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Integrating Professional and Folk Models of HIV Risk: YMSM's Perceptions of High-Risk Sex

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Abstract

Risks associated with HIV are well documented in research literature. While a great deal has been written about high-risk sex, little research has been conducted to examine how young men who have sex with men (YMSM) perceive and define high-risk sexual behavior. In this study, we compare the "professional' and "folk" models of HIV-risk based on YMSM's understanding of high-risk sex and where and how they gathered their understanding of HIV-risk behaviors. The findings reported here emerged from the quantitative and qualitative interviews from the Healthy Young Men's Study (HYM), a longitudinal study examining risk and protective factors for substance use and sexual risk among an ethnically diverse sample of YMSM. Findings are discussed in relation to framing how service providers and others can increase YMSM's knowledge of sexual behavior and help them build solid foundations of sexual health education to protect them from STI and HIV infection.

Keywords

HIV prevention; young men who have sex with men (YMSM); sexual-risk behavior; risk perceptions; gay men

INTRODUCTION

How one perceives or assesses his or her risk for a particular situation is grounded within a cultural framework and based on one's experiences within that culture or society (Douglas, 1992; Kelly, 2005). Within a society, different groups or individuals may have different ways of conceptualizing risk. It is important to study and understand these differences within different groups or populations, as these perceptions often inform behaviors and may be passed on to others within the group as "truths". While researchers have investigated how men who have sex with men (MSM) may perceive their individual risk for HIV or other STIs (D. A. MacKellar et al., 2007), how individuals conceptualize or understand what constitutes a high-

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risk sexual experience has not been fully explored. This is an important piece of the puzzle to study, as how an individual defines a high-risk situation may directly affect his or her engagement in risk or protective behavior. Borrowing from a model developed by Agar (Agar, 1985), which examined the risks involved in illicit substance use through a lens of "folk" and "professional" models, this paper provides a description of the traditional "professional" or public health model of high-risk sex in contrast to the "folk model" or how young men who have sex with men (YMSM) actually assess risk and define risk within the context of sexual behavior. In addition, through the use of qualitative interview data, the types of situations in which one may perceive susceptibility to risk are explored.

Behaviors that put MSM at increased risk for HIV and other STIs have been well documented by public health professionals (R. D. Stall, Hays, Waldo, Ekstrand, & McFarland, 2000). These behaviors include, but are not limited to: unprotected sex (either oral or anal), having a greater number of sexual partners, and the use of drugs and/or alcohol before or during sex. The following summarizes the professional model of HIV-risk for YMSM.

Professional Model of HIV-Risk

With the HIV/AIDS epidemic came the idea of a "prevention ethic" in gay communities which revolved around the idea of a "condom every time" (Race, 2003). As a method of decreasing HIV infection, most studies examining HIV-risk have focused on unprotected anal sex (UAI) and situational or individual factors that may influence one's decision to engage in this activity. Studies have shown that YMSM have relatively high rates of self-reported UAI, with study samples ranging from 14% – 51% (Guenther-Grey et al., 2005; R.B. Hays, Kegeles, & Coates, 1990; Lemp et al., 1994; Valleroy et al., 2000). Factors identified as influencing YMSM to engage in UAI include general preferences and beliefs regarding condoms (Díaz & Ayala, 1999), mood or psychological states (Gold & Skinner, 1992), as well as substance use (e.g., alcohol, crystal methamphetamine, cocaine) (Celentano et al., 2006; Seage et al., 1998; R. Stall et al., 2001).

HIV risk from oral sex has been difficult to examine due to the high correlations between partners engaging in both oral and anal sex (Osmond et al., 1994). Some evidence suggests that MSM are unclear of the risks related to unprotected oral sex due to the inconsistent public health messages regarding associated risk (Halkitis, 1997), as well as the promotion of unprotected oral sex as a harm reduction technique (Halkitis & Parsons, 2000). While most studies show that transmission of HIV through oral sex is relatively low, some factors which may increase risk of transmission include open sores or recent dental work in the receptive partner (Centers for Disease Control and Prevention, 2003).

The influence of partner characteristics on risk assessment and sexual decision-making have also been studied. There is strong evidence that YMSM are more likely to engage in UAI with a primary partner compared to other partner types (R.B. Hays et al., 1990; Lemp et al., 1994; Valleroy et al., 2000). In addition, to ascertain whether or not a sexual encounter is potentially high risk, YMSM may rely on their partners' disclosure of HIV status before deciding to engage in UAI. However many studies have shown that HIV-positive men may be reticent to reveal their HIV status (Serovich & Mosack, 2003), while some HIV-negative YMSM rely on stereotypes about HIV-positive men (e.g., physical traits, hygiene, behavioral traits) when making assumptions about a partner's HIV status (Gold, Skinner, & Hinchy, 1999).

In an effort to reduce risk for those who wish to discontinue condom use within the relationship, public health professionals developed the concept of "negotiated safety" (Kippax, Crawford, Davis, Rodden, & Dowsett, 1993), where sexual partners enter into an agreement regarding sexual activities and condom use within and outside the relationship to minimize the chances of HIV infection. For example, those in an open relationship will also stipulate consistent use

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of condoms when engaging in anal intercourse with another partner. Central to the effective use of this strategy is trust between partners, honest and open communication as well as accurate information regarding each partner's HIV serostatus. Furthermore, prior to entering into a negotiated safety agreement, the risk reduction technique requires both partners to test together after six months in a monogamous relationship. Current guidelines recommend MSM test for HIV on at least an annual basis (D. A. MacKellar et al., 2006).

