured at very low frequencies” (p. 1222). Unfortunately, I did not know of this information at the time when I conducted the interview with these participants. Regardless, taking PrEP and new strains of HIV being created, as expressed by the participants, is minimal and has a low possibility of happening (at least based on current knowledge).

While many participants discussed various levels of doubt about PrEP, its efficacy and other various medical criticisms, some participants expressed concern and a sense of trust when it came to others taking the daily regimen. Jack notes:

That person who says that might be on it, but they might only take it once. They might forget to take it every few days or whatever and you have to take 'em consistently for it to work to the point where it's gonna work. I tried to do before this, before we started talking, I did my own research. I definitely, as I read in the article, I don’t think that it should be used as the sole-- end all, be all. I don't think that—I guess that's not the right way to say it. Not that I don't think I—well, yeah. I don’t think many people would be as religious as taking it as one would hope. If you say, “Oh, I'm on Truvada or whatever,”—is that how you say it? Truvada? (2013, October 15, Interview)
Jack is specifically talking about adherence, which is the commitment to take and finish a medication as prescribed by a physician. Harley’s take was more personal when it came to adherence and trusting himself to take the daily PrEP regimen:

I’m not a big person—I hate taking pills. I don’t take vitamins. I don’t take anything. That’s the struggle that I would have- is every morning I’m supposed to get up and pop a pill in my head or pop a pill for that purpose when I might go over a week without even having sex. It’s not like—Right. I mean in my mind it’s not—I guess if I was having random sex and going to bath houses or a movie house. I mean there are people that I know that do that. If they’re doing that every day, then I think maybe it would be, in my mind, worth it. I also know if you were to have AIDS, there’s other things that you can do. I mean if you have HIV, I should say, there’s other things that you can take and medication you can take that would limit its impact on you. Either way, you’re gonna have to take pills. Either take it before or take it after. There’s people now that have lived a long life with HIV. (2014, April 5, Interview)

Harley’s disclosure is very telling on many levels. First, he discusses his personal commitment and assessment to take a daily pill to prevent HIV and compares that to the amount of sexual contact he is having on a week to week basis. Secondly, he then elaborates and hints on how when engaging in gay sexual contact whether it is before or after acquiring HIV there are pills regardless. Also, it is important to note that Harley talked extensively about his barebacking experiences and partners (see chapter five). He
disclosed to me, just recently, that he is now taking a PrEP regimen after learning about his partner’s recent HIV-positive diagnosis.

Whether it is Gay Men trusting themselves to take the daily PrEP regimen or trusting others to take it, adherence is certainly a valid issue. Psaros, et al. (2014) found in their study of PrEP adherence among serodiscordant couples in Uganda that their participants were able to adhere to the prevention measure even after the intervention. The specific intervention to increase adherence was a cognitive-behavioral counseling session among participants in the study. They also note that future PrEP adherence studies are needed to find and implement the best strategy. For Gay Men who are HIV-positive, drug adherence paints a different picture. Oh et al. (2009) noted that “blacks and Hispanics are more likely to be nonadherent and that individuals from Central and South America and the Caribbean are especially at risk of nonadherence” (p. 293). Additionally, Reback, Larkins, and Shoptaw (2003) found that of all the HIV-positive gay and bisexual men they interviewed, “Methamphetamine use as a barrier to adherence was coded into two themes: (1) planned non-adherence and (2) unplanned non-adherence” (p. 781).

While these two studies discuss adherence for those Gay Men who are HIV-positive, these studies reveal who is at risk of nonadherence – those who use recreational drugs and differences by race and ethnicity. These populations could provide a great area of research for future PrEP adherence studies.

Another medical interpretation that came up was whether or not PrEP had medical side effects. What was interesting to me was that only one person expressed concern about it – just one. PG stated, “I have to read about it and make sure the side effects—I'd
like to understand that first. Yeah, I would give it some serious thought.” This lone
revelation was shocking to me as I expected nearly all of participants to raise issues and
concerns with regards to side effects of the taking a daily PrEP regimen. This was
brought up by Leydorf (2011) when PrEP was first introduced. Of all the PrEP studies
that have been conducted, the CDC (2014g) reported:

None of the studies found any significant safety concerns with use of daily oral
PrEP. Some trial participants reported side effects such as an upset stomach or
loss of appetite but these were mild and usually resolved in the first month.

(“PrEP Clinical Trials,” para. 3)

This is promising information for those who are concerned about the side effects of PrEP.
Again, this is information that I did not have available to me when I first started the
project and interviewed participants. Brandon, one of the two participants taking PrEP,
did mention some stomach and lower intestinal issues when he first started the regimen
and he mentioned that was short-lived and those symptoms never returned.

Another medical interpretation of PrEP, provided by Damon, related to how PrEP
allows him to take control of his own health in ways that he was never able to do as a
sexually active gay man. He disclosed:

Well, PrEP, for people who prefer to bottom, it's the first time that we've had the
ability to prevent HIV. We've always had to depend on the top to do it. We've
always had to rely on the top and the condoms for our own protection. Now,
anyone who prefers to bottom is completely autonomous of that and has the
ability to control whether they become HIV positive or not. We don't have to
control the condom use or not. That's major, that's major. Just for psychological reasons I prefer the PrEP approach than only the task—the treatment as prevention approach.30 (2014, January 16, Interview)

Damon, who sexually identifies himself as a bottom, is on PrEP and prefers that tops (i.e. sexual partners who penetrate him) not use condoms. He talked extensively in his interview about how PrEP has allowed him to no longer worry like he used to before he started the regimen. What I think is interesting about this disclosure is how Damon discusses how men who bottom can now protect themselves instead of worrying about the top to use the protection (i.e. a condom) in a sexual encounter. For Damon and other Gay Men, who identify as a bottom, PrEP can become an important part of their sexual health, but will this idea create an expectation for Gay Men who bottom (i.e. the receptive anal partner) to be the ones to protect themselves while letting tops off the hook? While this concern did not come up from any of the participants in the interviews it could be a greater, long-term concern among men in the gay community who wish to no longer use condoms. Additionally, this can potentially create an expectation among women to be on PrEP if a man does not want to wear a condom. As discussed earlier in chapter two, seropositioning is when an HIV-negative person will seek out an HIV-positive bottom, because the risk of transmission is low, as opposed to the other way around. If there is an expectation that Gay Men who prefer to bottom should be on PrEP so their top partners can enjoy bareback sex will this create “PrEP-positioning?” Obviously, more research is needed in this area about the expectations and perceptions of PrEP and its users.

30 This philosophy and approach to HIV prevention is the idea of getting HIV-positive people on ARVs to bring them to an undetectable level so they will not pass the virus on to others.
One final element within this health and medical interpretation of PrEP is a sense of stigma around having to take PrEP. Christian noted:

I also think about it, and this might be my work coming in, but it—not surveillance, but it feels different to have to take a pill in order to stay healthy.

Oh, I’m on the fuckin’ pill. I’m on the HIV prevention pill – like it’s helping a problem. Like I’m on an antidepressant. (2013, November 21, Interview)

Christian’s sense of uncertainty and concerns about PrEP is not so much medical or scientific but is social. Specifically, having to disclose that he is on PrEP and having to disclose that others may, perhaps, put the wrong notion or image into the minds of others. Thomas C. mentioned something similar:

I understand the purpose of it. You take it if you think you’re gonna—if there’s a strong chance that you might get AIDS or if you’re in a relationship with someone who has AIDS. I don’t think I would ever take it only because I think there’s still—and this is bad on my end—but I think there’s still a stigma in my mind of I don’t wanna be attached. I don’t wanna be attached to something like that even if it could prevent it just ‘cause I don’t want my name under that category. Does that make any sense? (2014, October 10, Interview)

Whether it is not wanting to be connected to the drug because of what others think or any other stigma associated with the behavior that could potentially come out by taking PrEP (i.e. bareback sex), there is a little concern about being associated with HIV medication. After all, that is how Truvada first started to be used when it came to the market – it was prescribed as an HIV medication. Kroker (1992) coined the term “Body McCarthyism”
which is the idea of “political discourse is reduced to the purity of your bodily fluids” (p. 325). Lupton (2007) elaborates:

The contemporary obsession with clean bodily fluids has been termed ‘Body McCarthyism’ and viewed by critics as an hysterical new temperance movement that targets the body’s secretions and which expresses anxiety over the invasion of the body by viral agents. (p. 38).

Specifically, the disclosures stated by Christian and Thomas C. bring forth a hypothetical situation, and potential judgment, of others if they were to disclose that they are taking PrEP. Disclosure of being on PrEP can potentially make people think that the sex partner has too much sex, are always reckless, have no respect for her/his body, etc. PrEP has the potential to bring on a new era of “Body McCarthyism” in that judgment is passed on those who take PrEP. Damon and Brandon have not had instances where they experienced stigmatization from any sexual partners but I have observed on the PrEP Facebook page where men voluntarily submitted Grindr or Scruf\\(^{31}\) conversations where others outright rejected them as a result of disclosing their use of PrEP. Again, this is an interesting element for future study of PrEP from a social perspective.

**Negative criticism & interpretations of PrEP.** The criticism laid against PrEP was not as pronounced in the interviews as it is in some media outlets and by some organizations. Overall, the participants expressed concerns and doubts about PrEP, not so much criticism, with various notions about Truvada – mostly cost, efficacy and side effects of the drug. Nearly all of the participants expressed concerns about possible side

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\\(^{31}\) Interactive mobile phone apps designed for gay men.
effects of taking PrEP, but Paul articulately expressed concern for the larger, greater issues of PrEP existing in society. His long, important narrative expresses a criticism that has the potential to emerge among the public:

People basically said, “You can’t give children this vaccine because it will give them license to engage in sex.” Right. Is there that danger that, again, because of how we talk about sex and sexual health in this country, that there are forces that say, “No, we can’t actually give people something like PrEP cuz it will mean they’re just gonna go crazy and have lots of sex, and we don’t like that cuz we’re Puritans, right?” We think that sex should always be for procreation within marriage, and there are obviously still a staunch force in our society that believes this. The notion of sexual freedom and sexual health are intertwined. It is a political issue because medical issues are political issues, and sexual issues are political issues. To me, this is not a battle that’s been won. We saw this with HPV and the vaccine. We saw it with the slippage back into abstinence-only education, which as I say, I think has been a fiasco. All these things have to interact in general. I’m for one real reluctant to say, “Oh, PrEP is the silver bullet that’s gonna solve the HIV crisis.” I don’t think it is. I think it may be one very important component within a much larger social medical, political, personal change that’s going on or that constantly is going on. That’s always going through change, but I see it as part of a much broader complex of how sex actually functions or it actually is as individuals, as couples, as communities, as society, right? It’s all that. (2013, June 26, Interview)
Paul was the first interview I conducted for this project and PrEP was slowly becoming noticed by just a few media outlets at the time. I am not sure if his intelligent, thoughtful insight was the result of being informed on the issue or his experience of living through the 1980s and 1990s at the height of the HIV/AIDS crisis. During the interview, I did not really reflect on what he said until well after all of the interviews were transcribed and I moved forward with the project. I now see the various societal, political and medical implications of PrEP after studying the interview data and seeing what people are saying about PrEP.

While Paul discusses the great societal issues about PrEP in the first interview I conducted, one of the last interviews I conducted was with Damon, who is a user of PrEP, and he captured a lot of the overall negative criticism that surrounds PrEP. He argues that PrEP is the best thing we have so far in the fights against HIV:

Also, just to say, if I'm your doctor, what if there was a vaccine for HIV? Wouldn't you want me to have that? Wouldn't you share that with me? This is 99 percent effective. It's not a vaccine, but this is the next best thing we have to a vaccine until we have a vaccine and/or a cure. Let's do this. That's how I approach that with my parents and then my friends are just used to hearing me talk about sex anyway, so it wasn't really a thing. The only—I didn't get any negative feedback from them; it was just concern because the science was new. Nobody really understood it; most people still don't understand it, even after the FDA approved it. People still don't really understand what this is. Wow. This is—I mean, let's think about that, this is an FDA approved medication and it's covered
by all insurances. Yet most people still don't have any clue that this exists. On—
today is Thursday, I think Tuesday—Monday or Tuesday this week, landmark
case that the Department of Health in New York finally publicly is now offering
guidelines for doctors. That's huge. Now doctors can consult the CDC, but in New
York State, the Department of Health now offers guidelines for practitioners to
prescribe PrEP, whereas they would not do that before. That's new and we're
hoping that's gonna be another legitimate step towards doctors and medical
providers really getting a sense like, "Oh, okay, this actually makes sense for
some of my patients." Now, you asked about the negative stuff. Yes, there's plenty
of that. It's probably—I don't know why, but I was a little bit naïve. I thought,
"Okay, if people don't understand this, they'll maybe think about this with an open
mind and they'll be curious. They'll ask questions. They'll wanna know about
this." I would say for the most part, people do. There's a small group of very loud
people who are encountering PrEP with trepidation and fear and rage and vitriolic
name calling, slut shaming, crap. (2014, January 16, Interview)

Damon was correct in that New York City’s Department of Health (2015) did pass
guidelines for use of PrEP and PEP for at-risk populations. Damon’s advocacy has helped
spread the word about PrEP both in the gay community and to doctors as many have
taken to prescribing it to Gay Men in major cities but the uptake on PrEP has been
dreadfully slow. According to the latest estimates, “As of March 2013, less than 1,800
people had filled PrEP prescriptions. Pickett32 said he has heard anecdotally that the

32 Jim Pickett is the Director of Prevention Advocacy & Gay Men’s Health at the AIDS Foundation of
Chicago.
number has now surpassed 3,000, but added that he has not seen conclusive data” (Heitz, 2014, “Providing Help with Insurance,” para. 1). Perhaps some of the slow uptake of PrEP could be the result of the negative criticisms launched by some in the media.

One specific negative criticism is the term “Truvada Whore” created by writer David Duran (2012) in The Huffington Post. He has since apologized for those terms but this criticism and language creates a backlash from those who are taking PrEP and those considering the regimen as well as fueling the fire of opponents who against the idea of PrEP. Damon talked extensively about these negative criticisms fired towards users of PrEP and provides an interesting rationale for what creates this condemnation:

I mean he's [David Duran] still on the records calling Truvada—people who use PrEP, “Truvada whores.” That is one of the terms that's been used. “Silent murderer,” geez what else? “Nape oil salesman”—Yeah. Now what I have seen now is that people who really feel that strongly against PrEP generally are part of the first wave survivors of AIDS, people who are severely traumatized either as a—they're positive now or they're negative, but they went through that experience of the trauma and death and devastation of seeing the—what AIDS really did to people at the beginning. They're still carrying that. They're still reacting to that. That's PTSD. PTSD is when we use the past trauma to experience what's happening in the present. It often comes out, especially in men, in terms of vitriol, in terms of rage. It's a hyper vigilance. It's an easily startled response that comes out in anger and impulsive rage. We see this in people who come back from war, specifically more often in men who come back...
from war. Not that women don't get PTSD, but the rageful component of that is more common in men. People who have survived war, or trauma, or kidnapping, sometimes domestic violent relationships, are traumatized. I am seeing this in many of the first—the people who are negative about PrEP, who are angry about PrEP, seem to be mostly part of that first wave of AIDS. They're still responding now as if this is something that happened before. They cannot—they only in their minds, they only see condomless sex with the traumatic, horrible, devastating death that they witnessed firsthand up close. The funerals they went to, their friends and the loved ones that they lost, the people they held and took care of. In their minds, they equate condomless sex in 2014 with the devastating impact of 1984. There's no separation. I get—I totally understand that from a psychological point of view. From a political and a medical standpoint, I do take issue with this. Now if you're trying to use that logic to stop science and to stop young people who weren't even alive in 1984 from becoming HIV positive, you want to stop them from using PrEP and you wanna “should” them and shame them into becoming HIV positive now, that's not cool. That's not effective. That does not move us forward as a society or as a community. (2014, January 16, Interview)

Damon’s conclusions are present and alive when it comes to competing discourses about PrEP. For example, while David Duran has since apologized for using the “Truvada Whore” label for those choosing to use PrEP (Duran, 2014), many in the PrEP community, especially Gay Men, have taken ownership of the label and have created t-shirts with “#TruvadaWhore” emblazoned in white letters on light blue fabric which the
same shade of blue as the actual Truvada pill (this can be seen in figure 12). This controversial label, once used in a negative connotation deriving images of highly sexual active Gay Men engaging in risky behavior, is now being championed by those in the community using and advocating for PrEP. In a sense, it is claiming ownership of a negative term and redefining it – just as police did with “pig” in the Vietnam protest era, and has been done with “queer.”

Figure 12. Image of #TruvadaWhore t-shirt. This is an example of those taking PrEP and reclaiming a derogatory phrase as a form of empowerment. http://www.huffingtonpost.com/david-duran/truvadawhore-an-evolved-o_b_5030285.html
This “slut shaming,” called out by many users of PrEP, including Damon, is believed to prevent many Gay Men from talking to their doctors and sexual partner(s) about PrEP and sexual behaviors. In an article titled, “Slut-Shaming Is a Cause of HIV,” Hussain Turk (2014) lays out some interesting arguments that are directed to those in the gay community. Specifically, he is responding to a letter from a reader after *HIV Plus* magazine did a profile on Turk. He argues:

This kind of moral rectitude is an honest reflection of the mainstream gay community’s retreat into a closet where good sex has been forsaken for same-sex marriage. I don’t just mean good in the sense of orgasmic-good, I mean good in the sense of healthy, consensual, engaging, and mutually fun….Our sexual shame erases the history of years of queer community organizing and consciousness-raising around good sex. It blinds us from our own desires as homo-sexual beings. It prevents us from showing our faces on Grindr and Scruff, forcing us instead to beg for face pics after we’ve supposedly already come out of the closet. It sucks us into bars and meth houses in thirsty droves, desperately seeking escape from our inhibitions. It precludes the gay rights corporations we fund from campaigning for treatment as prevention and PrEP or for educating about the implications of an undetectable viral load. (para. 3 & 6)

Turk’s argument is certainly unique to the gay community in that the focus is on responsible, consensual sex. Decades ago, when Gay Men were afraid to be out to their families, friends and workplaces, gay sex found its way into the empty piers of New York City, the back of tractor trailers, discreet bathhouses (*Gay Sex in the 70s*, 2005) – way
before the private conversations taking place on social networking sites and apps. Discretion, anonymity and pleasure were the practices of the time and along came HIV/AIDS and it spread quickly because a sexual system was in place (Shilts, 1987). This is not to say that gay sex was wrong but it made it difficult to talk about gay sexuality to the general public that held strong heterossexual views. As a result, Gay Men had many struggles in the early years of HIV/AIDS activism when it came to communicating, protesting and demanding services, research and treatment.