Specific to understanding how risk is assessed in relation to HIV is examining the information that has been disseminated regarding HIV risk and to what extent it has been incorporated into behavior. Knowledge about modes of HIV and STI transmission, and especially the risks involved with sex, are important for developing effective prevention strategies ((DiClemente, Crosby, & Wingood, 2002). Apart from knowledge, other factors that have been investigated as related to YMSM's engagement in sexual-risk behaviors include recent changes in HIV treatment and management (Halkitis, Zade, Shrem, & Marmor, 2004), power differentials within intimate relationships (R B Hays, Kegeles, & Coates, 1997), and partner inter-dependence or a preference for sex without a condom (Appleby, Carol-Miller, & Bothspan, 1999). Understanding the type of knowledge that individuals have with regards to HIV and STI and the specifics about how this knowledge informs one's perceptions of what constitutes a high-risk sexual experience is critical, as interventions should be designed with the understanding of how individuals perceive risks.

This paper includes a mixed method design, drawing from both survey data and semi-structured qualitative interviews, to explore the sexual behavior and related perceptions among an ethnically diverse cohort of YMSM.

METHODS

Quantitative Study Design, Sampling, and Measures

Between February 2005 and January 2006, a total of 526 young men were recruited into the Healthy Young Men's (HYM) Study, a two-year longitudinal study of a cohort of ethnically diverse YMSM in Los Angeles. Young men were eligible to participate in the study if they were: a) 18- to 24-years old; b) self-identified as gay, bisexual, or uncertain of their sexual orientation and/or reported having had sex with a man; c) self-identified as Caucasian, African American, or Latino of Mexican descent; and d) a resident of Los Angeles County, and they anticipated living in Los Angeles for at least six months.

Young men were recruited at public venues (e.g., bars, clubs, street corners, and special events) using a stratified probability sampling design (D. MacKellar, Valleroy, Karon, Lemp, & Janssen, 1996; Muhib et al., 2001). Additional descriptions of the sampling procedures and methodologies are described in other publications (Kipke et al., 2007).

HYM participants complete an extensive 1 to 1 ½-hour survey every six months over the course of two years. The surveys are administered in both English and Spanish, using audio computer-assisted self-interviewing (ACASI) technologies and an on-line testing format. ACASI technologies have increasingly been found to improve both the quality of the data being collected and the validity of subjects' responses, particularly to questions of a sensitive nature, such as drug use and sexual behavior (Kissinger et al., 1999; Ross, Tikkanen, & Mansoon, 2000; Turner et al., 1998).

For the purposes of this analysis, the following measures were included:

Demographic variables—Participants were asked to report their: age; race/ethnicity; residence; status; employment status; sexual identity; HIV serostatus; HIV testing history;

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whether they were diagnosed with an STI since their baseline interview; and whether they had ever engaged in sex exchange.

Sexual Behavior—Participants were asked their age of initiating both oral and anal sex (receptive and insertive); use of condoms during their initial sexual experiences; and use of condoms in the last 3 months.

Qualitative Sub-Study Design and Sampling

In addition to the longitudinal study, a smaller, targeted group of 24 respondents was chosen from the larger HYM cohort for semi-structured qualitative interviews designed to provide context to key study domains such as relationship experiences and ideals, sexual preferences and perspectives, and sexual behavior. All of the qualitative interviews were completed from October 2006 – January 2007. Individuals were selected based on responses to key items in wave 2 (six-month follow-up) quantitative survey. Specifically, half (n=12) of the qualitative respondents reported that they had used a condom inconsistently during anal intercourse (either receptive or insertive) in the previous three months and the other half (n=12) had never used a condom during anal intercourse (either receptive or insertive) in the prior three months. These selection criteria were selected to ensure that all respondents had recently engaged in UAI; individuals' differences in condom use were selected as a criterion to understand how and in what situations YMSM may choose not to use a condom. Qualitative respondents were then randomly chosen from those respondents who met these criteria. Twenty-four qualitative interviews were conducted, but one was removed from analysis due to inconsistencies in response; therefore, a total of 23 interviews were analyzed for this discussion.

The interview discussion guide used in this phase of the HYM Study was designed to gather in-depth information on a variety of constructs related to sexual behavior such as: current and future expectations and desires regarding intimate relationships; what kinds of information respondents received while growing up regarding sex and sexuality; communication with sexual partners; how respondents defined high-risk sex; and detailed information surrounding two separate sexual experiences, one described as "low-risk" and the other as "high-risk" by the respondent. This line of questioning allowed respondents to determine for themselves what constituted a low-risk and high-risk experience. Responses from several sets of questions related to: knowledge of sex and STIs; how individuals define and perceive high-risk sex; specific behavior self-identified as high-risk; decision-making surrounding use of condoms and sexual preferences were selected for analysis. Each interview lasted an 1½ to two hours and was digitally recorded and professionally transcribed. All interviews were conducted in the HYM project offices or at a location convenient to the respondent (e.g., coffee house or park). Respondents were provided a $35 incentive for completing each interview. The research received approval from the Institutional Review Board of Childrens Hospital Los Angeles.

ANALYSIS

Quantitative Analysis

All statistical analyses were conducted with responses from Wave 2 data using SPSS version 15.0. Because the current study is largely descriptive, results presented are based on univariate analyses of key variables. Results from frequency analyses characterized key demographics (e.g., age, ethnicity, employment) of the study sample. Chi-square analyses were used to test whether use of a condom at sexual debut was related to condom use in the past three months.

Qualitative Analysis

The qualitative analysis for this study was based on grounded theory, which entails the simultaneous process of data collection, analysis and theory construction (Glaser, 1992; Glaser

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& Strauss, 1967). As the data are collected, they are immediately analyzed for patterns and themes, with the primary objective of discovering theory implicit in the data. Atlas.ti was used for coding and analysis of relationships between and within text segments.