Overall, PrEP seems to parallel the early years of HIV/AIDS in trying to get Gay Men, as well as the straight community, to understand the efficacy of PrEP in addition to sexual rights and responsibilities. Instead of the sexual shaming trope of “gay men should not be engaging in so much risky sexual behavior,” the conversation should focus on Gay Men, as well as others, having every right to protect themselves in any sexual situation. But as PrEP gains more attention, the sexual shaming has continued. Dan Savage, who is openly gay, is an internationally syndicated sex advice columnist, journalist and author. He stated in the *New York Times* that PrEP users are “self-identified idiots who can only be saved by a vaccine” (Morgan, 2013, para. 15). Larry Kramer, arguably the Dr. Martin Luther King of gay rights and AIDS activism in the 1980s and 1990s, also stated in an interview about Gay Men who take PrEP:

Anybody who voluntarily takes an antiviral every day has got to have rocks in their heads. There’s something to me cowardly about taking Truvada instead of using a condom. You’re taking a drug that is poison to you, and it has lessened your energy to fight, to get involved, to do anything. (Healy, 2014, para. 10)
David Duran, Dan Savage and Larry Kramer are not the only individuals who have spoken out against PrEP (Savage has at least placed videos on his website supporting, and accurately, explaining PrEP).

As noted earlier in chapter one, Reagan Hoffman (2011), the former editor-in-chief of POZ magazine, stated in an editorial that “Make no mistake: PrEP is a profit-driven sex toy for rich Westerners, disguised as a harm-reduction and prevention tool for disenfranchised people at risk for HIV. And it’s coming to a drugstore near you” (para. 24 & 25). Speaking out against PrEP, in these contexts, can potentially push sexually active Gay Men (as well as at other-risk communities) away from seeking the needed advice about PrEP, talking with their healthcare provider about the regimen. These individuals collectively are more than just negative towards PrEP, they are visible, popular media figure and HIV/AIDS activists who all have wide-reaching audiences.

While these criticisms thrown towards PrEP are disconcerting, the most egregious of these comes from Michael Weinstein – the President of the AIDS Healthcare Foundation (AHF). According to AHF’s (2014a) website, they are “a global organization providing cutting-edge medicine and advocacy to over 350,000 patients in 36 countries. We are the largest provider of HIV/AIDS medical care in the U.S.” (“About,” para. 1). Michael Weinstein has stated the following about Truvada, the pill used as PrEP, as "If something comes along that's better than condoms, I'm all for it, but Truvada is not that. Let's be honest: It's a party drug." (AP, para. 4, 2014). When I asked Damon if he has personally experienced any negative criticism about openly talking about or taking PrEP he responded with the following:
Actually, no. All of it's been online in the safe zone of people's computers where they can just say whatever they want. If you go on any of the pages on the internet you'll see my comments and then you'll see the words that people use. I've gotten some messages. Some of these rageful fires are flamed by a certain organization out of LA who has been the AIDS Health Care Federation Foundation, Michael Weinstein's dog and pony show. He's really fanning the flames of this vitriol. He is so anti-PrEP. He is taken—he, as the CEO of AHF, which is supposedly a non-profit AIDS service organization, have taken out full page magazines and newspapers, billboards in Los Angeles, they've rented trucks and driven around Los Angeles calling Gilead of greed. Saying, "People should not be using PrEP, they should only be using condoms," should, should, should, "Condoms, condoms, condoms, only. Condoms only. There should be no other thing." Now you gotta wonder why an AIDS service organization would be so diametrically opposed to the science that actually protects people by 99 percent if adhered to. That's more effective than condoms. Condoms—there's been very little research, actual research, done about condoms. At best, in these two landmark studies about condoms, both in 1989 and 2013, condoms—I can show you this research, condoms are found to be maybe 75 percent, 80—between 75 and 80 percent effective. PrEP, if taken every day, is 99 percent effective. Okay, why do we fight this? Why are we so angry about this? (2014, January 16, Interview)

Damon brings to light many interesting points and his interview was the first time I was made aware of Michael Weinstein and what he stood for when it came to PrEP. Michael
Weinstein and his organization have since taken out full page advertisement space in many publications in which they are advocating against PrEP. The controversial advertisement, with erroneous medical information on it about PrEP, can be seen in figure 13 – it also appeared “in 11 print magazines in California and Florida” (Heywood, 2014, para. 1). There have also been similar advertising campaigns launched by AHF speaking against PrEP and even watching and consuming bareback only pornography. This is problematic on a number of levels. For one, they are reporting incorrect scientific data to the public. Secondly, they are engaging in fear-mongering, especially for Gay Men who take PrEP (they mostly publish in free gay publications). According to their website they note that, “Generating and defining new, innovative ways of treatment, prevention and advocacy is the hallmark of our success” (“About,” para. 1). This remark runs counter to what Weinstein has stated about PrEP in public forums.
Figure 13. AHF anti-PrEP advertisement.
This is the anti-PrEP full-page advertisement created by the AIDS Healthcare Foundation (AHF, 2014b). aidshealth.org
Some believe that Weinstein and the AHF are more concerned about protecting their interests and the bottom line of their organization. While this is unfounded, it does however beg the question as to why they are saying such things, especially as they are an organization that provides healthcare services to those affected by HIV/AIDS.

Additionally, AHF and Michael Weinstein criticized the FDA for passing the use of Truvada as a form of PrEP. He specifically stated, “From the beginning, we believe there was a rush to judgment by government officials and others in favor of such approval despite decidedly mixed studies offered in support” (Young, 2012, para. 14). In 2008, Weinstein again made news when he penned a piece in the *L.A. Times* about how federal funding for an HIV/AIDS vaccine should be ceased because it costs too much money and the attention and resources need to be put into treatment programs. He specifically wrote:

> Our position is this: In light of over 20 years of failed AIDS vaccine research on which billions of dollars of U.S. taxpayer money have been spent, we believe it is simply unconscionable for the U.S. government to continue such wasteful funding while millions worldwide dies for want of access to the AIDS research breakthrough that occurred more than 10 years ago – life saving antiretroviral treatment. (para. 2)

While some may see some value in what Weinstein thinks, the real question is how he truly feels about overall HIV prevention. He and AHF advocate for condoms only in an era where condom usage is low, especially in the gay community. Weinstein has thrown criticism towards funding of an AIDS vaccine and now PrEP. Many have questioned, especially on the PrEP Facebook page, where his true interests and intentions lie.
In addition to these negative interpretations and perceptions of PrEP, I asked Brandon if he had experienced any backlash or negative criticism. He stated the following:

I’ve heard some of the backlash and the fact that even guys who play raw all the time don’t want to be on it. They don’t want to ever think about being on it, because why take a pill when they’re negative every day? Cuz if they get positive, then they’ll just take a pill. (2014, February 6, Interview)

This negative criticism toward PrEP is what possibly could be the biggest barrier to getting people, especially sexually active Gay Men, to adopt and embrace this prevention tool. It is clear that Brandon is not talking about men, that he has encountered, who are denying or questioning the efficacy, safety, and/or cost of the medication. These are men who are suggesting that there is essentially no difference between taking one pill prior to an HIV diagnosis or taking a pill after an HIV diagnosis. While there is logistically, and arguably medically, no difference between taking a pill prior to or after HIV (assuming the HIV-positive person is in care and taking his/her daily prescribed medication), I would argue the biggest difference is that an HIV-positive person will more likely experience more stigma than the HIV-negative person. The negative criticism surrounding PrEP will not go away any time soon. People like Damon, as well as others, will need to remain vigilant in communicating a positive, receptive message about PrEP as Gay Men try to understand the science and medicine of this important prevention measure.
Positive embracement of PrEP. In addition to the negative criticism steered toward PrEP, through these various dimensions, there were some positive interpretations of the prevention measure. For example, when I asked Philipe if he would consider a daily regimen of PrEP he stated the following, “Yeah. Cuz I was like, if there's this pill that's been proven to increase your chances of not getting infected by HIV, would you not take that preventive measure? That's how I viewed it once I looked into it.” Harley had a similar response in that he believes PrEP comes at a time when many are forgoing condoms in their sexual encounters. He stated:

I think I see PrEP as just, I guess, basically from what I know about it, I don’t see it as a separate thing. I see it in the whole context of, “All right, if you get it, there’s a way to deal with it.” There’s a way to deal with it before you get it. I mean there’s—I mean obviously it proves that using a condom all the time for sex, that whole argument and that whole movement didn’t work. If it worked, then they wouldn’t have to find a cure for AIDS or HIV. We wouldn’t have to come up with PrEP and all these others things would be better off. (2014, April 5, Interview)

Harley sees the greater social and scientific implications of PrEP within the realm of what is happening in the gay community among men who are not using the traditional form of prevention – the condom. Instead, Harley argues for a sense of taking control of HIV prior to acquiring the virus.

Similarly, Brandon has also had positive interpretations toward PrEP when communicating with other men about its efficacy. He stated the following:
Yeah. I think that if you tell them that it’s the HIV-prevention medication that’s out, they are fascinated by it because they’ve never heard of this. When you break it down and you tell them that this piece of the medicine is actually one part of a cocktail that someone who is positive on there, they almost get weirded out because they know that you’re now on part of a cocktail. But they now realize that it’s because of your viral loads, which is really the case behind when you’re positive to lower your viral loads. (2014, February 6, Interview)

It seems as if Brandon runs into guys who are curious about PrEP but then question why he is taking an HIV medication. Overall, he has had a positive reception from others who are genuinely interested in PrEP as a prevention measure.

Damon obviously has a positive perception and interpretation of PrEP, not just because of its efficacy, but because of his history in working in HIV/AIDS advocacy. He describes his original contact with information on PrEP:

I was part of the study, what they called the 502 study in 2006 where I received an experimental HIV vaccine. Once my part of that trial ended, I started to work for them as an educator and as a recruiter in the field, and would go out to bars and clubs and talk to people about vaccine trials and try to get them interested. This is how I heard about PrEP in the first place was because I was working for this HIV prevention organization. When the first results of the iPrEx study came out, the day before Thanksgiving in 2010, that's how I heard about it was 'cause I was working that day the news came in. It was like, “Whoa, really big stuff.” (2014, January 16, Interview)
Damon had a personal yet indirect connection to PrEP when its efficacy was first revealed. He, like most Gay Men, have seen trial after trial of failed HIV vaccines only to then be exposed to PrEP – sort of “the next best thing.” In addition to Damon’s disclosures and how he views PrEP, the Advocate magazine ran a story on Gay Men who take PrEP. In addition to Damon, who was featured in the article, five other openly Gay Men discussed why they use PrEP. Christopher Glazek stated in an interview (Reynolds, 2014) that “I started taking it after writing about it for The New Yorker. In the course of my reporting, it became clear to me that there was no reason not to take it! It’s time to leave AIDS in the past” (para. 1).

Since AHF’s advertisement questioning the efficacy of PrEP, there have been counter advertisements and campaigns against their view. Figure 14 illustrates a counter-advertisement from Project Inform. This battle and fight over the message of PrEP, whether it is from within or outside of the gay community, does not seem like it will go away any time soon. Based upon the interview and evidence that has been reported in the media, it seems as if the fight and message of PrEP and its efficacy will continue to be played out in the gay community and beyond.
The HIV/PrEP body. The various meanings provided by participants within this theme with regards to PrEP varied across participants. PrEP in and of itself is an object, specifically a social object loaded with great meaning within itself. But when PrEP is separate from the body, as it was for most participants, there seems to be a disconnect. Grosz (1994) states:

Because my body is not seen as a mere object by me, I necessarily have a different relation to it than to any other objects. It is by means of my body that I am able to perceive and interrelate with objects; it is my mode of access to objects. And unlike my perspectival access to all other objects, my own body is not accessible to me in its entirety” (pp. 91-92).

Although PrEP is a new medical phenomenon, many of the participants (i.e. those not using PrEP) are trying to figure out what it means for them within the context of HIV prevention and gay sexuality. PrEP, as a social object, paralleled with the deep, complex meanings within the gay male body, are about navigating a sense of place within the gay male body and how it fits. PrEP is more than a medical and biological phenomenon, instead it adds another complex level of meaning as both a medical and social object onto the landscape of the gay male body.

PrEP, as a new phenomenon of HIV prevention, is simple in its purpose (i.e. its efficacy with preventing HIV) but is layered with many complex meanings. From a biological perspective, PrEP serves a great purpose for the gay male body. From a socio-cultural perspective, PrEP offers more than a simple biological, medical answer to HIV prevention. Grosz (1994) states:
In itself, the body is not a machine; but in its active relations to other social practices, entities, and events, it forms machinic connections. In relation to books, for example, it may form a literary machine; in relation to tools, it may form a work machine. The body is thus not an organic totality which is capable of the wholesale expression of subjectivity, a welling up of the subject’s emotions, attitudes, beliefs, or experiences, but is itself an assemblage of organs, processes, pleasures, passions, activities, behaviors linked by fine lines and unpredictable networks to other elements, segments, and assemblages. (p. 120)

The gay male body is no different especially with regards to PrEP. The gay male body is an entity through which it interacts through an intricate landscape of gay sexuality, health, HIV and PrEP. And the specific, individual experiences of the participants, along with their bodies, are subjectively embodied and interpreted with all of these phenomena. This theme summarizes the notion that Grosz (1994) argued early in her text: that is the body “must refuse singular models, models which are based on one type of body as the norm by which all others are judged” (p. 22). Although this project does not encapsulate one comprehensive theory of the gay male body, the narratives and disclosures show a plurality and subjectivity that our bodies, while they speak, do not all speak, interpret, or create meaning in the same way.

**Summary.** Baglia (2005) wrote that “As a nation, we do love our pills. A pill satisfies both our love of techno-science and our culture’s quick-fix mentality” (p. 52). For PrEP, the “little blue pill” is a piece of techno-science that does provide this “quick-fix mentality,” but it is much more than that. It is a commitment to a daily regimen to
prevent a virus that has plagued and stigmatized the gay community for more than three
decades. Taking a daily pill that prevents a stigmatized virus, coupled with the vision and
assumption of sex without a condom, is complicated in our culture to the say the least. It
raises doubts as well as negative criticism from those in and outside of the gay
community. For some it is an embraced phenomenon that encourages Gay Men to take
control of their health, their bodies and sexuality. Due to how new PrEP is, the gay
community is still trying to navigate how all of these competing discourses and
interpretations affect one another. There is both fear and hope in PrEP as well as stigma
and empowerment.


Chapter 7: Discussion & Conclusion

Sexuality must not be thought of as a kind of natural given which power tries to hold in check, or as an obscure domain which knowledge tries to gradually uncover. It is the name that can be given to a historical construct: not a furtive reality that is difficult to grasp, but a great surface network in which the simulation of bodies, the intensification of pleasures, the incitement to discourse, the formation of special knowledges, the strengthening of controls and resistances, are linked to one another, in accordance with a few major strategies of knowledge and power. (Foucault, 1978, pp. 105-106)

When it comes to understanding all of the ideas presented in this project, there are no simple answers. In fact, there are more likely to be more questions produced from this project than “take-aways.” Corbin and Strauss (2008) seem to capture how this project has evolved since its inception:

The world is very complex. There are no simple explanations for things. Rather, events are the result of multiple factors coming together and interacting in complex and often unanticipated ways. Therefore any methodology that attempts to understand experience and explain situations will have to be complex. We believe that it is important to capture as much of this complexity in our research as possible, at the same time knowing that capturing it all is virtually impossible. We try to obtain multiple perspectives on events and build variation into our analytic schemes. We realize that, to understand experience, that experience must be located within and can’t be divorced from the larger events in a social,
political, cultural, racial, gender-related, informational, and technological framework and therefore these are essential aspects of our analyses. (p. 8)

This project certainly was not easy. From the discovery of PrEP to the present, there were many paths that opened that simply could not easily be separated from one another nor ignored. Specifically, PrEP cannot be isolated without careful reflection paid to gay sexuality, gay health, HIV and the gay male body. These interconnected phenomena are inextricably tied together and provide a better context for not only understanding PrEP but for comprehending its relationship to each phenomena individually. With regards to stepping away from the examination of these phenomena, this chapter will attempt to discuss what all of this means for Gay Men and their community.

This chapter will address the theoretical implications and connections of what all of these phenomena mean for the gay male body. There will be careful reflection and discussion of the research questions proposed in chapter one. There will also be a discussion of future research with regards to PrEP. Additionally, there will be a thorough discussion of the challenges facing PrEP moving forward as well as potential solutions to get around these barriers. Finally, there will be a discussion of my own reflexivity as a researcher studying these phenomena.

**Theoretical Implications**

In order to make sense out of what the analysis and interlocking phenomena mean, this section will revisit the theoretical ideas outlined in chapter two. Additionally, this section will answer the research questions outlined in chapter one. Those questions are:
1) What meanings do Gay Men subscribe to barebacking within the context of PrEP regimens?

2) What meanings do Gay Men subscribe to HIV/AIDS within the context of PrEP?

3) What do Gay Men (re)think about gay sexuality and gay health in regards to PrEP treatments?

4) What does PrEP mean for the gay male body?

Coupled with the analysis chapters, nearly all of these questions can be answered by revisiting the theoretical ideas of Elizabeth Grosz, Kenneth Burke, and Michel Foucault.

As outlined in chapter two, Grosz (1994) detailed six elements of a body theory. The first is that the study of the body “must avoid the impasse posed by dichotomous accounts of the person which divide the subject into the mutually exclusive categories of mind and body” (p. 21). I think this project fit well into this implication because participants thoroughly discussed how they navigate a complex sexual terrain in the gay community through both mind and body. Specifically, participants thoroughly discussed how and why they pursue the sex they do, whether or not they would use PrEP, and how their behavior and choices would affect their health. Not only did the participants discuss and rationalize these in length, when given the time to think about these ideas, they also talked extensively about how their body navigated these phenomena. Hawhee (2009) provides a discussion on Burke and piety in her text; she states, “Thus the body is where something like beliefs and even morals are formed” (p. 68). This project shows that no
matter how Gay Men think, feel or rationalize about any of the phenomena, they embody these ideas in concert through the body and mind as opposed to one over the other.