Members of the research team reviewed an initial sample of interviews to identify key themes, which formed the basis of the project codebook. Codes focusing on a range of topics were identified and defined based on the key constructs included in the discussion guides. The codebook was modified as needed and once finalized, four members of the research team were responsible for coding the interviews. Inter-coder reliability was assessed through double coding a sample of approximately 17% of the interviews. Differences in coding were discussed and resolved by the team. After the initial coding phase, the open coding process began, allowing for constructs of interest to be identified and labeled. Codes related to risk perceptions (e.g., definitions of high- and low-risk and related sexual experiences), as well as information related to condom use and sexual behavior (e.g., preferences and experiences) were included in the analysis. This open coding process included refining the codes based on the data. During this phase, issues surrounding trust and knowing partners, substance use, HIV testing and type of sex (e.g., oral or anal) emerged as the most commonly described determinants of UAI in the interviews. These determinants emerged as the primary constructs that make up the folk model of risk and are presented in this paper. Throughout the paper, pseudonyms are used to identify respondents.

The following discussion is organized to first provide an overview of the “folk” knowledge related to HIV risk and general sexual behavior as described by the qualitative respondents as a backdrop to provide context to their discussions of risk and sexual decision-making. The determinants that were found to be most commonly associated with risk (e.g., partner characteristics, HIV/STI testing, general perceptions of condoms and descriptions of sexual risk) are then presented and summarized.

RESULTS

Quantitative

Table 1 presents the demographic data for the full sample of HYM respondents (N=499) who completed the wave 2 survey. Qualitative respondents do not differ considerably from the rest of the sample. However, a larger proportion (30% of qualitative v. 12% of total sample) reported having an STI since their last interview. Both groups reported similar HIV-testing patterns, with 63% of the total sample reporting being tested for HIV in the past year and 65% of the qualitative respondents reporting the same frequency. The majority of the HYM sample (77%) identified as gay, with 15% identifying as bisexual. Most (63%) of the participants reported having tested for HIV in the past year.

Table 2 presents data related to respondents’ general sexual behavior, both at initiating sex and in the last three months. Respondents report initiating oral sex at about 15.5 years (both receiving and giving) and anal sex at about 17.2 years (both receptive and insertive). About a quarter of the respondents (25% insertive and 26% receptive) reported not using a condom during their first anal sex experience, compared to 37% (insertive) and 33% (receptive) in the last three months. The vast majority of respondents reported not using condoms when engaging in oral sex both at initiation (87%) and in the last three months (82%). Those who did not use a condom at sexual debut were significantly less likely to use a condom in the past three months for receptive ($p < .001$) and insertive ($p < .01$) anal sex, and both receiving and giving oral sex ($p < .01$).

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Qualitative

Obtaining "Folk" Knowledge of STIs and HIV—In general, respondents mentioned that at initiation of anal intercourse, they had limited information about HIV and other STIs. Interestingly, most respondents felt that they now "knew everything" about sex, HIV and STIs. Many of the young men interviewed reported having a lack of information about STIs and HIV when they first began to engage in anal intercourse. In some cases, this lack of information resulted in the perception that certain activities were "low risk". For example, Julio explains how when he first began to engage in anal sex, he didn't "protect himself" by using condoms because he was unaware of the risks associated with that activity.

> When I first did it [anal intercourse] I didn't do it with protection. But then I learned that that's the main risk that you could get a transmitted disease through there. And from there on I always protect myself…I thought it was like it could be low risk…I didn't know about the risk back then.

Having limited or incomplete information about how STIs and HIV are transmitted did not uniformly result in perceptions that certain activities were "low risk". In some cases, as demonstrated by Danny's experience, a lack of information resulted in the perception that certain activities that were not high risk, were high risk. Danny's first anal intercourse experience was unprotected, and he explains that he felt anxious after the experience because he thought that he could "make AIDS" from having UAI.

> But you know, what I did think the whole time [we had unprotected sex]…I thought that you could-- I thought that-- I got really scared after that because I thought that you could make AIDS. Just by not using a condom. I didn't know someone had to have it or HIV. I thought it could be made by not using a condom, I didn't know you have to catch it from someone that has it.

Respondents were asked to recount where and how they first learned about anal intercourse and to describe some of their early anal sex experiences. Many young men reported that they learned very little or nothing at all about anal intercourse while growing up, neither in school nor from their families. A few mentioned learning about it through friends. Tai explains that he remembers what was not talked about in sexual education classes when he was younger, *I remember what they didn't talk about [in sex ed]. They didn't talk about gay sex at all. They didn't talk about any other types of sexuality other than straight people. That's pretty much all I remember.*

Many young men mentioned that they first learned about anal sex during their sexual debut. In these cases, respondents often described painful and/or unpleasant first anal sex experiences. Guillermo, whose first anal sex experience was very painful, describes how he assumed anal sex was supposed to be painful because he did not have enough information about ways to make the experience pleasurable.

> I still wanted it [anal sex], but I assumed that's how it was suppose to feel…So I was informed but not completely yet. So I was not ready for that. So I didn't know it wasn't suppose to hurt that much. I didn't know he wasn't suppose to do certain things. I knew he was supposed to do things leading up to it, which he did some of, but not enough of to make my body ready for receiving him.

Guillermo's experience was not entirely unique. Several respondents talked about what they did not know about anal sex before initiating it. Examples ranged from not knowing about the mechanics of sex to not knowing how to avoid painful receptive sex. Indeed, these first experiences seemed to influence their future perceptions of anal sex, as many young men described painful anal receptive sex experiences and/or reported that at some point in their lives they believed that anal receptive sex was painful, and consequently did not expect a

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pleasurable experience. For some, their first experiences, such as Jonah's below, also relied on measures to alleviate pain that may inadvertently have increased their risk for HIV: *And even though I wanted it, it was just really painful…I didn't expect it to be that bad. And he wasn't particularly rough…and I don't think we had a lot of lube. I think we used lotion. It could've been just lotion burning.*

In some instances, respondents benefited from learning about anal sex from a more experienced or older sexual partner before engaging in it. For example, Lucas describes how he did not know anything about anal sex until age seventeen when he met his first boyfriend. In Lucas's case, his partner talked with him before they engaged in anal sex, and gave him important information about the mechanics of anal intercourse. However, similar to David, some of this information (e.g. douching) may also have inadvertently increased his risk for HIV.

> I learned from my first boyfriend that I had when I was 17. Before that, I didn't know. All I knew about was oral. And like just rubbing on each other and stuff. But I didn't know about that. It was kinda weird. And then it kinda disgusted me, but then they said you clean it out first. I was like "If you stick that in there, won't you defecate on somebody?" But they said you gotta douche like a female does so yeah…He told me that you clean it out and everything. He told me basically a lot of stuff, from oral to anal.

The internet was often mentioned as a resource for finding information on anal sex and gay men's health issues, as described by one respondent, *From online, it was probably how I learned of everything or guessed of everything or thought about everything.* Respondents usually described "googling" particular terms or issues they wanted to know about, rather than visiting a specific webpage. Some mentioned finding information related to STIs or HIV via websites, and others described going to chat rooms or similar sites where there may be links to gay health issues. Some reported that pornography on the internet was another valuable resource for information related to sexual behavior and health.

In some cases, pornography, whether straight or gay, provided them with instruction on the mechanics of anal intercourse and was the primary source of their sexual education in the absence of friends, parents or other sources. Interestingly, many young men reported that they first learned about anal sex through watching pornography either on videos, cable television or the internet. Pornography, for these respondents, provided a resource for sexual information that "no one ever showed or talked about". This was the case with Joaquin, who explained that viewing anal sex in a heterosexual pornographic video was one of his primary sources of sexual education information: *Don't forget porn cause it was very important! It was like "Oh my God, I didn't know you could do that!" That's where I first saw anal sex. Just like everything.* Joaquin's experience was similar to many of the young men interviewed who felt that pornography, in the absence of other sources of anal sex education like school or family, provided needed information.

For some, pornography was also a way to satisfy their natural curiosities about sex and begin to understand some of their own sexual urges. Eddie explains how both a close friend and pornography played a role in his own discovery of his sexual orientation.

> And so he [friend] made me realize what I was and who I am and I was always looking at porn, but I was looking more at gay porn than I did at straight porn! So you know, basically the person who helped me discover who I am and what I am truthfully is [Friend] and my curiosity [about anal sex] is through porn. [I: So is that how you first learned about anal sex?] Yes, through porn.

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Oral Sex—While respondents often reported that they thought they currently knew all there was to know about sex and related health issues, when discussing oral sex, respondents were somewhat unclear on how risky this particular activity was with regards to STI or HIV transmission. When asked to describe a scenario that included something that they perceived to be "low risk", most scenarios typically included an unprotected oral sex experience. Some mentioned that this was "lower risk" than anal sex, but most seemed to agree that having open sores, gingivitis or other oral lesion in the mouth would increase one's risk for an STI during oral sex. Many seemed sure that they would be able to identify signs of increased risk from their partners (e.g., sores, bleeding gums). This lack of clarity regarding the relative risk of oral sex may be partially explained by the sometimes conflicting messages respondents reported receiving from health professionals.

> Every time I get HIV tested, that practitioner or nurse, is always giving me a different story about what's risky for HIV contraction…And that's not only disheartening, but confusing. Just like how can you get the message out about how to be safe when I'm not sure what's safe and what's not. I had one person say, "Yeah, if you have gingivitis and you floss and your gums are bleeding…like licking a guy's ass or giving him head, you can totally give him HIV. Or he could give you HIV". And I had someone else go "That's absolute bull crap. There's no way in hell"…So I don't know what to even engage in or how to prevent these things.

Young men mentioned that using condoms during oral sex was not something that they typically thought about, and that the taste of condoms was a reason for not using in that scenario. One young man, who was unsure of the risk level attached to oral sex, mentioned that he assumed that there must be some risk attached to it, otherwise flavored condoms would not exist. Some young men mentioned that while condoms were typically thought of as almost routine when having anal sex, when engaging in oral sex, condoms were generally not used. Jamie reported: *I've never used a condom for oral sex. I think I would probably look at a guy like he was crazy if he asked me to use a condom for oral sex. It's just so low risk to me that it's not worth it.*

Oral sex was perceived as less personal than anal sex, with some respondents mentioning that given its less risky nature, it was acceptable to have oral sex with someone you did not know well. As Caspar explains, one needed to have a greater emotional attachment for anal sex: *Well, let me, I'll say of the anal part. I'm not gonna do that every night. But I will do oral with you or play around with you on one night, yes, I'm willing to do that.*

Condom Use & Anal Sex—In general, respondents reported using condoms the majority of the time when having anal sex. While condom use was sometimes referred to as routine and something that was taken for granted when having sex, there was a reported general preference for sex without a condom. Reasons for this preference included discomfort in wearing a condom, lessened sensation, decreased intimacy and an interruption in the sexual passion in order to put on a condom. Nonetheless, respondents, like Guillermo, reported that while condoms may interrupt the passion in a sexual encounter or create a barrier between sexual partners, the specter of HIV-transmission outweighed the benefits.

> Most of the time I'm usually like "You know what? I am not gonna get a disease because I didn't wanna stop and put on a condom". But it doesn't feel as much as intense as it… It's gratification if I'm having sex, but not at the risk of my life. So for the most part, I prefer not to - I prefer to use a condom than not use a condom.

Some respondents reported preferring unprotected anal intercourse with regular and, to a lesser extent, casual partners.