For Grosz’s (1994) second element of studying the body, she argues that “corporeality must no longer be associated with one sex (or race), which then takes on the burden of the other’s corporeality for it” (p. 22). This is a powerful statement by Grosz because, as it relates to this project, Gay Men have had to live in the shadows of a heteronormative world and among heteronormative bodies. As a result, the understanding of gay male bodies, in comparison to heterosexuals, is different. For example, participants drew parallels of PrEP as birth control. While birth control is still a contentious issue today, it is more mainstream than PrEP at least for now. This project shed light onto the various complexities that Gay Men face with regards to their bodies. Because this project is a moment captured in time, the gay male body may look different in the future in that it is always in flux, especially when it comes to sexuality. Foucault (1978) discusses the notion of “the body that produces and consumes” (p. 107). He elaborates on this idea by stating:

Sexuality is tied to recent devices of power; it has been expanding at an increasing rate since the seventeenth century; the arrangement that has sustained it is not governed by reproduction; it has been linked from the outset with an intensification of the body – with its exploitation as an object of knowledge and an element in relations of power. (p. 107)

Throughout time, the gay male body, especially with regards to sexuality, has looked different and has been conceptualized at various levels. This project would have probably
looked different pre-AIDS, pre-Stonewall and or pre-ARV therapies as those eras would have derived different gay male corporealities because of the various interpretations Gay Men have created around this phenomenon. And as a result, Gay Men have produced different cultures and lived experiences than today. With each new era in gay culture, Gay Men “build their cultures by huddling together, nervously loquacious, at the edge of the abyss” (Burke, 1954, p. 272).

In addition to Grosz (1994) arguing against a singular body form when it comes to sex and race, she also argues for no one single corporeal form within those forms. She specifically argues:

Third, it must refuse singular models, models which are based on one type of body as the norm by which all others are judged. There is not one mode that is capable of representing the “human” in all its richness and variability. A plural, multiple field of possible body “types,” no one of which functions as the delegate or representative of the others, must be created, a ‘field’ of body types – young and old, black and white, male and female, animal and human, inanimate and animate – which, in being recognized in their specificity cannot take on the coercive role of singular norm or ideals for all the others. (p. 22)

This element laid out by Grosz calls for plurality and multiplicity in the study and research of the body. This project would probably have produced different results and a different view of the gay male body if there were more Gay Men of color who could have been participants as this group is one most affected by HIV today. Similarly, different results would have also been produced for the lesbian body, the non-abled gay male
body, the bisexual body, etc. Furthermore, the gay male body, as it is presented today in this project will arguably look different in the future.

For Grosz’s fourth element of a body theory, she argues that “while dualism must be avoided, so too, where possible (though this is not always the case – one is always implicated in essentialism even as one flees it), must biologistic or essentialist accounts of the body” (p. 23). This falls directly in line with Burke’s (1954) idea of efficiency which, he notes, “endangers proper preservation of proportions” (p. 248). Specifically, he explains:

“Efficiency,” to borrow a trope from the stock exchange, is excellent for those who approach social problems with the mentality of the “in and out” trader. It is far less valuable for those interested in a “long-pull investment.” Otherwise stated: It violates “ecological balance,” stressing some one ingredient rather than maintaining all ingredients by the subtler requirements of “symbiosis.” (p. 250)

Safe, gay sex, up until 2010, has always been the use of condoms and the argument has been for men in the gay community to use them. This embraces Burke’s notion of “efficiency” as it allows for the acceptance of Gay Men to live freely in a society which constrains sexual liberty and desire. Gay Men cannot openly discuss habits of barebacking or their lack of condom usage with others, especially outside of the gay community, for fear of judgment or not being “efficient” with their bodies or health.

Additionally, the essentialist, biologistic account of the body that Grosz argues against also aligns with Foucault’s (1980) notion of biopower which is the prevalent ideas of power installed onto a population and their bodies. PrEP is loaded with many
meanings – both medically and socially. These meanings that exist both inside and outside of the body, and how Gay Men respond to these meanings, provide for a powerful interaction between their bodies and PrEP. Specifically, PrEP, which scientifically and sexually allows for Gay Men to engage in bareback sex because the fear of acquiring HIV is lessened, goes against the establishment and prevalent narrative of safe, gay sex which was promoted since the inception of the AIDS epidemic. PrEP, instead, allows another alternative to safe sex that, while unorthodox to some, is quite meaningful to others, especially in preventing HIV. Also, it goes against an old, outdated model of taking care of the gay male body by only using condoms. Heading toward the future, one may write about how PrEP is essentialist and biologic to the gay male body with regards to the prevention of HIV and may someday be part of the biopower lexicon.

Grosz’s fifth point for studying the body argues for both the internal and external meanings and interpretations to be articulated. Specifically, she states, “whatever models are developed must demonstrate some sort of internal or constitutive articulation, or even disarticulation, between the biological and the psychological, between the inside and the outside of the body, while avoiding a reductionism of mind to brain” (p. 23). This is an important element for this project as there are competing discourses, as outlined in the fourth theme in chapter six, regarding PrEP, gay sexuality and gay health – both inside and outside of the body. For one, PrEP, the management of personal gay health, and the sensual feelings of bareback sex are felt and managed inside the body but are also reflected on the outside of the gay male body. The criticisms launched against men who
wish to practice bareback sex, whether they are on PrEP or not, is sensed and consumed from outside as well as inside the gay male body.

To build upon this idea, Grosz (1994) used the metaphor of the Morbius strip which is a loop that shows the outside as well as the inside of a loop or ribbon. Similarly, the body acts as the same phenomenon as argued by Grosz. All of the interconnected elements and phenomena discussed in this project are projected biologically inside the body as well as outside of the body. Specifically, medical research, as well as popular culture outlets, discussed PrEP as having tremendous, positive, biological and medical effects inside the body when it comes to preventing HIV. Outside of the gay male body, as noted by some participants, is the hesitancy in wanting to take PrEP and the uncertainty in understanding how it works. Additionally, there are some social effects to taking the pill – those who take the pill are questioned about their sexual practices or perhaps judged for their promiscuity. When it comes to gay sexuality and practices, with specific regards to the phenomenon of barebacking, many of the participants, as reflected by scholarly literature on barebacking, showed that Gay Men embody and embrace barebacking as a sexual practice. Internally, many Gay Men love the feeling and eroticism of bareback sex and externalize it through their bodies by talking about it, placing personal profiles on gay social media sites and consuming bareback pornography. Then it comes to gay health, many Gay Men obviously try to make decisions that will keep them healthy but however sometimes embrace behaviors that are social behaviors on the outside of the body (i.e. sex, drinking, not discussing sexuality and practices with doctors, etc.). It is important to note that the Morbius strip and the connection between
internal and external embodiment are not two separate phenomena but display an inextricable relationship between the two. What Gay Men do externally or the behaviors they exhibit, that are observable to others, are internalized and embodied in this interconnected relationship. The four interlocking phenomena discussed in this project exhibit an internal and external relationship.

Finally, Grosz’s (1994) sixth argument for a theory of the body argues for corporeal recognition at any point in a binary. Specifically, she argues:

Sixth, instead of participating in – i.e., adhering to one side or the other of – a binary pair, these pairs can be more readily problematized by regarding the body as the threshold or borderline concept that hovers perilously and undecidably at the pivotal point of binary pairs. (p. 23)

Whether Gay Men choose to bareback or practice safe sex, choose to take PrEP or not, choose to disclose sexuality and practices to doctors or HIV status to partners or not, the gay male straddles all of these binaries created by Gay Men. This sixth and final element presented by Grosz in a way captures the essence of this project in that the four interlocking phenomena, or binaries, of PrEP, HIV, gay health and gay sexuality are encased in the gay male body. The body cannot be taken out of these phenomena as this project is more about the interactions between and among the body, PrEP, HIV and gay sexuality.

As humans, our bodies carry rich narratives, histories and meanings. Cooks & Warren (2011) note that, “And yet, our bodies remain our mediators of the world; our physical and social deformities and our pain, far from marking us as deviants, teach us
much about the limits of received knowledges.” (p. 212). For Gay Men, the narratives, histories and meanings of gay health, HIV, PrEP and gay sexuality show multi-faceted, complex lenses of how the gay male body is seen in the 21st century. Simply put, there are no easy answers and some of them are conflicting and convoluted as well as difficult to navigate and mediate. Simply put, our bodies are a complex phenomenon loaded with various meanings placed by ourselves as well as society. Foucault (1977) talks about the notion of the political economy of the body – specifically, how various phenomena have power within the body that ultimately creates a political field of the body. He argues:

But the body is also directly involved in a political field; power relations have an immediate hold upon it; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs. This political investment of the body is bound up, in accordance with complex reciprocal relations, with its economic use; it is largely a force of production that the body is invested with relations of power and domination; but, on the other hand, its constitution as labour power is possible only if it is caught up in a system of subjection (in which need is also a political instrument meticulously prepared, calculated and used); the body becomes a useful force only if it is both a productive body and a subjected body (pp. 25-26).

For PrEP, HIV, gay health and gay sexuality, these create an elaborate and intricate political field within and among the gay male body. The analysis, as well as the scholarly and pop culture sources, show the terrain of the gay male body to be one loaded with
multiple meanings. This insight presented by Foucault aligns with the intricate connections of the four interlocking phenomena that have been discussed in this project.

Overall, our bodies are highly communicative. According to Grosz (1993), “Bodies speak without necessarily talking, because they coded with and as signs. They speak social codes” (p. 199). All of the phenomena studied and discussed in this project are built into the body that provide in-depth meanings and embedded codes of the gay male body. PrEP, HIV status, how Gay Men navigate their sexuality and manage their health are specific codes that build powerful meanings within their bodies. Also, this mapping, or placement of various landmarks loaded with meaning, of the gay male body is not new in communication scholarly literature. Fox (2007) conducted a similar project with his mapping of HIV within and among the gay male body. Specifically, he explained his project as:

I, for example, employed a narrated rendition of my lived experiences to help “map out” the discourses that influence my thoughts about HIV, AIDS, and HIV testing. As I navigated my way through a “sea of signification,” I became better able to explicate my own prejudices and fears. (p. 17)

While this specific project is not a continuation of Fox’s ideas, which deal primarily with performativity, his work stands an example of how the gay male body is always in flux and a moment in time, loaded with deep meanings and significations. Similar to Fox’s work, the narratives and disclosures of the participants, coupled with the other resources, show an elaborate mapping of the gay male body with deep, complex meanings. Future projects and scholarship dedicated to the gay male body will most likely look
theoretically similar but the content and context of the phenomena may change. Hawhee (2009) states, “Contemporary theory thus has a tendency to freeze bodies, to analyze them for their symbolic properties, thereby evacuating and ignoring their capacity and ignoring their capacity to sense and to move through time” (p. 7). Bodies are always in flux and changing, especially when new innovations (i.e. PrEP), diseases or technologies are introduced to the body.

**Revisiting Research Questions**

It is clear that the gay male body is the ever-present phenomenon of study within this project but as this project draws to a close, I will revisit the proposed research questions from chapter one. The first questioned asked, “What meanings do Gay Men subscribe to barebacking within the context of PrEP regimens?” As outlined in chapter five, within the second theme, there are really no differences in viewing barebacking from a PrEP or non-PrEP perspective. In fact, a lot of what was discussed by participants – their specific barebacking experiences, the natural feeling of barebacking, body positing, selection of particular bodies, the emotional bond and connection with partners, the flirtation with risk and danger, perceptions of condoms, and bareback pornography – reflects nearly all of the reasons why Gay Men forgo condoms for the embracement of bareback sex. While this is not necessarily nothing new, what is really interesting is the sense of peace the PrEP brings when it comes to unprotected, bareback sex for the two participants who are on PrEP. For them, the dread of having to wait for what could be a

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33 The next page is a table that summarizes all of the themes and dimensions from chapters 5 and 6 as I will be making reference to them throughout this chapter.
positive test result are gone. The fear associated with acquiring HIV, as result of practicing bareback sex and being on PrEP, is nearly vacated.
Table 1

*Summary of Themes & Dimensions*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Dimension</th>
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<tbody>
<tr>
<td><strong>The Body</strong></td>
<td>HIV Testing &amp; the Body</td>
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<td>PrEP &amp; HIV testing</td>
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<td>OraQuick &amp; HIV testing</td>
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<td></td>
<td>Bareback Sex &amp; the Body</td>
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<td></td>
<td>Medical Conditions &amp; the Body</td>
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<td><strong>Medical &amp; Sexual Communication &amp; Knowledge</strong></td>
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<td>Informal Sex Education</td>
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<td>Sexual Health Communication with Doctors</td>
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<td>Communication with Sexual Partners</td>
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<td><strong>Interpretations of HIV</strong></td>
<td>Medical Optimism</td>
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<td>Personal Optimism</td>
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<td>Social &amp; Personal Pessimism</td>
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<td>Knowledge Absence &amp; Presence of HIV</td>
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<td>Language of HIV/AIDS</td>
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<td>Silence &amp; Stigma</td>
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<td>HIV as Object/“It”</td>
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<td>Being Gay = HIV</td>
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<td><strong>Interpretation of PrEP</strong></td>
<td>Language of PrEP</td>
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<td>Birth Control References</td>
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<td>Doubt about PrEP</td>
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<td>Increased Sexual Risk</td>
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<td>Health &amp; Medical Interpretations</td>
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<td>Negative Criticism &amp; Interpretations of PrEP</td>
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<td>Positive Embrace of PrEP</td>
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For the Gay Men who were not taking PrEP, which was nearly all of the participants, they saw barebacking pretty much in the same manner, both in practice and sensuality. For these participants, most of them rejected the idea of going on PrEP to enjoy the freedom from worrying about HIV within the context of bareback sex. What is interesting about them is that many discussed in depth the dread and fear of going in and then waiting for a result of an HIV test. Additionally, was the questioning of the efficacy, science and other various doubts of PrEP by participants. For some, PrEP was not worth taking as they did not bareback often or identified as a “top.” For others, depending on their connection to HIV (i.e. whether they knew someone or are in a relationship with someone who is HIV-positive), PrEP was very meaningful in their lives. One participant, who was in an open relationship, was not willing to consider PrEP but now that his partner seroconverted he transitioned to a PrEP regimen because HIV is more personal in his life. This is just one illustration of the way in which meaning shifts from “not necessary” to “necessary”—and further explains the complex interaction that exists as Gay Men make choices between and among alternative responses to HIV-AIDS.

The first research question spring boards onto the next research question in that when it comes to barebacking prior to the advent of PrEP, the literature shows that barebacking became prolific as ARV therapies showed great efficacy in treating HIV. Within the third theme of the analysis, and reflected in the literature, there is a sense of HIV optimism among Gay Men, as well as others, when it comes to treating HIV. The second research questions, which specifically asked, “What meanings do Gay Men subscribe to HIV/AIDS within the context of PrEP?” has at least shown that the attitudes
of participants are perhaps even more solidified when it comes to HIV optimism. Nearly all of the participants thought that PrEP was great for the prevention of HIV in theory but less than half were willing to take the regimen. The various interpretations subscribed to HIV within the third theme, whether they were thinking about PrEP or not, show many complex issues with the virus in the gay community, especially when older and younger participants are compared in their views of HIV. In a sense, this is what Burke (1984) discussed with regards to “frames of acceptance” which he describes as “the more less organized system of meanings by which a thinking man gauges the historical situation and adopts a role with relation to it” (p. 5). I think the answer(s) to this question will continue to evolve for Gay Men. For most of the participants, although they had a basic understanding of PrEP, I think for most of them PrEP is too new of a technology for them to adopt. As more positive information comes out about PrEP, and more people start taking PrEP as a form of HIV prevention, the meanings that Gay Men subscribe to PrEP will most likely change. Additionally, the answers to this question will change as new prevention measures and HIV treatments become available, especially potential cures.

For the third question, “What do Gay Men (re)think about gay sexuality and gay health in regards to PrEP treatments?” participants provided an array of interesting responses. From the literature and response provided by participants, many Gay Men are simply not discussing health issues or sexuality with doctors. Additionally, the lack of formal sexual education, and conversations about such, are potential barriers to increased PrEP use and awareness. Similar to the result of the first proposed research question, the difference between the two participants who are on PrEP, and all of the others not on
PrEP, were night and day. For the two users of PrEP, they were forced to be proactive in getting an HIV test and visiting and talking to their doctor about their sexuality and practices whereas the other participants rarely talked to their doctors about their sexuality and HIV. While participants saw a lot of potential health benefits, with regards to PrEP, mainly in preventing HIV, the two PrEP participants saw greater benefits beyond HIV in that they were forced to get periodic tests for HIV and other STDs. Again, the more prolific PrEP becomes, it has the potential to change the landscape, or mapping, of gay health and sexuality in a positive way. It will hopefully encourage Gay Men, and their doctors, to have honest conversations about sexuality, sexual practices and HIV testing. It will also force and encourage conversations about HIV and STD status among sexual and romantic partners.

The fourth and final research question, “What does PrEP mean for the gay male body?” is highlighted throughout this entire project. With the vast history and elements that have marked the gay male body, PrEP is another added, new narrative placed upon the body. First, there was criminalization of the gay body, then the Stonewall liberation, then HIV/AIDS, then protease inhibitors, then gay marriage and now PrEP. Not only is PrEP simply an added marker on the gay male body, is it loaded with various and competing meanings and narratives as outlined in the fourth theme of chapter six. For instance, it was interesting to how participants created language around PrEP in addition to other interpretations that resulted in an array of how PrEP was viewed by the participants. Again, there were some conflicting ideas within this theme – most notably, those who had a lot of doubt and negative criticism about the regimen and those who
embraced it as a viable form of HIV prevention. Another interesting element was the comparison between PrEP and birth control. As PrEP continues to become mainstream and more credible in the eyes of Gay Men, the varying interpretations will likely continue to evolve. These ideas will be elaborated on in the next two sections of this chapter.