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> I'm just gonna be honest. I like without. Pretty much all my partners have been without…seeing since I haven't really just even had in mind to use one, like I haven't experimented with [condoms], I mean now, I would definitely use. I would find ones that are the closest thing to not I guess you can say. But I would definitely make that attempt and experiment that's a definite. Well, that's a definite hope. A definite hope that I would.

In addition, partner characteristics, which may further determine whether to use a condom, included having a partner who was in the pornography industry who was assumed to be tested regularly as part of the job, seeing a partner's HIV results (within an unspecified period of time) and "not caring enough" about their own or their partner's health.

Among respondents who expressed a general dislike for condoms, some preferred to have unprotected sex with a friend that they know well and could trust to not bring risk for HIV, such as a new or lesser known partner. Jonah reported that he typically prefers sex without a condom, in part due to their perceived association with STIs and HIV.

> Just condoms remind me of safe sex. Like the person I'm having sex with is risky. And I don't like feeling like that. So I would just rather know that the person I'm having sex with is not risky and not have to worry or think about it.

Explicit communication between partners about condom use did not always occur according to respondents. Some described situations where non-verbal cues were given to them about condom use. Others, like Silas below, described assuming that a condom would be used, stating that a discussion was not generally needed.

> We don't sit there and map out a game plan. We pretty much do what feels comfortable…If I can tell that they're not really pushing for it [using a condom] then yeah, that's when I'll be like "No, we're gonna do it this way". Most of the times when I've done it, it hasn't come up. It's just been a given.

Many of these scenarios of UAI were related to sex with newer or more casual partners. However, respondents often described the timing of deciding to not use a condom within more committed relationships in similar ways. One respondent described how at one point his boyfriend stopped his hand from reaching for the condom, and that after that instance, they permanently stopped using condoms within their relationship. HIV testing was often the arbiter of when to stop using condoms within a relationship and, in some cases, this decision regarding condom use was based more on a feeling or instinct about the relationship. Chad reported that this is something that "needs to be discussed" but is often not. He described how he and his ex-fiancé came to the decision that they were no longer going to use condoms:

> I know that when - my fiancé and I first started having sex, we did use condoms. And we used 'em for quite a while actually, and then it was after like two months, and we both just kind of went "OK, it's fine". Which we had no right in saying cause we didn't know if it was fine or not. But we just kind of like put it out there.

While communicating about whether or not to use a condom was often minimal or taken for granted, some respondents reported some confusion regarding whose responsibility it was to initiate a discussion about condom use, the bottom or the top. A few explained that anal sex was riskier for the bottom, and that this might influence whether a condom was used. Interestingly, some did not see it as a mutual responsibility, reporting that it was up to the "top" to use a condom, that it was his responsibility to put it on and take the precautions. Others reported that while it was riskier for the bottom to have unprotected sex, it was not their decision alone. For example, Lane reported that even if he was with a partner (a bottom) who requested that they not use a condom, if he, as the top, wanted to use a condom he would.

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> Well, I mean, since I'm on top it's kind of my responsibility to just do it, you know… Granted, I mean, I could probably just not, but I mean, they might not care, but I'm going to. I mean really, it's both people, both party's responsibility. But, the fact that, you know, I'm the one who needs to put on a condom. I'm the one that will make sure it happens.

Partner Characteristics—Consistent with professionals, young men discussed how partner characteristics, such as age and experience, influenced how they perceived risk and their ability to advocate to protect themselves and communicate their preferences. In some cases, respondents discussed having a sexual partner that was more experienced and on whom they relied to guide them through the sexual experience. This partner dynamic was sometimes considered more risky as young men expressed that they were not comfortable in asserting their own desires in these sexual situations. Some respondents reported feeling "too shy" to ask for a condom or express other sexual preferences during early sexual encounters with more experienced partners. In most cases, the characteristics of these types of relationships seemed to be considered more risky, often putting the less experienced (and typically younger) partner at risk, as described by Dwayne in the following:

> Well, not necessarily peer pressure but pressure from the other person tends to - if you're not strong and you're not secure within yourself, you tend to be a little bit more lenient and be a little bit more passive in terms of what you won't do or will do.

Similar to what others have described (Gold et al., 1999), partner characteristics were often based on assumptions respondents made about a partner's HIV status based on behavior or appearance such as appearing to be clean, being smart or holding a certain type of job. In these cases, respondents at times described asking a potential partner about his HIV status and feeling that because he was clean or appeared to be truthful, there was no reason for him to lie. These individuals maintained that they would be aware if someone was lying to them about their status. Not surprisingly, many respondents reported seeking sexual partners on internet sites. Some of these sites require an individual posting an ad to report his HIV status. While not common, some respondents reported using this information as a guide to determine a partner's status; more commonly respondents were wary of this information on potential partners and consequently reported using condoms when having anal sex with internet partners.

Some respondents reported making assumptions about someone's HIV status based on what they perceived to be their limited sexual experiences. They described younger partners who they believed to have little to no prior sexual experiences as well as partners who they believed were concealing their sexual identity and were not involved in the gay community as less risky than other potential partners. In these cases, respondents typically described not using a condom with such partners as low-risk, as Danny's highlights below.

> I got a good sense from him, from his personal experiences and his identity, that he was dealing with that he more than likely was STD free…well he doesn't want anyone to know that he is gay. He doesn't have a lot of gay friends. He doesn't really sleep around. So you just have to kind of take that and just kind of believe the person…it doesn't mean that he's not having it, but if he did have a lot of gay friends and he did want everyone to know he is gay, he is cute, and so he probably would have more sex.

In addition to making assumptions about a partner based on appearance, some made assumptions based on their behavior – specifically related to a sexual encounter. Alvaro, an HIV-positive young man, described an instance where he visited a bathhouse and had unprotected sex with several other men. When asked about their HIV status, he replied: *I'm assuming the guys that let me cum inside them, I'm guessing that they're already positive.*

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Because if I was negative, I wouldn't let anyone cum inside of me, especially a stranger that I don't know.

Risks Related to Trust and Knowing Partners—The use or non-use of a condom for individuals involved in a more committed relationship was an important factor. Some respondents offered that not using condoms created a greater sense of intimacy and closeness within the relationship. Or, in some cases, requesting that partners use a condom created a wedge of trust. In one case, a respondent described a scenario where, after breaking up with his fiancé, they got together again and had sex where the ex-fiancé asked him to use a condom. This was seen as "a hurtful, distant type of thing" after such a long period of time of being together without the use of condoms. Situations such as these signaled to the respondents that their partner was having sex with other people. Sex without condoms often seemed to imply a commitment or emotional bond as explained by Tai, *There has to be something more than like "I'm fucking you" if I'm gonna let someone have sex with me without a condom so there's obviously more of an emotional attachment.*

Respondents reported that knowing someone and having trust in them often played an integral role in determining if a condom was needed, yet some acknowledged they could not trust someone entirely and that their choices may put them at risk. One respondent defined high-risk sex as "*putting too much trust in someone to believe that what they say is truth in gold",* even while relating his instances of unprotected sex with someone he felt he knew well.

For the most part, respondents felt that knowing someone for a long time or the perception of knowing someone well affected their perception of the risk associated with having sex. However, definitions of knowing someone for "a long time" varied greatly. In some instances these "lower risk" encounters were unprotected. What respondents felt made them low-risk encounters was that they occurred with someone they knew intimately, like a close friend, a boyfriend or ex-boyfriend. For example, Danny met one of his partners online and had developed a close friendship with him, but had never met him in-person until a visiting this friend in New York City where they had unprotected sex. He explains that knowing him as a friend and trusting him for a period of time made him feel that not using a condom was still safe.

> We've just been talking and talking over all these years and finally we're like-- because we met on Live Journal and Myspace and we were like, you know what we are finally going to meet each other. He is in a relationship and we ended up having sex in New York. We were all staying together, so and I didn't use a condom and I kind of regret that but I do know that-- I don't, I mean of course I can't know 100% for sure, but I was very under the big impression that he was clean. Because he was in one relationship for like two years with this older guy, like this forty-year old guy. And he tells me a lot of stuff…embarrassing stuff like you know, my teeth are getting really yellow or something and my breath is getting bad, something like that. So I feel like he would tell me if he had something. You know, because he really cares about me a lot as a friend really. And so, he wouldn't.

Other cases of perceived low-risk unprotected anal intercourse occurred within more intimate and/or long-term relationships. These cases were perceived to be low risk due to amount of time and commitment as well as the extent to which they felt they knew and trusted each other. For example, Jamie reported having unprotected sex with an ex-boyfriend who had cheated on him in the past; in spite of this, Jamie reported still trusting that this partner would not put him at risk. *I mean no matter how much of an asshole I like to call him, he was a very decent person. He would not put me at risk if he knew that he had done something risky.*

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Risks Related to Not Knowing Partners/Multiple Partners—Many respondents equated high-risk sex with having multiple partners, particularly with partners they did not know well. For some respondents, this seemed to be the most common association with high-risk sex, the idea of "anonymous" sex, which was most often linked to having a large number of intimate partners. This is explained through Chad's description of making a "timeline" of his sexual history and realizing that he had a number of "random times of drunk ecstasy" which he had not previously included in his list of sexual partners. The realization of the long list of partners hit him hard, and he said that as a result he had "put himself on pause".

> Like yeah, looking back on it, it's almost repulsive. Is there a magic eraser or something that I can do? It's crazy. Especially the fact that I know how young I am, that means I was even younger when it was happening. All that knowledge… is now actually taking to understanding, it's more real. Even though I learned it back then.

Respondents related having multiple partners with increased odds for contracting HIV or other STIs. Again, the idea of "knowing someone" could imply a long history of friendship or acquaintance, and for others it was a short period of time. Many, like Silas, felt that at least getting to know someone a little bit would at minimize the risk. *Do you really wanna be going very far with someone that you just met? Someone that you at least have talked to and kind of tried to get a little bit of their background and what they've done in the past?*

HIV and STI Status and Testing—Respondents all spoke of testing as a way to assess their own and their partner's HIV status. However, while there was some general agreement on using an HIV test to assess risk, how testing is being used by respondents does not comply completely with what professionals recommend, in particular the six-month waiting period. For example, Julio described how he will not have anal sex with someone until he sees HIV test results.

> I need to see a paper, and because I'm being honest with them and I could prove to them that I had to take my test and I show them to them. They have to be honest with themselves and with me too, so they have to show me a paper that they took a test.

Julio described a scenario in which he asked his partner to be tested and once he saw the negative results, he felt comfortable enough to have anal sex. However, it was unclear whether he followed the timeline as suggested by the professional model, which would require negative HIV test results after a six-month period of monogamy.

Some respondents described getting tested with their partner as a kind of milestone in the relationship, sometimes as a precursor to engaging in a more committed relationship. Others described testing together as something that they would do at the beginning of a relationship, prior to engaging in any sexual activity. Again, respondents did not typically describe a specific "waiting period" that they followed with regards to testing and engaging in unprotected sex. For example, Lane related an experience in which he had unprotected sex first and then decided to get tested with his partner to make sure that they were both "safe". During the time between testing and receiving results, they continued to have unprotected sex, as he explains: *We got tested and had to wait for results, but kind of kept doing it anyway because really we already did. And let's just hope that our results are negative, and they were, so it was cool.*

Generally, respondents did not seem cognizant of the recommended time intervals between testing. For example, Fernando described an experience where, as part of a human sexuality class in college, he and a classmate got tested for HIV together. A few months later, he and that classmate began dating, and he described their first sexual experience, as low risk because they had tested together in the recent past, and he "knew he [his partner] was clean". Fernando reported that he started out using a condom that evening, but at some point "disillusioned" it.