This project, and its results, have major implications for communication. For one, there is a public fight going on between getting the accurate information about PrEP out to those at highest risk of HIV and those who are creating campaigns questioning its efficacy. The media campaigns, the language they choose and how their messages are presented, are all important phenomena in the future of study of PrEP in the field of communication. Also, PrEP is now, or at least will be, part of the health communication lexicon. There have been decades of HIV/AIDS and STD prevention research, mostly dedicated to condoms, that has appeared in the health communication research. Now, PrEP is a viable and effective HIV prevention measure that has the potential to make just as big of a presence in that literature. In reflecting on this project and some of the readings about HIV/AIDS I had in my doctoral program I am so impressed with the potential and promises of PrEP and the future of HIV prevention. Specifically, in reading Adelman and Frey’s (1997) book, The Fragile Community: Living Together with AIDS, HIV/AIDS scientific and medical research has come a long way and so has the social research. The social, cultural and communicative research about PrEP should continue to create a path of literature in the field.

Additionally, this project also touched upon the verbal and nonverbal elements of the central, interlocking phenomena that were discussed in this project. As new
innovations, such as PrEP, are introduced into a society, the language of sexual education and safety also change. From a nonverbal standpoint, participants discussed how observing the bodies of other Gay Men play a role in the sexual encounter – both in interpersonal and pornographic encounters. This project also has implications for how Gay Men could talk to their healthcare providers about sexuality and practices because the one major element separating them from PrEP is a prescription, or essentially “permission,” from a doctor. Navigating the healthcare landscape, and the interactions with providers, have important implications for how PrEP figures into the health communication field whether it is the knowledge and education gained from public health campaigns, as well as schools, all the way down to the interpersonal connections Gay Men have with their providers as well as their sexual partners. In addition to the disclosure in a healthcare setting, are the conversations that take place among sexual partners. This project discussed both the verbal (although limited) and nonverbal interactions between Gay Men in the sexual encounter. Again, disclosure, conversations about risk, HIV/STD status, assessment of risk as well as communicating sexual desire to one’s partner(s) also has an important place in sexual and health communication. Finally, communication scholars should continue to examine the intricate and complex meanings about sex, HIV, sexuality and identity. These projects should look at this at the intrapersonal, interpersonal, group and organizational (i.e. community) levels.
Barriers & Challenges Facing PrEP

Looking forward, and trying to navigate what PrEP means for the gay male body, bareback sex, gay health, and HIV, there is a lot of evidence to show that PrEP has an uphill battle. One of the biggest barriers to PrEP, to getting an accurate message out to those who are at high risk, is the AIDS Healthcare Foundation (AHF). Since writing this, AHF has launched more public health campaigns against PrEP, with Michael Weinstein calling the prevention measure “a public health disaster in the making” (Barro, 2014, para. 2). Their latest advertisement, running in a newspaper geared for the gay demographic, is an open letter to the CDC titled, “What if you’re wrong about PrEP?” (the ad is shown in figure 15).

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34 In the first chapter of this document, I spent time discussing criticisms and barriers to PrEP. This section builds upon those arguments and adds additional elements of various barriers and challenges facing PrEP that evolved as I was working on this project.
Charles King, who is the president of an HIV nonprofit Housing Works and co-chairman of an anti-HIV task force created by Gov. Cuomo of New York stated in the same New York Times article that “There’s no large controversy; there is one loud voice” (Barro, 2014, para. 4). While Weinstein and the AHF are a very loud voice, they are also a powerful voice as they are “are the largest provider of HIV/AIDS medical care in the U.S.” (AHF, “About,” para. 1). They have the resources and ability to run a lot of advertisements against PrEP. Prior to writing the open letter advertisement to the CDC, they put together a similar ad titled, “There is no magic pill” which was an open letter to Gilead, the maker of the drug (i.e., Truvada) for PrEP. Additionally, Peter Staley, a veteran HIV/AIDS activist, was cited in the same article calling Weinstein “a menace to HIV prevention” (Barro, 2014, para. 7). Weinstein and the AHF are powerful voices in
the fight against getting the accurate messages out to the public about PrEP. Additionally, they, along with others such as Larry Kramer and Reagan Hoffman, seem credible because they are a large HIV/AIDS organization that aims to help people diagnosed with HIV so their messages carry powerful clout. With their standing, resources and history of advocating against PrEP, AHF will most likely not back down in this fight.

In addition to some loud voices and money leading the anti-PrEP rhetoric, if a sexually active gay man can navigate through the competing discourses, and make the correct decision for his health and body, there are so many steps needed before a gay man starts a PrEP regimen. First, he needs to visit a doctor and talk openly and honestly about his sexuality, sexual practices and get an HIV test. While this sounds simple, it simply is not. Hamel et al. (2014), in their comprehensive study of gay and bisexual men, found some discrepancies in what the participants reported. For example, they noted that most gay and bisexual men know that they should be tested often for HIV, but the main reason for them not getting tested was that they did not believe that they were at risk – 85% of respondents reported that. This was asked after only 25% reported consistent, 100% condom use. And among those who did get tested, 50% simply stated “it just seemed like a good idea” (p. 22). Even more troubling, was when the participants were asked about getting any kind of disease. Participants expressed more concern about “developing cancer, having a heart attack, developing diabetes, and becoming infected with a sexually transmitted disease other than HIV” (p. 7) all before they expressed concern about becoming infected with HIV. This data, coupled with the disclosures and narratives of the
participants shows that HIV is almost out of sight, out of mind for most gay and bisexual men.

Assuming they get to the doctor, get the HIV test, acquire proof of a negative result, another potential barrier is within the medical system. Dr. Joel Gallant, a long-time HIV specialist, stated in an interview:

One of the obstacles to the widespread use of PrEP is that HIV experts, who are familiar with antiretroviral agents and might be comfortable prescribing PrEP, often don’t see HIV-negative patients, while primary care providers who don’t prescribe antiretrovirals for treatment may be reluctant to prescribe them for prevention. (San Francisco AIDS Foundation, 2014b, para. 7)

HIV specialists, also known as Infectious Disease (ID) doctors, have the knowledge and understanding of how ARVs work and therefore understand the science and medicine behind PrEP, while primary care doctors may not be as well versed. Gallant goes on to argue that doctors need to do away with “paternalistic or moralistic thinking” (para. 9). He cited examples of doctors not prescribing PrEP if patients disclosed that they would not use condoms on a regular basis. This action taken by doctors can be perceived by Gay Men as them taking control of gay male bodies within the confines of a physician’s office.

Assuming a gay man is successful in getting a prescription for PrEP, he then must adhere to the prescription. In the iPrEx Open-Label Extension study (Grant et al., 2014), the researchers took participants from previous PrEP studies to see if they continued with PrEP adherence when their respective studies concluded. They found that 76% continued
to take and adhere to PrEP. But Landovitz and Coates (2014) raise a good issue by asking if the 76% continuation figure of PrEP is a good enough number. They specifically argue, “Because the participants were in a previous trial, the sample is biased towards a highly motivated population; therefore one might have expected nearly universal uptake” (p. 782). They argue that side effects were not the reason for the uptake but they found “participant preference’ was the most common reason for drug interruption” (p. 782). They raised questions such as daily pill fatigue or “the stigma of using a drug that has been saddled with an association with promiscuity” could be other potential reasons for the lower than expected uptake. Outside of research studies, it is difficult to predict how many Gay Men, as well as other high-risk groups, would go through the steps to acquire PrEP and then adhere to staying on the regimen. Unfortunately, there are potential barriers in place to make those steps less successful.

Another barrier for some Gay Men is whether or not their health insurance would cover the prevention measure. While I wrote about health insurance companies covering Truvada as PrEP, it is unclear how many insurance companies do not cover the regimen. Additionally, it is unknown how access to PrEP is affecting poor populations and communities of color such as African-American and Latino men – two groups at most risk of acquiring HIV. Since less than 2,000 prescriptions have been filled for Truvada to be used as PrEP, it is unclear what the population and demographics looks like for those taking PrEP, as Gilead has not publicized that information (Kirby & Thornber-Dunwell, 2014).
Another barrier and challenge to PrEP’s success is the new generation of Gay Men are growing up without having witnessed the many deaths and struggles of AIDS. In the report compiled by Hamel et al. (2014), gay and bisexual men 35 and over in their study found that 47% of that population that someone close to them has died of AIDS while only 8% of gay and bisexual men ages 18-34 knew someone who passed away as a result of the virus. Similarly, when I interviewed participants, the participants 42 and older went into great detail about people they knew who passed away as a result of AIDS while those younger than 42 did not have nearly the same experiences. This is also evidence of how there are various levels to HIV optimism outlined in the third theme of the analysis in chapter six. Furthermore, in the same report by Hamel and her colleagues, only 32% thought that the number of new HIV infections was increasing and HIV was ranked as the fourth most important issue facing gay and bisexual men today – behind discrimination, equal rights and marriage equality respectively. Peter Staley, a gay activist who founded the Treatment Action Group, stated in an interview:

Gay marriage is the feel-good story for our age. It's a noble cause. It's about love.

We were so burnt about HIV/AIDS. The younger generation views that as something the older generation went through. And they are very resistant to having it define them. (Flock, 2013, paras. 32 & 33).

While gay marriage is an important issue, it is arguably not the issue that affects the gay community as much as HIV.

Coupled with these problems, HIV education, literacy and prevention are simply not a sexy issue any longer. These attitudes greatly affects misunderstanding and
illiteracy with regards to understanding various facets of gay health, especially HIV. Yes, it is treatable, but even the information that gay and bisexual men have about ARVs is misunderstood. Within the Hamel et al. (2014) report, only 25% knew that taking ARVs consistently, as prescribed, can dramatically reduce the risk of HIV transmission. Additionally, only 26% knew about PrEP preventing HIV. These knowledge gaps are in direct competition with the discourse from AHF and others who do not embrace or believe in PrEP’s scientific efficacy.

Part of the problem for this misunderstanding, or what I call “HIV illiteracy,” is the lack of presence of HIV related information and news stories. According to Flock (2013), she reported that the Human Rights Campaign (HRC), an LGBTQ organization that advocates and lobbies for marriage equality, raises and spends millions of dollar for gay marriage while spending next to nothing on HIV/AIDS awareness and education. In fact, they were calling me repeatedly for money and I finally said “No, on the grounds that they do not do enough for raising awareness for HIV prevention and treatment.” Also there is an overall lack of media stories about HIV in the news cycle. According to Brinker and Maza (2014), during the 2013 calendar year, there have been minimal stories in general about HIV – a year that one would think PrEP would be widely discussed as an incredible medical breakthrough. What is even more troubling is that when networks did broadcast stories about HIV, only eight of the 19 stories featured an HIV/AIDS expert on CNN, Fox News and MSNBC. The results are illustrated in figure 16.

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35 HRC is typically seen in its nonverbal form as bumper stickers – it showcases the square blue sticker with a yellow equal sign on it.
Additionally, during the summer and fall of 2014 there was so much media time and attention devoted to Ebola but the chances of acquiring that disease is way less than the chances of acquiring HIV or other diseases (Doucleff, 2014). This phenomenon is illustrated in figure 17. What is important is not necessarily that there is a lack of news stories dedicated to HIV treatment and prevention. What does matter is that a new, innovative and safe prevention measure is out there for people who are at high risk of
acquiring HIV, especially Gay Men, and there are minimal news stories about this – all of
which is in the shadow of 50,000 new infections every year with no sign of slowing or
stopping any time soon.

The number of **people** that **one sick person** will infect (on average) is called \( R_0 \).
Here are the maximum \( R_0 \) values for a few viruses.

![Diagram showing level of contagion of various diseases.](image)

*Figure 17. Diagram showing level of contagion of various diseases. Comparison of infectious diseases and their level of contagion. Doucelf (2014).*

Another barrier and challenge to getting Gay Men who are high risk of acquiring
HIV on PrEP is the sexual shaming and judgment. Rich Juzwiak, a writer for Gawker,
originally spoke out against PrEP (2014a) but has since embraced the prevention measure
(2014b). In the course of investigating and learning more about PrEP, he wrote about the
process of talking to other Gay Men:

I've witnessed more frank conversations about gay men's sex and sexuality in the
past few months than I have ever before in my life. These exchanges aren't always
informed or eloquent, and they aren't always without the cloud of shame that has
tended to hang over any discussion about gay men's sexuality since before the AIDS epidemic. But they are, by and large, marked by honesty. (para. 2)

This is telling in that with the new innovation of PrEP comes a lot of judgment, shaming and lack of understanding of greater issues other than simply taking a daily pill regimen to prevent HIV. That notion raises questions from others about the presumed sexual promiscuity among Gay Men and risk that they take—an issue that is not too far off from the instance when media figure Rush Limbaugh called Sandra Fluke “a slut” when she advocated for a woman’s right to access safe birth control (Fard, 2012).

Shaming people for consensual sex is nothing new in American culture. I personally believe that the rhetoric launched by AHF as well as other figures is just the beginning of not only misinformation but the shaming of Gay Men and their sexuality.

During the 2014 summer, a controversial Supreme Court decision came out in the case of Burwell v. Hobby Lobby. In a 5-4 decision, the Court sided with Hobby Lobby so as they do not have to provide contraception under the Affordable Care Act to their family employees (Liptak, 2014). While PrEP was not named in the case, it may potentially be only a matter of time before it comes up before the Court. If a family-owned business that has conservative, Christian values and thus believes that homosexuality is deemed unnatural or immoral, what is to stop them from wanting to have their gay employees not get access to PrEP?

What could potentially be another barrier and challenge to getting credible and accurate information out about PrEP are the attacks launched against Gilead, the maker of Truvada. At the 2014 International AIDS Conference in Melbourne, Australia, groups
protested Gilead’s high cost of their HIV and Hepatitis C drugs. Their drug to treat Hepatitis C, called Sovaldi, is $84,000 for a 12-week daily dose (Curry, 2014). Their successful and one-a-day pill to treat HIV, Stribild comes in at a yearly cost of $28,500 – it is important to note that this is a lifetime prescription in order to successfully treat the virus which means years of profits for the company. Additionally, in 2009, the nonprofit group AIDS Treatment Activists Coalition compiled a report card of nine major pharmaceutical companies that market and sell HIV medications. The average grade was a C-minus with Gilead earning a C-plus (Wilson, 2009). While this may seem trivial to some, these messages about “big-pharma” are in direct competition with the advocacy and credibility of Truvada even though Gilead, as of now, has not been marketed or advertised the drug as use for PrEP. If someone who is considering Truvada as PrEP comes into contact with these messages, who does not look kindly upon big corporations or pharmaceutical companies, they can alter the person’s decision about whether or not go on this prevention measure.

Also, another barrier and challenge to PrEP is an overall misunderstanding of science and medicine. Unfortunately, there seems to be a sense of science illiteracy throughout American society. In a national Associated Press poll (2014), 42% of respondents believed that humans on Earth did not evolve from the process of evolution. Additionally, only 33% felt extremely confident that the average temperature of the planet is increasing as a result of man-made events. Even more shocking, only 53% were extremely confident that childhood vaccines are safe and effective. This line of thinking with regards to basic, fundamental understandings of science and medicine is scary for a
society that wishes to solve the major health problems of a population. With the misunderstanding of vaccines, how can advocates of HIV prevention get people to take a daily pill to prevent the virus? The competing discourses in the media, as well as others, with regards to information related to science and medicine, unrelated to HIV, create a culture of ignorance and misunderstanding. When groups such as the AHF spend a lot of money smearing the truth about the efficacy of PrEP, along with the perception of Americans toward things like vaccines and disease prevention, it makes it difficult to persuade people who have doubt about new forms of prevention which was discussed by some participants in chapter six.

Finally, there seems to be news stories that pop up about potential “cures” for HIV. Since starting this project, there have been a number of news stories about such cures that have actually been sent to me by friends. Some examples include how an antifungal foot cream can kill HIV (Moore, 2013), another discussed how bee venom can also stop the virus (Koebler, 2013). Other potential cures including the elimination of HIV in human cells from research at Temple University (Mieshaonthemic, 2014). The most famous case recently was the known “cure” in the “Berlin Patient” which was cited in many media outlets. Since that announcement, researchers noted that “Although it is possible that there is some residual virus present and that Brown is a case of a ‘functional cure’ rather than complete HIV eradication.” (Jefferys, 2012, para. 2). Similarly, there were cases announced in July of 2013 that boasted of “cures” in two HIV-positive patients as a result of bone marrow transplants (McNeil, 2014b). Shortly

36 This is the famous case, known as “The Berlin Patient” where the patient was originally identified as “cured,” after receiving stem cell therapy from a cancer diagnosis, was labelled as cured form HIV.
after this news story, it was found that HIV rebounded in both patients (Sanchez, Wills, & Young, 2013). It was also reported by *The Telegraph* that Danish scientists were within a short period of time of having a cure for HIV (Simons, 2013) but blogger Daniel MacDonald (2013) outlined how that was not the case and the potential cure would take a lot of time to come to fruition after more years of research. Finally, there was also a story about an immune-suppressant HIV vaccine taking place in monkeys that looks promising to researchers (Cairns, 2014b).

What do these potential “cures” have to do with them being barriers to PrEP? For one, it may communicate a message to Gay Men and other high risk groups about a hope that can cause them to relax HIV prevention measures in their own lives – not to mention false hopes for those who are infected with HIV. Sepkowitz (2014) argues about these “cures” broadcasted in the media that:

> Hope, of course, is an essential commodity for anyone facing a substantial illness, and promising developments placed in the not-too-far-off future can become a lifeline for those cornered by a relentless disease. But unsubstantiated hope, hope that rides on the wings of people selling ad space rather than on the shoulders of those making careful scientific observations, represents nothing but a fairy tale. (para. 9)

Not only are these cures a false hope for those afflicted with HIV, they are also potential false hopes for those who think that HIV is a minimal medical condition which further expands HIV optimism. One interview participant, Jack, discussed how he was talking to a friend about how she thought HIV was curable. Unfortunately, no matter how
promising these news stories appear to be, many people do not follow up on the science of the potential cure which makes the news story that cure was indeed a misleading news report. This stands in the way of all prevention measures whether it is PrEP or another method.

Finally, another barrier to the success of PrEP is traditional sex education. According to the CDC (2011), there were increases in HIV cases, along with HPV and other STIs, from ages 10-24. They argue that teens need better sex education both in school and at home. Unfortunately, there are always roadblocks to safe, sex education throughout the county. In Idaho, the police were called by parents after students at the Meridian school district were handing out a novel that had references to masturbation – this was after parents were successful in getting the book removed from the 10th grade curriculum (Hathaway, 2014). In California, parents complained about a 10-year old sex education book that mentions masturbation, foreplay, bondage and how young people can talk to their partners about their sexual histories (Alter, 2014). This caused 2,000 parents to sign a petition to the school board to have the book removed; an action the district decided not to take. These are a just a few stories that actually made news with regards to sexual education. If society cannot have open, honest discussions about sex, masturbation and various forms of safe, consensual sex then how can society teach young people to make informed decisions about sexual health such as PrEP? Open, honest discussions about sex with young people, who most likely know how their bodies work, is something that has always been a barrier for them to make educated decisions about preventing HIV and STIs.
When it came to understanding the barriers surrounding PrEP, participants discussed a number of issues outlined in chapter six. Zander seems to capture a lot of the potential barriers in his disclosure:

I mean, I don’t know. It’s so new. I don’t know. I mean, it might be. I mean, I guess it’s something that I could consider. I just feel like it’s—wear a condom. I mean, I’m guilty of it too. Where you get into these situations and you make the wrong decisions, but for everyone to have to be on—I shouldn’t have to take a pill because I’m—I don’t know. I don’t know. I just feel like I shouldn’t have to do that. I feel like it should be communicated enough to me that when I ask you what’s your status, if you don’t know your status, you should say, “I don’t know my status.” If I say—if you are HIV-positive, you should tell me. I guess that’s part of it is if I don’t trust people, then maybe I do need to start being more proactive about my own body. Yeah. (2013, July 5, Interview)

It is obvious that Zander is struggling to talk about PrEP and its promise. What his disclosure could suggest is that something so new, such as PrEP, is not yet easy to talk about and as a result could make it difficult for others to understand. As PrEP gains more attention and credibility among Gay Men, these barriers will hopefully dissipate over time.

**Solutions & the Future of PrEP**

While there are a number of barriers and challenges facing PrEP, there is also an array of opportunities that offer potential solutions to the barriers. Arguably, the greatest opportunity and benefit that PrEP provides is that it is still more effective than a condom
– both in practicality and complexity. Specifically, PrEP gets around the complexities of intermittent condom usage and gets around all of the various reasons as to why many Gay Men do not use condoms. Dr. Robert Grant, principal investigator of the iPRex, Grant et al. (2010) study, stated in an interview for the Bay Area Reporter that “Having used a condom yesterday provides no protection if you don’t use a condom today” (Highleyman, 2014a, “iPrex by the numbers,” para. 16). In addition to these complexities, is the efficacy of condoms versus PrEP. PrEP, as outlined in chapter one, has shown excellent efficacy (nearly 100% in those taking the pill daily) in studies while condoms do not have such a good track record. According to Smith et al. (2013), MSM who used condoms 100% of the time, were less likely to acquire HIV 70% of time. PrEP, with its near 100% efficacy, if taken daily, gets around all of the complexities and weaker than efficacy of condoms.

While Truvada is currently the primary drug used as PrEP, scientists are looking into other methods to accomplish the same goal. According to Highleyman (2014b), “Tenofovir used as a single agent for pre-exposure prophylaxis (PrEP) may be as effective as the Truvada (tenofovir/emtricitabine) coformulation for preventing HIV infection, which, if confirmed, could have implications for cost and access worldwide” (para. 1). This is excellent medical news as this can increase access to PrEP at a lower cost than Truvada. When adding medicines to either existing HIV treatments or to a PrEP regimen, the cost dramatically increases as do complexities with side effects. In addition to other drug options that could be potentially used as PrEP, there are other methods for the delivery of the prevention regimen. According to AVAC (2014), scientists are testing
the method of long-term injectables (e.g. monthly shots) that “persists in the body for an extended period of time” (para. 2) for both HIV treatments and the use of PrEP. This can obviously get around the idea of poor adherence for both HIV-positive and HIV-negative people on PrEP. Additionally, scientists are currently exploring options of delivering PrEP through the method of “locally applied prevention strategies” (Canon, 2014, “Question 5,” para. 2). Specifically, in this interview with Susan Buchbinder, MD, director of Bridge HIV, discussed how the MTN-107 study is currently underway to test a locally applied rectal lube with the drugs of PrEP in it. This too can get around those with histories of poor adherence with a daily pill. Also, these various innovative methods of PrEP can help personalize the HIV prevention strategy that works best for the individual if that person does not want to take a pill a day.

In addition to finding the right PrEP plan and regimen for Gay Men, there is a more comprehensive plan created by the Treatment Action Group (TAG) which is “an independent AIDS research and policy think tank fighting for better treatment, a vaccine, and a cure for AIDS” (“Mission Statement,” para. 1). Currently, they have a working figure that seems to capture the continuum of care for people who are HIV-positive and HIV-negative (Johnson, 2014). Specifically, they call this the double-helix, multi-tiered HIV prevention and care continuum plan. Within this concept, they outline ways in which people who are HIV-negative can stay negative, including the use of PrEP and getting people who are HIV-positive to undetectable levels. Additionally, their multi-step, multi-tiered system captures all of the ideas that were discussed and researched for this project – getting linked to care, talking to a healthcare provider to assess HIV and
STD risk, education and of course, PrEP. Their working model is illustrated in figure 18. This model captures a well thought-out approach to get Gay Men, as well as others, to constantly think and act upon HIV, especially if they are high risk. This model, while ideal, has the potential to motivate Gay Men to seek care to increase health.

Figure 18. Double-helix HIV prevention & care continuum. A double-helix suggesting how the healthcare community can care for and treat people who are HIV-negative and HIV-positive. Johnson (2014).

Also, it should be noted that there is no one-size-fits all model for HIV prevention and treatment because Gay Men are diverse in race, ethnicity, age and socio-economic status. In December of 2013, a group called the “Gay Men’s Sexual Health Think Tank
Meeting” took place which was co-sponsored by the San Francisco AIDS Foundation and Gilead Sciences. One of the major takeaways from the meeting had to do with a more inclusive approach of approaching gay sexual health. They note:

The study demonstrated there is no one-size-fits-all model of how gay men access sexual health care. Different gay men need different services in different venues, depending on HIV status, health insurance status, provider setting, perception of health needs, and other motivating factors. As a main takeaway point for the think tank discussion, the finding that the majority of HIV-negative men are less likely to consolidate their sexual health care services in one primary care location is highly relevant for HIV testing, STI testing, and PrEP program implementation, especially as current efforts to scale up PrEP are currently specifically focused on PCP (Primary Care Physician) settings. (p. 6).

This finding shows that perhaps medical practitioners need LGBTQ training in both medical and nursing schools as well as offered as professional development workshops. Gay sexual health, as outlined in this project shows that gay sexuality and practices are complex and they are in need of complex, creative solutions and approaches.

While finding solutions for addressing gay health from a holistic perspective is important, so is the use of language surrounding gay sexuality and sexual practices. When this project started, “barebacking” was the traditional term to describe unprotected anal intercourse. It is loaded with many levels of meaning in the literature and among interview participants. Now that this project is coming to a close, this language has since changed, at least by the CDC, in light of the innovations and promises delivered by PrEP.
The *HIV Prevention Justice Alliance* (Madoori, 2014) wrote an open letter to the CDC asking them to consider changing their language from “unprotected sex,” which denotes the deliberate flirtation with risk, to “condomless sex” or “sex without condoms” to note that a person may have taken the necessary measures to ensure HIV prevention such as being on PrEP or in monogamous relationships. On January 23, 2014, in a conference call with HIV advocacy leaders, the CDC made their announcement noting this change in language. This change is phenomenal news in linking an effective prevention measure, such as PrEP into positive language for those who wish to pursue this regimen. In an email sent to *RH Reality Check* (Kempner, 2014), Madoori wrote the following in an email that this change:

> Opens doors for us to discuss the myriad of challenges and progress on effective methods of HIV prevention. By continuing to use ‘unprotected sex’ to mean ‘condom-less sex’ you fail to acknowledge and lose the breadth of the entire prevention narrative in how individuals and groups choose to protect themselves and mitigate risk. (para. 9)

While PrEP may be an effective prevention measure, if these changes become standard expressions, they would accurately reflect the aim and sense of what it aims to do – prevent HIV.

Other solutions that can promote and raise awareness to PrEP include increased communication about gay sexual health issues, especially among Gay Men and their healthcare providers. For example, Thompson (2014) notes that there are eight questions Gay Men should communicate to their doctors – they include: Are you aware that I’m
gay? What sexually transmitted infections should I worry about? Do I need to be screened for HPV? Am I eating right and exercising enough? Should I be worried about my drinking or drug use? What other health screenings do I need at my age? Can you help me quit smoking? Am I at risk for depression, anxiety, or another mood disorder? These important questions provoke excellent conversations about risk, prevention and overall positive gay health. Secondly, society needs to do a better job of communicating about sexual health at an early age. The CDC (2010) notes:

Research shows that well-designed, well-implemented school-based HIV/STD prevention programs can significantly reduce sexual risk behaviors among students. A review of 48 studies found that sexual health education programs resulted in a delay in first sexual intercourse, a decrease in the number of sex partners, and an increase in condom or contraceptive use. None increased the likelihood of having sex. (“HIV/STD Prevention,” para. 1)

Additionally, talking to young people about sexual health, from both heterosexual and LGBTQ perspectives, needs to focus on their needs as young people. Richey (2014) argues that if society expects HIV rates to drop among young people then, “First, we have to stop thinking about young people as though they are a lost cause. Second, we have to communicate in a way that feels authentic to them” (para. 4). This is important because it focuses on not just putting together and implementing a program of sexual health and education but it focuses on the needs of young people in addition to relating to them.
Finally, there needs to be leadership in getting out the message about PrEP, especially among lawmakers. In the state of New York, Governor Cuomo released a three-point plan to reduce and end new HIV cases in the state. One of his plans is to provide access to PrEP. Along with New York, but acting more progressively, is the state of Washington. They are the first in the country to offer free access to PrEP through their Drug Assistance Program (Rodriguez, 2014). What is amazing about their program are the two pieces of criteria they establish – the person must have a known HIV-positive partner(s) or:

Be a gay or bisexual man who lives in an area of high HIV prevalence, has been diagnosed with a sexually transmitted infection (STI) in the past year, has been exposed to a sexually transmitted infection (STI), has had 10 or more sexual partners in the past year, has used meth in the last year, or has had condomless sex in the past year. (para. 2)

This phenomenal example of a state taking the lead and making it truly accessible for all to help curb HIV rates in the state is astonishing. Also, specific leaders can take a positive stand on PrEP as either advocates of the prevention measure or by publically talking about how they take the drug. Scott Weiner, who is on San Francisco’s Board of Supervisors, and openly gay, has come out publically talking about how he is “Coming out of the PrEP closet” (Skinner, 2014, para. 5). This leadership taken by states cannot only help to prevent HIV transmission but can de-stigmatize the virus.

Finally, the best way to understand how PrEP has a promising future is through the narrative of Damon, a participant who uses PrEP. He states;
I was pretty worried until I started using PrEP in 2011. Not because I really had reason to be worried, not because I'd been exposed, not because I'd put myself—or ever taken—not because I'd ever had been actually exposed to HIV in any concrete way that I was aware of, but I've been sexually active. I've always had partners that are positive. I've always had partners that are negative. I'm primarily a bottom and before PrEP, it was really just depending on that condom to be used and depending on it not breaking. There's times that I wasn't even always sure of that. There was always that fear involved. Yes, there was always a fear and trepidation about possibly becoming HIV positive until PrEP came along in 2011…I didn't even know how deep that fear was entrenched in my brain until after starting PrEP. Only—I mean it's been rare in my sexual life that I wasn't worried about HIV or AIDS for some reason. What if a condom breaks? What if something broke and I didn't even know about it? Then before—in the years before taking PrEP, I wasn't using condoms as consistently as before. I started having experiences without condoms that felt wonderful and then was horrified and fearful afterwards. They didn't involve ejaculation, but they involved getting fucked without condoms without ejaculation, which I know as an educator—again, the community—there's two minds about that. (2014, January 16, Interview)

As a proud user of PrEP, Damon shows it has great promise in helping to quell the fear of HIV transmission and for those who are HIV-positive. Its use can further de-stigmatize the virus. Again, over time, the understanding about the efficacy of PrEP becomes more
credible through narratives such as the one provided by Damon. When compared to Zander’s disclosure, which concluded the previous section, there are clearly two different perspectives at play from what these two participants disclosed – one PrEP user and one a non-PrEP user. These different perspectives will continue to play out in the gay community as PrEP becomes more prolific and battles through the challenges that lie ahead. Dr. Mayer, who is a professor of medicine at Harvard University and medical research director at Fenway Health, stated in an interview, “PrEP is not a panacea, but it is clearly part of the pantheon of HIV prevention” (Tuller, 2014, para. 8).

**Project Reflexivity**

When I step back away from this project, there is so much to think about with regards to the entire process of this project, its content, and myself as researcher. Typically, when I am not writing, I am constantly thinking about this project. Now that the project is coming to a close, I am going to write about the pauses I had along the way that have encouraged me to be reflexive in the choices I made as well recognizing my positionality in that process. To begin, Finlay (2002) describes reflexivity as a valuable tool to:

- Examine the impact of the position, perspective, and presence of the researcher;
- Promote rich insight through examining personal responses and interpersonal dynamics; Empower others by opening up a more radical consciousness; Evaluate the research process, method, and outcomes; and Enable public scrutiny of the integrity of the researcher through offering a methodological log of research decision. (p. 532)
Operating from this definition, I will use this section to discuss my personal reflexivity and how it has influenced some of the decisions I made in addition to provide a summative reflection of the entire project.

First, I need to reflect upon my own positionality and my presences as a researcher. As a gay man, this project, and its content came easy to me. I understood the complexities of all the answers that the participants provided. For one, talking about sex and sexuality openly, is not an easy process. I am not so sure that if someone who identified as straight would have as much success in gaining the trust and credibility necessary to obtain the responses provided by the participants. As a result, would the participants have opened up if the researcher were not a gay man? Lerum (2001) discusses this notion in depth:

Rather than maintaining a socially distant stance that is both powerful and above scrutiny, emotionally engaged researchers may find themselves in the ironic situation of having to “come out” as academics. In a sense, coming out as an emotionally vulnerable academic and coming as a sexual deviant are similar processes because both entail moving from a comfortable place with plenty of insider perks to a place that is rockier but more true to one’s heart. As an academic, one comes from a place of academic privilege, and as with other kinds of privilege, this position is safe if one “passes” as an insider, refrains from harsh institutional critique, and follows the rules. (p. 470).

Reflecting on this privileged position of where I stand as an academic, I found this project and topic easier to pursue than as being simply an “academic.” Being gay helped
me to understand the complexities of gay sexuality and sexual practices that emerged in this project. As a result, this helped me to strongly identified with the narratives disclosed by the participants.

Furthermore, this notion aligns with me discussing my dissertation topic and research with outsiders. Specifically, when asked about my dissertation topic, I in a sense “come out” on three different levels. Once, as a gay man, secondly, as a possible sexual deviant and finally, having to reveal my HIV status. Typically, the conversation with outsiders, and even academics sometimes, typically start with the traditional question, “So what is your dissertation about?” I always feel obliged to provide a lengthy discussion and tutorial about PrEP as nearly no one, other than the interview participants and some Gay Men, have never heard of the prevention measure. Usually, when I describe that PrEP is a new way to prevent HIV by using a successful, two decade-old HIV treatment in the form of a daily pill it typically piques the curiosity of nearly all of the people I talk to about the dissertation. When I disclose this, I quickly jump to the assumption that they are questioning why I am researching such a thing so I typically respond with the well-rehearsed line, “So as a gay man, who is HIV-negative, I can take this daily pill and it can prevent HIV.” At this point, the person may ask why I would want to do that when there are condoms or I again see the distressed look on their faces. As a result, I begin to educate them about them decreasing of condom usage over the past decade and a half, how there are 50,000 new HIV infections every year, especially affecting Gay Men, and how this treatment has great potential in breaking through barriers of how we approach HIV prevention.
This scenario I have probably faced at least 50 times – whether it is at academic conferences, with colleagues at work, with students, family members and even complete strangers. Fox’s (2007) brilliant essay interrogated what he called “HIV serostatus performativity” which he describes as “the ways in which people perform their subjectivities to presumed HIV-positivity and HIV-negativity” (p. 5). It was not until I started to reflect on these conversations that I am performing multiple narratives in front of others when they ask about my dissertation. While I do not know what conclusions the person I am conversing with is jumping to, I immediately assume that they think I am an HIV-positive gay man who has, or had, a lot of unsafe, risky sex. Fox goes on to write that “HIV serostatus performativity connotes multiple, layered, and oftentimes, unintended actions, behaviors, and attitudes that are prompted by discourse” (p. 5). These conversations made me realize that this project is not just about the macro, theoretical phenomenon of the gay male body, nor the bodies of the interview participants, but is about my body, my gayness, my sexual practices and my HIV serostatus.

This sense of personal reflection aligns with Ellingson’s (2009) fourth criterion for a crystallized text. She states, “A fourth principle of crystallized texts feature a significant degree of reflexive consideration of the researcher’s self in the process of research design, data collection, and representation” (p. 12). Looking back on this project, specifically, in relation to methodology, I do not regret doing interviews because it allowed for in-depth, complex disclosures and narratives that are reflective of my own life as a gay man. Specifically, sexuality and sex are not easy to discuss with others nor are they easy navigate. In fact, they are messy, contentious, challenging and often times,
judgmental phenomena to manage, especially in the minds of others and within ourselves. Ellingson goes on to state, “Crystallization necessitates a deep degree of reflexivity because it invokes the researcher’s self on so many different levels as it constructs and deconstructs meanings” (p. 177). After writing, reading and editing the analysis section I realized that the complex narratives and disclosures shared by the interview participants, and the deep meanings they produced, are also my meanings and my reservations. Adams (2011) wrote in his autoethnography of closet:

> The ethnographer of LGBTQ cultures must also find a way to study invisible and ephemeral phenomena, such as the closet, coming out, and same-sex attraction. For me, this means reflecting on and using my experience with the closet, talking with others about their experience with coming out, and examining mass-mediated representations of same-sex attraction (p. 157).