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Some respondents' perceptions of risk changed after contracting an STI or having an HIV scare. These experiences caused a great deal of anxiety and often resulted in a change in either behavior or perceptions of risk. Respondents described how instances of contracting an STI caused them to reflect on their sexual behavior. After fearing that he had contracted HIV from an internet partner, Orlando cancelled his internet accounts and reported changing his sexual behavior. He said that after that experience, he felt that even kissing someone he did not know would be considered high-risk as he now considers risk from other STIs (e.g., herpes) that he had not previously thought about.

> It [HIV scare] really traumatized me. And after that, I didn't go out for like two months and I didn't drink. I was, I was like a good little boy. And now I kind of feel guilty for drinking and doing stuff like that, because I was praying a lot and saying, "I won't do it, like please". So I kind of feel guilty a little bit.

Reported Triggers to Unprotected Anal Intercourse—A respondent's emotional state was at times described as contributing to a high-risk situation, and some reported engaging in sex was a means to alleviate emotional stressors such as loneliness, boredom or anger. For example, one respondent reported that when he first moved to Los Angeles, he went on a "sexual escapade" that was triggered by being bored and lonely. He would go online to find sexual partners to fill up his time. Alvaro reported that after arguments with his partner, he sometimes had the urge to go to a bathhouse, which generated detached feelings after the experience:

> When I go down to bathhouses, it's more like "What did I do?" And then I just tend to forget about it, like if it was just a dream. It's weird cause when I go to a bathhouse, it's like it's a different world. A different dimension, a different world, a different planet…Everything's dark and it's like a dream. It's like it never really happened. And it just happened.

Similar to the professional model, respondents described substance use, most often alcohol, as something they commonly associated with high-risk sex. While a couple of respondents also described crystal meth as something that may put them at-risk, alcohol was more commonly described as making someone "not care" about themselves or their partner enough to remember to use a condom. Several respondents described scenarios where they knew they had sex with someone while drunk, but were unable to recall any details surrounding the event. David, a respondent who described condoms as part of his typical routine before having sex, *("You're like OK, gonna have sex, put a condom on.")*, reported that the only times where he has ever engaged in what he considered high-risk sex, he had been drinking. Here he describes an experience where he believed he contracted Chlamydia as a result of his forgetting to use a condom.

> It just felt so good because I could see how much I was pleasing him, it didn't matter. And I was drunk. I was completely impaired. I wasn't my normal self if you will. I was wasted. And that's where it becomes high-risk because you don't think. You're only thinking just to feel good.

While acknowledging that alcohol can potentially contribute to a high-risk situation, some reported using alcohol as a way to relax or help them enjoy sex more. Others reported that alcohol would help them to engage in something that they might not ordinarily do. This was often related to anal sex, with some respondents, such as Orlando, reporting that alcohol helped them to relax, reduce or alleviate physical discomfort or pain, and/or make the experience more enjoyable.

> I would prefer not to do it [anal sex]. Unless I'm kind of like a little bit buzzed because it, I don't know, I'm really sensitive, I guess, or I just, it kind of, it just hurts. And, so

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> I prefer not to do it. Like I prefer not to have it done, but I see it as kind of, that's like another level of sex.

DISCUSSION

Findings from this study highlight many similarities between folk and professional models of HIV risk for YMSM. What does differ between the two models is the level of detail and nuance that YMSM tend to have regarding HIV risk and prevention efforts, in particular concerning HIV testing and negotiated safety. It is also of interest to note that while participants in this study generally felt that they currently knew all there was to know regarding sex and sexuality, their initial learning regarding sex and sexual health was, by and large, very limited, with the majority relying on pornography and initial sexual experiences. This is particularly relevant given that chi-square analyses indicate that use of condoms at sexual debut is significantly related to more recent reported condom use, and the mean age of initiating anal sex was about 17 years old for the HYM sample, indicating that many are initiating sex in the relatively recent past.

These interviews made it evident that YMSM have limited sources of relevant information for their own sexual health. None of the respondents recalled their sexual education classes in school providing any information on anal sex. For many this resulted in being ill equipped to understand the mechanics of sex; uninformed about risks for HIV and STIs; and unable to advocate for what they might find pleasurable, let alone for safer sex during their sexual debut. This creates unique vulnerabilities for UAI during sexual initiation, which can lead to riskier sexual trajectories- e.g. increased number of partners, inconsistent condom use and STI infections (Shafi, Stovel, & Holmes, 2007).

What and how information is disseminated to YMSM is at times dictated by policies that stipulate how funding is allocated within HIV-prevention work. As a result, information that is regularly disseminated to YMSM may change from time to time, adding to the sense of inconsistent messages. For example, officially, service providers should encourage YMSM to use condoms for every sexual encounter (both oral and anal). However, service providers may introduce negotiated safety and endorse oral sex as a less risky sexual act to YMSM as harm-reduction techniques (Halkitis & Parsons, 2000), creating challenges in developing trusting relationships with service providers.

Many respondents reported utilizing testing as a means to determine their own and their partner's HIV status, and the majority (63%) of the HYM sample reported testing within the last year. While the use of HIV testing as a prevention method has been endorsed by service providers and policy makers, the participants in this study were not fully informed about the three to 6-month waiting period before antibodies are present for testing, during which time one is highly infectious. Understanding the nuances involved in HIV testing can be difficult, particularly for young men. Translating complex information to YMSM that is critical to safeguarding health should be of utmost importance to service providers.