While this project is a not an ethnography, I think Adams’ work and his insight are excellent motivators to provoke LGBTQ scholars to push ourselves, as well as participants, toward a space to openly discuss these issues and to help and encourage others share their lived experiences.

> Finally, when reflecting upon the analysis and the themes that I wrote about extensively, I am reminded of an incredible scene from the movie Sideways (London & Payne, 2004). The scene is an intense, symbolic dialogue between Maya (played by Virginia Madsen) and Miles (played by Paul Giamatti) in which they are discussing why they have the passion for wine in their lives. Maya discloses her love of wine to Miles:
I like to think about the life of wine….How it's a living thing. I like to think about what was going on the year the grapes were growing; how the sun was shining; if it rained. I like to think about all the people who tended and picked the grapes. And if it's an old wine, how many of them must be dead by now. I like how wine continues to evolve, like if I opened a bottle of wine today it would taste different than if I'd opened it on any other day, because a bottle of wine is actually alive. And it's constantly evolving and gaining complexity.

This powerful and moving narrative about wine is a lot like the narratives, stories and disclosures shared by the participants of this project. Specifically, the themes that were developed from the interviews were simply one lens of viewing them. Within the 386 pages of transcripts, I noticed quickly, upon each reading of them, that multiple lenses and angles could be used to derive different meanings and associations of the participants’ narratives and disclosures. In a sense, their stories are alive and if I were to come back to them later I believe I would derive different meanings and interpretations from what was disclosed.

Plummer (2009) also identifies with the pluralism of stories. As a scholar who studies gay and sexual identity, he too agrees with the living identities of stories and narratives by Gay Men. He specifically discusses the often chaotic yet fluid structure of stories:

Stories do not take a naturally linear form, nor do they develop in naturally linear ways. They bump you around and are contingent upon the events of everyday life. They change from place to place and from time to time. They offer you moments
of choice and moments of utter fatalism. And stories themselves are never free-floating and random. They have historical roots, connect to wider patterns, cluster into structures and habits, and indeed become (often much loved) habits – part of what some sociologists now call our *habitus*. (p. viii).

The narratives and disclosures produced by the participants, along with the resources that exist in pop culture, are evidence of phenomena that simply does not stand still. While this project is a brief capture of a moment in time, there is great fluidity with each reading of a transcript as well where and how that transcript will be read later in time. This plurality of meanings and interpretations was at first difficult to navigate when the transcripts were produced. While the themes emerged, there were often competing discourses between and within participants which made analysis more difficult. But due to the nature of the topic, and its contents, this is evidence of what Plummer calls a “*pluralistic cosmopolitan sexual life*” (p. xiii) which seemed evident in the transcripts of the participants. Finally, Plummer argues that stories are embodied experiences which align with the theoretical implications of this project. Specifically, he notes:

> The telling of stories is not just about the words we speak: it is about the ways in which we move through the world with hurting and joyful bodies – our feelings, our thoughts, our bodily sensations. Stories are embodied: they are told by tellers with body processes always at work. (pp. xiii-xiv).

I believe these insights by Plummer encapsulate the narratives disclosed by the participants of this project. My hope, is that my analysis of their worldviews, their
embodiment was captured and described accurately in telling the story of PrEP, HIV prevention, gay health, gay sexuality and the gay male body.

Alvesson and Skoldber (2000) write that “There is no one-way street between the researcher and the object of study; rather, the two affect each other mutually and continually in the course of the research process” (p. 19). It was difficult to separate myself from the topic, the content, the research and the voices of the participants. I have found, through this project, a research voice that I am proud of and will hope to continue into the future as it relates to the LGBTQ community. Reflexivity is a fluid phenomenon and I may not reflect on this project in the future like I am now. Looking back on this entire process, it made me have an appreciation for this work and as Chesney (2001) states, “Reflecting honestly and openly has helped me retain some integrity and develop insight and self-awareness, and it has given me a certain self-confidence” (p. 131).

**Future Research Possibilities**

When looking at this project through the lens of reflexivity, there are a number of ways with which projects can move in the future. Personally, I would like to conduct in-depth interviews with Gay Men who consistently take PrEP to see how they navigate gay sexuality, gay health and HIV prevention. While this project had two interview participants who consistently took PrEP, they were clearly outnumbered by the non-PrEP participants. This route may possibly produce a different gay male body to understand loaded with different meanings than what were produced in this project. Also, through the narratives shared by older interview participants (i.e. 42 and older), there were stark differences between those who lived through the initial days and years of HIV/AIDS in
the gay community. Specifically, their narratives were about losing friends and family members that the younger participants simply did not experience. The specific stories told by older participants varied on many levels but it was clearly a sense of experiencing HIV/AIDS within a well-connected gay community that the younger participants simply could not articulate.

Another project that I would like to pursue in the near future would be a rhetorical analysis of the language of sex without condoms. Specifically, it would be a historical genealogy of the language from pre-condom, to safe sex, to barebacking and now to condomless sex. This study has, in a sense, started in the middle of this language transition, as it highlights the meanings attached to bareback sex in the context of what is now becoming called condomless sex. This language is interesting because of its historical association around the terminology and how it has influenced sexual behavior among Gay Men. Also, another research project that would be worth pursuing is studying HIV optimism by doing a content analysis on HIV medication advertisements in gay publications. My reason for pursing such a project is because gay lifestyle magazines (e.g. OUT & The Advocate) have multiple HIV medication advertisements. I typically see three to five of these advertisements in every issue but I never see any advertisements on HIV prevention. It would be interesting to see how many such ads there are in the publications as well as to examine the content within the advertisements.

Another future project about PrEP can be discussing the differences in discourse for and against PrEP. Since the prevention measure is relatively new and there is a lot of rhetoric against PrEP, it will be a fascinating project to pursue with regards to how anti-
PrEP messages are articulated by both Gay Men as well as organizations. Some other future research projects that would be interesting for other scholars to pursue would be quantitative pieces in which many Gay Men (both PrEP and non-PrEP users) can be surveyed about their perceptions of PrEP, HIV gay health and gay sexuality. These research projects would be excellent supplements to the qualitative, rhetorical and critical research with regards to PrEP.

When it comes to communication and sexuality research, these projects should aim to dig deep into the various meanings that are embedded in all aspects of our communicative lives. Comella & Sender (2013) argue:

In a highly interdisciplinary field such as communication, what might a communication approach to sexuality look like? To bring this question back to communication scholarship more generally, the subject resides not in words, objects, bodies, or the brain, but in the dynamic and complex processes of meaning-making. This attention to meaning-making in social interaction and organizational contexts, as well as among media texts and interpretive communities, unites otherwise seemingly disparate subdivisions of the wider field. (pp. 2562-2563)

This project sought to understand PrEP from the various perspectives of HIV, gay health, gay sexuality and the gay male body. Additionally, this project aimed to understand PrEP from not only a scholarly perspective and the narratives and disclosures of participants but to embrace the perspectives of popular culture in various media outlets. Meaning is all around us, and as communication scholars we need to embrace the various approaches
to understand the world and meanings through diverse avenues that capture the breadth and depth of the phenomena that we study.

**Conclusion**

This project is simply a snapshot of PrEP as it stands at this moment in time. Future research projects and dissertations may go into more investigation in studying PrEP, gay sexuality, gay health and HIV in relation to the gay male body. While this project is far from being comprehensive with regards to PrEP, there was at least a solid beginning in understanding PrEP on a number of contextual levels. While I embrace the promise of PrEP, and what it does for HIV, gay sexuality, gay health and the gay male body, I hope it someday becomes obsolete. I honestly hope for the day where this project becomes insignificant. What I mean by these statements is that PrEP faces a number of great challenges and I am not sure if society or the gay community can absolve itself from the competing rhetoric and attacks towards PrEP and those who take the prevention regimen. As a result of this rhetoric, my hope is that one day there will be an effective HIV vaccine and/or cure for a virus that is deeply imbedded into the history of the gay male body.

I started off this project with a narrative about why I am pursuing this project. Specifically, I discussed how watching the movie *Philadelphia* (Demme, 1993) with Tom Hanks and Denzel Washington impacted me as a young, not yet out of the closet, gay teenager. I also discussed how being gay is closely tied with deep connection and recognition to HIV/AIDS even though I remain negative. And now, this project comes full circle at it comes to a close even though the ideas will not conclude. This past year,
2014, saw the awarding of numerous accolades for the movie *Dallas Buyers Club* (2013) – a film about people suffering from HIV/AIDS in the 1980s who tried to get drugs not available in the U. S. from Mexico, in order to survive. While watching that film, I reflected on my own sexuality and understanding with being gay. The film took place in 1985, I was five years old then, and I was shocked with the advancements of HIV prevention and treatment since those early years when the virus was attacking the gay male body.

This project about the gay male body is one lens of understanding it within the context of PrEP, HIV, gay health and gay sexuality. The gay male body in the past looked very different, especially when there was no hope for treating HIV/AIDS and this phenomenon will look different in the future with different innovations and prevention and treatment measures. Twenty years ago, Uría & Terry (1995) intelligently wrote that:

> Certainly, in our contemporary cultural context, bodies have become sites of political struggles precisely over representation and over the meaning of what is normal and what is not. Through their motions, habits, behaviors, and significations, bodies have been territorialized, inscribed, contained, and dispersed in relation to high-stakes political positioning about what should be permitted and what should be forbidden in issues as disparate as abortion, reproduction, homosexuality, genetic screening, drug consumption, crime, and disease control. (p. 6)

Their argument is still relevant today, especially for Gay Men and PrEP. By itself, PrEP is not the only controversial phenomenon thrusted onto the gay male body. Instead, PrEP
is only one of many phenomena that Gay Men are trying to navigate and understand including the large spectrum of gay health, the complexities of gay sexuality and practices, and the historical, social, political contexts of HIV.

I do not know what is next for PrEP or HIV prevention but I do know that when I peak back into history with such films as Philadelphia (Demme, 1993) and the Dallas Buyers Club or reading Shilts’ (1987) book, And the Band Played On, I look at gay culture today and think that many of us are so lucky, so fortunate. With the HIV treatments today, we are so lucky. With HIV prevention measures such as PrEP, we are so fortunate. In the 1980s and 1990s, there was a lot of fear about acquiring HIV; there was even more fear about surviving the virus. Today is a new era of HIV prevention with the advent of PrEP and Gay Men no longer need to live in as much fear. Grindley (2014) states, “Years from now, you won’t regret having spoken up. But I suspect detractors of PrEP will one day find that they have another thing in common with the right wing – that they were on the wrong side of history” (para. 23).

Epilogue

This process was not an easy one. I originally set out to gain an inquiry into PrEP, a new and innovative way to prevent HIV – a godsend for Gay Men. I quickly learned that I could not simply research and understand PrEP in isolation but I needed to think, research and write about it in relation to other contexts that Gay Men embody. I did not think that I could deliver an honest dissertation without careful consideration to HIV, barebacking and gay health. These phenomena, as noted, are interdependent and deeply connected to one another as discussed in both research and interview content.
This dissertation taught me more about being a gay man than it taught me about
the phenomena I was researching. I realized, through the research and narratives from the
participants, that there are deep issues that the gay rights movement has to face. Prior to
this project, I always saw gay marriage as a civil right worth fighting, especially within
the gay community. While I still believe that, I think the far greater issues deal with a
number of health inequalities. For one, HIV is still a major problem within the gay
community. With all of the research from the CDC stating that MSM are at greatest risk
of acquiring the virus, sexual practices have not changed. Additionally, PrEP is not wide-
spread, it is widely misunderstood, and sexual politics are at play – even though PrEP has
been scientifically and medically proven to be effective.

In addition to HIV, research also shows that people in the LGBTQ community,
especially Gay Men, are also behind in other health indicators when it comes to smoking,
STDs, eating disorders, homelessness, and drug use. PrEP is a fantastic, effective tool to
prevent the disease that has plagued the gay community for decades, but so many steps
need to take place before there is a high adoption rate from Gay Men looking to take
PrEP. For one, those at risk need to get into medical care and need an assessment of not
just sexual practices but should also be checked for all medical issues. Secondly, a candid
conversation about sexuality and practices needs to take place between the patient and
physician. Next, a prescription needs to be written by the physician who has the power
over the patient in order to allow for the use of PrEP. Following this step, the prescription
needs to be filled and taken as prescribed. In the meantime, HIV tests, refilling
prescriptions and 100% adherence needs to be followed in order for the effective use of
PrEP. While these steps may seem easy and accessible to some, for others there can be many barriers that prevent people from attaining this optimum care and treatment. Despite the legislation of the ACA, it is no secret that vast inequalities exist in healthcare - class, race, gender and sexuality all play a role within those inequalities. The same is true for those who are HIV-positive and not on medications as indicated by the continuum of care. Regardless of HIV status, the virus is front and center in the gay community, even though it may not be as publically discussed as gay marriage.

The various parts and steps that need to take place for successful implementation and efficacy of PrEP are detailed and highly formulaic. While PrEP is used to prevent HIV, sex on the other hand is not so formulaic. Specifically, there is a gap between the desired sexual behavior, which tends to take on its own organic process, and the many steps that are needed to successfully get and stay on PrEP. One thing PrEP does not address is whether one believes that she or he may still need PrEP when entering a new, monogamous relationship or when a sexually active person decides to not be as sexually active as they used to be in their past. I believe the science and medical literature on PrEP is clear - if its adhered to then it is highly effective. What is unclear, for now, is how PrEP plays a role in the "gray" area that encompasses the fluidity of sexuality and promiscuity. Does it become the way paralleling how condoms have evolved in the AIDS-era? That is, condoms were the only HIV prevention measure then along came the medications in the 1990s to help those living with HIV in controlling the virus. During this time many Gay Men started to forgo condoms. With so few Gay Men on PrEP, has the mentality and culture of HIV prevention gone by the wayside? While there is no way
to know that for sure, there is a suggestion, by both participants in this study and the sexual culture surrounding Gay Men that HIV prevention is not a priority for all Gay Men. Coupled with the notion that PrEP is not being advertised and erroneous, competing information is being spread about this prevention measure, it further buries the potential PrEP possesses in helping reduce the rates of HIV transmission.

This begs the question - although there is a medical and public health need for PrEP, will it help curb the increase of new HIV rates? While the potential for prevention is there, the reality shows that there is a long way to go in order to successfully get those most at risk to follow all of the necessary steps to successfully adhere to PrEP.

Additionally, the health deficits of Gay Men, according to the research, also show many concerns for the overall health of Gay Men and their community. This project taught me that gay health needs to be a priority of the community and PrEP can certainly be part of that conversation. This, I believe, is the major issue facing the community at large - not gay marriage. Due to all of these concerns, that ultimately focus on health and well-being, I believe the gay male community is a community in crisis. That being said, the gay community needs to rally around the word “community” especially when it comes to sex and overall health.

It is too early to tell what the future of PrEP and HIV prevention and treatment will bring. My hope is that it becomes embraced and easily accessible to all Gay Men. This includes the slut shaming for those who elect to use PrEP will cease and all body shaming towards Gay Men will also come to end (i.e. on the basis of race/ethnicity, body type, age, ability, etc.). My hope is that this dissertation becomes insignificant at some
point. Hopefully our world will see a time where either a cure and/or vaccine will replace all of the suffering and stigma of HIV.
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Appendix A: Glossary of Sexual & Medical Terms

ART – Antiretroviral Treatment that consists of a combination of ARV.
ARV – Antiretroviral drugs used to treat HIV.
HIV Care Continuum – also known as the “HIV treatment cascade” which illustrates the variance between those who are HIV-positive and those who are HIV-positive and undetectable.
HPTN 052 – HIV Prevention Trials Network is a study that discusses the use of HIV ART/ARV to prevent HIV.
iPrEx Study – the original PrEP study by Grant et al. (2010).
MSM – Men who have sex with men but may not always identify as “gay.”
MSM/G – Men who have sex with men and Gay Men.
PEP – Post Exposure Prophylaxis treatment is the medical procedure to treat HIV is someone believe she/he has been exposed to the virus. This is typically prescribed within 72 hours of exposure.
PLWHA – People Living with HIV/AIDS.
PrEP – Pre-Exposure Prophylaxis is the daily medical treatment used to prevent HIV.
Seroconversion – the process of the body going from an HIV-negative status to an HIV-positive status.
Serodiscordant – a relationship between an HIV-negative person and an HIV-positive person.
Seropositioning – the process of positioning one’s body and sexual activities to their partner’s sexual activities and HIV status (e.g. an HIV-positive person may bottom for an HIV-negative person).
Serosorting – the process of picking a sexual partner that matches one’s HIV status (e.g. HIV+/HIV+ or HIV-/HIV-).
TasP – Treatment as Prevention is the idea of getting people who are HIV-positive to take and stay on ART so that transmission is dramatically reduced.
Truvada – the current drug, made my Gilead pharmaceuticals, used as PrEP.
UAI – Unprotected Anal Intercourse.
Viral Suppression – also known as “undetectable,” is obtained through taking the daily ARVs to suppress the HIV virus in the body.
### Appendix B: Probability of HIV Risk

Table B1
Average Risk of HIV Transmission Per Exposure to Infected Source

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
<th>Odds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nonsexual Modes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>90%</td>
<td>9 in 10</td>
</tr>
<tr>
<td>Needle sharing (injection drug use)</td>
<td>0.67%</td>
<td>1 in 149</td>
</tr>
<tr>
<td>Needlestick (percutaneous; through the skin)</td>
<td>0.30%</td>
<td>1 in 333</td>
</tr>
<tr>
<td>Biting, spitting, throwing body fluids (including semen or saliva), sharing sex toys</td>
<td>negligible</td>
<td>negligible</td>
</tr>
<tr>
<td><strong>Oral Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receptive partner (example, giving a blow job)</td>
<td>0%-0.04%</td>
<td>0-1 in 2,500</td>
</tr>
<tr>
<td>Insertive partner (example, getting a blow job)</td>
<td>0%</td>
<td>about zero</td>
</tr>
<tr>
<td><strong>Vaginal Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk to female with HIV-positive male partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-income countries</td>
<td>0.08%</td>
<td>1 in 1,250</td>
</tr>
<tr>
<td>Low-income countries</td>
<td>0.30%</td>
<td>1 in 333</td>
</tr>
<tr>
<td>Risk to male with HIV-positive female partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-income countries</td>
<td>0.04%</td>
<td>1 in 2,500</td>
</tr>
<tr>
<td>Low-income countries</td>
<td>0.38%</td>
<td>1 in 263</td>
</tr>
<tr>
<td><strong>Anal Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insertive partner’s risk (circumcised)</td>
<td>0.11%</td>
<td>1 in 909</td>
</tr>
<tr>
<td>Insertive partner’s risk (uncircumcised)</td>
<td>0.62%</td>
<td>1 in 161</td>
</tr>
<tr>
<td>Receptive partner’s risk (without ejaculation)</td>
<td>0.65%</td>
<td>1 in 154</td>
</tr>
<tr>
<td>Receptive partner’s risk (with ejaculation)*</td>
<td>1.43%</td>
<td>1 in 70</td>
</tr>
</tbody>
</table>

The sources and rates of HIV increase with:
Acute infection, roughly the 12 weeks after contracting HIV, can increase transmission likelihood 26 times, raising a 1.43% risk to 37%—higher than 1 in 3. This is because viral load skyrockets during the acute phase.
Presence of other sexually transmitted infections (STIs) can amplify risk by as much as 8 times.
Exposure to gender inequality and intimate partner violence can raise a woman’s HIV risk 1.5 times.

Appendix C: Gay Sexual Body Types & Co-Communities

Bear: A typically heavier, hairier, and older gay man.
Bear chaser: A gay man who pursues bears.
Bottom: The receptive sexual partner.
Cub: A typically heavier, hairier, and younger gay man.
Daddy: A typically older, financially established gay man.
Daddy chaser: A gay man who pursues daddies.
Discreet: Indicates a gay man who is reserved, private, or secretive about his identity, particularly where it applies to arranging sexual encounters.
Dominant: Indicates a gay man who prefers to play a more assertive, aggressive, authoritative sexual role.
Geek: A gay man with deep and enthusiastic knowledge of one or more hobbies, sports, activities, professional fields, or intellectual pursuits.
Ginger: A gay man with red hair.
Hook-up: A casual sex encounter.
Jock (person): A gay man with an athletic build who typically enjoys sports.
Kink: A non-standard sexual activity, fetish, or interest.
Leather: Community of gay men who have a fondness for leather gear / fetish play.
Military (person): Community of gay men who serve / have served in the armed forces (and those who are fond of them).
NSA: No strings attached; casual sex.
Otter: A typically thinner, hairier gay man.
Poz (person): HIV+.
Smooth: Indicates a gay man who is hairless or shaves his body hair.
Submissive: Indicates a gay man who prefers to play a more passive, subordinate sexual role.
Top: The inserting sexual partner.
Twink (person): A typically younger, thinner, gay man with little or no body hair.
### Appendix D: Colored Handkerchiefs & Meanings

Table D1: continued

<table>
<thead>
<tr>
<th>Color</th>
<th>Worn on Left</th>
<th>Worn on Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLACK</td>
<td>heavy SM top</td>
<td>heavy SM bottom</td>
</tr>
<tr>
<td>GREY</td>
<td>bondage top</td>
<td>fit to be tied!</td>
</tr>
<tr>
<td>BLUE, Light</td>
<td>wants head</td>
<td>cocksucker</td>
</tr>
<tr>
<td>BLUE, Robin's Egg</td>
<td>69er</td>
<td>anything but 69ing</td>
</tr>
<tr>
<td>BLUE, Medium</td>
<td>cop</td>
<td>copsucker</td>
</tr>
<tr>
<td>BLUE, Navy</td>
<td>fucker (top)</td>
<td>fuckee (bottom)</td>
</tr>
<tr>
<td>BLUE, Airforce</td>
<td>pilot-flight attendant</td>
<td>likes flyboys</td>
</tr>
<tr>
<td>BLUE, Light w/ WHITE Stripe</td>
<td>sailor</td>
<td>lookin' for salty seamen</td>
</tr>
<tr>
<td>BLUE, Teal</td>
<td>cock &amp; ball torturer</td>
<td>cock &amp; ball torturee</td>
</tr>
<tr>
<td>RED</td>
<td>fist fucker</td>
<td>fist fuckee</td>
</tr>
<tr>
<td>MAROON</td>
<td>cuts</td>
<td>bleeds</td>
</tr>
<tr>
<td>RED, Dark</td>
<td>2-handed fister</td>
<td>2-handed fistee</td>
</tr>
<tr>
<td>PINK, Light</td>
<td>dildo fucker</td>
<td>dildo fuckee</td>
</tr>
<tr>
<td>PINK, Dark</td>
<td>tit torturer</td>
<td>tit torturee</td>
</tr>
<tr>
<td>MAUVE</td>
<td>into navel worshippers</td>
<td>has a navel fetish</td>
</tr>
<tr>
<td>MAGENTA</td>
<td>suck my pits</td>
<td>armpit freak</td>
</tr>
<tr>
<td>PURPLE</td>
<td>piercer</td>
<td>piercing</td>
</tr>
<tr>
<td>LAVENDER</td>
<td>likes drag queens</td>
<td>drag queen</td>
</tr>
<tr>
<td>YELLOW</td>
<td>pisser/WS</td>
<td>piss freak</td>
</tr>
<tr>
<td>YELLOW, Pale</td>
<td>spits</td>
<td>drool crazy</td>
</tr>
<tr>
<td>MUSTARD</td>
<td>hung 8&quot;+</td>
<td>wants 8&quot;+</td>
</tr>
<tr>
<td>GOLD</td>
<td>two looking for one</td>
<td>one looking for two</td>
</tr>
<tr>
<td>ORANGE</td>
<td>anything anytime</td>
<td>nothing now (just cruising)</td>
</tr>
<tr>
<td>APRICOT</td>
<td>two tons o' fun</td>
<td>chubby chaser</td>
</tr>
<tr>
<td>CORAL</td>
<td>suck my toes</td>
<td>shrimper (sucks toes)</td>
</tr>
<tr>
<td>RUST</td>
<td>a cowboy</td>
<td>a cowboy's horse</td>
</tr>
<tr>
<td>FUSCHIA</td>
<td>spanker</td>
<td>spankee</td>
</tr>
<tr>
<td>GREEN, Kelly</td>
<td>hustler (for rent)</td>
<td>john (looking to buy)</td>
</tr>
<tr>
<td>GREEN, Hunter</td>
<td>daddy</td>
<td>orphan boy looking for daddy</td>
</tr>
<tr>
<td>OLIVE DRAB</td>
<td>military top</td>
<td>military bottom</td>
</tr>
<tr>
<td>GREEN, Lime</td>
<td>dines off tricks (food)</td>
<td>dinner plate (will buy dinner)</td>
</tr>
<tr>
<td>BEIGE</td>
<td>rimmer</td>
<td>rimmee</td>
</tr>
<tr>
<td>BROWN</td>
<td>scat top</td>
<td>scat bottom</td>
</tr>
<tr>
<td>BROWN LACE</td>
<td>uncut</td>
<td>likes uncut</td>
</tr>
<tr>
<td>BROWN SATIN</td>
<td>cut</td>
<td>likes cut</td>
</tr>
<tr>
<td>CHARCOAL</td>
<td>latex fetish top</td>
<td>latex fetish bottom</td>
</tr>
<tr>
<td>GREY FLANNEL</td>
<td>owns a suit</td>
<td>likes men in suits</td>
</tr>
<tr>
<td>WHITE</td>
<td>beat my meat (J/O)</td>
<td>I'll do us both (J/O)</td>
</tr>
<tr>
<td>HOLSTEIN</td>
<td>milker</td>
<td>milkee</td>
</tr>
<tr>
<td>CREAM</td>
<td>cums in condoms</td>
<td>sucks cum out of condoms</td>
</tr>
<tr>
<td>BLACK w/WHITE Check</td>
<td>safe sex top</td>
<td>safe sex bottom</td>
</tr>
<tr>
<td>RED w/WHITE Stripe</td>
<td>shaver</td>
<td>shavee</td>
</tr>
<tr>
<td>RED w/BLACK Stripe</td>
<td>furry bear</td>
<td>likes bears</td>
</tr>
<tr>
<td>WHITE LACE</td>
<td>likes white bottoms</td>
<td>likes white tops</td>
</tr>
<tr>
<td>BLACK w/WHITE Stripe</td>
<td>likes black bottoms</td>
<td>likes black tops</td>
</tr>
</tbody>
</table>
Table D1

Gay Hanky Codes & Meanings

<table>
<thead>
<tr>
<th>Color</th>
<th>Worn on Left</th>
<th>Worn on Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>BROWN w/WHITE Stripe</td>
<td>likes latino bottoms</td>
<td>likes latino tops</td>
</tr>
<tr>
<td>YELLOW w/WHITE Stripe</td>
<td>likes asian bottoms</td>
<td>likes asian tops</td>
</tr>
<tr>
<td>BLUE, Light w/WHITE Dots</td>
<td>likes white suckers</td>
<td>likes to suck whites</td>
</tr>
<tr>
<td>BLUE, Light w/BLACK Dots</td>
<td>likes black suckers</td>
<td>likes to suck blacks</td>
</tr>
<tr>
<td>BLUE, Light w/BROWN Dots</td>
<td>likes latino suckers</td>
<td>likes to suck latinos</td>
</tr>
<tr>
<td>BLUE, Light w/YELLOW Dots</td>
<td>likes asian suckers</td>
<td>likes to suck asians</td>
</tr>
<tr>
<td>RED/WHITE GINGHAM</td>
<td>park sex top</td>
<td>park sex bottom</td>
</tr>
<tr>
<td>BROWN CORDUROY</td>
<td>headmaster</td>
<td>student</td>
</tr>
<tr>
<td>PAISLEY</td>
<td>wears boxer shorts</td>
<td>likes boxer shorts</td>
</tr>
<tr>
<td>FUR</td>
<td>bestialist top</td>
<td>bestialist bottom</td>
</tr>
<tr>
<td>GOLD LAME</td>
<td>likes muscleboy bottoms</td>
<td>likes muscleboy tops</td>
</tr>
<tr>
<td>SILVER LAME</td>
<td>starfucker</td>
<td>celebrity</td>
</tr>
<tr>
<td>BLACK VELVET</td>
<td>has/takes videos</td>
<td>will perform for the camera</td>
</tr>
<tr>
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<td>voyeur (likes to watch)</td>
<td>will put on a show</td>
</tr>
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<td>LEOPARD</td>
<td>has tattoos</td>
<td>likes tattoos</td>
</tr>
<tr>
<td>TAN</td>
<td>smokes cigars</td>
<td>likes cigars</td>
</tr>
<tr>
<td>TEDDY BEAR</td>
<td>cuddler</td>
<td>cuddlee</td>
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<tr>
<td>KEWPIE DOLL</td>
<td>chicken (likes older)</td>
<td>chicken hawk (likes younger)</td>
</tr>
<tr>
<td>DIRTY JOCKSTRAP</td>
<td>wears a dirty jock</td>
<td>sucks dirty jocks clean</td>
</tr>
<tr>
<td>DOILY</td>
<td>tearoom top (pours)</td>
<td>tearoom bottom (drinks)</td>
</tr>
<tr>
<td>MOSQUITO NETTING</td>
<td>outdoor sex top</td>
<td>outdoor sex bottom</td>
</tr>
<tr>
<td>ZIPLOC BAG</td>
<td>has drugs</td>
<td>looking for drugs</td>
</tr>
<tr>
<td>COCKTAIL NAPKIN</td>
<td>bartender</td>
<td>bar groupie</td>
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<tr>
<td>KLEENEX</td>
<td>stinks</td>
<td>sniffs</td>
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<td>looking for a ride</td>
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<td>needs a place to stay</td>
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<td>willing to be bitten</td>
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<td>looking for an orgy</td>
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Retrieved from https://user.xmission.com/~trevin/hanky.html
Appendix E: IRB Approval & Consent Form

Title of Research: Investigating Gay Male Attitudes towards Sex & HIV-prevention
Researchers: Dante E. Morelli (Ph.D. Candidate) & Dr. Raymie Mckerrow (Advisor)

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

Explanation of Study

My name is Dante E. Morelli and I am a doctoral student at Ohio University. I am conducting this study for the completion of my dissertation. This study is being done to understand how gay men view barebacking, HIV/AIDS, gay sexuality and health, and the gay male body all within the context of PrEP prevention treatments.

You can participate in this study if:
- You are 18 years of age or older.
- You are male.
- You identify as gay.
- You are known to be HIV negative.
- You have a basic understanding of PrEP.

If you agree to participate, you will be asked to take part in a one-on-one interview and will be asked questions in regards to how you view PrEP, HIV/AIDS in the gay community, the sexual practice of barebacking, and gay health and sexuality.

Your participation in the study will last approximately 90-120 minutes

Risks and Discomforts
Your participation in this study is completely voluntary. If you begin to feel uncomfortable at any time, you have the right to stop participating in the interview or to skip questions. As some questions may ask about sexual behavior that is or could be considered "taboo" by society, please know that you can skip any questions you might feel uncomfortable answering. This study is completely confidential and your identity will be kept secret in any reports, publications, and/or presentations that will result from this study.

Benefits
This study is important to science/society because PrEP is a new medical treatment found to prevent the risk of acquiring HIV "by more than 90 percent" (CDC, 2012, p. 1). While the medical research is ongoing, there has not yet been a published study regarding the social implications of PrEP within the gay male community. This project will make an attempt at trying to understand this phenomenon especially in how PrEP is understood within the context of HIV/AIDS and gay sexual practices.

APPROVED
JUN 13 2013
OHIO UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Confidentiality and Records
Your study information will be kept confidential. You will be referred to by pseudonym and thus remain anonymous in any reports and presentations that will result from this study. The master list, which includes your name and contact information, will be kept on my password-protected laptop that will be kept in a locked filing cabinet in my personal faculty office at Suffolk County Community College in Selden, NY. The master list, with your name and contact information, will also be password-protected as a Microsoft Word file. Also, all digital audio recordings of this interview will also be placed on the same laptop. If you are going to be referring to a particular person during the interview then please do not state their name or provide any other identifying information about that person (e.g., instead of saying "I once dated (or had sex) a guy named Paul," simply state "I once dated (or had sex) with a guy..."). Once when all audio interviews are gathered for this study, they will professionally transcribed without your name or contact information. Specifically, this means that the recorded interview will be given to a professional transcriber who will listen to the interview and type the script of the entire interview into an electronic document. Your name or contact information will not be given to the professional transcriber. You then will be contacted by me (by both phone and email) to review only your own personal transcript so you can check for accuracy in what was recorded during our interview. If you believe that something is inaccurate in the transcript then it will be deleted from the transcript and will not be included in any publication or presentation that will result from this study. Your name and contact information, including your audio recording from the interview, will be destroyed by January 31, 2014.

Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with:

* Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research.
* Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU.

Contact Information
If you have any questions regarding this study, please contact Dante Morelli at morelli.dante@gmail.com or by cell phone at 631.707.4335 or Dr. Raymie McKerrow at mckerrow@ohio.edu 740.593.4843

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered
- you have been informed of potential risks and they have been explained to your satisfaction.
- you understand Ohio University has no funds set aside for any injuries you might receive as a result of participating in this study.
- you are 18 years of age or older
- your participation in this research is completely voluntary
- you may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you and you will not lose any benefits to which you are otherwise entitled.

Signature ___________________________ Date __________________

Printed Name ________________________

Version Date: [insert mm/dd/yyyy]
Appendix F: CDC PrEP Fact Sheet

PrEP: A New Tool for HIV Prevention

Pre-exposure prophylaxis, or PrEP, is a new HIV prevention method in which people who do not have HIV infection take a pill daily to reduce their risk of becoming infected. The pill contains medicines that prevent HIV from making new virus as it enters the body. In this way PrEP medicines can help keep the virus from establishing a permanent infection.

Providing a preventive medication before exposure to a germ or virus is not a new practice and has been used to prevent other diseases. For example, when individuals travel to an area where malaria is common, they are advised to take malaria medication before and during travel to prevent getting infected if bitten by a mosquito carrying the malaria parasite. However, the use of medication to prevent HIV infection has only recently been evaluated. When used consistently, PrEP has been shown to reduce the risk of HIV infection among adults at very high risk for HIV infection through sex, including men who have sex with men and heterosexual-active men and women. CDC is also evaluating PrEP’s effectiveness in preventing HIV infection among individuals exposed to HIV through inject drug use, but those results are not yet available.

For some individuals at very high risk for sexual exposure to HIV, PrEP may represent a much-needed additional prevention method — but it will not be right for everyone. PrEP is an intensive approach that requires strict adherence to daily medication and regular HIV testing. It is not intended to be used in isolation, but rather in combination with other HIV prevention methods. If it is used effectively and by persons at very high risk, PrEP may play a role in helping to reduce the number of new HIV infections in the United States.

PrEP Medications

Most PrEP efficacy trials have tested a combination of the antiretroviral drugs tenofovir disoproxil fumarate (also called TDF, or tenofovir) and emtricitabine (also called FTC), taken in a single pill daily for HIV prevention. This combination pill (brand name Truvada®) was approved by the U.S. Food and Drug Administration (FDA) for use as an HIV treatment in 2004, and was approved as PrEP in July 2012. Some clinical studies have also evaluated the use of tenofovir on its own as a preventive drug, but this drug alone is not FDA-approved as PrEP.

PrEP Proven Safe and Effective in Preventing Sexual HIV Acquisition

Strong research evidence indicates that PrEP, when used consistently, is safe and effective for reducing the risk of acquiring HIV sexually.

Research among Men Who Have Sex with Men

In November 2010, the multinational IP/Ex study showed that a once-daily pill containing tenofovir plus emtricitabine was safe and provided an average of 44 percent additional protection against HIV infection among men who have sex with men (MSM) who were also provided with a comprehensive package of prevention services. These services included provision of condoms, monthly HIV testing, counseling to reduce risk behavior and encourage adherence to the daily pill regimen, and management of other sexually transmitted infections.

The level of protection varied widely depending on how consistently participants used PrEP with significantly greater levels of protection among those who adhered well to the daily dosing regimen. Among MSM with detectable levels of the medication in their blood, the risk of HIV acquisition was reduced by more than 50 percent.
The IPEx study followed an earlier study by CDC that examined safety and adherence among MSM in the United States who were using daily tenofovir alone. The study found that the regimen was safe and did not lead to increases in risk behavior.