There was similar confusion surrounding negotiated safety and the intimate relationships that young men form. During late adolescence and early adulthood (or "emerging adulthood"), young people begin to explore new roles and establish more intimate and sexual relationships with both male and female peers (Arnett, 2000). While the data presented here describe some of the experiences and perceptions of a specific population, they do not differ a great deal from experiences of the general adolescent population who typically seek close and intimate sexual relationships. However, there is a general lack of role models to serve as examples of same-sex relationships. The young men described here have an underlying desire to develop close and intimate relationships and, therefore, tend to idealize their current intimate partners, often

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reporting that they have "no reason to lie to me" or relying on instincts and feelings that they can fully trust a partner. Given their relatively young age, this is not surprising; and it will be important to understand if and how these YMSM may change their perceptions and beliefs over time.

Respondents often spoke of "knowing" and/or trusting a partner, but the period of time that this relationship was based on differed from a few weeks to several years. Indeed, the success of integrating negotiated safety into an intimate relationship is built on the idea of trust built over time between sexual partners. While respondents did not use the term of "negotiated safety" when describing their prevention efforts, their descriptions of forming relationships and engaging in UAI lend themselves to this model. In an effort to obtain a close and intimate relationship, some respondents reported engaging in UAI based on an instinct or feeling about that partner. Information about building and maintaining a healthy intimate relationship is generally lacking for YMSM, but should be integrated into intervention work with YMSM.

There are several limitations to this study. The frequency of engaging in UAI and individual perceptions are all based on self-reported data. However, we believe that the use of ACASI in the quantitative survey minimizes any potential bias. While preliminary bivariate analyses indicate a relationship between condom non-use at sexual initiation and more recent sexual behavior, these findings are cross-sectional in nature. Future analyses will examine this relationship longitudinally as well as in a multivariate model. In addition, the developmental trajectories of these YMSM should also be explored to understand how their perceptions may change over time. Future studies should explore how high-risk sex is perceived by other sexual minority youth, particularly those with limited connections to gay communities. Because this study's recruitment efforts were conducted at gay-identified venues, this study's sample may have a greater-than-average connection to gay communities. Most research with YMSM includes respondents recruited from venues, and little is known about those who do not have access to or choose not to access these venues. Therefore research focusing on youth with less connection to gay communities may reveal different perceptions or behaviors.

Our findings suggest that YMSM who have limited exposure to sexual and health education are uniquely vulnerable to HIV and other risks when initiating sex, and that this vulnerability continues if they are misinformed or confused about HIV testing and strategies for building trust and intimacy in relationships. These findings carry significant implications for HIV counselors and other professionals in working with YMSM. Early education around the mechanics of anal sex and negotiation of safer sex for same-sex sexual partners is critical to minimize high-risk sexual activities. Likewise, to safeguard one's physical and sexual health, an understanding of how testing can most effectively be incorporated into prevention strategies should be consistently and successfully communicated to YMSM. Finally, these results indicate that YMSM continue to engage in risky behaviors, in part due to their desire to develop a trusting and intimate relationship with their partners. Counselors and other service providers should ensure that YMSM are provided information on developing healthy relationships to guide them in this process.

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Table 1

Description of the Study Sample from Wave 2 Survey (N=499)

Variables	Categories	Total Sample n (%)	Qualitative Respondents n (%)
Age	18 – 19 yrs	143 (29)	7 (30)
	20 – 21 yrs	186 (37)	10 (44)
	22+ yrs	170 (34)	6 (26)
Race/ethnicity	African- American	115 (23)	8 (35)
	Caucasian	188 (38)	8 (35)
	Mexican descent	196 (39)	7 (30)
Residence	Family	255 (51)	11 (48)
	Own place/apartment	199 (40)	8 (35)
	With friends/partner	35 (7)	4 (17)
	No regular place/other	10 (2)	--
Employment	In school	78 (16)	5 (22)
	In school, employed	146 (29)	9 (39)
	Employed, not in school	227 (46)	7 (30)
	Not employed, not in school	48 (10)	2 (9)
Sexual identity	Gay	384 (77)	18 (78)
	Other same-sex identity	27 (5)	3 (13)
	Bisexual	76 (15)	2 (9)
	Straight	5 (1)	--
	DK/RF	7 (1)	--
Sexual attraction	Males only	363 (73)	16 (70)
	Males and females	126 (25)	7 (30)
	Females only	4 (1)	--
	Neither/don't know	6 (1)	--
HIV Serostatus	Positive	17 (3)	2 (9)
	Negative	412 (83)	18 (78)
	Don't know	69 (14)	3 (13)
STI (since last interview)	Yes	58 (12)	7 (30)
	No	441 (88)	16 (70)
HIV Testing Status [a]	Never tested	83 (18)	4 (19)
	Tested ≥ 1 year ago	92 (20)	3 (13)
	Tested 6 mos – 1 year ago	109 (23)	3 (13)
	Tested ≤ 6 months ago	188 (40)	11 (52)
Sex exchange (ever)		70 (14)	5 (22)

[a]Only those reporting any lifetime sexual activity are included in this analysis. Other missing respondents include those who could not remember the date of their last HIV test.

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Table 2

General Sexual Behavior of HYM Respondents

Sex Act	Age of initiation Mean (SD)	W/out condom at initiation[a] n (%)	W/out condom past 3 months n (%)
Oral Sex	15.2 (SD=3.04)	396 (87)	410 (82)
Received*	15.5 (SD=2.92)	396 (80)	391 (78)
Gave*	15.5 (SD=3.12)	432 (87)	373 (75)
Anal Sex*	16.9 (SD=2.33)	128 (28)	219 (44)
Insertive*	17.2 (SD=2.22)	123 (25)	182 (37)
Receptive**	17.2 (SD=2.35)	130 (26)	162 (33)

[a]Without condom at initiation for general anal and oral sex, excludes respondents who initiated general anal/oral sex at the same age but had different responses condom use

*$p < .01$

**$p < .001$