**Research among Heterosexually-active Men and Women**

In July 2011, researchers announced the results of two PrEP studies finding strong evidence that PrEP is effective and safe among heterosexually-active men and women.

- The TDF2 study found that a once-daily tablet containing tenofovir plus emtricitabine reduced the risk of acquiring HIV infection by roughly 62 percent overall in the study population of uninfected heterosexual men and women.
- The Partners PrEP study found that daily doses of tenofovir plus emtricitabine or daily doses of tenofovir alone reduced HIV transmission among heterosexual serodiscordant couples (in which one partner is infected with HIV and the other is not) by 75 percent and 67 percent, respectively. The trial found that PrEP was equally effective among men and women, and that there was no statistically significant difference in efficacy between the two medication regimens.

As with the IPEx study, both TDF2 and Partners PrEP showed that the level of protection offered by PrEP is strongly related to the level of adherence to the daily medication doses.

- In Partners PrEP, participants in the tenofovir-plus-emtricitabine group with detectable levels of the medication experienced a 90 percent reduction in risk for HIV infection. In the tenofovir-only group, the presence of medication in the blood was associated with an 86 percent reduction in risk.
- In TDF2, only half of the participants in the tenofovir-plus-emtricitabine group who became infected with HIV had any detectable medication in their blood, and even those participants had very low levels of medication present. This suggests that they had not taken PrEP consistently. In contrast, over 80 percent of matched participants who remained uninfected had detectable medication in their blood and the average medication level was substantially higher.

Two other research studies also reported results in 2011: a study called FEM-PrEP examining PrEP with tenofovir plus emtricitabine and a single group of participants in the VOICE trial examining PrEP with oral tenofovir alone did not show a protective effect among heterosexually-active women. Further sub-analysis of a sample of women in the FEM-PrEP trial showed that fewer than half of women assigned to take tenofovir plus emtricitabine were actually taking the drug, indicating that lack of adherence was likely a major factor contributing to the lack of efficacy in that trial.

Other than low adherence, no factors have yet been identified that appear to influence the efficacy of PrEP in reducing sexual transmission of HIV. The VOICE trial, which is still evaluating daily oral tenofovir plus emtricitabine in women, remains underway and may provide additional insight once those results are available.

**CDC Interim Guidance on PrEP Use**

MSM: Following the publication of the IPEx trial results, CDC published interim clinical guidance for physicians electing to provide PrEP for HIV prevention among MSM in January 2011. CDC guidance stressed the importance of targeting PrEP to MSM at very high risk for HIV acquisition; delivering PrEP as part of a comprehensive set of prevention services; providing counseling regarding risk reduction and the importance of PrEP medication adherence; ensuring MSM who are prescribed PrEP are confirmed to be HIV negative prior to use; and providing regular monitoring of HIV status, side effects, adherence, and risk behaviors.

Heterosexuals: Following the publication of final results from the TDF2 and Partners PrEP trials, in August 2012 CDC published interim guidance to help clinicians safely and effectively provide PrEP for heterosexually-active adults. This guidance included recommendations similar to those for MSM, as well as new recommendations relevant to women who may become pregnant while taking PrEP and to couples in which one partner is HIV-positive and the other is HIV-negative.
CDC is also leading the development of comprehensive U.S. Public Health Service (PHS) guidelines on the use of PrEP for the prevention of sexually-acquired HIV infection. These guidelines will include more detailed recommendations for PrEP use with adults at very high risk for HIV infection, including MSM as well as heterosexually-active men and women. They are being developed in partnership with other PHS agencies and will incorporate input from providers, HIV prevention partners, and affected communities. The guidelines will be updated as information from additional trials and studies about factors affecting efficacy and safety for all transmission risk groups becomes available.

### CDC Interim Guidance on HIV Pre-Exposure Prophylaxis

#### Before Initiating PrEP

**Determine eligibility:**
- Document negative HIV antibody test immediately before starting PrEP medication.
- Test for acute HIV infection if patient has symptoms consistent with acute HIV infection or reports unprotected sex with an HIV-positive person in the preceding month.
- Determine if women are planning to become pregnant, are currently pregnant, or are breastfeeding.
- Confirm that patient is at ongoing, very high risk for acquiring HIV infection.
- If any sexual partner is known to be HIV-infected, determine whether receiving antiretroviral therapy; assist with linkage to care if not in care or not receiving antiretroviral therapy.
- Confirm that calculated creatinine clearance is ≥60 mL per minute ( Cockcroft-Gault formula).

**Other recommended actions:**
- Screen for hepatitis B infection; vaccinate against hepatitis B if susceptible, or treat if active infection exists, regardless of decision regarding prescribing PrEP.
- Screen and treat as needed for sexually transmitted infections (STIs).
- Disclose to women that safety for infants exposed during pregnancy is not fully assessed but no harm has been reported.
- Do not prescribe PrEP to women who are breastfeeding.

#### Beginning PrEP medication regimen:

- Prescribe tenofovir disoproxil fumarate 300 mg (TDF) plus emtricitabine 200 mg (FTC) (i.e., one Truvada [Gilead Sciences] tablet) daily.
- In general, prescribe no more than a 90-day supply, renewable only after HIV testing confirms that patient remains HIV-uninfected. For women, ensure that pregnancy test is negative or, if pregnant, that the patient has been informed about use during pregnancy.
- If active hepatitis B infection is diagnosed, consider using TDF/FTC, which may serve as both treatment of active hepatitis B infection and HIV prevention.
- Provide risk-reduction and PrEP medication-adherence counseling and condoms.

#### Follow-up while PrEP medication is being taken:

- Every 2–3 months, perform an HIV antibody test (or fourth generation antibody/antigen test) and document negative result.
- At each follow-up visit for women, conduct a pregnancy test and document results; if pregnant, discuss continued use of PrEP with patient and prenatal-care provider.
- Evaluate and support PrEP medication adherence at each follow-up visit; more often if inconsistent adherence is identified.

#### On discontinuing PrEP (at patient request, for safety concerns, or if HIV infection is acquired):

- Perform HIV test(s) to confirm whether HIV infection has occurred.
- If HIV positive, order and document results of resistance testing, establish linkage to HIV care.
- If HIV negative, establish linkage to risk reduction support services as indicated.
- If active hepatitis B is diagnosed at initiation of PrEP, consider appropriate medication for continued treatment of hepatitis B infection.
- If pregnant, inform prenatal-care provider of TDF/FTC use in early pregnancy and coordinate care to maintain HIV prevention during pregnancy and breastfeeding.

Recommendations in black apply to both adult MSM and heterosexually-active men and women; items in blue are specific to heterosexual women.
Ongoing and Planned PrEP Trials

Injection Drug Users

CDC is sponsoring the only clinical trial of PrEP among injection drug users (IDUs), the Bangkok Tenofovir Study. The study, being conducted in Thailand, is assessing the efficacy of PrEP with daily oral tenofovir alone to prevent HIV infection among 2,400 male and female IDUs. Like other PrEP trials, this study is also examining the effects of taking a daily pill on HIV risk behaviors, adherence to and acceptability of the regimen, and in cases where participants become HIV-infected, the resistance characteristics of the acquired virus. Results are anticipated in late 2012.

Other PrEP Studies

Other trials are underway or planned to examine the safety, adherence, acceptability, and feasibility of other PrEP regimens and dosing strategies. For detailed information on the full range of PrEP trials, visit www.avac.org.

Next Steps in Assessing and Maximizing the Benefits of PrEP

PrEP offers a new tool to help combat the HIV epidemic among the hardest-hit populations in the United States and around the world, but its overall impact on the epidemic will depend on many things that at this point remain unknown, including access and acceptability among the populations at highest risk. Impact will also depend upon whether programs implemented in community settings can achieve the key requirements for success, including ensuring regular HIV testing, maintaining high levels of medication adherence, and preventing increases in risk behavior.

CDC and its partners are working to assess many of these key questions to determine how PrEP can most effectively be used in the United States.

- "Open-label extension" studies of the IPrEx, Partners PrEP, and TDF2 trials — in which all participants in those trials are provided PrEP knowing that they are taking medication with proven efficacy — are planned or underway, and will provide additional valuable information in research settings about acceptability, adherence to PrEP, and risk behavior.
- Demonstration research projects to evaluate PrEP use among MSM are planned in several California cities and Miami to provide similar information in "open-label" studies conducted with new research participants.
- CDC is working with federal, state, local, and private partners to identify additional ways to evaluate key PrEP implementation questions at community sites providing PrEP as a clinical HIV prevention service.

With limited resources available to combat the HIV epidemic, we will have to carefully consider how to most effectively use this tool in combination with other proven approaches to have the greatest possible impact on the HIV epidemic. Other key strategies such as HIV testing and treatment of individuals with HIV infection are critical, and will need to be expanded to reach the substantial number of Americans who are either unaware of their HIV status or not being effectively treated. CDC estimates indicate that only one-quarter of Americans with HIV currently have their virus suppressed to the levels needed to maintain their own health and prevent transmission to others.

Nevertheless, while expanded HIV treatment for those with HIV infection is essential, it will not be sufficient to end the epidemic. Even if we can improve treatment outcomes for all of those diagnosed with HIV, individuals who do not know they are infected are likely to continue to unknowingly transmit HIV infection to others.

With 2.7 million people becoming infected annually worldwide, including approximately 50,000 in the United States, we must capitalize on every available prevention tool. While the most appropriate uses of PrEP as part of these efforts is yet to be determined, available data suggest that this prevention method, if used strategically and effectively, could be cost-effective and may help reduce the continuing toll of HIV infection in this nation.
Appendix G: Interview Protocol

Introduction to the Study
First, thank you so much for your time in participating in this interview – your thoughts are greatly valued. As a gay man (meaning myself), am very curious about how HIV/AIDS effects our community. My interest in this topic has piqued as a result of the new PrEP regimen that was approved by the CDC & FDA to prevent HIV by up to 90 percent. Furthermore, I believe this drug comes at a time when the sexual practice of barebacking has been prevalent in our community. These interests have culminated into my current research interest and more specifically my dissertation. My interest in having you and other Gay Men participate in this interview is to gather your perceptions and opinions of all of these ideas as well.

Warm-Up & Background Questions:
**Note: My rationale for asking such questions has to deal with the fact that I am asking about sensitive, personal behaviors (i.e. barebacking). Instead of asking directly about barebacking as the first set of interview questions I wish to ask these questions as to gain rapport with each individual participant.

Name (this will be asked before the recording of the interview begins and will only appear on the master code list).
1. What is your pseudonym for this study?
2. How old are you?
3. How would you describe your relationship status (i.e. single, dating, partnered, married, divorced, widowed)?
4. If you are currently in a relationship, would you describe it as mutually exclusive (i.e. monogamous) or inclusive (i.e. “open relationship”)?
5. How long have you identified yourself as gay?
6. Are you “out” to friends and/or family about being gay? If so, for how long?

HIV/AIDS Questions:
7. What are your overall thoughts/perspectives towards HIV/AIDS at this time?
8. Do you think HIV is a problem in the gay community?
9. Do you know of anyone in the gay community who is HIV-positive? If more than one person, then approximately how many?
10. When do you first remember hearing about HIV/AIDS? Where and what did you learn about the virus?
11. Have you ever worried about an HIV or STD infection? If so, please explain.
12. Do you get tested regularly? If so, how often? When was the last time you were tested?
13. In terms of emotion, what is the experience like when you went to get tested (i.e. worried, scared, confident, worry-free, etc.)?
PrEP Questions:
14. What have you heard about PrEP as an HIV preventive measure?
15. How does PrEP change/alter your perception of safe sex?
16. Do you now, or would you take a PrEP regimen so that you can enjoy bareback sex? Why or why not?
17. Would you speak to your doctor about taking the PrEP regimen?
18. Does PrEP change your perspective on HIV/AIDS?

Sexual Practice Questions: [some of these questions will be revised if participants are in a committed relationship (e.g. committed, married, etc.)]
19. In terms of sex, how would you identify your sexual identity (e.g. top, bottom, versatile, etc.)? **Note to IRB: this language of “top,” “bottom,” etc. is most universally known in the gay community by both sexually and non-sexually active men.
20. One of the criteria for this study is engaging in bareback sex at least once within the past 6 months. Why did you engage in barebacking?
21. How often do you engage in bareback sex?
22. As you may be aware, there has been an increase in bareback-only gay pornography. Why do you believe it has increased? What do you think it contributes, if at all, to the gay community?
23. Approximately how many partners have you engaged in bareback sex?
24. Are these partners “repeat-partners” or one-time encounters?
25. How do you meet men for sex (i.e. online, bars, bathhouses, etc.)?
26. How do you talk or communicate with your sexual partner(s) about barebacking?
27. Do you know other Gay Men who engage in bareback sex? Do you think it’s more common or less common than condom usage?
28. Tell me about the experience of barebacking and what it means to you as a sexual practice.
Appendix H: Anonymous NYC HIV Testing Centers

The locations listed below are Department of Health anonymous HIV testing sites. Many of these locations also offer free and confidential STD services, although their hours may vary. These testing sites do not require you to give your name or any other identifying information. Therefore, the test results can never be linked to you. If you test positive, they may ask for your name, but you don’t have to give it to them.

You may call the New York City Department of Health at (800) TALK HIV or (800) 825-5448 or at (212) 447-8200 (follow the instructions to reach the AIDS hotline) with questions regarding anonymous HIV testing or to make an appointment at one of these sites.

<table>
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<tr>
<th>Borough/Area</th>
<th>Address</th>
<th>Telephone</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manhattan</td>
<td>Central Harlem 2238 Fifth Ave., 3rd Floor (at 137th Street) New York, NY 10037 (212) 690-1760 Or call the AIDS hotline at (800) 825-5448 for an appointment Monday-Friday 8:30am-4:30pm (Must arrive by 2:00pm or call before coming.)</td>
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<tr>
<td>Manhattan</td>
<td>East Harlem 158 East 115th St., Rm. 158 (off Lexington Avenue) New York, NY 10029 (212) 360-5962 Or call the AIDS hotline at (800) 825-5448 for an appointment Monday-Friday 8:30am-4:30pm (Tuesday-Thursday: STD testing)</td>
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<tr>
<td>Manhattan</td>
<td>Chelsea 303 Ninth Ave., 2nd Floor (at 28th Street) New York, NY 10001 (212) 239-1723 also offer confidential STD exams Or call the AIDS hotline at (800) 825-5448 for an appointment Monday-Friday 8:30am-4:30pm 1st come 1st served (Arrive very early, between 8-8:30am--limited time slots available.)</td>
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<tr>
<td>Manhattan</td>
<td>Riverside 160 West 100th Street, 1st Floor (betw. Columbus &amp; Amsterdam) New York, NY 10025 (212) 865-7757 Or call the AIDS hotline at (800) 825-5448 for an appointment Monday-Friday 8:30am-4:30pm (Arrive at 8:30am if possible--it’s very crowded and time slots are limited.)</td>
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<td>Bronx</td>
<td>Morrisania 1309 Fulton Ave., 2nd Floor (E. 169th St., off 3rd Ave.) Bronx, NY 10456 (718) 579-7714 Or call the AIDS hotline at (800) 825-5448 for an appointment Monday-Friday 8:00am-4:00pm Saturday arrive no later than 8:30am</td>
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<td>Queens</td>
<td>Corona 34-33 Junction Blvd., Rm. 143 or 116 (Roosevelt/Northern) Jackson Heights, NY 11372 (718) 476-7815 Or call the AIDS hotline at (800) 825-5448 for an appointment Monday, Wednesday, Thursday 8:30am-4:30pm (anonymous testing) Walk-ins accepted Tuesday and Friday: confidential STD and HIV testing 8:00am-4:00pm</td>
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<td>Location</td>
<td>Address</td>
<td>Phone Number</td>
<td>Available Times</td>
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<td>Queens Jamaica</td>
<td>90-37 Parsons Blvd., 1st Floor Annex (off Jamaica Ave.) Jamaica, NY 11432</td>
<td>(718) 262-5572 Or call the AIDS hotline at (800) 825-5448 for an appointment</td>
<td>Monday-Friday 8:30am-4:00pm Saturday 8:30am-12:00pm Walk-ins accepted (arrive very early)</td>
</tr>
<tr>
<td>Queens Rockaway: Addabbo Health Center Staten Island</td>
<td>1288 Central Ave. Far Rockaway Queens, NY 11692</td>
<td>(718) 868-8230 (You’ll get a recording--press zero to talk to a person.)</td>
<td>Monday and Saturday 9:00am-1:00pm Monday evenings 5:00pm-8:00pm Monday-Friday 8:30am-4:30pm Walk-ins accepted STD testing Monday and Thursday 1:00pm-4:00pm</td>
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<tr>
<td>Staten Island</td>
<td>51 Stuyvesant Place, 1st Floor (at Wall Street) Staten Island, NY 10301</td>
<td>(718) 420-4994 Or call the AIDS hotline at (800) 825-5448 for an appointment</td>
<td>Monday-Friday 8:30am-4:00pm Walk-ins accepted but it’s best to call before coming</td>
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<tr>
<td>Brooklyn Crown Heights</td>
<td>335 Central Ave. (betw. Linden &amp; Grove) Brooklyn, NY 11213</td>
<td>(718) 573-4820 Or call the AIDS hotline at (800) 825-5448 for an appointment</td>
<td>Monday-Friday 8:30am-4:00pm Walk-ins accepted but it’s best to call before coming</td>
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<tr>
<td>Brooklyn Fort Greene</td>
<td>295 Flatbush Ave. Ext., 2nd Floor (betw. Willoughby &amp; DeKalb), Brooklyn, NY 11201</td>
<td>(718) 643-4133 Or call the AIDS hotline at (800) 825-5448 for an appointment</td>
<td>Monday-Saturday 8:30am-4:00pm Walk-ins accepted but it’s best to call first or you may not be seen</td>
</tr>
<tr>
<td>Brooklyn Bedford-Stuyvesant</td>
<td>485 Throop Ave., 1st Floor (Madison &amp; Putnam) Brooklyn, NY 11221</td>
<td>(718) 574-2482 Or call the AIDS hotline at (800) 825-5448 for an appointment</td>
<td>Monday-Friday 8:30am-4:00pm</td>
</tr>
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